Briefing for: **Members of the Stroke Prevention Scrutiny Review Panel**

Meeting Date: **October 2008**

Title: Summary of relevant Action points and Quality Markers from the National Stroke Strategy

<u>Ten point action plan</u>

1 Awareness: what action is your local area taking to improve public and professional awareness of stroke symptoms?

2 Preventing Stroke

How effectively is your area supporting healthier lifestyles and taking action to tackle vascular risk, for example hypertension, arterial fibrillation and high cholesterol.

4 Acting on the warnings

TIAs are a clear warning sign that a further stroke may occur and the time window for action is very short, in about half the cases this is a matter of days. Has your local area put in place a system that responds quickly to people who have had a TIA (meaning within 24hrs for the group most at risk of stroke)?

7 Rehabilitation and community support

Intensive rehabilitation immediately after stroke, operating across the seven-day week, can limit disability and improve recovery. Specialised rehabilitation needs to continue across the transition to home or care home, ensuring that health, social care and voluntary services together provide the long-term support people need, as well as access to advocacy, care navigation, practical and peer support. Is commissioning and planning integrated across the whole care pathway in your area?

9 Workforce

People with stroke need to be treated by a skilled and competent workforce. Resources to assist services in planning their workforce requirements are signposted in this strategy. Has your local area undertaken a local needs assessment and developed a workforce action plan?

Quality Markers

QM1. Awareness raising

Marker of a quality service

- Members of the public and health and care staff are able to recognise and identify the main symptoms of stroke and know it needs to be treated as an emergency.

Rationale

We know that a fast response to stroke reduces the risk of death and disability (see Chapter 2). However, this cannot be delivered without recognition of the symptoms of stroke and without responsive systems. To initiate an emergency response to a suspected stroke, it is crucial that staff who have contact with the public (including GP receptionists, NHS Direct call handlers, ambulance control call handlers, hospital triage staff, social care staff and allied health professionals) are able to recognise the symptoms of stroke or TIA, even when they cannot see the individual, and that they all share a common understanding of the importance of dealing with stroke as rapidly as possible.

Commissioners have a role to play in raising both public and professional awareness of stroke, and in doing so to ensure that people receive the right care. Part of building a good stroke service means including stroke awareness as part of staff training (see Chapter 4). Initially the focus may be on frontline staff. Many voluntary organisations already support this process at a local level, providing information, such as leaflets advising on stroke prevention, and support for those who have had a stroke and their carers.

Action needed

- Review local training plans for key frontline staff to ensure that training includes the use of the FAST test to recognise stroke symptoms (see Chapter 2 for importance of FAST response).
- Establish local initiatives to support the national programme

Measuring success

- Greater proportion of individuals who seek medical attention within two hours of stroke symptom onset
- Greater proportion of individuals with a suspected acute stroke seen within the recommended time window (currently three hours)
- Greater proportion of individuals with a suspected stroke receiving Category A, or at least Category B, response from ambulance crews[16]

QM2. Managing risk

Markers of a quality service

- Those at risk of stroke and those who have had a stroke are assessed for and given information about risk factors and lifestyle management issues (exercise, smoking, diet, weight and alcohol), and are advised and supported in possible strategies to modify their lifestyle and risk factors.

- Risk factors, including hypertension, obesity, high cholesterol, atrial fibrillation (irregular heartbeats) and diabetes, are managed according to clinical guidelines, and appropriate action is taken to reduce overall vascular risk.

Rationale

Promoting healthy living is very important in helping to prevent stroke, particularly in disadvantaged areas and groups. Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke. It is estimated that 20,000 strokes a year could be avoided through preventive work on high blood pressure, irregular heartbeats, smoking cessation, and wider statin use. Preventing strokes can not only reduce the associated suffering, morbidity and mortality caused by strokes; it may also lead to NHS savings, as each stroke costs approximately £15,000 to treat over five years.

For those who have already had a stroke or TIA, prevention advice is even more important. This means assessing individuals for their risk factors and giving them information about possible strategies to modify their lifestyle that can reduce their risk. GPs need to actively manage these conditions in line with national guidelines (see Annex B: ‘Key resources’).

