Stroke

NICE quality standard

Draft for consultation

September 2015

Introduction

This quality standard covers diagnosis and initial management, acute-phase care, rehabilitation and long-term management of stroke in adults (aged over 16 years). For more information see the stroke topic overview.

It will update and replace the existing quality standard for stroke.

Why this quality standard is needed

Stroke is defined by the World Health Organization as a clinical syndrome consisting of 'rapidly developing clinical signs of focal (at times global) disturbance of cerebral function, lasting more than 24 hours or leading to death with no apparent cause other than that of vascular origin'. A transient ischaemic attack (TIA) is defined as ‘stroke symptoms and signs that resolve within 24 hours’.

Stroke is a major health problem in the UK. The Stroke Association’s report, State of the Nation, highlighted that stroke accounted for over 40,000 deaths in the UK in 2013, which represents 7% of all deaths. Each year there are approximately 152,000 cases of stroke in the UK, of which about 25–33% are recurrent. Most people survive a first stroke, but often have significant morbidity. About 1.2 million people in the UK live with the effects of stroke, and over a third of these are dependent on other people.

The State of the Nation highlights that stroke is estimated to cost the UK economy around £9 billion per year. This comprises direct costs to health and social care of £4.38 billion, costs of informal care of £2.4 billion, costs because of lost productivity of £1.33 billion and benefits payments totalling £841 million.

Development of stroke services, and particularly access to acute stroke care on a stroke unit, has resulted in improvements in mortality and disability outcomes post stroke. However many people who have a stroke will need long-term support to help them manage any difficulties they have, participate in society and regain their independence. Stroke rehabilitation aims to help people to restore or improve their physical and mental functioning, and adapt to any loss of function. It involves many different specialists for different areas of care depending on the person's needs.

The quality standard is expected to contribute to improvements in the following outcomes:

- mortality rates of adults who have a stroke
- long-term disability of adults who have a stroke
- patient experience of stroke services
- carer experience of people who have had a stroke.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2015–16
- Adult Social Care Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–2016.

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults 1b Life expectancy at 75 i Males ii Females ***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.1 Under 75 mortality rate from cardiovascular disease (PHOF4.4*)
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions (ASCOF 1A**) ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions(ASCOF 1E**, PHOF 1.8*) **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers (ASCOF 1D**)
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11*) ***Improvement areas*** **Improving recovery from stroke** *3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months* **Helping older people to recover their independence after illness or injury** 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service (ASCOF 2B[1]*) ii Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2B [2]*)

4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4b Patient experience of hospital care 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *ii Hospital care* ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to inpatients' personal needs **Improving people's experience of accident and emergency services** 4.3 Patient experience of A&E services **Improving the experience of care for people at the end of their lives** 4.6 Bereaved carers' views on the quality of care in the last 3 months of life **Improving people's experience of integrated care** *4.9 People's experience of integrated care (ASCOF3E**)*
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Overarching indicators*** *5a Deaths attributable to problems in healthcare* *5b Severe harm attributable to problems in healthcare* ***Improvement areas*** **Reducing the incidence of avoidable harm** 5.1 Deaths from venous thromboembolism (VTE) related events 5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile *5.3 Proportion of patients with category 2, 3 and 4 pressure ulcers* **Improving the culture of safety reporting** 5.6 Patient safety incidents reported
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 The Adult Social Care Outcomes Framework 2015–16

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life (NHSOF2**) ***Outcome measures*** **People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs** 1B Proportion of people who use services who have control over their daily life 1C Proportion of people using social care who receive self-directed support, and those receiving direct payments **Carers can balance their caring roles and maintain their desired quality of life** 1D Carer-reported quality of life (NHSOF 2.4**) **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation** 1I Proportion of people who use services and their carers, who reported that they had as much social contact as they would like
2 Delaying and reducing the need for care and support	***Overarching measure*** 2A Permanent admissions to residential and nursing care homes, per 100,000 population ***Outcome measures*** **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs** **Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services** 2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (NHSOF 3.6 [1]*) *Placeholder 2E The effectiveness of reablement services* **When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence** 2C Delayed transfers of care from hospital, and those which are attributable to adult social care

