Stroke Group Network Conference

Monday 10 – Tuesday 11 October 2022

Rebuilding lives after stroke

Stroke Association

Housekeeping

The Stroke Care Pathway

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Stroke Association

stroke.org.uk

What is the Stroke Care Pathway?

Pre-hospital stroke care

Hyper-acute stroke care

Discharged Home

Acute stroke care

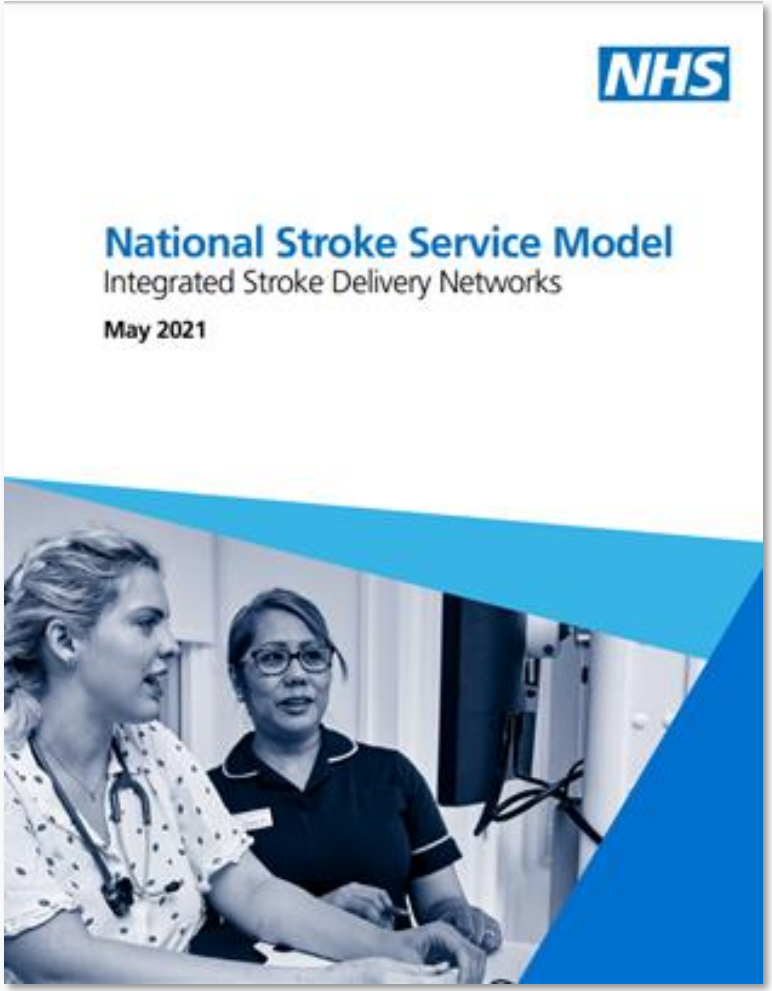
Rehabilitation

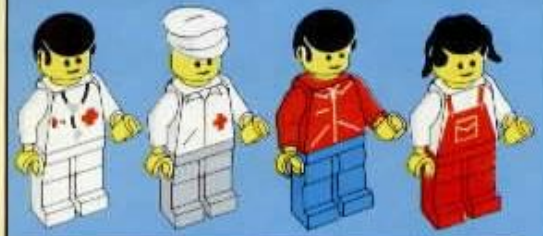
Life after Stroke Support

National Stroke Service Model

Outlines **best practice** stroke care for the NHS

Optimal pathway for **joined-up stroke care** throughout the patients journey





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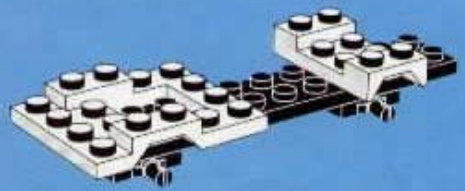

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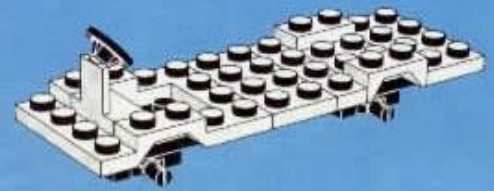