We know that some groups (e.g. people from black and minority ethnic communities and the economically disadvantaged) are at greater risk, and for example South Asian people are less likely to have hypertension managed.[19] This means that targeting prevention work at those groups has the potential to lead to significant results. However, more innovative ways of working may be needed to ensure that the message is received by those who need it. That may mean taking services closer to the community and greater voluntary sector involvement in service planning and provision at all levels. Targeted prevention schemes can be very effective. For example, a Stroke Association health promotion scheme in Hull provides intensive follow-up and support to help individuals make necessary changes to their lifestyle, thus reducing the risk of stroke or recurrent stroke. The scheme has had a proven positive effect in terms of an increase in stroke prevention knowledge, and changes in attitude and behaviour.[20]

Primary care services are at the forefront of activity to encourage people to change their lifestyle in order to reduce the risk of ill-health, including stroke, as GPs manage risk factors according to national guidelines.[21] It is important that all primary care professionals (e.g. GPs, nurses and allied health professionals) update and maintain their knowledge of these guidelines and implement them in their practice, specifically targeting higher-risk groups. The Quality and Outcomes Framework (part of the GPs' contract) includes a number of quality indicators relating to measurement of risk associated with vascular disease, for example a section devoted to recording diagnosis and ongoing management of high blood pressure. This has already had a positive impact on management of hypertension in primary care. Social care services also work in partnership with primary care and the voluntary sector to deliver healthy living support, for example by using day services and other commissioned services.

Commissioning framework for health and well-being set out ways in which practice-based commissioners can use NHS money flexibly on non-health interventions to improve health and well-being outcomes.[22] This could include exercise classes, or weight management programmes. Further details about these flexibilities will be set out in the practice-based commissioning clarifying guidance, which will be published alongside the 2008/09 NHS operating framework.

Adult social care workers, along with staff in the voluntary sector, can be key providers of generic healthy living information, specific information on stroke, and delivery of services for those who have had a stroke and their carers. A partnership approach across services is likely to deliver the best results. For example, social services and the NHS are already working together to develop 'information prescriptions' providing a structure around information provision, and in the provision of equipment and minor adaptations.

ASSET 2 and *Improving Stroke Services: a guide for commissioners* can assist commissioners when they are assessing how best to organise multidisciplinary services. ASSET shows how many lives could be saved through improved prevention measures.[23]

Action needed

Commissioners and providers use ASSET to establish a baseline and to ensure that there are systems in place locally for the following key prevention measures:

- – managing hypertension so systolic blood pressure is below 140 mmHg;
- – warfarin for individuals with atrial fibrillation;
- – statin therapy for all people with more than 20 per cent risk of cardiovascular disease within ten years; and
- – smoking cessation for all individuals who have had a stroke or TIA.

Review information and advice strategies to ensure that clear, consistent, culturally sensitive messages are being given to those who have had a stroke, their families and those at high risk.

Ensure that stroke features in local needs assessment activities (see Chapter 5 in relation to Joint Strategic Needs Assessments).

Directors of Public Health support the prevention message, particularly in disadvantaged areas and groups, and incorporate stroke into existing healthy lifestyle or information programmes. Where appropriate, links could be made to the forthcoming cross-government strategy for tackling obesity.

As part of the Quality and Outcomes Framework, participating GPs produce a register of patients who have had a stroke or TIA, which forms the basis of a suite of indicators to provide quality of care. GPs should maintain the stroke register in line with the business rules and guidance that support the Quality and Outcomes Framework.

Measuring success

- Greater proportion of individuals who have a history of stroke or cardiovascular disease, or who are at a high risk, who have had advice and/or are receiving treatment

QM3. Information, advice and support

Marker of a quality service

- People who have had a stroke, and their relatives and carers, have access to practical advice, emotional support, advocacy and information throughout the care pathway and lifelong.

Rationale

Individuals who have had a stroke, and their relatives and carers, want to be kept informed, be included and have a clear, consistent point of contact throughout the care pathway, for as long as they live with the effects of stroke, which for many people will be life-long. Stroke can affect all aspects of life and may require considerable changes in daily activity. People who have experienced stroke and their carers benefit from consistent support in accessing information about their condition, and knowing how to access a full range of services from the NHS, social care and others. They also ask for more support in navigating the health and social care systems. This is important whether people are returning to their own home or going into a care home.

Service providers often work closely with voluntary sector organisations, which have traditionally undertaken this information and navigation role in some areas. This may take the form of a support worker, who can provide practical advice, information, signposting, advocacy and emotional support on a short- or long-term basis both to individuals who have had a stroke and to their carers. A national helpline and website with a variety of information and support are available to individuals and their carers from the Stroke Association.[24] Another example is the Brain and Spine Foundation Information Access Toolkit for professionals and individuals and their families to access information.[25]

The information needs of people who have had a stroke and their carers are diverse and change over time. Quality information and education, provided at the right time and in an accessible format, can improve opportunities for choice and levels of independence.[26] It can also enhance morale, confidence and well-being.