3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carers with social services *Placeholder 3E The effectiveness of integrated care* ***Outcome measures*** **Carers feel that they are respected as equal partners throughout the care process** 3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual** This information can be taken from the Adult Social Care Survey and used for analysis at the local level.
Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 3 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services (NHSOF 2.2*, ASCOF 1E**)
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.3 Mortality rate from causes considered preventable (NHSOF 1A**) 4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke) (NHSOF 1.1*) 4.11 Emergency readmissions within 30 days of discharge from hospital (NHSOF 3b*) 4.13 Health-related quality of life for older people
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to stroke.

NICE has developed guidance and an associated quality standard patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

There are a number of additional NICE quality standards relevant to aspects of safe care for adults who have a stroke. In particular the NICE quality standard on Venous thromboembolism prevention provides details on venous thromboembolism (VTE) prophylaxis, for which adults who have a stroke are at high risk.

Coordinated services

The quality standard for stroke specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole stroke care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to adults who have a stroke.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality stroke service are listed in Related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health and social care practitioners involved in assessing, caring for and treating adults who have a stroke should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development sources on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting adults who have a stroke. If appropriate, health and social care practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. Adults presenting at an accident and emergency (A&E) department with suspected stroke are admitted to a specialist acute stroke unit within 4 hours of arrival.

Statement 2. Adults with acute stroke and indications for immediate brain imaging have a scan performed within 1 hour of arrival.

Statement 3. Adults with stroke having stroke rehabilitation are offered at least 45 minutes of each relevant therapy for a minimum of 5 days per week.

Statement 4. Adults with stroke who are able to move from bed to chair (with or without help) are offered early supported discharge.

Statement 5. Adults with stroke have their rehabilitation goals agreed within 5 days of arrival.

Statement 6. Adults who have had a stroke have their health and social care needs reviewed at 6 months after the stroke and annually thereafter.

Statement 7 (placeholder). Identification of stroke in adults without Face, Arm and Speech Test symptoms.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement? Are any other areas required to ensure diagnosis and initial management, acute-phase care, rehabilitation and long-term management of stroke are covered? For example a named rehabilitation contact throughout rehabilitation?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection. Examples of using NICE quality standards can also be submitted.

Questions about the individual quality statements

Question 4 For draft placeholder statement 7: Do you know of any relevant evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance that covers identifying stroke in adults without Face, Arm and Speech Test symptoms have the potential to improve practice? If so, please provide details.

Question 5 For draft statement 3: Does this statement adequately address rehabilitation intensity within community settings?

Question 6 For draft statement 5 and 6: Do these statements adequately address the ongoing need to review goals?

Quality statement 1: Prompt admission to specialist acute stroke units

Quality statement

Adults presenting at an accident and emergency (A&E) department with suspected stroke are admitted to a specialist acute stroke unit within 4 hours of arrival.

Rationale

Specialist acute stroke units are associated with better outcomes, such as reduced disability and mortality, because of the range of specialist treatments they provide. Admission to these units should be within 4 hours of arrival so that treatment can be received as quickly as possible, and to help prevent complications. Some adults with acute stroke may need treatment in higher level units, such as high dependency or intensive care units.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults presenting at an A&E department with suspected stroke are admitted to a specialist acute stroke unit within 4 hours of arrival.

Data source: Local data collection.

Process

Proportion of A&E department presentations of suspected stroke in adults that are admitted to a specialist acute stroke unit within 4 hours of arrival.

Numerator – the number in the denominator that are admitted to a specialist acute stroke unit within 4 hours of arrival.

Denominator – the number of A&E department presentations of suspected stroke.

Data source: Local data collection. Data can be collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), question 1.15 and CCG Outcomes Indicator Set indicator 3.5.

Outcome

a) Mortality rates of adults who have a stroke.