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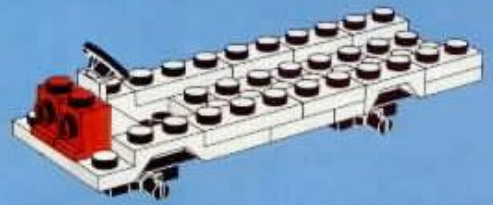

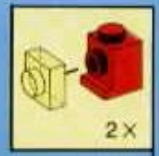

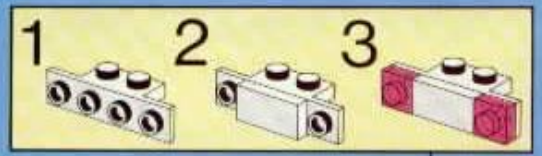

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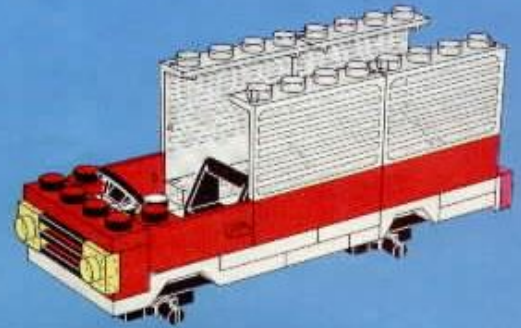


Instruction Manual for Stroke Care and Treatment

Part 2: ISDN Pathway Specification

Introduction

This part outlines what we understand to be best practice for the NHS in caring for adult (over 16 years of age) stroke patients, reflecting a recently commissioned evidence review from King's College London and examples of excellence witnessed by the GIRFT stroke programme. It presents clear ambitions for every area of the country to develop and implement as part of its strategic delivery of the NHS Long Term Plan.

Many ISDNs will already be achieving much of the network specification below. This specification defines the optimal pathway for a new era of joined-up stroke care enabled by technology and supporting the delivery of personalised care throughout every patient journey. It highlights the importance of pre-hospital, post-acute and longer-term care, as well as the need for urgent care pathways to increase access to thrombolysis and thrombectomy.

Following extensive consultation with stroke survivors and stroke specialis… propose renaming the stroke units to:

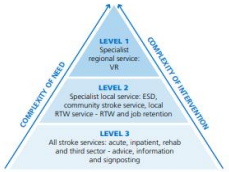
- comprehensive stroke centre (CSC) – hyper-acute, acute and inpatient rehabilitation including thrombectomy and neurosurgery
- acute stroke centre (ASC) – hyper-acute, acute and inpatient rehabilita… excluding thrombectomy and neurosurgery
- stroke recovery unit (SRU) – acute and inpatient rehabilitation only.

1: Prevention

Stroke prevention is achieved primarily in the community: targeting both the… risk general population (primary prevention) including those specifically at h… risk through social inequalities, and those discharged following a stroke or t… ischaemic attack (TIA) (secondary prevention). It is however the responsibility… ISDN and all healthcare practitioners involved in stroke care to ensure that s… prevention is considered, risk factors screened for and patients offered inter… every opportunity and with regular follow-up.

There should be a focus on communication with patients, their relatives or c… and others involved in their care, to ensure patient ownership of decisions r… them. Patients' differing health beliefs and needs should be clearly acknowle… with particular attention paid to seldom heard groups and those with comm… difficulties. Patient understanding of, and adherence to, prevention should b… responsibility.

Figure 3: Model for stroke vocational rehabilitation. The model pathway is dynamic, with the stroke survivor able to move non-linearly between its levels, depending on their changing needs and circumstances. Services must be sufficiently flexible to be able to respond to increasing/decreasing levels of need in a timely and responsive way.



ceptance and exclusion criteria and thresholds

el 3 (Advice and sign-posting on return to work)
stroke survivors, regardless of age, should be offered appropriate, advice, signposting referral for more support to return to work.

el 2 (Return to work service)
ke survivors who have a job to return to and want/need support to do so; or require ice on alternative options (ie redeployment, medical retirement, etc). A return to k plan should be implemented within six months.

el 1 (Specialist vocational rehabilitation)
stroke survivor with a disability that prevents their return to work and/or for om the return to work plan will take longer than six months to implement (eg they currently unable to fulfil their present position; need additional support/advice on oing for suitable alternative employment; were not in work before their stroke and d additional support to find work; employer is not supportive of return to work s; work environment cannot be adapted, etc).

