Group arrangements:
Salford Royal NHS Foundation Trust (SRFT)

Northern Care Alliance
NHS Group

COVID 19- PERIOD temporary Guidelines amended for TIA - Guidelines for Initial Assessment and Management of Crescendo Transient Ischaemic Attacks CTIA/TIA and Minor ischaemic stroke

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Applies to:	Salford Royal Care Organisation
Date approved:	31.03.2020
Expiry date:	Until COVID PERIOD- 19 ended and review regular throughout the period

Contents

Section			Page
1	What is the policy about?		2
2	Where will this document be used?		2
3	Why is this document important?		2 - 3
4	What is new in this version?		3
5	What is the Policy?		
	5.1	How do patients with TIA/minor stroke access the stroke services?	4-5
	5.2	Investigation of Crescendo TIA / recurrent Transient Ischaemic Attack/minor stroke on Best Medical Treatment (BMT)	5-6
	5.3	Treatment Of Crescendo TIA / recurrent Transient Ischaemic Attack/minor stroke on Best Medical Treatment (BMT)	7-8
	5.4	Individualised assessment of risk and post TIA/minor stroke restrictions.	8-9
	5.5	Follow up	9
6	Roles and responsibilities		9
7	Monitoring document effectiveness		9-10
8	Abbreviations and definitions		10
9	References and Supporting Documents		10-11
10	Document Control Information		12-13
11	Equality Impact Assessment (EqIA) screening tool		14-15
12	Appendices		
	Appendix 1	Stroke prevention pathway.	

	Appendix 2	Referral documentation	
	Appendix 3	TIA clinic information leaflet (standard version).	
	Appendix 4	TIA clinic information leaflet (Aphasia friendly version).	
	Appendix 5	Contact information for TIA services in other areas.	

1. What is this policy about?

1.1 This policy is developed to cover the initial assessment and management of patients thought to have experienced a Transient Ischaemic Attack (TIA).

1.2 This current policy has been updated due to the need for urgent change during the COVID -19 period. The relevant sections have been highlighted in RED to emphasise the temporary changes

1.3 All of the changes are based on COVID-19 guidance produced on national levels by the British Vascular Society and the National Stroke Guidance document and most recent, best evidence, published articles

2. Where will this document be used?

2.1 This policy is designed for use in Salford Royal Care Organisation.

2.2 The policy is designed for use within Salford Care Organisation and is designed for the use in Adult care settings.

3. Why is this document important?

3.1 Transient ischaemic attacks are sudden onset neurological syndromes likely to be cerebrovascular in origin and lasting less than 24 hours (Hankey and Warlow 1994). They will usually be fully resolved or rapidly resolving at first presentation to a healthcare professional. Such episodes require assessment to establish the diagnosis (approximately 50% are not TIA) and early institution of a management plan to reduce the risk of stroke.

5.2% of patients with a diagnosis of TIA will go on to develop a stroke within 7 days (Giles and Rothwell 2007) and the risk may be particularly high in some patient groups (e.g. atrial fibrillation and carotid artery stenosis). Not all TIAs behave the same way however and patients can be split into low risk and high risk on the basis of their ABCD2 score (Johnston et al 2007). For those patients at high risk of stroke early intervention is effective at reducing the risk of early stroke (Luengo-Fernandez et al 2007).

How can patients be stratified as high risk or low risk?

Previously, TIAs have been risk stratified using the ABCD2 assessment tool. Royal College of Physician guidelines (2016) suggest that we no longer stratify these patients suggesting that all patients with a suspected TIA are reviewed within a specialist clinic within 24 hours of onset of symptoms. Those patients with a suspected TIA which occurred more than one week ago should be seen within specialist services within 7 days.

4. What is new in this version?

4.1

- The policy has updated contact information for TIA services within other trusts to allow for easier referral.
- Newly designed TIA leaflets in conjunction with the Operational Delivery Network both written and aphasia friendly versions.
- We have identified that all patients referred to the Rapid Access TIA Service are seen within 24 hours of referral and as such are no longer risk stratified using the ABCD2 tool.
- New flow sheet for documenting all TIA assessments found on EPR entitled 'TIA rapid access clinic'.
- **COVID -19 period: as the interim policy for Crescendo TIA/ TIA and MINOR STROKE during COVID – 19 period. To be used as guidance for this period only.**
- **Delivery of medical treatment prescriptions – during COVID period**

5. Policy

5.1 How do patients with TIA access the stroke services?

5.1.1 The daily TIA clinic is commissioned for the local residents of Salford. Patients who attend from outside the Salford area should, in most circumstances, be referred by the initial assessing team to their local TIA service (Appendix 1 & 5). Most TIA patients should be managed as outpatients.