Data source: Local data collection. Data can be collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), question 7.1 CCG Outcomes Indicator Set indicator 1.5.

b) Rankin score of people who have had a stroke at 6 months.

Data source: Local data collection. Data can be collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), question 7.4.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as secondary care providers) ensure that systems are in place for adults presenting at an A&E department with suspected stroke to be admitted to a specialist acute stroke unit within 4 hours of arrival.

Healthcare professionals admit adults presenting at an A&E department with suspected stroke to a specialist acute stroke unit within 4 hours of arrival.

Commissioners (such as clinical commissioning groups) ensure that they commission services that can demonstrate that adults presenting at A&E departments with suspected stroke are admitted to a specialist acute stroke unit within 4 hours of arrival.

What the quality statement means for patients and carers

Adults with suspected stroke who go to an A&E department are admitted to a special unit called an acute stroke unit within 4 hours of arrival. An acute stroke unit has special equipment and a team of doctors, nurses, physiotherapists and other healthcare professionals who are experts in the care of people who have recently had a stroke.

Source guidance

- Stroke (2008) NICE guideline CG68, recommendation 1.3.1.1 (key priority for implementation) and expert consensus.

Definitions of terms used in this quality statement

Admission to a specialist acute stroke unit

Admission should be within 4 hours of arrival for adults with suspected stroke (unless their care needs should be provided elsewhere, such as an intensive care unit). [Stroke (NICE guideline CG68) recommendation 1.3.1.1 and expert consensus]

Specialist acute stroke unit

A discrete area in the hospital that is staffed by a specialist stroke multidisciplinary team. It has access to equipment for monitoring and rehabilitating patients. [Stroke (NICE guideline CG68)]

Quality statement 2: Prompt brain imaging

Quality statement

Adults with acute stroke and indications for immediate brain imaging have a scan performed within 1 hour of arrival.

Rationale

Brain imaging is essential to guide treatment in adults who have had acute stroke, and it should be performed immediately in adults with particular symptoms or indications that suggest haemorrhage as the cause. Brain imaging is used to determine whether the stroke is ischaemic or due to a haemorrhage. Once the cause has been identified, changes in clinical management (for example, thrombolysis cannot start until a haemorrhage has been excluded as the cause) should take place as soon as possible.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with acute stroke and indications for immediate brain imaging have a scan performed within 1 hour of arrival.

Data source: Local data collection.

Process

a) Proportion of adults with acute stroke and indications for immediate brain imaging who have a scan performed within 1 hour of arrival.

Numerator – the number in the denominator who have brain imaging within 1 hour of arrival.

Denominator – the number of adults with acute stroke and indicators for immediate brain imaging.

Data source: Local data collection.

b) Proportion of all adults with acute stroke who have a scan within 1 hour of arrival.

Numerator – the number in the denominator who have brain imaging within 1 hour of arrival.

Denominator – the number of all adults with acute stroke

Data source: This is data is nationally collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), question 2.4 with an achievement target set at 50%.

Outcome

a) Mortality rates of adults who have a stroke.

Data source: Local data collection. Data can be collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), question 7.1.

b) Rankin score of people who have had a stroke at 6 months.

Data source: Local data collection. Data can be collected using the Royal College of Physicians'' Sentinel Stroke National Audit Programme (SSNAP), question 7.4.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care providers) ensure that systems are in place for adults with acute stroke and indications for immediate brain imaging to have a scan performed within 1 hour of arrival.

Healthcare professionals ensure that they are aware of indications for immediate brain imaging in adults with acute stroke, and refer adults for brain imaging within 1 hour of arrival if they have any of these indications.

Commissioners (clinical commissioning groups) ensure that they commission services that make sure adults with acute stroke and indications for immediate brain imaging have a scan performed within 1 hour of arrival.

What the quality statement means for patients and carers

Adults with acute stroke should have an immediate brain scan (performed within 1 hour of arrival) if they have certain symptoms or other problems. These include taking, or having symptoms that mean they may need to take, blood-thinning treatment, problems with bleeding, losing consciousness, worsening or changing symptoms, a very bad headache, increased pressure at the back of their eyes, neck stiffness or fever. A brain scan will show the type of stroke the person has had, which is important to help decide on the best treatment.