Intra-hospital transfers:

- Intra-hospital transfer for thrombectomy should be treated at least as a category 2 call or time-critical transfer where a new ambulance is needed, via standing arrangement with ambulance providers.
- Systems should develop pathways, including pre-notification of arrival, such that urgent stroke imaging, interpretation and transfer decisions can be completed in a sufficient timescale, ideally within 20 minutes of arrival to make it possible for the initial ambulance team to be the one to transfer viable thrombectomy patients onward from an ASC to a CSC.

3: Hyper-acute stroke care

Hyper-acute care typically covers the first 72 hours after admission. Every patient with acute stroke should gain rapid access to a stroke unit (<4 hours) and receive an early multidisciplinary assessment.

Hyper-acute stroke services provide expert specialist clinical assessment and rapid multi-modal brain imaging, and the ability to deliver intravenous thrombolysis 24/7 transfer or treatment for thrombectomy. These services must be delivered in an ASC or CSC that provides hyper-acute and acute care 24/7, and each centre must care for a volume of patients that makes the service clinically sustainable, maintains workforce expertise and ensures good clinical outcomes.

As part of the National Medical Director's Clinically-led Review of NHS Access Standards, critical time standards are being developed in partnership with expert clinicians and patient groups, which will set out a package of tests and interventions expected to be delivered within a given time period for patients presenting at EDs with suspected stroke, against which services will be measured. Services should also implement pathways which seek to meet these standards, if they are different to those set out above

Neurovascular imaging

Neurovascular imaging of the brain and vessels supplying it underpins the diagnosis and management decisions for the modern treatment of stroke. ISDNs should ensure that there is a networked agreement to the pivotal role of rapid imaging using the most appropriate modality; and that this aligns with up-to-date evidence and national guidance. This will ensure effective use of limited imaging resources while enabling stroke teams to deliver cost-efficient, time-dependent interventions to reduce disability and/or extended hospital admissions. The use of artificial intelligence (AI) in stroke care should be encouraged and deployed in line with its certified and pre-specified use or within a research environment. Image sharing between centres within and external to each ISDN should be optimised to provide timely patient-centred decisions and to align with the ICS imaging networks.

support aid
- assessment or treatment by all appropriate specialist therapists (physiotherapist, occupational therapist, speech and language therapist) within 24 hours of admission, and others (eg dietitian, orthoptist) within 72 hours
- protocols for the promotion of bladder and bowel continence, including a policy to avoid use of urinary catheters and a policy for prevention of pressure sores
- reassessment if loss of bladder control continues two weeks after diagnosis, and by week 3 for an ongoing treatment plan that has involved patients and carers to be jointly agreed
- comprehensive secondary prevention advice and treatment must be provided to all with interventions to improve adherence and persistence with medication and lifestyle modification
- a dysphagia management service must be available, including best interest meetings where appropriate and access to services to insert a gastrostomy tube where indicated within 72 hours of decision
- a formal discharge summary report must be shared with the referrer, GP and patient, with a named contact (if requested) for the day of transfer of care
- 6/52 follow-up; for most patients this need not be from a medically qualified individual, but must include the capability to confirm the diagnosis, interventions received, prognosis, secondary prevention investigations undertaken and measures instituted, and medication adherence, along with an understanding of the condition

PROMS).

with other services/providers
…-site access to brain imaging (MRI and CT).
must have agreed access (not necessarily on-site) via
…port services and clinical interpretation:

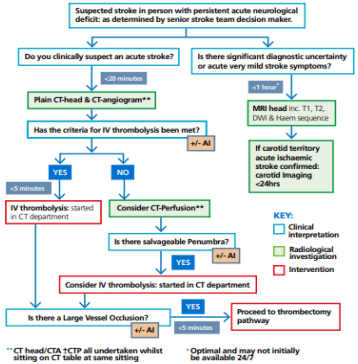
…ound/MRA/CTA)

…terectomy as per Section 3.

…nd rapid diagnostic assessment urgently, without risk …f referral. This applies only to patients who through …id a TIA; other patients who require review should …sted to more appropriate clinics. After specialist …er MRI (including diffusion-weighted and blood- …the territory of ischaemia, or to detect haemorrhage …done, perform it on the same day as the assessment.

A national optimal stroke imaging pathway has been developed based on the best evidence and extensive expert consensus, including the NHS National Imaging Optimisation Delivery Board and the Intercollegiate Stroke Working Party (Figure 2).