For patients with 'crescendo TIA' (two or more TIAs in one week) consideration should be given to admit the patient for further assessment. There is a facility to see and assess TIA patients at SRFT 7 days a week.

COVID period – 19 referral pathway :
The referrals are received via the usual referral pathway from outside SRFT or other departments in SRFT or patients that are seen by the stroke team in SRFT

5.1.2 Patients referred on the 'rapid access TIA pathway'

These are usually from the patient's primary care surgery. **Referrals are to be submitted by email. Please follow the below flow chart:**

COVID- 19 TIA/minor stroke FLOW CHART (PROCESSING TIA'S referrals on the pathway)

REFERRAL FROM ED
(TRANSIENT ISCHAEMIC ATTACK GUIDELINES FOR INITIAL ASSESSMENT /MANAGEMENT -PROFORMA ON INTRANET)

REFERRAL FROM GP

↓

EMAIL TO salford.tia@nhs.net or FAX to 0161 206 0899 (If Salford GP patient)
If NOT Salford GP – please see list of contacts below to send referal on to

↓

Admin Team pick up Monday to Friday 8am to 4pm to process booking

↓

Admin Team log on TIA Spreadsheet, book to TIATRCL for triage purposes,
All appointments are telephone consultations during the COVID-19 period and patients will be called in the morning, so that a prescription can be made before 12:00 hrs of the day of the consultation if needed. The stroke team will take the prescription before 12:00 hrs to Lloyds Pharmacy in SRFT and the Pharmacy team will deliver to the patients home address, via courier aiming for the same day but within 24 hours.

Contact List for NON Salford GP patients

Pennine:- pah-tr.stroketiareferrals@nhs.net or Fax 01706 906 677 or call 0161 778 2233
Manchester Royal: mft.geriatrics-stroke.manchester@nhs.net or Fax 276 3541 or call 276 4568
Bolton:- Boh-tr.boltonstrokeunit@nhs.net
Stockport:- anne.clements1@nhs.net; donna.murkin@nhs.net; emma.higginbottom@nhs.net; Sheila.appleton@nhs.net or Fax 0161 419 5792
Trafford:- bookingoffice.t36@nhs.net or Fax 0161 746 2071
Tameside:- tga-tr.stroketeamthft@nhs.net or Tel 0161 922 6991
Wythenshawe:- Elaine.french@uhsm.nhs.uk or Fax 0161 291 6075 Tel 0161 291 6374
Wright/Wigan and Leigh wwl-tr.TIApatients@nhs.net or 01942 822 596
Warrington:- Tel: 01925 662 268

Some patients may be referred from A+E in this way.

Instructions regarding Crescendo TIAs: this patient group will definetly need admission

Instructions regarding Minor stroke if in ED: please assess and may be able to go home direct from ED discuss with consultant on call. However, if they have significant impairment that does not allow safe discharge from ED then need admission.

5.1.3 Patients self-presenting to A+E

These patients are ordinarily seen in the first instance by the A+E team. **They may be referred by way of email, or for patients for whom there is concern, the case may be discussed with the on-call Registrar / AP who should, under most circumstances, aim to see the patient for assessment on this attendance**. Patients who reside from outside the Salford catchment area should be referred back to their local TIA service see above flowchart.

5.1.4 Patients brought on the 'stroke pathfinder' route

Patients who come on this route would normally be seen by the attending stroke team. They should be assessed and then further investigation arranged as appropriate. Patients would ordinarily be referred to their local TIA service. Don't forget to fill out TIA rapid access document**. For the COVID – 19 period please inform the patients that the referred teams will contact them via a telephone consultation.**

5.1.5 Roles and Responsibilities

The stroke coordinator will collate all referrals received via fax and preferred option now by email.

