Quality of stroke care in 2004

Someone in the UK has a stroke every 5 minutes and the consequences can be devastating – 48% are dead or disabled at 6 months (Mant et al, 2004). Despite this, until relatively recently stroke patients were regarded as boring and bed blocking by some clinicians and stroke services were not a priority for health policy makers.

Fortunately times have changed. There is now a strong evidence base for stroke prevention, acute care, rehabilitation and long-term support, as summarized in the National Clinical Guidelines for Stroke (Intercollegiate Stroke Working Party, 2004a). The cornerstones of a hospital-based stroke service are a stroke unit and a neurovascular clinic.

Further good news is that stroke medicine has recently gained recognition as a sub-speciality from the Joint Committee for Higher Medical Training and a training programme for specialist registrars will be established within each deanery shortly.

The inclusion of stroke within the *National Service Framework for Older People* (Department of Health, 2001) was welcomed. April 2004 was a key milestone by which time every district general hospital that cares for stroke patients should have had a specialist stroke service. Many trusts established multidisciplinary stroke groups to reorganize their service to meet this target. But what has been achieved?

NATIONAL SENTINEL AUDIT OF STROKE

The results of the organizational audit component of the National Sentinel Audit of Stroke (Intercollegiate Stroke Working Party, 2004b) show that although there have been significant improvements in the quality and availability of inpatient stroke services, there are still a number of areas where services need to be improved. Eighty five per cent of hospitals in Northern Ireland, 82% in England and 45% in Wales now have a stroke unit (the Scottish Stroke Collaboration runs a separate audit). The 39 hospitals in England that do not have a stroke unit will be helped by the Department of Health's recovery and support unit to rapidly overcome any difficulties they may have in implementing the National Service Framework requirements.

Stroke units improve outcome regardless of age or stroke severity, but few units currently have the capacity to treat all stroke patients. On any day within a typical hospital only 50% of stroke inpatients are on a stroke unit, the remainder being treated on other wards. Surely we can do better than this?

One way to increase stroke unit capacity is to reduce length of stay. This can be achieved by supported discharge by specialist community stroke teams. Patients and carers value these services and there is some evidence to suggest that they reduce long-term disability. Only 27% of hospitals in England and 5% of hospitals in Wales have access to specialist community stroke services.

Stroke is a medical emergency but too often is not treated as such. Acute stroke units aim to run along the same lines as coronary care units with rapid admission for assessment, diagnosis, treatment and monitoring. An early brain scan is needed to distinguish cerebral infarction from cerebral haemorrhage and some stroke mimics. Access to brain imaging within 24 hours has significantly improved over the last few years and the number of acute stroke units is increasing but too many of these do not even have access to physiological monitoring.

Only two-thirds of hospitals have a neurovascular clinic and just over half of these are able to see patients within 14 days, with waiting times for carotid Doppler sometimes being weeks or months. As the risk of stroke is highest in the weeks immediately following transient ischaemic attack, patients should be seen, investigated and have a management plan in place within 7 days. Current services are not offering timely access to this high-risk group and this needs to be urgently reviewed.

TAKING THIS FORWARD

The audit has given a clear picture of the structure of stroke services nationally. New services have been established and there has been widespread improvement in stroke care, but there remain a number of aspects of care which need to be addressed before all stroke patients and carers have timely access to the quality services they deserve. It is important that momentum is not lost to ensure that this can be achieved. HM

Helen Rodgers
Reader in Stroke Medicine
School of Population and Health Sciences
University of Newcastle, Newcastle upon Tyne
Anthony Rudd
Chairman, Intercollegiate Stroke Working Party and Consultant Stroke Physician, Stroke Unit
St Thomas' Hospital
London SE1 7EH

Department of Health (2001) *The National Service Framework for Older People.* Department of Health, London

Intercollegiate Stroke Working Party (2004a) *National Clinical Guidelines for Stroke.* Royal College of Physicians, London www.rcplondon.ac.uk/pubs/books/stroke/

Intercollegiate Stroke Working Party (2004b) *National Sentinel Audit of Stroke 2004.* Royal College of Physicians, London www.rcplondon.ac.uk/pubs/books/strokeaudit/

Mant J, Wade D, Winner S (2004) Health care needs assessment: stroke. In Stevens A, Raftery J, Mant J, Simpson S, eds. *Health Care Needs Assessment: the Epidemiologically Based Needs Assessment Reviews.* 2nd edn. Radcliffe Medical Press, Oxford

KEY POINTS

- Stroke is a treatable disease and the earlier the patient is admitted the better the chance of a good outcome.
- Specialist registrars can now train for specialist recognition in stroke.
- The quality of stroke care in England has improved steadily in recent years.
- Despite an increase in the numbers of stroke units only 50% of stroke patients are treated in one.
- Neurovascular clinics should be established in all districts so that patients with transient ischaemic attack can be seen and investigated within a maximum of 7 days.