NICE National Institute for Health and Care Excellence

NICE quality standard

Stroke in adults

Quality standard
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This standard is based on CG68, NG128 and NG236.

This standard should be read in conjunction with QS15, QS71, QS93, QS100, QS3, QS54, QS28, QS24, QS86, QS136 and QS201.

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. **[2010, updated 2016]**

Statement 2 Adults having stroke rehabilitation in hospital or in the community are offered at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week. **[2010, updated 2016]**

Statement 3 Adults who have had a stroke have access to a clinical psychologist or a clinical neuropsychologist with expertise in stroke rehabilitation who is part of the core multidisciplinary stroke rehabilitation team. **[new 2016]**

Statement 4 Adults who have had a stroke are offered early supported discharge if the core multidisciplinary stroke team assess that it is suitable for them. **[new 2016]**

Statement 5 Adults who have had a stroke are offered active management to return to work if they wish to do so. **[new 2016]**

Statement 6 Adults who have had a stroke have their rehabilitation goals reviewed at regular intervals. **[2010, updated 2016]**

Statement 7 Adults who have had a stroke have a structured health and social care review at 6 months and 1 year after the stroke, and then annually. **[new 2016]**

In 2016, this quality standard was updated, and statements prioritised in 2010 were updated (2010, updated 2016) or replaced (new 2016). For more information, see update information.

The previous version of the quality standard for stroke in adults is available as a pdf.

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. **[2010, updated 2016]**

Rationale

Specialist acute stroke units are associated with improved patient safety due to 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 at A&E, so that treatment can begin 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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: Data can be collected from information recorded locally by healthcare provider organisations, for example, from clinical or service protocols.

Process

Proportion of A&E department presentations of suspected stroke in adults in which the person is admitted to a specialist acute stroke unit within 4 hours of arrival.

Numerator – the number in the denominator in which the person is 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: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The Sentinel Stroke National Audit Programme (SSNAP) clinical audit and the NHS Digital Clinical Commissioning Group (CCG) Outcomes Indicator Set indicator 3.5 include the percentage of patients directly admitted to a stroke unit within 4 hours of arrival at hospital.

Outcome

a) Mortality rates of adults who have a stroke.

Data source: Data can be collected locally using the SSNAP clinical audit and the NHS Digital CCG Outcomes Indicator Set indicator 1.5 to report mortality within 30 days of hospital admission for stroke.

b) Change in Modified Rankin Score at 6 months after a stroke.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The SSNAP clinical audit includes the Modified Rankin Score at 6 months after a stroke.

What the quality statement means for different audiences

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 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.

Adults with suspected stroke who go to A&E are admitted to an acute stroke unit within 4 hours of arriving at A&E. An acute stroke unit has special equipment and a team of doctors, nurses, physiotherapists and other healthcare professionals who provide specialist treatment as quickly as possible and help to prevent further problems.

Source guidance

- Stroke and transient ischaemic attack in over 16s: diagnosis and initial management. NICE guideline NG128 (2019, updated 2022), recommendation 1.3.1
- The 4-hour timeframe is based on the SSNAP target

Definitions of terms used in this quality statement

Admission to a specialist acute stroke unit

Admission should be within 4 hours of arrival at the A&E department for adults with suspected stroke, following an initial assessment (unless their care needs should be provided elsewhere, such as an intensive care unit). [Adapted from NICE's guideline on stroke and transient ischaemic attack in over 16s, recommendation 1.3.1, and SSNAP]

Specialist acute stroke unit

A discrete area in the hospital designated for people with stroke. It is staffed by a specialist stroke multidisciplinary team, who have access to equipment for monitoring and rehabilitation. The Stroke Unit Trialists' Collaboration provides 5 key characteristics of markers of a good specialist acute stroke unit:

- a consultant physician with responsibility for stroke

- formal links with patient and carer organisations
- multidisciplinary meetings at least weekly to plan patient care
- provision of information to patients about stroke
- funding for external courses and uptake.