Good information needs to be tailored to individual requirements, sensitive to cultural needs, and flexible enough to meet the different requirements of different people. A significant proportion of people have aphasia as a result of stroke, which means they find it difficult to speak, read, write or understand what people are saying, especially if they are rushed or under pressure. It is important to provide information in a variety of ways, for example by supporting verbal information with written information or diagrammatic material. Good examples of accessible information include Connect's *Stroke Talk* and *The Stroke and Aphasia Handbook*.[27]

This is an important area for local authorities, health services and the voluntary sector to work on together, and they should consult people who have had a stroke and their carers on the relevance, suitability and completeness of materials to meet their individual needs.

Action needed

- Commissioners ensure that people who have had a stroke, and their families and carers, are informed and empowered to take control of their care and support, by:
  - – reviewing current information, advice and support;
  - – involving voluntary sector organisations;
  - – ensuring that service is in place to support people – providing information, advice and practical support;
  - – including information to signpost people back into services if their needs change; and
  - – ensuring that messages are consistent across health and social care services.

Measuring success

- Systems in place to provide prompt, sensitive information in a variety of formats accessible to all those who have experienced a stroke, and their carers, with clear routes to accessing information life-long, where needed
- Survey to determine if advice and support matches individual needs

QM4. Involving individuals in developing services

Marker of a quality service

- People who have had a stroke and their carers are meaningfully involved in the planning, development, delivery and monitoring of services. People are regularly informed about how their views have influenced services.

Rationale

The Government's 2005 White Paper on health and social care, *Our health, our care, our say*, and the *Commissioning framework for health and well-being* emphasised the need for people's voices to be heard at a local level where spending decisions are taken, and it will be important to include those who have had a stroke in these discussions.

Involving people who have had a stroke and their carers in the development of services at the outset can help drive improvement and tackle problems.[28] For example, consulting people with stroke and their carers on the relevance, suitability and completeness of services and resources to meet their individual needs will improve the quality of information that services provide. Regular audits involving people with stroke and their carers, including people with communication and cognitive difficulties, should improve the effectiveness of information provision. Voluntary sector organisations can be effective in supporting this.

Some people may have specific support needs (e.g. those with aphasia, or hard-toreach groups such as people who do not have English as their first language) which need to be met to enable them to be involved in service development. Commissioners should take into account the needs of all the community in their planning.

This includes conducting an Equality Impact Assessment identifying how the different needs of their communities will be met in implementing changes. Strategic health authorities have a role in performance managing primary care trusts on their production of the Equality Impact Assessment and can check whether services are developing in line with any actions identified.

Action needed

- Establish a mechanism for regular consultation and involvement of those who have had a stroke and their carers.
- Ensure that this facilitates the involvement of all groups who are affected by stroke.

Measuring success

- Regular opportunities for people who have experienced stroke and their carers to have an effective voice in the development, delivery, quality and further assessment of stroke services.

QM5. Assessment – referral to specialist

Markers of a quality service

- Immediate referral for appropriately urgent specialist assessment and investigation is considered in all patients presenting with a recent TIA or minor stroke

- A system which identifies as urgent those with early risk of potentially preventable full stroke – to be assessed within 24 hours in high-risk cases; all other cases are assessed within seven days

- Provision to enable brain imaging within 24 hours and carotid intervention, echocardiography and ECG within 48 hours where clinically indicated.

Rationale

Judging the likely early risk of a recurrent stroke will determine the response to a TIA or minor stroke. This will represent a challenging step change in the handling of TIA and minor stroke cases. The evidence for treating TIA has developed significantly in the past few years: the time in which there is a significant risk of having a major stroke is now acknowledged as much shorter, which means the response needs to be urgent. For those individuals attending primary care, advice needs to be given about taking aspirin and avoiding driving following a suspected TIA, in addition to rapid referral to emergency care.

All patients with minor stroke and all higher-risk patients with TIA and minor stroke (e.g. ABCD2 score >_4 – see Glossary) need to be assessed by a specialist and treated within 24 hours. Patients assessed as an emergency in the community should be taken by ambulance to an appropriate acute stroke service if their symptoms have not resolved, or if they are otherwise considered to be at high risk of stroke. Patients who attend emergency departments, out-of-hours treatment centres or similar providers soon after a TIA or minor stroke must be treated and must not be sent home and simply told to see their GP in due course.

