Greater Manchester Stroke
Operational Delivery Network

Greater Manchester compliance with the RCP National Clinical Guideline for Stroke 2016

1. Context

In January 2017, the network audited all stroke unit and community rehabilitation teams treating stroke patients in Greater Manchester for compliance with the updated clinical guideline. Hyper acute, District Stroke Centre (DSC) and community teams were asked to assess whether they fully complied with recommendations in the guideline that were appropriate to their service, and to provide details of any action plans for addressing areas of partial or non-compliance.

Please note, in a few cases due to the way post-acute care is commissioned, a community team may not have responsibility for a recommendation as managed by another team but will have reported non-compliance.

2. Executive summary

- HASUs were audited for compliance against 348 recommendations with overall compliance of 91%. PAT 98%, SHH 90% and SRFT 86%
- DSCs were audited against 332 recommendations with overall compliance of 93%, ranging from 98% (UHSM) to 88% (Bolton)
- Community teams were audited against 188 recommendations with overall compliance of 79%. There was significantly lower compliance from two CNRTs (41% HMR & 46% Salford) with other teams ranging from Trafford ESD (96%) to CMFT (67%)
- Compliance of at least 89% by HASUs & DSCs for sections 2 (organisation of stroke services), 3 (acute care) and 4 (recovery and rehabilitation). DSCs scored very well (98%) for section 5 (long term management and secondary prevention)
- Community teams scored best for section 4 (87%), with sections 2, 4 & 5 all achieving similar scores between 72-79%. Section 3 was not relevant
- Overall, there was poor compliance with recommendations relating to psychological services (2.12 & 4.10.1.1) as they are not commissioned sufficiently or at all across Greater Manchester teams (Tameside, Trafford and Wigan have no inpatient service; Bolton, Bury, CMFT, North, Trafford ESD, UHSM & WWL community teams who have zero or very limited access)
- Section 2 compliance was HASU 89%; DSC 89% and community 72%
    - Key areas of poor compliance across teams in different settings:
        - 2.4.1 *Hyper acute and acute staffing levels matching recommendations* by one HASU and 4 DSCs
        - 2.12.1 All seven recommendations relating to psychological services by DSCs and community teams
        - 2.16.1 *Educational programmes for carers* by HASUs and community teams
- Section 3 compliance was HASU 89% & DSC 94%
- Key issues:
    - *3.2.1 Patients with acute neurological symptoms that resolve completely within 24 hours should be given aspirin 300 mg immediately and assessed urgently within 24 hours…* 4/6 DSCs did not comply and only high risk patients are seen within 24 hours and/or there is no weekend service.
    - *3.11.1 Patients with acute stroke should have an initial specialist assessment for positioning…within 4 hours of arrival at hospital.* One HASU and 3 DSCs did not comply due to limited weekend working by the stroke team and/or limited resources not permitting assessments within the time period
- Section 4 compliance was HASU 93%; DSC 93% and community 87%
    - Key areas of poor compliance across teams in different settings:

        - 4.1.4.1 *Return to work and vocational support by t*wo HASU and three DSCs (some teams did not feel it was their responsibility)
        - 4.3.1.1 & 4.10.1.1 *Access to clinical psychology* by DSCs and community teams
        - 4.9.3.1 S*tandardised assessment of fragility fracture risk* by 3 DSCs and 7 community teams who did not use specific assessment in managing risk
        - 4.9.4.1 *Access to electromechanical assisted gait training* by DSCs and seven community teams as no access to equipment
- Section 5 compliance was HASU 91%; DSC 98% and community 79%
- The only key issue was access to 6 and 12 month review as almost all areas do not offer a 12 month review, although most do a review at 6 months

3. Results

3.1. Section 2 - Organisation of stroke services

HASUs were audited against 71 recommendations. Overall there was 89% compliance with this section, with SRFT complying with 80%, SHH 92% and PAT 96%. Areas of poor compliance (i.e. at least 2/3 HASUs did not comply) were:

- 2.7.1 *Hospital in-patients with stroke who have mild to moderate disability should be offered early supported discharge, with treatment at home beginning within 24 hours of discharge.* There is no community service commissioned in Stockport at present and Salford ESD/CNRT does not treat within 24 hours
- 2.12.1. *Services for people with stroke should consider a collaborative care model for the management of people with moderate to severe neuropsychological problems who have not responded to high-intensity psychological interventions or pharmacological treatments...* This service is not available at SHH or PAT.
- 2.16.1 *The primary carer(s) of a person with stroke should be offered an educational programme…* This is not available at SRFT or SHH