[Adapted from NICE's guideline on stroke and transient ischaemic attack in over 16s, recommendation 1.3.1, and SSNAP]

Quality statement 2: Intensity of stroke rehabilitation

Quality statement

Adults having stroke rehabilitation in hospital or in the community are offered at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week. **[2010, updated 2016]**

Rationale

Higher-intensity stroke rehabilitation therapies can improve the quality of life for adults who have had a stroke. The improvements that an adult with stroke should expect to achieve will depend on their health and abilities before and after the stroke, the severity of the stroke and the intensity of the rehabilitation therapy. The intensity of stroke rehabilitation should be suitable for the person, so that they are able to participate and make progress towards their functional goals.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults having stroke rehabilitation in hospital or in the community are offered at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week.

Data source: Data can be collected from information recorded locally by healthcare provider organisations, for example, from service or clinical protocols.

Process

a) Proportion of adults having stroke rehabilitation in hospital who receive at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week.

Numerator – the number in the denominator who receive at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week.

Denominator – the number of adults having stroke rehabilitation in hospital.

Data source: The Sentinel Stroke National Audit Programme (SSNAP) clinical audit collects information on how many minutes and how many days patients receive different types of therapy in hospital.

b) Proportion of adults having stroke rehabilitation in the community who receive at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week.

Numerator – the number in the denominator who receive at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week.

Denominator – the number of adults having stroke rehabilitation in the community.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Change in Modified Rankin Score at 6 months after a stroke.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The SSNAP clinical audit includes the Modified Rankin Score at 6 months after a stroke.

What the quality statement means for different audiences

Service providers (such as secondary care providers and community care providers) ensure that adults having stroke rehabilitation are offered at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week.

Health and social care practitioners offer adults having stroke rehabilitation at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week.

Commissioners ensure that they commission services in which adults having stroke rehabilitation are offered at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for a minimum of 5 days a week.

Adults having rehabilitation therapy after a stroke are offered at least 3 hours of rehabilitation therapy that they need on at least 5 days a week. Rehabilitation therapy is long-term support to help people regain their independence and cope with any remaining disabilities after a stroke. It may involve many different specialists, such as physiotherapists, occupational therapists and speech and language 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 in adults. NICE guideline NG236 (2023), recommendation 1.2.16

Definitions of terms used in this quality statement

Rehabilitation covering a range of multidisciplinary therapy

A range of multidisciplinary therapy includes physiotherapy, occupational therapy, and speech and language therapy. Adults who have had a stroke should be offered all rehabilitation therapies that are suitable for their needs, as long as they have the ability to

participate and make progress towards their functional goals. Adults with stroke should be able to access rehabilitation at any stage of the stroke care pathway when needed. [Adapted from NICE's guideline on stroke rehabilitation in adults, recommendation 1.2.16, and expert opinion]

Equality and diversity considerations

Some adults who have had a stroke may not have the mental or physical ability to participate in at least 3 hours of rehabilitation covering a range of multidisciplinary therapy each day. Where it is agreed with the person that they are unable, or do not wish, to participate in rehabilitation therapy for at least 3 hours a day, service providers should ensure that therapy is still offered 5 days a week but for a shorter amount of time. It should be given at an intensity that allows the person to actively participate and at a level that enables them to make progress.

Quality statement 3: Access to a clinical psychologist

Quality statement

Adults who have had a stroke have access to a clinical psychologist or a clinical neuropsychologist with expertise in stroke rehabilitation who is part of the core multidisciplinary stroke rehabilitation team. **[new 2016]**

Rationale

Many adults who have had a stroke experience psychological difficulties, including low mood and anxiety, as well as difficulties with cognition such as problems with memory and information processing. Psychological therapies may help people and their families or carers with these difficulties. Having a clinical psychologist or a clinical neuropsychologist as part of the core multidisciplinary stroke rehabilitation team can help to ensure that people have access to psychological therapy tailored to their needs.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and protocols to ensure that services providing stroke care have a core multidisciplinary stroke rehabilitation team that includes a clinical psychologist or a clinical neuropsychologist with expertise in stroke rehabilitation.

