ACCELERATING STROKE IMPROVEMENT

NHS Improvement Stroke

Accelerating Stroke Improvement Metrics
Frequently Asked Questions

GENERAL

Q. Are these new set of targets for the NHS?
A. No. It is important to recognise that these are not in anyway 'new targets' for the NHS. All nine link directly to quality makers in the National Stroke Strategy. Two can already be measured by the existing Tier 1 vital sign on stroke. The remainder represent a balance between the need to track progress and what can be collected using existing information systems. Networks will already be working on at least some of these nine areas in their existing plans.

Q. How will data be collated at national level?
A. It will be the role of the SHAs to collect this information via the stroke networks and the PCTs and an overall picture will be collated for organisations at both Network and SHA level. SHAs may then share the information nationally with the Stroke Improvement Programme so that a cohesive national picture can be developed to highlight progress and identify and areas for more intensive support.

Q. When do we start collecting data?
A. There is an expectation that a baseline will be collected as soon as possible ideally starting in May 2010.

Q. The end date given in the metrics is 'by April 2011' does this mean the data will be taken from Quarter 4 of 2010/11?
A. Data will be used through the year to support and guide stroke service improvement and to collate a local and national picture. The last period data will fall under accelerating stroke improvement will be quarter 4 of April 2010/11. Data from this period will indicate progress services have made towards the aspirations of the metrics.

Q. What is the difference going to be between the proposed spreadsheet and the operational definitions in the Accelerated Metric spreadsheet?
A. The Excel spreadsheet will provide networks/teams with an optional data collection tool. The operational definitions describe the parameters of the metrics. The spreadsheet to be offered will be adapted from the Surrey Heart and Stroke Network data collection tool.

METRIC 1: PREVENTABLE STROKES

Q. Can you confirm that the removal of the TIA presentations is intentional and if so, what is the rationale for removing TIA?
A. Removal of TIA was intentional in order to simplify data collection and because treatment of high risk TIA is included in metric 5.

Q. Can you confirm that patients who decline anticoagulation or are contraindicated are neither counted in the denominator nor excluded from the denominator?
A. The metric has already taken into account the proportion likely to be excluded i.e. patients in whom anticoagulation is contraindicated or who decline, so all patients presenting with stroke with AF should be included in the denominator.

Q. The denominator refers to patients admitted with a stroke. Does this mean admitted with a new stroke or admitted with another condition but having a pre existing stroke
A. Only patients admitted with the presenting condition of new acute stroke should be included in the denominator

Q. Is there a definitive list of drugs that are counted as anticoagulants?
A. Warfarin, Phenindione

METRIC 2: DIRECT ADMISSIONS TO STROKE WARD

Q. The numerator contradicts the title of the metric. The numerator asks for the number of patients in an acute stroke unit bed at 4 hours after arrival at hospital but does not state 'admitted directly
A. The operational definition makes it clear that to be counted in the numerator the patient should go straight to the acute stroke unit without spending time on another ward including assessment units. The metric allows for up to four hours to be spent in the Emergency Room/ Accident and Emergency or in the imaging department en route to the stroke unit.

METRIC 4: ACCESS TO BRAIN IMAGING

Q. Is the denominator all stroke patients or those eligible for 60 minute scan? The fact that eligibility criteria are listed suggests only those eligible but is not stated in the numerator. Counting only those eligible would tie in with best-practice tariff and would make the 50% target more sensible
A. The denominator is all stroke patients. The aspiration for the metric has taken into account those who would not be eligible. Eligibility criteria are included to clarify which patients would require imaging within one hour and not to suggest exclusion of patients from the denominator

Q. The metrics refer to time of arrival, but the operational definition refers to time of admission. Which is correct?
A. This is an error in the operational definition**.** The metrics should be calculated from time of arrival at hospital and not from time of admission

Q. Is the 50% target based on evidence or consultation with imaging specialists?
A. At least 50% of patients presenting with stroke symptoms are likely to need an urgent scan based on NICE criteria:

- 10% of stroke patients should be thrombolysed, these would all need immediate scans
- 20% of patients would be considered for thrombolysis (and therefore need an immediate scan) but not meet all the criteria for lysis
- 10% of stroke patients have haemorrhages, and are likely to have a depressed level of consciousness and /or be on warfarin
- 10% of patients will have unexplained or fluctuation symptoms

Q. The target of 100% of stroke patients scanned within 24 hours is impossible to achieve (consider terminal patients
A. The operational definition allows for the exclusion of these patients from the denominator making it possible to achieve 100% of those eligible for imaging. *'Exclude patients not scanned or had a delayed scan for clinical reasons and patients who declined'*

METRIC 6: ACCESS TO PSYCHOLOGICAL SUPPORT

Q. **Why are peer support and befriending not mentioned?**
A. The intention isn't to exclude peer support and befriending from psychological support, rather to attempt to ensure that the individual is assessed in the first instance by an individual with some competence and expertise in psychological support and/ or stroke. The decision to recommend any service for psychological support would ideally be based on an appropriate assessment of need and this is the intention of the metric

Q. Is there a definition for staff with special expertise and competence in assessing, treating and monitoring people with these needs?
A. Limited guidance is given in the definition. Work is being carried out to define further guidance about psychological services for stroke

METRIC 7: JOINT HEALTH AND SOCIAL CARE INVESTMENT

Q. Does this refer to a joint patient and carer care plan rather than joint NHS/local authority care plan?
A. No, it refers to joint working between health and social care services. Joint patient and carer care plans are often valuable, but not appropriate in every case and the key here is to measure how services are working together.

METRIC 8: SIX MONTH REVIEW

Q. Some patients currently got to a specific community facility after they leave hospital. This provides the same service and fulfils the same role as inpatient rehabilitation albeit in a different location. Would '6 months' mean 6 months from being discharged home from hospital or from this facility?
A. Calculation of the 6 months should start at the point of discharge from an in-patient setting for acute care or rehabilitation to the patient's final place of residence.

METRIC 9: ACCESS TO AND AVAILBILITY OF ESD SERVICES

Q. The metric doesn't appear to take into account the catchment population, especially with the prospect of PCTs merging and becoming much bigger – having an ESD in one corner of the county does not equal improved services for the majority of the population
A. The metric is intended for PCTs and ultimately SHAs to understand which of their stroke services available for early specialist rehabilitation and where these services are located in the PCT catchment. There is no indication from the metric that provision of ESD in one corner of a county is the optimal position, rather to assess plans for and intentions to establish services where they are not in place.