DSCs were audited against 67 recommendations. Overall there was 89% compliance with this section, ranging from 96% (UHSM) to 84% (Tameside & WWL). Areas of poor compliance (i.e. at least 3/6 DSCs did not comply) were:

- *2.4.1 A hyper acute and/or stroke service should provide specialist medical, nursing and rehabilitation staffing levels to match the recommendations…[in the guideline].* 4/6 DSCs did not comply. A previous audit of service specifications showed DSCs were not complying with the recommended staffing level for at least one professional group
- *2.5.1 People with acute stroke who cannot be admitted to hospital should be seen by a specialist team at home or an outpatient within 24 hours…at a standard comparable to that for inpatients .* No DSC complied. Reasons included lack of weekend services or no service provision at all and no nurse or doctor in community team

Four recommendations in 2.12.1 that relate to psychology were not fully complied with by at least 3 DSCs. In each case the deficiencies relate to a lack of commissioning, as Tameside, Trafford and Wigan have no inpatient psychology service:

- *Services for people with stroke should have a comprehensive approach to delivering psychological care that includes specialist clinical neuropsychology/clinical psychology input within the MDT*
- *Services for people with stroke should offer psychological support to all patients …and use matched care model to select the level of support appropriate to the person's needs*
- *Services with stroke should include specialist clinical neuropsychology/clinical psychology provision for severe or persistent symptoms of emotional disturbance, mood or cognition*
- *Services for people with stroke should consider a collaborative care model for the management of people with moderate to severe neuropsychological problems who have not responded to high-intensity psychological interventions or pharmacological treatments…*

Community teams were audited against 52 recommendations. Overall there was 72% compliance with this section, ranging from 92% (Bury) to 15% (Salford CNRT). Areas of poor compliance (i.e. at least 5 teams did not comply) were:

2.6.1 *Transfers of care for people with stroke between different teams or organisations should: – occur at the appropriate time, without delay; – not require the person to provide information already given; – ensure that all relevant information is transferred, especially concerning medication; – maintain a set of person-centred goals; 18 –*

preserve any decisions about medical care made in the person's best interests. Key issues were: waiting times for patients to be assessed and treated and problems transferring information from HASUs/DSCs

Seven recommendations relating to transfers of care from hospital to home (2.7.1) were poorly complied with, especially by the CNRTs:

- *Hospital in-patients with stroke who have mild to moderate disability should be offered early supported discharge, with treatment at home beginning within 24 hours of discharge.* Key issues were: unable to meet 24 hour timeline due to staffing levels; using 72 hour instead of 24 hours protocol; teams not offering 7 days service; delays between ESD and CNRT where separate team model in place; only telephone contact possible within timeframe
- *An early supported discharge team should care predominantly for people with stroke and should provide rehabilitation and care at the same intensity as would be provided if the person were to remain on a stroke unit.* Key issues: unable to provide intensity due to staffing levels; limited community service commissioned (Stockport)
- *A stroke early supported discharge team should be organised as a single multi-disciplinary team including specialists in: – medicine; – nursing; – physiotherapy; – occupational therapy; – speech and language therapy; – clinical neuropsychology/clinical psychology; – with easy access to social work, dietetics, pharmacy, orthotics, orthoptics, specialist seating, assistive technology and information, advice and support for people with stroke and their family/carers.* Not all staffing available in teams
- *A stroke early supported discharge team should be organised as a single multi-disciplinary team....* Key issues: no or very limited access funded psychologist who may be part of inpatient team (Bolton, Bury, CMFT, North, Trafford ESD, UHSM & WWL); no nurse; limited access to social workers
- *Before the transfer of care for a person with stroke from hospital to home (including a care home) occurs: – the person and their family/carers should be prepared, and have been involved in planning their transfer of care, if they are able; – primary healthcare teams and social services should be informed before or at the time of the transfer of care; – all equipment and support services necessary for a safe transfer of care should be in place; – any continuing treatment the person requires should be provided without delay by a coordinated, specialist multi-disciplinary service; – the person and their family/carers should be given information and offered contact with relevant statutory and voluntary agencies.* No comments provided
- *Before the transfer home of a person with stroke who is dependent in any activities, the person's home environment should be assessed by a visit with an occupational therapist. If a home visit is not considered appropriate they should be offered an access visit or an interview about the home environment including photographs or videos taken by family/carers.* No comments provided
- *People with stroke and their family/carers should be involved in decisions about the transfer of their care out of hospital, and the care that will be provided.* No comments provided