Source guidance

- Stroke (2008) NICE guideline CG68, recommendation 1.3.2.1 (key priority for implementation).

Definitions of terms used in this quality statement

Indications for immediate brain imaging

Brain imaging should be performed immediately (within 1 hour) for adults with acute stroke if any of the following apply:

- indications for thrombolysis or early anticoagulation treatment
- on anticoagulant treatment
- a known bleeding tendency
- a depressed level of consciousness (Glasgow Coma Score below 13)
- unexplained progressive or fluctuating symptoms
- papilloedema, neck stiffness or fever
- severe headache at onset of stroke symptoms.

For adults with acute stroke and without any of these indications, brain imaging should be performed within 24 hours.

[Stroke (NICE guideline CG68) recommendations 1.3.2.1 and 1.3.2.2].

Quality statement 3: Intensity of stroke rehabilitation

Quality statement

Adults with stroke having stroke rehabilitation are offered at least 45 minutes of each relevant therapy for a minimum of 5 days per week.

Rationale

The higher the intensity of relevant stroke rehabilitation therapies, the better the outcomes for adults with stroke, provided that the person is able to participate. The outcomes that an adult with stroke should expect to achieve will depend on the type of stroke rehabilitation needed.

Quality measures

Structure

a) Evidence of local arrangements and written clinical protocols to ensure that adults with stroke having stroke rehabilitation are offered at least 45 minutes of each relevant therapy for a minimum of 5 days per week.

Data source: Local data collection.

b) Evidence of local arrangement to ensure that community rehabilitation services offer at least 45 minutes of each relevant therapy for a minimum of 5 days per week.

Data source: Local data collection.

Process

Proportion of adults with stroke having stroke rehabilitation are offered at least 45 minutes of each relevant therapy for a minimum of 5 days per week.

Numerator – the number in the denominator who receive at least 45 minutes of each relevant therapy for minimum of 5 days per week.

Denominator – the number of adults with stroke having stroke rehabilitation.

Data source: Local data collection. Data can be collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), question 4.5 and 4.6.

Outcome

a) Readmission rates of adults with stroke.

Data source: Local data collection.

b) Rankin score of people who have had a stroke at 6 months.

Data source: Local data collection. Data can be collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), question 8.4.

What the quality statement means for service providers, health, social care practitioners, and commissioners

Service providers (such as secondary care providers and community care providers) ensure that adults with stroke having stroke rehabilitation are offered at least 45 minutes of each relevant therapy for minimum of 5 days per week.

Health and social care practitioners offer adults with stroke having stroke rehabilitation at least 45 minutes of each relevant therapy for minimum of 5 days per week

Commissioners ensure that they commission services in which adults with stroke having stroke rehabilitation are offered at least 45 minutes of each relevant therapy for minimum of 5 days per week.

What the quality statement means for patients, service users and carers

Adults with stroke having rehabilitation therapy (this is long-term support to help them regain their independence and cope with any remaining disabilities) are offered at least 45 minutes of each type of rehabilitation therapy that they need on at least 5 days a week. Rehabilitation therapies may involve many different specialists, such as physiotherapists, speech therapists and occupational therapists. They can help people who have problems with their memory and concentration; speaking, reading

and writing; emotions and feelings; sight; swallowing and eating; strength, balance and movement; and shoulder pain. They also include help to encourage physical activity and independent living.

Source guidance

- Stroke rehabilitation (2013) NICE guideline CG162, recommendation 1.2.16 (key priority for implementation).

Definitions of terms used in this quality statement

Relevant stroke rehabilitation

Adults with stroke should be offered all rehabilitation therapies that will be relevant to them, as long as they have the ability to participate, and where functional goals can be achieved. Adults with stroke should be able to access rehabilitation at any stage of the stroke care pathway when needed. Rehabilitation should be offered for as long as the person is making progress [Adapted from Stroke rehabilitation (NICE guideline CG162) recommendation 1.2.16 and expert opinion].