Figure 2: National Optimal Stroke Imaging Pathway



Section 7: Life after Stroke

Life after stroke services provide….

Ongoing personalised care and support that people need to

- rebuild their lives
- minimise risk of future cardiovascular events

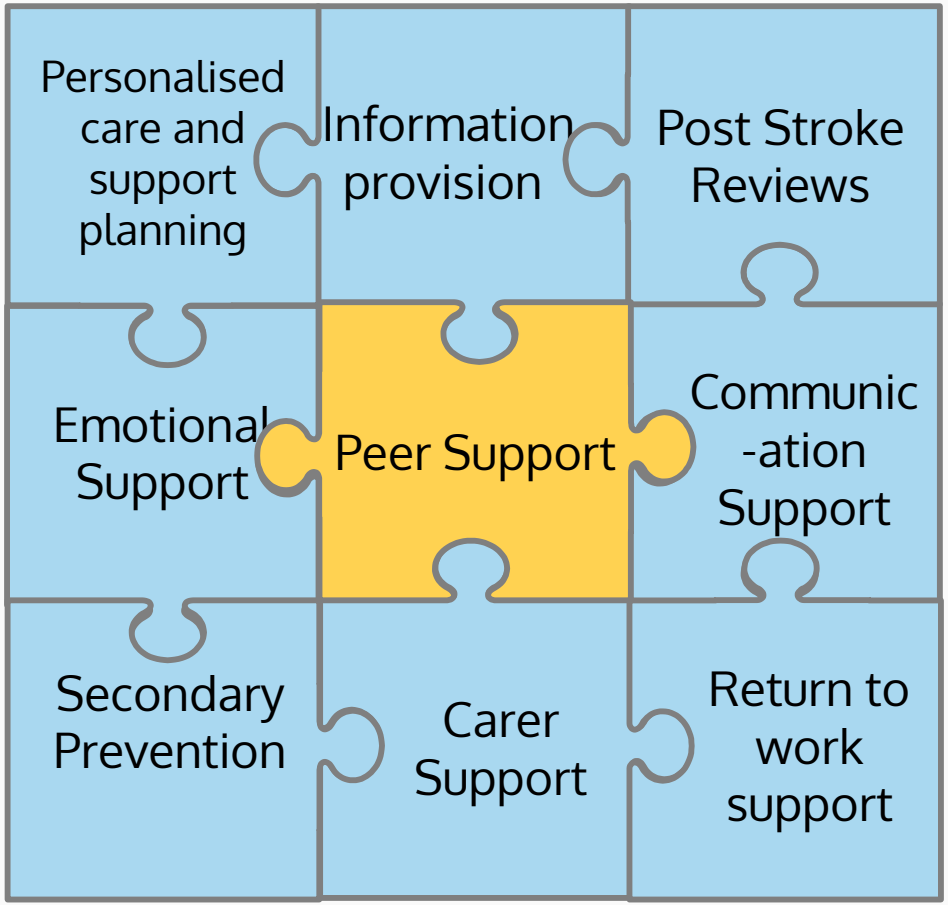
Section 7: Life after Stroke

Life after stroke services should be…

- **accessible to all people** affected by stroke
- **from the very acute phase onwards.**

People's **needs**, **circumstances** and what is important to them can **change** significantly over time, so they may need to **continue** to **access services** long after their stroke.

Core components of Life After Stroke



Peer support in the Integrated Life after Stroke

It can take a variety of forms

Could be led by volunteers

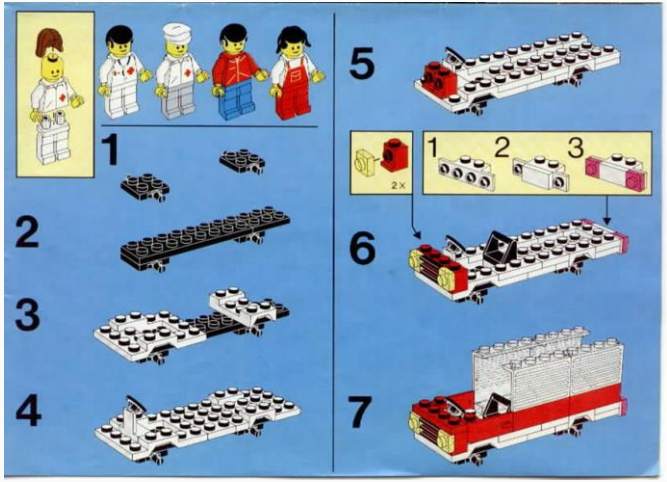
It includes locality stroke support groups