2.11.1 *People with stroke should accumulate at least 45 minutes of each appropriate therapy every day, at a frequency that enables them to meet their rehabilitation goals, and for as long as they are willing and capable of participating and showing measurable benefit from treatment.* Needs based approach and low staffing levels cited as key issues

2.11.1 *In the first two weeks after stroke, therapy targeted at the recovery of mobility should consist of frequent, short interventions every day, typically beginning between 24 and 48 hours after stroke onset.* Needs based approach and low staffing levels cited as key issues

Four recommendations in 2.12.1 that relate to psychology were not fully complied by many teams. In each case the deficiencies relate to a lack of commissioning (Bolton, Bury, CMFT, North, Trafford ESD, UHSM & WWL).

- *Services for people with stroke should have a comprehensive approach to delivering psychological care that includes specialist clinical neuropsychology/clinical psychology input within the MDT*
- *Services for people with stroke should offer psychological support to all patients …and use matched care model to select the level of support appropriate to the person's needs*
- *Services with stroke should include specialist clinical neuropsychology/clinical psychology provision for severe or persistent symptoms of emotional disturbance, mood or cognition*
- *Services for people with stroke should consider a collaborative care model for the management of people with moderate to severe neuropsychological problems who have not responded to high-intensity psychological interventions or pharmacological treatments…*

Six recommendations in 2.15.1 that relate to end of life care were poorly complied with by most teams, although four complied with all recommendations (Bury, North, Stockport & WWL). Teams that did not comply were either not commissioned or designed to treat end of life patients:

- *Services providing acute and long-term care for people with stroke should provide high quality end-of-life care for those who need it.*
- *Staff caring for people dying of stroke should be trained in the principles and practice of end of-life care…*
- *Decisions to withhold or withdraw life-prolonging treatments after stroke including artificial nutrition and hydration should be taken in the best interests of the person…*
- *End-of-life (palliative) care for people with stroke should include an explicit decision not to impose burdensome restrictions that may exacerbate suffering…*
- *People with stroke with limited life expectancy…should be offered advance care planning, with access to community palliative care services when needed*
- *People dying of stroke should have access to specialist palliative care…*

2.16.1 *The primary carer(s) of a person with stroke should be offered an educational programme ...* No comments provided

3.1.1. Summary of results

- Compliance was 89% HASU; 89% DSC and 68% community
- Teams with compliance below 80% were all community teams - Bolton, CMFT, HMR CNRT & ESD, Oldham, Salford CNRT & ESD and Stockport
- Significant number of recommendations not complied with by community teams, however, some areas (HMR, Salford & Trafford) have a multiple team model so some recommendations may not apply to all teams in that locality
- Key areas of poor compliance across teams in different settings:
    - 2.4.1 *Hyper acute and acute staffing levels matching recommendations.* One HASU and 4 DSCs did not meet these staffing levels
    - 2.12.1 All seven recommendations relating to psychological services were poorly complied with by DSCs and community teams, with SHH and PAT unable to provide a collaborative care model for the management of people with moderate to severe neuropsychological problems – due to lack of commissioning of psychologists, or insufficient capacity funded
    - 2.16.1 *Educational programmes for carers* – poor compliance in HASUs and community teams, but DSCs were all compliant

3.2. Section 3 - Acute care

HASUs were audited against 67 recommendations. Overall there was 83% compliance with this section, with SRFT complying with 84%, SHH 90% and PAT 94%. Areas of poor compliance (i.e. at least 2/3 HASUs did not comply) were:

3.2.1 *Patients with a confirmed diagnosis of TIA should receive clopidogrel…and high intensity statin therapy…started immediately.* SRFT and SHH use a different drug regimen.

3.11.1 *Patients with acute stroke should have an initial specialist assessment for positioning…within 4 hours of arrival at hospital.* SRFT would comply if a nurse is classed as a specialist.