Equality and diversity considerations

Some adults with stroke may not have the mental or physical ability to participate in 45 minutes of each rehabilitation therapy. Service providers should ensure that therapy is still offered 5 days per week for a shorter time at an intensity that allows them to actively participate and at a level that enables them to meet their rehabilitation goals.

Question for consultation

Does this statement adequately address rehabilitation intensity within community settings?

Quality statement 4: Early supported discharge

Quality statement

Adults with stroke who are able to move from bed to chair (with or without help) are offered early supported discharge.

Rationale

Early supported discharge is the discharge of people from hospital into the community where they are able to continue their rehabilitation. It enables adults with stroke to spend less time in hospital, improving patient experience and quality of life.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with stroke who are able to move from bed to chair (with or without help) are offered early supported discharge.

Data source: Local data collection.

Process

a) Proportion of adults with stroke who are able to move from bed to chair (with or without help) who receive early supported discharge.

Numerator – the number in the denominator who receive early supported discharge.

Denominator – the number of adults with stroke who are able to move from bed to chair (with or without help).

Data source: Local data collection.

b) Proportion of all adults with stroke who are treated by an early supported discharge team.

Numerator – the number in the denominator who are treated by an early supported discharge team.

Denominator – the number of all adults with acute stroke.

Data source: This is data is nationally collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), which uses published literature to estimate that approximately 34% of all stroke patients are considered eligible for early supported discharge.

Outcome

a) Length of hospital stay for adults with stroke.

Data source: Local data collection.

b) Quality of life for adults with stroke.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as secondary care providers) ensure that systems are in place to offer early supported discharge to adults with stroke who are able move from bed to chair (with or without help).

Health and social care practitioners are aware of discharge pathways and offer early supported discharge to adults with stroke who are able to move from bed to chair (with or without help).

Commissioners (clinical commissioning groups) ensure that they commission services that can provide early supported discharge services for adults with stroke who are able to move from bed to chair (with or without help).

What the quality statement means for patients and carers

Adults with stroke who are able to move from a bed to a chair (with or without help) are able to go home as soon as possible and have their rehabilitation at home, as long as this can be done safely.

Source guidance

- Stroke rehabilitation (2013) NICE guideline CG162, recommendation 1.1.8 (key priority for implementation).

Definitions of terms used in this quality statement

Early supported discharge

A service for people after stroke which allows transfer of care from an inpatient environment to a primary care setting to continue rehabilitation, at the same level of intensity and expertise that they would have received in the inpatient setting. It is offered as long as a safe and secure environment can be provided. [Stroke rehabilitation (NICE guideline CG162) recommendation 1.1.8]

Equality and diversity considerations

Early supported discharge is only appropriate as long as a safe and secure environment can be provided. Therefore it may not be appropriate for some adults depending on their home environment, for example, it may not be possible for people who are homeless or have significant cognitive impairments.

Quality statement 5: Goal setting

Quality statement

Adults with stroke have their rehabilitation goals agreed within 5 days of arrival.

Rationale

Goal setting can help to identify the values, beliefs and preferences of an adult with stroke that may affect the kind of rehabilitation that would be suitable. This may help to encourage and motivate the person and can improve the outcomes of rehabilitation. It should be done within 5 days to ensure that goals are established from the start of the rehabilitation process and form part of the ongoing process to regularly review goals.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with stroke have their rehabilitation goals agreed within 5 days of arrival.

Data source: Local data collection.

Process

Proportion of adults with stroke who have their rehabilitation goals agreed within 5 days arrival.

Numerator – the number in the denominator who have their rehabilitation goals agreed within 5 days of arrival.

Denominator – the number of adults with stroke.

Data source: Local data collection. Data can be collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), question 4.7.

Outcome

a) Quality of life for adults with stroke.