Could be remote peer befriending or face to face support

Could include stroke survivors or carers of stroke survivors who are “experts by experience”

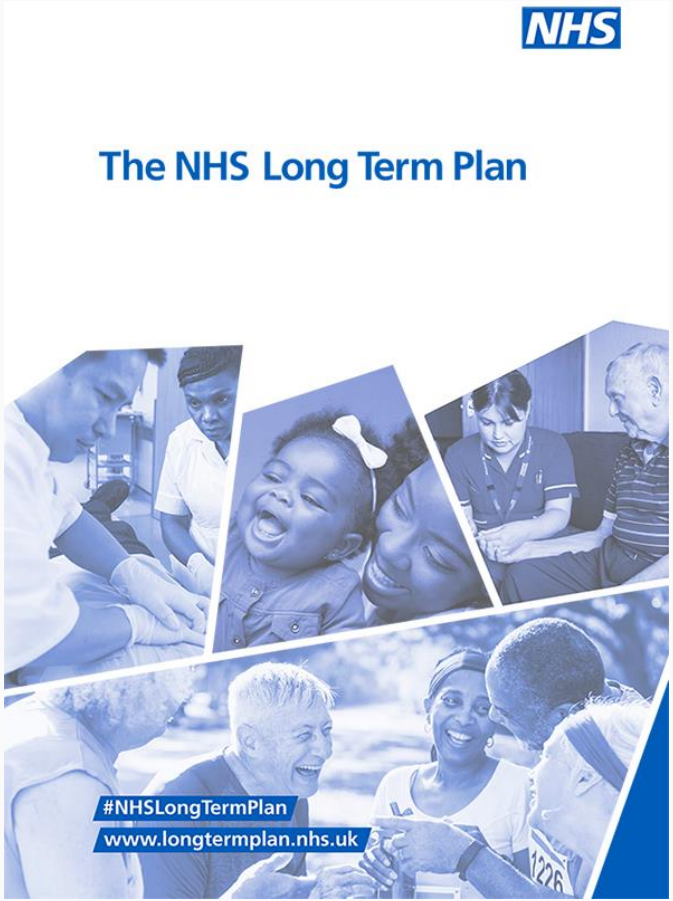
The voluntary sector has a lot of experience in providing peer support

Recap



NHS Long Term Plan

- Published in **2019**
- This plan sets out the **priorities** and **key ambitions** for the NHS over the next **10 years**
- **Stroke** was recognised as a priority and there were key ambitions for **stroke care and treatment**
- **Integrated Stroke Delivery Networks** are “key vehicle for transforming stroke care” – Long Term Plan 2019