DSCs were audited against 56 recommendations. Overall there was 94% compliance with this section, ranging from 96% (Trafford & UHSM) to 77% (MRI). Areas of poor compliance (i.e. at least 3/6 DSCs did not comply) were:

- *3.2.1 Patients with acute neurological symptoms that resolve completely within 24 hours should be given aspirin 300 mg immediately and assessed urgently within 24 hours...* 4/6 DSCs did not comply and only high risk patients are seen within 24 hours and/or there is no weekend service.
- *3.7.1 Patients with residual symptoms or disability after definitive treatment of subarachnoid haemorrhage should receive specialist neurological rehabilitation including appropriate clinical/neuropsychological support.* 3/6 DSCs did not fully comply due to lack of psychology support
- *3.11.1 Patients with acute stroke should have an initial specialist assessment for positioning…within 4 hours of arrival at hospital.* 3/6 DSCs did not comply due to limited weekend working by the stroke team and/or limited resources not permitting assessments within the time period

This section was not relevant for community teams

3.3. Section 4 – Recovery and rehabilitation

HASUs were audited against 144 recommendations. Overall there was 92% compliance with this section, with SRFT complying with 88%, SHH 96% and PAT 97%. Areas of poor compliance (i.e. at least 2/3 HASUs did not comply) were:

4.1.4.1 *People who wish to return to work after stroke (paid or unpaid employment) should: – have their work requirements established with their employer (provided the person with stroke agrees); – be assessed cognitively, linguistically and practically to establish their potential for return; – be advised on the most suitable time and way to return to work, if return is feasible; – be referred through the job centre to a specialist in employment for people with disability if extra support or advice is needed; – be referred to a specialist vocational rehabilitation team if the job centre specialist is unable to provide the necessary rehabilitation.* SRFT have no formal policy or arrangements in place and SHH felt it should be done by community services (although none are commissioned)

4.1.4.1 *Vocational rehabilitation programmes for people after stroke should include: – assessment of potential problems in returning to work, based on the work role and demands from both the employee's and employer's perspectives; – an action plan for how problems may be overcome; – interventions specifically designed for the individual which may include: vocational counselling and coaching, emotional support, adaptation of the working environment, strategies to compensate for functional limitations in mobility and arm function, and fatigue management; – clear communication between primary and secondary care teams and including the person with stroke, to aid benefit claims or to support a return to work.* SRFT have no formal policy or arrangements in place and SHH felt it should be done by community services (although none are commissioned)

DSCs were audited against 144 recommendations. Overall there was 93% compliance with this section, ranging from 99% (UHSM) to 87% (Tameside). Areas of poor compliance (i.e. at least 3/6 DSCs did not comply) were:

- *4.1.4.1 Vocational rehabilitation programmes for people after stroke should include…*3/6 DSCs did not comply as it was not felt appropriate in an inpatient setting.
- *4.3.1.1 People with severe or persistent cognitive problems after stroke should receive specialist assessment and treatment from a clinical neuropsychologist/clinical psychologist.* 4/6 DSCs did not comply due to lack of psychology
- *4.9.3.1 People at high risk of falls after stroke should be offered a standardised assessment of fragility fracture risk as part of their stroke rehabilitation.* 4/6 DSCs did not comply as not cited as routine practice or risks assessments not specific to falls.
- *4.9.4.1 People who are able to walk independently after stroke should be offered treadmill training with or without body weight support or other walking-orientated interventions at a higher intensity than usual care and as an adjunct to other treatments.*3/6 DSCs did not comply usually citing lack of access in an inpatient setting
- *4.9.4.1 People who cannot walk independently after stroke should be considered for electromechanical-assisted gait training including body weight support.* 5/6 DSCs did not comply usually citing lack of access in an inpatient setting
- *4.9.4.1 People with stroke who have reduced ability to dorsiflex the foot should be offered functional electrical stimulation to improve their gait.* 4/6 DSCs did not comply usually citing lack of access in an inpatient setting

Four recommendations in 4.10.1.1 that relate to psychology were not fully complied with by at least 3 DSCs. In each case the deficiencies relate to a lack of commissioning:

- *People with aphasia and low mood after stroke should be considered for individual behavioural therapy e.g. from an assistant psychologist.*
- *People with severe or persistent symptoms of emotional disturbance after stroke should receive specialist assessment and treatment from a clinical neuropsychologist/clinical psychologist.*
- *People with persistent moderate to severe emotional disturbance after stroke who have not responded to high intensity psychological intervention or pharmacological treatment should be considered for collaborative care. Their care should involve collaboration between the GP, primary and secondary physical*

health services and case management, with supervision from a senior mental health professional and should include long term follow-up

4.14.1 People with stroke should be asked, soon after discharge and at their 6-month and annual reviews, whether they have any concerns about sex… 3/6 DSCs did not comply stating it was not routinely assessed