Data source: Data can be collected from information recorded locally by healthcare provider organisations, for example, from service protocols. The Sentinel Stroke National Audit Programme (SSNAP) organisational audit collects information on the number of clinical psychologists for stroke unit beds.

Outcome

Quality of life for adults who have had a stroke.

Data source: Data can be collected from information collected locally by healthcare professionals and provider organisations, for example, from patient surveys.

What the quality statement means for different audiences

Service providers (such as secondary care providers) ensure that the core multidisciplinary stroke rehabilitation team includes a clinical psychologist or a clinical neuropsychologist with expertise in stroke rehabilitation.

Health and social care practitioners are aware of the need for a clinical psychologist or a clinical neuropsychologist with expertise in stroke rehabilitation to be part of the core multidisciplinary stroke rehabilitation team.

Commissioners ensure that they commission services that have a clinical psychologist or a clinical neuropsychologist with expertise in stroke rehabilitation as part of their core multidisciplinary stroke rehabilitation team.

Adults who have had a stroke who need help with psychological problems can see a clinical psychologist or a clinical neuropsychologist who specialises in stroke rehabilitation. The psychologist is part of the stroke rehabilitation team.

Source guidance

Stroke rehabilitation in adults. NICE guideline NG236 (2023), recommendation 1.1.3

Definitions of terms used in this quality statement

The core multidisciplinary stroke team

The team should comprise the following professionals with expertise in stroke rehabilitation:

- consultant physicians specialising in stroke, or rehabilitation medicine
- nurses
- physiotherapists
- occupational therapists
- speech and language therapists
- dietitians
- clinical psychologists or clinical neuropsychologists
- orthoptists
- rehabilitation assistants
- social workers.

[NICE's guideline on stroke rehabilitation in adults, recommendation 1.1.3]

Quality statement 4: Early supported discharge

Quality statement

Adults who have had a stroke are offered early supported discharge if the core multidisciplinary stroke team assess that it is suitable for them. **[new 2016]**

Rationale

Early supported discharge is an intervention for adults after a stroke that allows their care to be transferred from an inpatient environment to a community setting. It enables people to continue their rehabilitation therapy at home, with the same intensity and expertise that they would receive in hospital. This may not be suitable for all adults with stroke or in all circumstances. The decision to offer early supported discharge is made by the core multidisciplinary stroke team after discussion with the person and their family or carer if applicable.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults who have had a stroke are offered early supported discharge if the core multidisciplinary stroke team assess that it is suitable for them.

Data source: Data can be collected from information recorded locally by healthcare provider organisations, for example, from clinical or service protocols.

Process

a) Proportion of adults who have had a stroke and are assessed as suitable for early supported discharge by the core multidisciplinary stroke team who receive it.

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

Denominator – the number of adults who have had a stroke and are assessed as suitable for early supported discharge by the core multidisciplinary stroke team.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Proportion of adults who have had 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 adults who have had a stroke.

Data source: National data is collected using the Sentinel Stroke National Audit Programme (SSNAP) clinical audit, which reports the percentage of patients treated by a stroke-skilled early supported discharge team.

Outcome

a) Length of hospital stay for adults who have had a stroke.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. NHS England's Hospital Admitted Patient Care Activity includes average length of stay by primary diagnosis.

b) Quality of life for adults who have had a stroke.

Data source: Data can be collected from information collected locally by healthcare professionals and provider organisations, for example, from patient surveys.

What the quality statement means for different audiences

Service providers (such as secondary care providers) ensure that systems are in place to offer early supported discharge to adults who have had a stroke if it is assessed to be suitable for them by the core multidisciplinary stroke team.

Health and social care practitioners in the core multidisciplinary stroke team are aware of discharge pathways and offer early supported discharge to adults who have had a stroke if it is suitable for them.