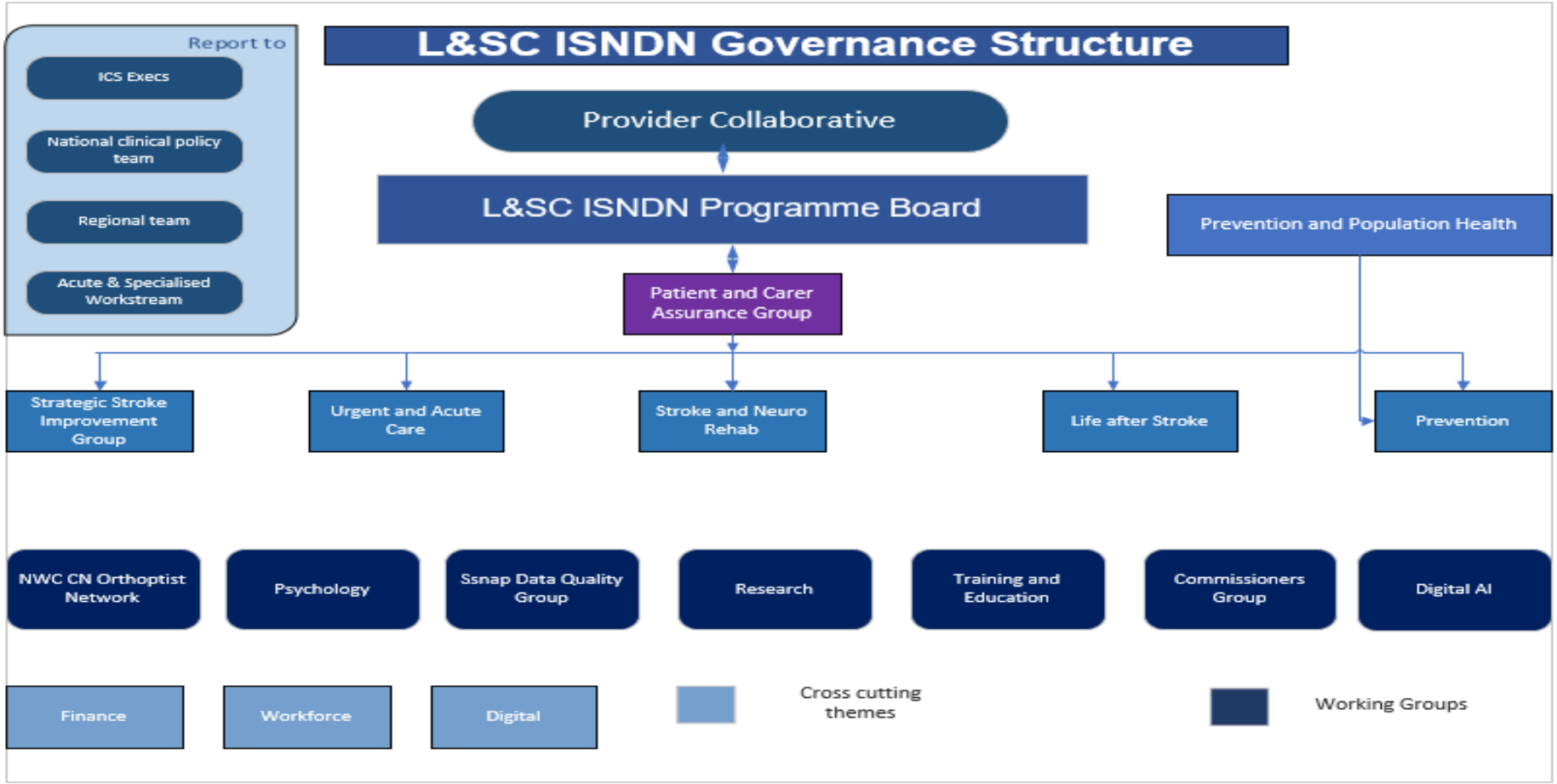
Integrated Stroke Delivery Networks (ISDN)

Integrated - Bring people and organisations **together** including providers and commissioners of services across the **whole stroke pathway**.

Delivery - responsible for **designing and delivering** optimal stroke pathways and enhancing the quality of stroke care

Network - a **collaborative** approach, bringing together stakeholders from pre-hospital, through to early supported discharge, community specialist stroke-skilled rehabilitation and **life after stroke.**

Lancashire South Cumbria ISNDN



Sharon Walkden

Programme Manager

North West Coast Clinical Network

Lancashire & South Cumbria ISNDN

Integrated Stroke Delivery Networks

Providing improved stroke outcomes in every ICS

Patient information and engagement is consistent throughout the single system via a patient passport

Data and information are digital, interactive and accessible to all across the whole system

Systems are aligned across the full pathway with strong clinical and network leadership

