Supporting Life After Stroke

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Overview

• Life After Stroke

• Together for Health: Stroke Plan

• SSNAP and the 6 month follow up

• Measuring success
Impact on Daily Living

• Complex physical, psychological and social needs
• Chronic condition
• Potentially years of living with stroke
• Impact of carers, family and friends
• Social impact
• Financial impact
• The “black hole” effect (feeling unsupported campaign)
Aim

• Help the individual return to health and independence

  – Communication
  - Coordination of care
  - Access to care
  - Support close to home
  - Respect of dignity
  - Information provision
  - Psychosocial and financial support
  - Return to work
Person centred care

- Preventing a stroke
- Detecting a stroke quickly
- Delivering fast, effective treatment and care
- Improving information
- Supporting life after a stroke
Person centred care

- Preventing a stroke
- Targeting research
- Detecting a stroke quickly
- Improving information
- Delivering fast, effective treatment and care

Supporting life after a stroke
Integrated Health and Social Care

• Work across sector boundaries
  – Including local government and third sector

• Multidisciplinary collaboration between agencies
  – Prompt discharge
  – Planned and delivered around the patient
New ways of working

• Early rehabilitation in specialist units

• Specialist ESD services

• Life After Stroke Programme
Solid Foundations

• Underpinned by

  – Good communication
  – Good information
  – Good care planning
  – Regular review
Local Health Boards will:

**ACTIONS**

Local Health Boards working with their partners will:

- Ensure discharge arrangements are planned through multi-professional locality networking and include close communication and co-ordination with the GP.
- Plan and deliver integrated health and social care services to meet the ongoing needs of people who have had a stroke as locally as possible to help them return to health and independence;
- Implement the Self Care programme of work once developed;
- Develop appropriate care plans to agree care and support based on the needs of individuals following a diagnosis of stroke;
Local Health Boards will:

- ensure regular review of stroke survivors with residual impairment and implement joint care plans;
- ensure stroke survivors are screened for visual impairment and psychological needs;
- involve stroke patients and their carers in the development of future services including creative ways of supporting them, listening to what they have to say about decisions that affect them and to provide accessible and meaningful information and training when they need it;
- plan and deliver palliative and end of life care services as locally as possible to meet the needs of people who have had a stroke, where appropriate.
SSNAP – Six month follow up

### Six month (post-admission) follow-up assessment

**B.1.** Did this patient have a follow-up assessment at 6 months post admission (plus or minus two months)?
- Yes ☐
- No ☐
- Not ☐
- No patient died within 6 months of admission ☐

**B.1.1.** What was the date of follow-up?

**B.1.2.** How was the follow-up carried out?
- In person ☐
- By telephone ☐
- Online ☐
- By post ☐

**B.1.3.** Which of the following professionals carried out the follow-up assessment:
- GP ☐
- District/community nurse ☐
- Voluntary Services employee ☐
- Therapist ☐
- Secondary care clinician ☐
- Other ☐

**B.1.4.** If other, please specify [Free text (max. 50 characters)]

**B.1.5.** Did the patient give consent for their identifiable information to be included in SSNAP?
- Yes, patient gave consent ☐
- No, patient refused consent ☐
- Patient was not asked ☐

**B.2.** Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?
- Yes ☐
- No ☐

If yes to B.2.1.
- B.2.1. Was the patient identified as needing support?
  - Yes ☐
  - No ☐

If yes to B.2.1.
- B.2.2. Has this patient received psychological support for mood, behaviour or cognition since discharge?
  - Yes ☐
  - No ☐

**B.3.** Where is this patient living?
- Home ☐
- Care home ☐
- Other ☐

**B.3.1.** If other, please specify [Free text (max. 50 characters)]

**B.4.** What is the patient's modified Rankin Scale score?

**B.5.** Is the patient in persistent, permanent or paroxysmal atrial fibrillation?
- Yes ☐
- No ☐

**B.6.** Is the patient taking:
- Antiplatelet ☐
- Anticoagulant ☐
- Lipid lowering ☐
- Antihypertensive ☐

**B.7.** Since their initial stroke, has the patient had any of the following:
- Stroke ☐
- Myocardial infarction ☐
- Other illness requiring hospitalisation ☐

*8.1.5. This question is mandatory to be collected at the 6 month review and is a requirement for collecting patient identifiable information as part of our Section 251 (NHS Act 2006) approval from the Ethics and Confidentiality Committee of the National Information Governance Board.