Commissioners ensure that they commission services that can provide early supported discharge services for adults who have had a stroke if it is assessed to be suitable for them by the core multidisciplinary stroke team.

Adults who have had a stroke are offered 'early supported discharge' if their stroke team decides that it is suitable for them. This means that they are supported to go home from hospital as early as possible and have the same rehabilitation care at home. This is only offered if the person is well enough and it can be done safely.

Source guidance

Stroke rehabilitation in adults. NICE guideline NG236 (2023), recommendation 1.1.9

Definitions of terms used in this quality statement

Early supported discharge

An intervention for people who have had a stroke that allows care to be transferred from an inpatient environment to a community setting to continue rehabilitation. The intensity of care and the expertise of those providing it is maintained. [Adapted from NICE's guideline on stroke rehabilitation in adults]

Suitable for early supported discharge

The core multidisciplinary stroke team will assess whether early supported discharge is

suitable for adults who have had a stroke. The assessment takes into account the person's functional, cognitive and social circumstances. This may include, for example, the person's ability to move from bed to chair independently or with assistance, and whether a safe and secure environment can be provided at home. [Adapted from NICE's guideline on stroke rehabilitation in adults, recommendation 1.1.9, and expert consensus]

The core multidisciplinary stroke team

The team should comprise the following professionals with expertise in stroke rehabilitation:

- consultant physicians specialising in stroke, or rehabilitation medicine
- nurses
- physiotherapists
- occupational therapists
- speech and language therapists
- dietitians
- clinical psychologists or clinical neuropsychologists
- orthoptists
- rehabilitation assistants
- social workers.

[NICE's guideline on stroke rehabilitation in adults, recommendation 1.1.3]

Equality and diversity considerations

Early supported discharge is only suitable in a safe and secure environment. Therefore, it may not be suitable for some people because of their living arrangements, for example, if they are homeless, recent refugees, asylum seekers or migrant workers. It may not be suitable for people with significant cognitive and functional impairments.

Quality statement 5: Return to work

Quality statement

Adults who have had a stroke are offered active management to return to work if they wish to do so. **[new 2016]**

Rationale

After a stroke, adults may have significant disabilities that prevent them from returning to work. Work can contribute to a person's identity and perceived status, has financial benefits, and can improve their quality of life and reduce ill health. Being able to return to work is also a sign that rehabilitation has been successful.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults who have had a stroke are offered active management to return to work if they wish to do so.

Data source: Data can be collected from information recorded locally by healthcare provider organisations, for example, from clinical or service protocols.

Process

Proportion of adults who have had a stroke who receive active management to return to work if they wish to do so.

Numerator – the number in the denominator who receive active management to help them

return to work.

Denominator – the number of adults who have had a stroke who wish to return to work.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Quality of life for adults who have had a stroke.

Data source: Data can be collected from information collected locally by healthcare professionals and provider organisations, for example, from surveys of people who have had a stroke.

b) Quality of life for carers of adults who have had a stroke.

Data source: Data can be collected from information collected locally by healthcare professionals and provider organisations, for example, from surveys of carers.

What the quality statement means for different audiences

Service providers (such as community services) ensure that systems are in place for adults who have had a stroke to be offered active management to return to work if they wish to.

Health and social care practitioners offer adults who have had a stroke active management to return to work if they wish to.

Commissioners ensure that they commission services that offer adults who have had a stroke active management to return to work if they wish to.

Adults who have had a stroke and wish to return to work are offered help and support to do this. This should include help to identify and manage any problems that might make it difficult to return to work.