An urgent assessment service provided by secondary care that allows same-day access for high-risk cases may best be achieved by allowing open-access for GPs, emergency department staff, paramedics and other providers. Appointment-based systems may introduce administrative delays.

Those at highest risk may justify immediate hospital admission. High-risk patients who are not felt to require immediate hospital admission have better outcomes if they are assessed, investigated and treated no later than 24 hours after referral (including cases presenting on weekends or public holidays). Treating TIA and minor stroke in this way will not only save lives, but can represent savings in the long term, because of fewer acute strokes and heart attacks. The ambition is for a twenty-four hour, seven day a week service to be available.

Lower risk patients with TIA or minor stroke are best investigated within seven days of the event.[35] Non-urgent referral for TIA or minor stroke is appropriate only for very low-risk patients, such as those presenting with events that occurred several weeks or months previously.

Imaging

High-quality imaging of the brain and blood vessels is a key part of a successful stroke service. Currently, computed tomography (CT) scans are sufficient to determine whether a stroke is due to a clot or a bleed, but the higher spatial resolution of magnetic resonance imaging (MRI) is better for determining whether the diagnosis for TIA is correct and how large any infarction may be. Both MRI and CT imaging will continue to have a role in the immediate term, but it is inevitable that advances will be made and therefore imaging for both stroke and TIA needs to be kept under review. It is a rapidly changing field and any definitive answer will soon be out of date. The Department of Health (DH) will be developing a stroke and TIA imaging guide to assist local decision-makers and to give further opportunity for the options to be discussed.

About 80 per cent of TIAs and minor strokes require scanning of the arteries around the throat, which provide blood supply to the brain. ‘Carotid imaging’ (Doppler ultrasound, magnetic resonance angiogram (MRA) or a computed tomography angiogram (CTA)[36]) should ideally be performed at initial assessment and should not be delayed for more than 24 hours after first clinical assessment in TIA or minor stroke patients at higher risk of stroke (e.g. ABCD2 score >_4) or in patients with non-cardioembolic carotid-territory minor stroke. DH recognises that this is an ambitious vision and is in discussion with the relevant professional colleges and societies on ways to translate it into reality.

MRI, including diffusion-weighted imaging (DWI), gradient echo imaging (GRE) and MRA, is the most useful imaging for TIA and minor stroke. Rapid (i.e. with 24 hours of referral) MRI needs to be performed in all patients seen acutely after a TIA or minor stroke in whom there is uncertainty about the diagnosis, vascular territory or underlying cause.

In those patients with a clinical need, echocardiography and 24-hour electrocardiogram (ECG) should be performed within 48 hours of initial assessment and the results acted upon immediately in cases where anticoagulation is required.

These markers are supported by quality requirements 2 and 3 of the *National Service Framework for Long-term Conditions*: ‘early recognition, prompt diagnosis and treatment’ and ‘emergency and acute management’.

Action needed

- Local referral protocols should be agreed between primary and secondary care to facilitate the timely assessment of people who have had a TIA or minor stroke.
- Review access to brain imaging.
- Estimate the likely impact on demand for brain imaging.

Measuring success

- Greater proportion of people who have had a TIA or minor stroke who have received a specialist assessment and brain scan within 24/48 hours or seven days, according to risk
- Reduced average time to carotid imaging
- Lower proportion of patients having a major stroke prior to investigation
- Greater proportion of people started on aspirin immediately

QM6. Treatment

Marker of a quality service

- All patients with TIA or minor stroke are followed up one month after the event, either in primary or secondary care.

Rationale

All patients with suspected TIA or minor stroke who are not already taking regular aspirin should be given 300mg aspirin immediately, or other agents as further evidence emerges.[37]

Carotid intervention for recently symptomatic severe carotid stenosis should be regarded as an emergency procedure in patients who are neurologically stable, and should ideally be performed within 48 hours of a TIA or minor stroke.

Investing in services to diagnose TIA and minor stroke and manage subsequent risk of stroke will result in savings to acute care costs, as more strokes will be prevented.

People who have had a stroke or TIA also need information and advice, particularly on smoking cessation, diet, exercise, alcohol, driving and what to do in the event of a recurrent TIA or stroke. Action may also be needed to manage other risk factors such as diabetes, hypertension, hyperlipidaemia or ischaemic heart disease. Individuals can be encouraged to take responsibility for monitoring and treating their own vascular risk factors by provision of personalised risk factor profiles, individualised targets and record sheets for ongoing monitoring of risk factors.