The Registrar / AP designated to cover TIA clinic should review referrals first priority in the morning . Each case will be triaged to effectively fill the available appointment slots.
During the COVID-19 period all consultations will be via telephone Consultations and only the necessary onsite investigations as per sections included in this guidance will be performed during the COVID-19 period.

It is expected that all patients will be discussed with the consultant on call overseeing TIA clinics.

The stroke coordinator will assist in the delivery of the service by contacting patients to inform them of their appointment.

5.2 Investigation of transient ischaemic attacks

5.2.1 Time frame for investigation and treatment

During the COVID-19 period:
All patients should be contacted within 24 hours of receiving the referral and fully investigated according to revised guidance based on British Vascular Society and

national stroke guidelines (included evidence and see sections for investigations) , and treatment plan in place within 24 hours of them being first seen by a healthcare professional.

Patients should be contacted via telephone by a member of the stroke team in a timely fashion in order to facilitate any urgent investigations. The clinics will be completed by either SpR or ACP with oversight from a Stroke Consultant who will be expected to advise on treatment pathways as necessary.

If referred from within the Trust, including A+E, the best practice would be to assess the patient directly on the same admission.

Patients will be

5.2.3 Brain imaging

Brain imaging is not routinely indicated in TIA.

It should be considered and can be helpful in the management when

1. Haemorrhage needs to be excluded: for example people on anticoagulation, long duration of symptoms or clinical signs have not fully resolved. CT should be the first line of brain imaging.

2. People being considered for carotid endarterectomy where it is uncertain whether the stroke is in the anterior or posterior circulation. MRI and MRA cervical vessels is the imaging modality of choice-

3. Where an alternative diagnosis is being considered. MRI is the imaging modality of choice

For the COVID-19 period this will need to be considered on a case by case basis and risk assessed to decide if a scan is needed or could be deferred to a later stage

5.2.4 Cervical artery imaging

Carotid Doppler ultrasound imaging (USS) is the preferred method of imaging in patients following anterior circulation TIA. USS imaging slots are available to the TIA service and take place on ward EAU.

Doppler imaging is not indicated in posterior circulation TIA

IMPORTANT NOTE: ADVICE FOR THE COVID-19 PERIOD

Indications for Carotid Doppler imaging or CTA of the Carotid arteries:

If Crescendo TIA in the anterior circulation or recurrent events of TIA/minor stroke despite Best Medical Treatment (BMT as per this policy - please see updated section):

The first choice would be CT angiogram of the Carotid Arteries and Carotid doppler only if the patient is allergic to Contrast medium.

5.2.5 Cardiac investigations.

All patients should have an ECG **– during the COVID- 19 period the patient might not be able to attend due to self-shielding needs. The department is available for urgent request.**

Requests will be completed online and the patient will be directed to cardio respiratory investigations in outpatient department. Specific attention should be paid to evidence of cardiac dysrhythmia (e.g. atrial fibrillation/flutter).

Further investigation such as echocardiography and prolonged ECG monitoring will be guided by clinical assessment and would normally be requested as outpatient investigation. **– please continue to request but advise the patient that there will be a significant waiting time due to the backlog building up. The department is available to provide a service for urgent tapes (this would be, for example, a patient presenting with cardiac syncope/pre-syncope to exclude a potential serious Tachy/Brady Arrhythmia.**

Cardiac investigations (except routine ECG) are generally not part of the '24 hour' or '1 week' target unless clinical assessment dictates urgent investigation is needed.

5.3 Treatment Of Transient Ischaemic Attack

During the COVID-19 Period:
Outpatient prescriptions are available for the telephone Rapid access TIA team for follow on medication. The ACP/SCF will take all prescriptions every day to Lloyds Pharmacy situated in the Hope Building. However, the courier everyday will pick up the outstanding prescription and deliver those on the same day. This might therefore on a Monday and Friday not be a possibility as those patients won't have been contacted and therefore on those days a phone call by the ACP/SCF to the GP surgery on those days to ask for an urgent prescription to be issued on that day.

5.3.1 Antithrombotic Therapy

5.3.2 Antiplatelet therapy

Most patients will have already been given Aspirin 300mg from the referring physician, if not, once a diagnosis of TIA, crescendo TIA and minor stroke is made in a patient without atrial fibrillation, 300mg Aspirin should be given (unless intolerant/contraindicated, in which case the 300mg loading dose of Clopidogrel can be given) followed by BEST MEDICAL TREATMENT (BMT) Aspirin 75mg once a day and

Clopidogrel 75mg once a day for a total of 21 days, followed by Clopidogrel 75 mg once a day.