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- [http://www.rcplondon.ac.uk/sites/default/files/ssnap_core_dataset_1.1.2_0.pdf](http://www.rcplondon.ac.uk/sites/default/files/ssnap_core_dataset_1.1.2_0.pdf)
- SSNAP [www.strokeaudit.org/Home.aspx](http://www.strokeaudit.org/Home.aspx)
- SSNAP Helpdesk: 020 3075 1383
Six month (post admission) follow-up assessment

8.1. Did this patient have a follow-up assessment at 6 months post admission (plus or minus two months)?
   Yes ○ No ○ No but ○ No, patient died within 6 months of admission ○

8.1.1. What was the date of follow-up?  dd mm yyyy

8.1.2. How was the follow-up carried out:  In person ○ By telephone ○ Online ○ By post ○

8.1.3. Which of the following professionals carried out the follow-up assessment:
   GP ○ District/community nurse ○
   Stroke coordinator ○ Voluntary Services employee ○
   Therapist ○ Secondary care clinician ○
   Other ○

8.1.4. If other, please specify  Free text (30 character limit)

8.1.5. Did the patient give consent for their identifiable information to be included in SSNAP?*
   Yes, patient gave consent ○ No, patient refused consent ○ Patient was not asked ○

8.2. Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?
   Yes ○ No ○ No but ○

   If yes to 8.2:
   8.2.1 Was the patient identified as needing support?  Yes ○ No ○

   If yes to 8.2.1:
   8.2.2 Has this patient received psychological support for mood, behaviour or cognition since discharge?
   Yes ○ No ○ No but ○
8.3. Where is this patient living?  
   Home ○  Care home ○  Other ○  
8.3.1. If other, please specify [Free text (30 character limit)]

8.4. What is the patient’s modified Rankin Scale score?  0 - 6

8.5. Is the patient in persistent, permanent or paroxysmal atrial fibrillation? Yes ○  No ○

8.6. Is the patient taking:
   8.6.1. Antiplatelet: Yes ○  No ○
   8.6.2. Anticoagulant: Yes ○  No ○
   8.6.3. Lipid Lowering: Yes ○  No ○
   8.6.4. Antihypertensive: Yes ○  No ○

8.7. Since their initial stroke, has the patient had any of the following:
   8.7.1. Stroke Yes ○  No ○
   8.7.2. Myocardial infarction Yes ○  No ○
   8.7.3. Other illness requiring hospitalisation Yes ○  No ○

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# Stroke Plan – Outcome Indicators

## Annex 3 – Measuring Success – Outcomes, Indicators and Assurance Framework

### Vision
- People in Wales are less likely to have a stroke
- If people in Wales do have a stroke, its impact is minimised to give them longer, healthier lives

### Outcome Indicators*
- Stroke incidence rates
- Stroke mortality rates (Cerebrovascular)
- Reported modified Rankin scale at discharge

### Preventing and Detecting Stroke
#### Overarching Outcome Indicator
- Stroke incidence rates

#### Assurance Measures
Evidence of a robust system to improve compliance with all Wales TIA and AF bundles, including:
- % of population with cardiovascular risk conditions managed appropriately
- % of atrial fibrillation (AF) patients managed appropriately
- % of high risk TIA patients managed appropriately (medical assessment)

### Delivering fast, effective care
#### Overarching Outcome Indicator
- Mortality within 30 days of admission
- Reported modified Rankin scale at discharge

#### Assurance Measures
Evidence of a robust system to measure and improve compliance with all Wales acute care bundles including:
- % of all strokes who receive thrombolysis and % receiving thrombolysis within optimal time (tbd)
- % of people who spend at least 90% of their time on a stroke unit

### Supported Life after Stroke
#### Overarching Outcome Indicator
- PROM (to be developed)

#### Assurance Measures
Evidence of a robust system to measure and improve compliance with all Wales rehabilitation bundles, including:
- % of people with joint care plans on discharge
- % of people who are supported to leave hospital by a skilled stroke early discharge team
- % of people who are reviewed 6 (+/- 2)

### Improving Information
- Compliance with stroke clinical indicators, audits and bundles

### Targeting Research
- % of people with stroke entered in to clinical trials

### Public Awareness and Health Prevention
- Overarching Indicator
  - Stroke incidence Rates

#### Performance Measures
- % of adults who smoke
- % of adults who are obese
- % of adults who report drinking above recommended guidelines
- % of adults who are physically active

*ICD10 Codes: 161, 163, 164*
Stroke Plan – Outcome Indicators

Annex 3 – Measuring Success – Outcomes, Indicators and Assurance Framework

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Outcome Indicators*

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Preventing and Detecting Stroke

Overarching Outcome Indicator

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- % of atrial fibrillation (AF) patients managed appropriately
- % of high risk TIA patients managed appropriately (medical assessment)

Delivering fast, effective care

Overarching Outcome Indicator

- Mortality within 30 days of admission
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Supported Life after Stroke

Overarching Outcome Indicator

- PROM (to be developed)

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- Compliance with stroke clinical indicators, audits and bundles

Targeting Research

- % of people with stroke entered into clinical trials

Overarching Indicator

- Stroke Incidence Rates

Performance Measures

- % of adults who smoke
- % of adults who are obese
- % of adults who report drinking above recommended guidelines
- % of adults who are physically active

Public Awareness and Health Prevention

* ICD10 Codes: 101, 103, 104
Life After Stroke

- Annual report by Health Board (with quarterly updates)
- Publicly available each time

**Supported Life after Stroke**

**Overarching Outcome Indicator**

- PROM (to be developed)

**Assurance Measures**

Evidence of a robust system to measure and improve compliance with all Wales rehabilitation bundles, including:

- % of people with joint care plans on discharge
- % of people who are supported to leave hospital by a skilled stroke early discharge team
- % of people who are reviewed 6 (+/- 2)