Optimising care pathways for acute stroke and transient ischaemic attack: learning from the project

Key findings

It is difficult to isolate the impact of the project since it took place within the context of the Coventry and Warwickshire Cardiovascular Network's work on implementing all 20 quality markers identified in the National Strategy for Stroke. However, for stroke, there has been a generally upward trend both in the number of patients being thrombolysed and the speed with which treatment is delivered.

Findings:

- Reduced variance in TIA pathway for high risk patients.
- Reduced the number of patients with incorrect paperwork at TIA clinic.

Successes

- The percentage of stroke patients thrombolysed increased from below 13% in quarter 4 of 2009/10 to above 20% for quarter 1 and quarter 2 of 2011/12. This compares favourably with a national thrombolysis rate of 9% for quarter 3 of 2010/11.
- There was a strong upward trend in the percentage of patients seen by a member of the specialist rehab team within 24 hours of admission and seen by all relevant members of the multidisciplinary team within five days of admission.
- Using Plan-Do-Study-Act (PDSA) cycles they developed 'pocket cards' to remind staff in emergency departments of the stroke pathway. This resulted in improved adherence to the acute pathway and increased thrombolysis rates.
- The percentage of patients with suspected TIA at high risk of stroke treated within 24 hours rose from below 70% in April 2010 to 95% in quarter 3 of 2011/12.
- Lower risk TIAs seen within 7 days also improved (though the trend is variable) from 60% in April 2010 to 99% in July-Dec 2011.

Challenges

- Programme staff leaving the project and needing to be replaced led to delays in work progressing and disruption to continuity.

- NHS reorganisations taking place during the project led to approvals (e.g. for the TIA referral form) needing to be sought twice, once from the original Primary Care Trust and again from the new Clinical Commissioning Groups.
- Clinician availability presented challenges and sometimes the project was mis-perceived as an outside demand rather than a collective, facilitative process.
- The team also struggled to engage with hard to reach groups which was very time consuming, though they did succeed in delivering awareness raising sessions to three different Black and Minority Ethnic (BME) groups.
- As the project progressed certain pieces of work were found to be outside the scope of the project, not measurable or too constricted by local guidelines to be delivered by the team, for example education of ambulance staff about FAST (Face, Arms, Speech Test) and measurement of the ABCD2 (Age, Blood Pressure, Clinical Features, Duration of symptoms, Diabetes) score accuracy.
- Difficulty in accessing training time with GPs led to them advising GPs through a stand at a GP Protected Learning Time event rather than conducting individual sessions.

Advice to others doing similar projects

- Regular stakeholder meetings facilitate the opportunity for staff to remain focused and motivated to complete the project.
- Need to be familiar with how local services are structured and know the key drivers in the local healthcare organisations.
- Invest time on relationship building to break down organisational barriers and natural resistance to change.
- Don’t underestimate the amount of work involved in reaching hard to reach groups. In this project, work with BME groups highlighted the need for a structured approach to information and education within the BME community that takes account of the cultural differences in the perception of what is preventable and what action is needed to prevent cardiovascular disease.
- Engage with local trust governance departments early on to prevent rework and delays.