4.14.1 People with sexual dysfunction after stroke who want further help should be: – assessed for treatable causes including a medication review; – reassured that sexual activity is not contraindicated after stroke and is extremely unlikely to precipitate a further stroke; – assessed for erectile dysfunction and the use of a phosphodiesterase type 5 inhibitor (e.g. sildenafil); – advised against the use of a phosphodiesterase type 5 inhibitor for 3 months after stroke and/or until blood pressure is controlled; – referred to a professional with expertise in psychosexual problems if sexual dysfunction persists. 3/6 DSCs did not comply stating it was not routinely assessed

Community teams were audited against 115 recommendations. Overall there was 87% compliance with this section, ranging from 98% (Trafford ESD) to 69% (HMR CNRT). Areas of poor compliance (i.e. at least 5 teams did not comply) were:

4.1.4.1 *People who wish to return to work after stroke (paid or unpaid employment) should: – have their work requirements established with their employer (provided the person with stroke agrees); – be assessed cognitively, linguistically and practically to establish their potential for return; – be advised on the most suitable time and way to return to work, if return is feasible; – be referred through the job centre to a specialist in employment for people with disability if extra support or advice is needed; – be referred to a specialist vocational rehabilitation team if the job centre specialist is unable to provide the necessary rehabilitation.* No specialist role in team, could have better links with job centres, nowhere to refer to

4.2.1 *People with stroke who have 20 degrees of active wrist extension and 10 degrees of active finger extension in the affected hand should be considered for constraint-induced movement therapy.* Key issues: therapy not offered within community team or informally used only; staff may not be trained

4.2.1 *People with reduced arm function after a stroke should only be offered robot-assisted movement therapy or neuromuscular electrical stimulation as an adjunct to conventional therapy in the context of a clinical trial.* No access to robot assisted therapy trials by teams

4.3.1.1 *People with severe or persistent cognitive problems after stroke should receive specialist assessment and treatment from a clinical neuropsychologist/clinical psychologist.* Lack of commissioned services

4.5.1 *People with stroke who have continued loss of bladder and/or bowel control 2 weeks after onset should be reassessed to identify the cause of incontinence, and be involved in deriving a treatment plan…*Usually managed via referral to continence/other team

4.5.1. *People with stroke with continued loss of urinary continence should be offered behavioural interventions and adaptation…* Usually managed via referral to continence/other team

4.5.1 *People with stroke with constipation should be offered: – advice on diet, fluid intake and exercise; – a regulated routine of toileting; – a prescribed drug review to minimise use of constipating drugs; – oral laxatives; – a structured bowel management programme which includes nurse-led bowel care interventions; – education and information for the person with stroke and their family/carers; – rectal laxatives if severe problems persist.* Usually managed via referral to continence/other team

4.9.3.1 *People at high risk of falls after stroke should be offered a standardised assessment of fragility fracture risk as part of their stroke rehabilitation.* Key issues: no falls specific risk assessment formally used; may refer to falls team

4.9.3.1 *People with stroke with symptoms of vitamin D deficiency, or those who are considered to be at high should be offered calcium and vitamin D supplements.* Not routinely considered, referral may be to GP

4.9.4.1 *People who cannot walk independently after stroke should be considered for electromechanical-assisted gait training including body weight support.* No access to equipment

Five recommendations in 4.10.1.1 that relate to psychology were not fully complied by many teams. In each case the deficiencies relate to a lack of commissioned services.

- *People with or at risk of depression or anxiety after stroke should be offered brief psychological interventions such as motivational interviewing or problem-solving therapy …before considering antidepressant medication*

- *People with aphasia and low mood after stroke should be considered for individual behavioural therapy e.g. from an assistant psychologist*
- *People with depression or anxiety after stroke who are treated with antidepressant medication should be monitored for adverse effects and treated for at least four months beyond initial recovery. If the person's mood has not improved after 2-4 weeks, medication adherence should be checked before considering a dose increase or a change to another antidepressant*
- *People with severe or persistent symptoms of emotional disturbance after stroke should receive specialist assessment and treatment from a clinical neuropsychologist/clinical psychologist.*
- *People with persistent moderate to severe emotional disturbance after stroke who have not responded to high intensity psychological intervention or pharmacological treatment should be considered for collaborative care…*

4.10.2.1 *People with stroke who persistently cry or laugh in unexpected situations or are upset by their fluctuating emotional state should be assessed by a specialist member of the multidisciplinary team trained in the assessment of emotionalism.* Some teams felt this was not the responsibility of the community team and referred to the GP if no psychologist was commissioned