In patients unable to tolerate Clopidogrel, Aspirin 75mg daily and Dipyridamole M/R200mg bd should be used. If patients are intolerant to both Aspirin and Clopidogrel, Dipyridamole M/R 200mg bd may be used as a single agent. The clinical situation will guide which combinations of antiplatelet agents are thought necessary.

5.3.3 Anticoagulant therapy

If the patient is found to have atrial fibrillation they should be anticoagulated immediately, but only in the following situations:

- With brain imaging to exclude haemorrhage
- Control of hypertension to an acceptable level

Immediate anticoagulation may include LMWH until anticoagulated with warfarin, or use of a NOAC. A discussion should be had with each patient, presenting the therapeutic options and the patient preference taken into account. Guidance issued by Medicines Management; New oral anticoagulant drugs (NOAC) and their use in the management of atrial fibrillation in Salford patients, and http://www.nyrdtc.nhs.uk/GMMMG/Groups/Publications/IPNTS_docs/IPNTS_recom_2/IPNTS%20NOAC%20recommendation%20%20updated.pdf gives comprehensive guidance on this process and information can be supplemented with SRFT guidance on anticoagulation after stroke and transient ischaemic attack.

If LMWH is to be used prior to the initiation of warfarin through the anticoagulation clinic, then the patient will be shown how to self-administer by the ward staff and supplied with a yellow sharps bin. If the patient is unable to self-administer, then a referral should be made to the district nurse team. If LMWH is chosen this should be prescribed as a STAT dose on a paper drug chart to allow the first dose to be administered on the ward. Further supply should be prescribed on an outpatient prescription to be taken to outpatient pharmacy. If a NOAC is selected, this should be initiated on an outpatient prescription from the clinic.

5.3.4 Statin therapy

Patients should also be prescribed a statin immediately (such as Atorvastatin 40mg each night), this can be prescribed by the GP surgery and stated so on the Rapid TIA Clinic letter to the GP surgery.

5.3.5 Surgical intervention

Urgent referral to vascular surgical SpR/SCF at Manchester Royal infirmary MFT Trust is via the MDSAS electronic referral pathway, used by a number of specialities including plastics and spinal surgery, which has been adapted for vascular and a specific pathway developed for stroke patients.

Enter ‘referrals.mdsas’ into the web browser bar and it will offer the home page, vascular is the bottom left option and follow the instructions to refer a patient. This results in an automatic email

generation to surgeons and although we ask your team to still contact us by phone every time for now, once it is working smoothly we can remove that requirement.

5.3.6 Addressing individual risk factors

An assessment should be made of all patients' individual risk factors, paying particular attention to hypertension, diabetes mellitus, diet (including salt), and smoking status. Consideration of referral to the appropriate team should be made, such as smoking cessation, dietetics, for example.

5.4 Individualised assessment of risk and post Transient Ischaemic Attack restrictions.

5.4.1 Addressing individual risk factors

An assessment should be made of all patients' individual risk factors, paying particular attention to hypertension, diabetes mellitus, diet (including salt), and smoking status. Consideration of referral to the appropriate team should be made, such as smoking cessation, dietetics, for example.

5.4.2 Driving Advice

All patients suffering a TIA/minor stroke who are group 1 licensed drivers should be advised that current (as of 4th of March 2020) Driver and Vehicle Licensing Authority (DVLA) regulations state they would not be allowed to drive for 1 month following a TIA and don't need to notify the DVLA . Currently group 2 license holders are required to notify the DVLA and their license is revoked for 1 year. You should always check the DVLA regulations to provide the most up to date information for the patient (www.dvla.gov.uk).

Crescendo TIA – licensed drivers group 1 should be advised that current (as of 4th of March 2020) must not drive for 3 months and must notify the DVLA. Group 2 currently must not drive and the licence will be revoked for 1 year and must notify the DVLA.

5.5 Follow up.

Patients from the Salford area are normally offered follow up in the stroke clinic after 6 weeks. The 6 week follow up will continue to be delivered within the Wednesday stroke outpatient clinic within the outpatients department. During the **COVID-19 period telephone consultations will replace the existing OPC.**

Patients from outside of the Salford area should have their follow up facilitated at their local hospital TIA clinic.