Source guidance

Stroke rehabilitation in adults. NICE guideline NG236 (2023), recommendation 1.16.4

Definitions of terms used in this quality statement

Active management to return to work

Active management to return to work should include:

- identifying the physical, cognitive, communication and psychological demands of the job (such as multi-tasking by answering emails and telephone calls in a busy office)
- identifying any problems that affect work performance (for example, physical limitations, anxiety, fatigue preventing attendance for a full day at work, cognitive impairments preventing multi-tasking, and communication problems)
- tailoring interventions (for example, teaching strategies to support multi-tasking or memory difficulties, teaching the use of voice-activated software for people with difficulty typing, and delivery of work simulations)
- educating about the Equality Act 2010 and support available (for example, an access-to-work scheme)
- workplace visits and liaison with employers to make reasonable adjustments, such as provision of equipment and graded return to work.

[NICE's guideline on stroke rehabilitation in adults, recommendation 1.16.4]

Equality and diversity considerations

Services should make reasonable adjustments to help adults with significant cognitive impairment and stroke to stay in work or education or find new employment, volunteering and educational opportunities.

Some adults may be unable to work, so other occupational or education activities should be considered, including prevocational training.

Quality statement 6: Regular review of rehabilitation goals

Quality statement

Adults who have had a stroke have their rehabilitation goals reviewed at regular intervals. **[2010, updated 2016]**

Rationale

Regularly reviewing the goals of an adult who has had a stroke helps to identify their values, beliefs and preferences, which may affect the kind of rehabilitation that would be suitable for them. It may also help to encourage and motivate the person, and improve the outcomes of rehabilitation. Goals should be set within 5 days of arrival at an accident and emergency (A&E) department to ensure they are established from the start of the rehabilitation process. They should then be reviewed at regular intervals to ensure that the goals are still relevant to the person who has had a stroke.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults who have had a stroke have their rehabilitation goals reviewed at regular intervals.

Data source: Data can be collected from information recorded locally by healthcare provider organisations, for example, from clinical or service protocols.

Process

a) Proportion of adults who have had a stroke who have their rehabilitation goals agreed within 5 days of arrival at A&E.

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

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

Data source: Data is collected using the Sentinel Stroke National Audit Programme (SSNAP) core dataset question 4.7 and reported in the results of the clinical audit.

b) Proportion of adults who have had a stroke who have their rehabilitation goals reviewed at regular intervals.

Numerator – the number in the denominator who have their rehabilitation goals reviewed at regular intervals.

Denominator – the number of adults who have had a stroke with agreed rehabilitation goals.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Quality of life for adults who have had a stroke.

Data source: Data can be collected from information collected locally by healthcare professionals and provider organisations, for example, from patient surveys. The SSNAP clinical audit includes a quality-of-life measure (EuroQoL EQ-5D-5L) at the 6-month post-stroke follow up.

b) Readmission rates of adults who have had a stroke.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

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 rehabilitation goals reviewed at regular intervals.

Healthcare professionals review regularly the rehabilitation goals of adults who have had a stroke.

Commissioners ensure that they commission services in which adults who have had a stroke have their rehabilitation goals reviewed at regular intervals.

Adults who have had a stroke have the opportunity to discuss and agree goals (things they would like to achieve) for their recovery and have them reviewed regularly to ensure they are still relevant.

Source guidance

Stroke rehabilitation in adults. NICE guideline NG236 (2023), recommendation 1.2.11

Definitions of terms used in this quality statement

Rehabilitation goals

Goals for rehabilitation for people after a stroke should:

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

[NICE's guideline on stroke rehabilitation in adults, recommendation 1.2.7]

Reviewing goals at regular intervals

Goals should be set within 5 days of arrival at A&E. Reviewing goals should take place at intervals suitable to the ability of the individual and nature of the goal, such as at 6 weeks, 3 months, 6 months and annually thereafter. Reviews should take place in goal-setting meetings that are timetabled and held regularly, involve the person after stroke and, where appropriate, their family members and carers, in discussions. [NICE's guideline on stroke rehabilitation in adults, recommendations 1.2.8 and 1.2.11, and expert consensus]

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.

Discussion about goals 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.