Data source: Local data collection.

b) Readmission rates of adults with stroke.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as secondary care providers) ensure that systems are in place for adults with stroke to have goals for their rehabilitation agreed within 5 days of arrival.

Healthcare professionals ensure that they agree goals for rehabilitation with adults with stroke within 5 days of arrival.

Commissioners (such as clinical commissioning groups) ensure that they commission services in which adults with stroke have goals for their rehabilitation agreed within 5 days of arrival.

What the quality statement means for patients and carers

Adults with stroke discuss and agree goals (things they would like to achieve) for their recovery with their healthcare team within 5 days of arrival.

Source guidance

- Stroke rehabilitation (2013) NICE guideline CG162, recommendation 1.2.8 and expert consensus.

Definitions of terms used in this quality statement

Agreeing goals for rehabilitation

Agreeing goals should take place in goal-setting meetings that are timetabled into the working week and involve the person with stroke, and where appropriate, their family or carer. Goals for rehabilitation are established as part of an ongoing process and people's goals should be reviewed at regular intervals [Stroke (NICE guideline CG68) recommendation 1.2.9 and 1.2.12]

Rehabilitation goals

Goals for rehabilitation should:

- be meaningful and relevant to adults with stroke
- focus on activity and participation
- be challenging but achievable
- include both short-term and long-term elements.

[Stroke rehabilitation (NICE guideline CG162) recommendation 1.2.8]

Equality and diversity considerations

When setting goals for rehabilitation healthcare professionals should be aware that adults with stroke may have cognitive or physical impairments, and at the acute stage participation for some adults may be limited until the person feels ready and more confident.

Any discussion about goals setting should take into account any additional needs, such as physical, sensory or learning disabilities, and people who do not speak or read English. People should have access to an interpreter or advocate if needed.

Question for consultation

Does this statement and statement 6 adequately address the ongoing need to review goals?

Quality statement 6: 6-month review

Quality statement

Adults who have had a stroke have their health and social care needs reviewed at 6 months after the stroke and annually thereafter.

Rationale

Reviewing the health and social care needs of adults who have had a stroke at 6 months after the stroke enables health and social care practitioners to identify any problems or difficulties. This can help adults who have had a stroke and their carers to change their health and social care according to their needs.

Quality measures

Structure

Evidence of local arrangements and written protocols to ensure that adults who have had a stroke have their health and social care needs reviewed at 6 months after the stroke and annually thereafter.

Data source: Local data collection.

Process

a) Proportion of adults who have had a stroke have their health and social care needs reviewed at 6 months after the stroke and annually thereafter

Numerator – the number in the denominator who have their health and social care needs reviewed at 6 months after the stroke.

Denominator – the number of adults who have had a stroke.

Data source: Local data collection. Data can be collected using the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), question 8.1.

b) Proportion of adults with stroke who have had their health and social care needs reviewed at 6 months after the stroke, who have an annual review thereafter.

Numerator – the number in the denominator who have had an annual review thereafter.

Denominator – the number of adults who have had a stroke who have their health and social care needs reviewed at 6 months after the stroke.

Data source: Local data collection. Data can be collected using Quality and Outcomes Framework indicator STIA0003.

Outcome

a) Quality of life for adults with stroke.

Data source: Local data collection.

b) Readmission rates of adults with stroke.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as primary, secondary and community care providers) ensure that systems are in place for adults who have had a stroke to have their health and social care needs reviewed at 6 months after the stroke and annually thereafter.

Health and social care practitioners ensure that adults who have had a stroke have their health and social care needs reviewed at 6 months after the stroke and annually thereafter.

Commissioners (such as clinical commissioning groups, NHS England and local authorities) ensure that they commission services that enable adults who have had a stroke to have their health and social care needs reviewed at 6 months after the stroke and annually thereafter.

What the quality statement means for patients and carers

Adults with stroke have a check at 6 months and 1 year after their stroke, and then once every year to make sure they are getting the care and support that they need.

Source guidance

- Stroke rehabilitation (2013) NICE guideline CG162, recommendation 1.11.5.