4.10.2.1 *People with severe or persistent emotionalism after stroke should be given antidepressant medication, monitoring effectiveness by the frequency of crying. They should be monitored for adverse effects and treated for at least four months beyond initial recovery. If the person's emotionalism has not improved after 2-4 weeks, medication adherence should be checked before considering a dose increase or a change to another antidepressant.* Some teams felt this was not the responsibility of the community team and referred to the GP if no psychologist was commissioned

4.11.1 *People in hospital or living in a care home after stroke should receive mouth care from staff who have been trained…*Some teams felt mouth care was not their responsibility

4.14.1 *People with sexual dysfunction after stroke who want further help should be: – assessed for treatable causes including a medication review; – reassured that sexual activity is not contraindicated after stroke and is extremely unlikely to precipitate a further stroke; – assessed for erectile dysfunction and the use of a phosphodiesterase type 5 inhibitor (e.g. sildenafil); – advised against the use of a phosphodiesterase type 5 inhibitor for 3 months after stroke and/or until blood pressure is controlled; – referred to a professional with expertise in psychosexual problems if sexual dysfunction persists.* Often referred elsewhere

4.17.1 *People with visual loss due to retinal artery occlusion should be jointly managed by an ophthalmologist and a stroke physician.* Visual screening may be carried out with referral to orthoptics

3.3.1. Summary of results

- Compliance was 93% HASU; 93% DSC and 87% community
- Only Salford CNRT was below 80% compliance at 70%, however, some teams felt some recommendations were not relevant to them (e.g. 4.10.2.1)
- Key areas of poor compliance across teams in different settings:
    - 4.1.4.1 *Return to work and vocational support.* Two HASU and three DSC teams did not comply but did not feel they were relevant for their team, 5 community teams also did not comply
    - 4.3.1.1 & 4.10.1.1 *Access to psychology*. All recommendations were poorly complied with by many DSCs and community teams due to lack of commissioned services in psychology
    - 4.9.3.1 S*tandardised assessment of fragility fracture risk.* Three DSCs and seven community teams failed to comply as did not use specific assessment in managing risk
    - 4.9.4.1 *Access to electromechanical assisted gait training*. Five DSCs and seven community teams had no access to equipment

3.4. Section 5 – Long term management and secondary prevention

HASUs were audited against 66 recommendations. Overall there was 91% compliance with this section, with SRFT complying with 91%, SHH 85% and PAT 97%. Areas of poor compliance (i.e. at least 2/3 HASUs did not comply) were:

5.8.1.1 *People with stroke or TIA should aim to achieve 150 minutes or more of moderate intensity physical activity per week in bouts of 10 minutes or more..they should also engage in muscle strengthening activities at least twice per week.* SRFT and SHH advised in principle only

5.8.1.1 *People with stroke or TIA who are at risk of falls should engage in additional physical activity which incorporates balance and co-ordination at least twice per week.* SRFT and SHH advised in principle only

5.9.1.1 *People with stroke, including those living in a care home, should be offered a structured health and social care review at six months and 1 year after the stroke, and then annually...* Only a 6 month review is commissioned in Salford, and no 6 or 12 month review is funded in Stockport

DSCs were audited against 66 recommendations. Overall there was 98% compliance with this section, ranging from 100% (MRI & UHSM) to 91% (Bolton). There were no areas of shared poor compliance.

Community teams were audited against 21 recommendations. Overall there was 79% compliance with this section, ranging from 100% (Salford & Trafford ESD) to 10% (HMR CNRT). Areas of poor compliance (i.e. at least 5 teams did not comply) were:

5.4.1 *Blood pressure-lowering treatment for people with stroke or TIA should be monitored frequently and increased to achieve target blood pressure as quickly as tolerated and safe in primary care. People whose blood pressure remains above target despite treatment should be checked for medication adherence before being referred for a specialist opinion.* Key issue was no nurse on team and/or not commissioned to do it

5.9.1.1 *People with stroke, including those living in a care home, should be offered a structured health and social care review at six months and 1 year after the stroke, and then annually…*Almost all teams do not offer a 12 month review, although most do a review at 6 months

3.4.1. Summary of results

- Compliance was 91% HASU; 98% DSC and 72% community
- A number of community teams were less than 80%: Bolton; CMFT; Salford CNRT & WWL
- The only problematic recommendation across care settings was access to 6 and 12 month review as almost all areas do not offer a 12 month review, although most do a review at 6 months