Quality statement 7: Regular review of health and social care needs

Quality statement

Adults who have had a stroke have a structured health and social care review at 6 months and 1 year after the stroke, and then annually. **[new 2016]**

Rationale

Reviewing the health and social care needs of adults who have had a stroke enables health and social care practitioners to identify any problems or difficulties the person who had the stroke and their family or carers may be experiencing. This can help adults who have had a stroke and their family or carers to make changes to their care according to their needs.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written protocols to ensure that adults who have had a stroke have a structured health and social care review at 6 months and 1 year after the stroke, and then annually.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from clinical protocols and service specifications.

Process

a) Proportion of adults who have had a stroke who have a structured health and social care review at 6 months after the stroke.

Numerator – the number in the denominator who have a structured health and social care review at 6 months after the stroke.

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

Data source: The Sentinel Stroke National Audit Programme (SSNAP) collects and reports information in the clinical audit on the proportion of patients who have a follow-up assessment at 6 months post-admission.

b) Proportion of adults who have had a stroke and had a structured health and social care review at 6 months after the stroke who have a review 1 year after the stroke.

Numerator – the number in the denominator who have a review 1 year after the stroke.

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

c) Proportion of adults who have had a stroke and had a structured health and social care review at 6 months and 1 year after the stroke, who have annual reviews thereafter.

Numerator – the number in the denominator who have annual reviews.

Denominator – the number of adults who have had a stroke and had a structured health and social care review at 6 months and 1 year after the stroke.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Quality of life for adults who have had a stroke.

Data source: Data can be collected from information collected locally by healthcare professionals and provider organisations, for example, from patient surveys. The SSNAP clinical audit includes a quality-of-life measure (EuroQoL EQ-5D-5L) at the 6-month post-stroke follow up.

b) Readmission rates of adults who have had a stroke.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

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 a structured health and social care review at 6 months and 1 year after the stroke, and then annually.

Health and social care practitioners ensure that adults who have had a stroke have a structured health and social care review at 6 months and 1 year after the stroke, and then annually.

Commissioners ensure that they commission services that enable adults who have had a stroke to have a structured health and social care review at 6 months and 1 year after the stroke, and then annually.

Adults who have had a 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 in adults. NICE guideline NG236 (2023), recommendation 1.17.5

Definitions of terms used in this quality statement

Structured health and social care review

These reviews should address the person's ability to participate in daily activities and their role in their community, as well as secondary prevention and continuing rehabilitation. An agreed local structured health and social care review tool can be used, for example, the Greater Manchester Stroke Assessment Tool (GM-SAT). [NICE's guideline on stroke rehabilitation in adults, recommendation 1.17.5, 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.

Update information

April 2016: This quality standard was updated and statements prioritised in 2010 were replaced.

Statements are marked as **[new 2016]** or **[2010, updated 2016]**:

- **[new 2016]** if the statement covers a new area for quality improvement
- **[2010, updated 2016]** if the statement covers an area for quality improvement included in the 2010 quality standard and has been updated.

Statements numbered 3, 5 and 7 in the 2010 version have been updated and included in the updated quality standard, marked as **[2010, updated 2016]**.

The previous version of the quality standard for stroke in adults is available as a pdf.

Minor changes since publication

October 2023: Changes have been made to align this quality standard with the updated NICE guideline on stroke rehabilitation in adults. Statement 2 on intensity of stroke rehabilitation had the minimum time of therapy each day increased. Statement 3 on access to a clinical psychologist was amended to include clinical neuropsychologists. Links, terminology, definitions, data sources and source guidance sections have also been updated throughout.

May 2019: Changes have been made to align this quality standard with the updated NICE guideline on stroke and transient ischaemic attack in over 16s. References and source guidance sections have been updated.

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.

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, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the

quality statements are highlighted in each statement.

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.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Chartered Society of Physiotherapy
- British Association of Prosthetists and Orthotists
- Stroke Association
- Royal College of General Practitioners (RCGP)
- Association of British Neurologists (ABN)
- Royal College of Occupational Therapists (RCOT)
- Royal College of Physicians (RCP)