Modernised and upskilled workforce are recruited in line with system need

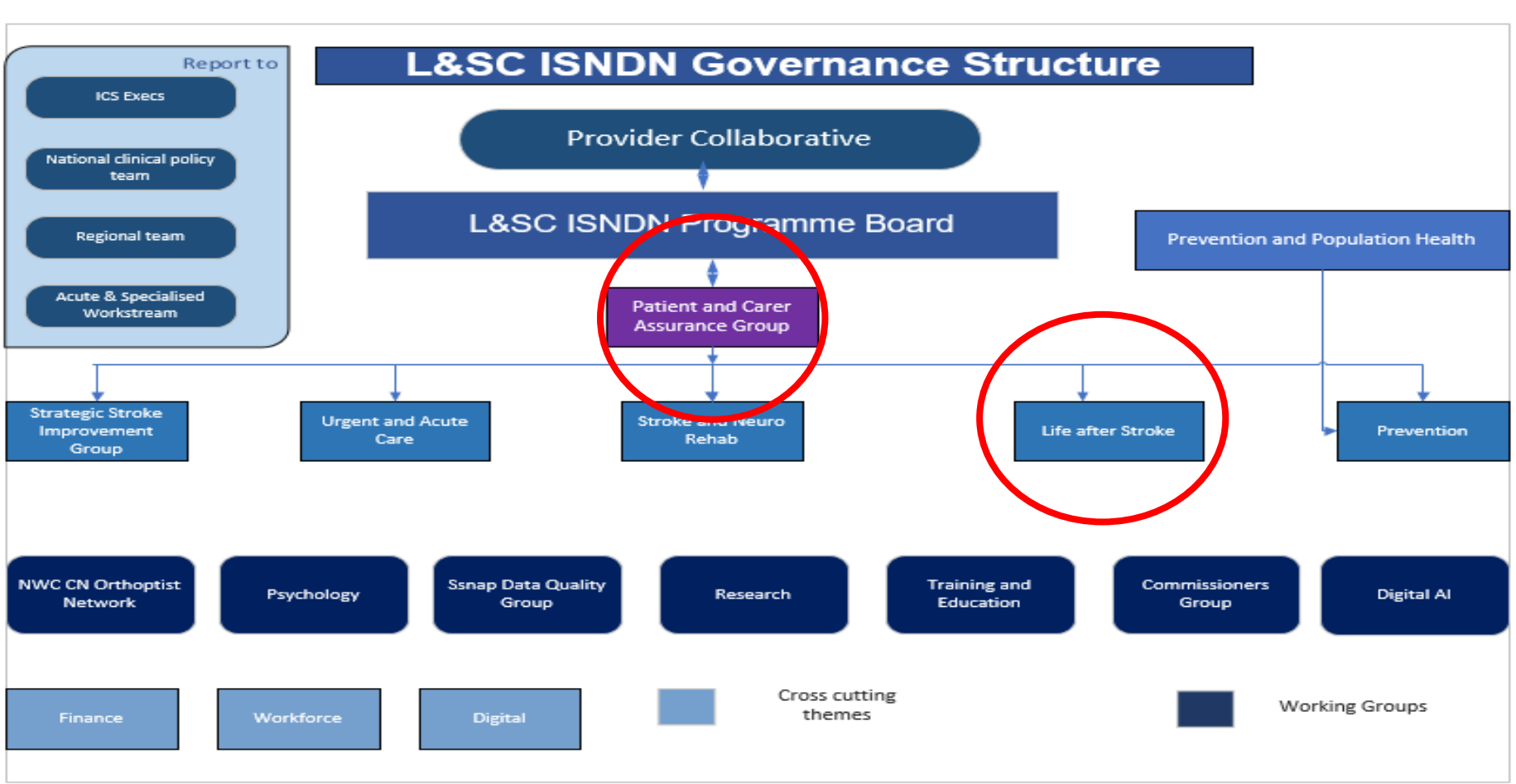
Prevention	Urgent care	Acute care	Rehabilitation	Long term support
Primary Care with Primary Care Networks (PCNs) **Community Pharmacy**	**999/111** **Ambulance Service** **Comprehensive Stroke Centres/ Acute Stroke Centres**	**Acute Stroke Centres**	**Inpatient stroke rehabilitation** **ESD services** **Social care**	**Primary care** **Community services** **Voluntary sector** **Social care**
Improved detection, primary and secondary prevention	Improved training and technology Increased availability of thrombectomy and stroke thrombolysis	Clear transfer pathways Seven day nursing and therapy services	Comprehensive ESD and needs based community stroke rehabilitation Seven day services	Comprehensive rehabilitation and personalised care and support for as long the person needs it

Over 10 years, thousands of premature deaths will be avoided, tens of thousands of disabilities will be prevented or lessened, and hundreds of thousands will benefit from better integrated person-centred care

Listening to patients and carers:

- ISNDN Board meeting
- Creating Acute and Comprehensive Stroke Centres
- Life after stroke – psychological support following stroke, support for carers
- Patient and carer assurance group

Lancashire South Cumbria ISNDN



Summary

- **NHS** places **value** on **peer support**
- **Peer support** is mentioned in key policy documents as an **essential part** of **stroke care** and **treatment**
- **Integrated Stroke Delivery Networks** have been **set up** to **improve stroke care** and **treatment**, ensuring access to all elements of support
- Hopefully **in the future** all **people** affected by **stroke** will have **access** to **peer support**.

Any Questions?