Definitions of terms used in this quality statement

Health and social care review

These reviews should address participation and community roles to ensure that people's goals are addressed as well as secondary prevention and continuing rehabilitation. [Stroke rehabilitation (NICE guideline CG162) recommendation 1.11.5 and expert opinion]

Equality and diversity considerations

Any review should take into account any additional needs, such as physical, sensory or learning disabilities, and the needs of people who do not speak or read English. People should have access to an interpreter or advocate if needed.

Question for consultation

Does this statement and statement 5 adequately address the ongoing need to review goals?

Quality statement 7 (placeholder): Identification of stroke in adults without Face, Arm and Speech Test symptoms

What is a placeholder statement?

A placeholder statement is an area of care that has been prioritised by the Quality Standards Advisory Committee but for which no source guidance is currently available. A placeholder statement indicates the need for evidence-based guidance to be developed in this area.

Rationale

A significant proportion of adults with acute stroke present with symptoms that are not detected by the Face, Arm and Speech Test (FAST), for example people with posterior circulation symptoms. Guidance on how to identify stroke in adults without FAST symptoms will improve the speed of identification and ensure appropriate acute stroke care.

Question for consultation

Do you know of any relevant evidence-based guidance that could be used to develop this placeholder statement? If so, please provide details. If not, would new evidence-based guidance that covers identifying stroke in adults without Face, Arm and Speech Test symptoms have the potential to improve practice? If so, please provide details.

Status of this quality standard

This is the draft quality standard released for consultation from 7 September to 5 October 2015. It is not NICE's final quality standard on stroke. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 5 October 2015. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from April 2016.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between health, public health and social care practitioners and adults with stroke is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults with stroke should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Stroke rehabilitation (2013) NICE guideline CG162
- Stroke (2008) NICE guideline CG68

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Royal College of Physicians (2015) Sentinel Stroke National Audit Programme (SSNAP): Clinical audit January – March 2015 public report
- National Audit Office (2010) Department of Health: Progress in improving stroke care

Definitions and data sources for the quality measures

- Royal College of Physicians (2015) Sentinel Stroke National Audit Programme (SSNAP)
- Quality and Outcomes Framework indicator STIA0003.

Related NICE quality standards

Published

- Atrial fibrillation: treatment and management (2015) NICE quality standard 93
- Falls in older people (2015) NICE quality standard 86
- Transient loss of consciousness (2014) NICE quality standard 71
- Faecal incontinence (2014) NICE quality standard 54
- Hypertension (2013) NICE quality standard 28
- Nutrition support in adults (2012) NICE quality standard 24
- Patient experience in adult NHS services (2012) NICE quality standard 15
- Venous thromboembolism prevention quality standard (2010) NICE quality standard 23

In development

- Cardiovascular risk assessment and lipid modification. Publication expected September 2015

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Falls: prevention
- Medicines optimisation
- Neurological problems
- Primary prevention: population and community based primary prevention strategies, including the role of A&E, at different stages of the life course.

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 1. Membership of this committee is as follows:

Dr Gita Bhutani (Chair)
Professional Lead, Psychological Services, Lancashire Care NHS Foundation Trust

Mrs Jennifer Bostock
Lay member

Dr Helen Bromley
Consultant in Public Health, Cheshire West and Chester Council

Dr Hasan Chowhan
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Mr Phillip Dick

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Ms Teresa Middleton

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Ms Jane Worsley

Chief Operating Officer, Options Group, Alcester Heath, Warwickshire

Dr Arnold Zermansky

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The following specialist members joined the committee to develop this quality standard:

Ms Paula Beech

Stroke Nurse Consultant, Salford Royal NHS Foundation Trust

Mr Robin Cant

Lay member

Dr Rory O'Connor

Associate Clinical Professor in Rehabilitation Medicine, University of Leeds

Mr Daniel Phillips

Paramedic Clinical Lead, East of England Ambulance Service NHS Trust

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Reader in Neurological Rehabilitation, UCL Institute of Neurology

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway on stroke.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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