A follow-up one month after the event, either in primary or secondary care, means that medication and other risk factor modification can be assessed, and screening for cognitive or other subtle neurological impairments should be performed. Any neurological deterioration or recurrence should trigger further investigation.

These markers are supported by quality requirements 2 and 3 of the *National Service Framework for Long-term Conditions*: ‘early recognition, prompt diagnosis and treatment’ and ‘emergency and acute management’.

Action needed

- Establish a clear pathway for managing TIA and minor stroke cases – high-risk and others.
- Establish a pathway for urgent carotid intervention.

Measuring success

- Greater proportion of people who have had a TIA or minor stroke who have received treatment within 24/48 hours.
- Greater proportion of people who receive a carotid intervention within 24/48 hours, according to risk.
- Smaller proportion of people having a major stroke prior to treatment.

QM16. Return to work

Marker of a quality service

- People who have had a stroke and their carers are enabled to participate in paid, supported and voluntary employment.

Rationale

Studies show that work is good for physical and mental health.[67] The inter-relationship between health, work and well-being was recognised by the *Commissioning Framework for Well-being.*[68] The workplace allows people both economic benefits and valuable social relationships. Many workplaces could offer simple, reasonable adjustments to enable people who have had a stroke to return to work, and are required to do so under the Disability and Discrimination Act 1995.

The workplace is also one of the best forms of rehabilitation.[69] Many people who have had a stroke will not be ready to return to work in the short term, but may be able to do so in the longer term and so can benefit from arrangements to give access to rehabilitation and support for return to work weeks, months or years post-stroke, as appropriate for the individual. There is evidence that this can be achieved by offering vocational rehabilitation to people after a stroke, and this may need to begin when they are in hospital.[70] It will also include access to government schemes for return to work. Volunteering can also provide both a means of trialling return to work and a satisfying alternative to paid employment for some people. Connect provides guidance about volunteering both for people with stroke and for voluntary organisations who want to involve volunteers with stroke and aphasia.[71]

Carers may also need support either to return or continue to work. In April 2003, the Government introduced a new right for parents of children up to age six and disabled children up to 18 to request flexible working and put a duty on the employer to consider their request seriously. The Work and Families Act extends the right to carers of adults from April 2007.

It may also be important to offer support for employers and voluntary organisations in adapting working conditions, especially for people with physical, communication and cognitive difficulties. This may include offering guidance on how to educate co-workers about the condition and what it means in practice for the individual's role in an organisation. Alternatively, support may be needed to facilitate, for example, reduced hours, and part-time working initially.

This marker is supported by quality requirement 6 of the *National Service Framework for Long-term Conditions*: 'vocational rehabilitation'.

Action needed

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- Ensure support is offered to both individuals and their carers to enable them to return to work or to other opportunities such as volunteering.
- Establish partnership with Pathways to Work locally.

Measuring success

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- Greater proportion of individuals and carers who return to paid work
- Greater proportion of individuals and carers volunteering

QM20. Research and audit

Marker of a quality service

- All trusts participate in quality research and audit, and make evidence for practice available.

Rationale

Provision of evidence-based services and participation in the development of research evidence for practice are key tenets of high-quality stroke service provision. The Stroke Research Network aims to facilitate stroke research by bringing about focused, effective investment to enhance NHS research infrastructure for stroke, and to increase collaborative working between academics, stroke clinicians, stroke service users and research funders. Local development of a co-ordinated infrastructure, including a workforce with the capacity and capability to participate is key.

The RCP National Sentinel Audit of the organisation of stroke care and its clinical audit has been carried out in two-yearly cycles since 1998. This enables providers to benchmark the quality of their services and assess progress on delivery of national guidelines and standards.

Action needed

- Strategic health authorities, providers and commissioners of services may need to:
    – ensure participation in high quality research, and audit.
    – consider roles, and ensure relevant research focuses on professional development.
    – ensure access to training for staff wishing to participate.
    – ensure user/carer involvement in setting priorities for participation in research.

Measuring success

- Development of links with local research networks for stroke
- Greater proportion of staff participating in UK Clinical Research Network, Stroke Research Network and local research network research training
- Greater proportion of staff with undergraduate, and/or postgraduate education and training in research
- Greater proportion of staff completing good clinical practice (GCP) training (in research)
- Greater proportion of patients recruited into trials, and other well-designed studies adopted by the Stroke Research Network

- Review knowledge of evidence for practice of staff
- Evidence of patient and public involvement mechanisms
- All trusts participating in the RCP Sentinel Audit

Source: National Stroke Strategy