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6. Roles and responsibilities

6.1 Clinical director for stroke Services has lead responsibility for Stroke department including TIA/stroke services Issues regarding services should be escalated for the Directors awareness.

6.2 Clinical Lead for TIA/stroke services is responsible to maintain the accuracy of information within this policy. Adverse events should be highlighted to the TIA/stroke lead so they may assess adverse events to be shared with individuals using the policy. TIA clinical lead also to audit outcomes of the service to ensure appropriate quality improvement measures are used to maintain service safety.

6.3 Those individuals assessing patients suspected of having had a TIA/CTIA/minor stroke are expected to be aware and to have accessed the policy to ensure appropriate and timely referral to services.

7. Monitoring document effectiveness

7.1 Key Standards:

1.) Patients with TIA/CTIA/minor stroke must be seen, basic investigation completed, diagnosed and treated within 24 hours of first being seen by a healthcare practitioner

2.) Patients with TIA over one week ago must be seen, basic investigation completed, diagnosed and treated within 7 days of first being seen by a healthcare practitioner

3.) All patients should have lifestyle and health advice provision of Stroke association leaflets, available on ASU.

4.) All drivers should be given the appropriate driving advice depending on their licensing group

- **Method(s):** Retrospective clinical audit of patient experience will be used via the TIA log which is documented collection of all referrals received and their outcomes. At each audit, which will be registered with clinical audit lead, will be assessed against the standards outlined above.

- **Team responsible for monitoring:** Clinical lead for TIA and other appropriate team members appointed to assist.

- **Frequency of monitoring:** Annually**.**

- **Process for reviewing results and ensuring improvements in performance:** Sharing of results will be via Clinical Governance meetings, Directorate meetings and through stroke specific education sessions.

8. Abbreviations and definitions

ASU	Acute stroke unit
CT	Computed tomography
DVLA	Driver and vehicle licensing authority
DWI	Diffusion weighted imaging
ECG	Electrocardiograph
FBC	Full blood count
LMWH	Low molecular weight heparin
MRA	Magnetic resonance angiography
MRI	Magnetic resonance imaging
NASCET	North American symptomatic carotid endarterectomy trial
NICE	National Institute of Clinical Excellence
N/DOAC	New/Direct oral anticoagulant (e.g. factor Xa inhibitors or direct thrombin inhibitors)
RCP	Royal College of Physicians
TIA	Transient ischaemic attack
U+E	Urea and electrolytes
USS	Ultrasound carotid imaging

9. References and Supporting Documents

9.1 References

- Intercollegiate Stroke Working Party. *National clinical guideline for stroke,* 4th edition. London: Royal College of Physicians, 2012.

- National Institute for Health and Clinical Excellence (2008b) *Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA)*. London: NICE (www.nice.org.uk/CG68).

- Hankey G,Warlow C (1994) *Transient ischaemic attacks of the brain and eye.* London: WB Saunders.

- Giles MF, Rothwell PM. Risk of stroke early after transient ischaemic attack: a systematic review and meta-analysis. *Lancet Neurol* 2007;6:1063–72.

- Johnston SC, Rothwell PM, Nguyen-Huynh MN *et al*. Validation and refinement of scores to predict very early stroke risk after transient ischaemic attack. *Lancet* 2007;369:283–92.

- Luengo-Fernandez R, Gray AM, Rothwell PM. Effect of urgent treatment of TIA and minor stroke on early recurrent stroke (EXPRESS study) a prospective population-based sequential comparison. *Lancet* 2007;8:1342–2.

- Young, G., Humphrey, P.R.D., Shaw, M.D.M., Smith, E.T.S. and Nixon, T.E. Comparison of MR Angiography, Duplex Ultrasound and OS Angiography in the assessment of extracranial carotid stenosis. J. Neuro. Neurosurg. & Psychiatry, 1994, 57, 1466-78.

- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200395/at_a_glance_1_.pdf

- **British Vascular Society Guidance on Carotid imaging During COVID -19 period**

  http://smtp.srft.nhs.uk:32224/?dmVyPTEuMDAxJiZiZTU2NTY3NzJiNmI1ZDY5YT01RTdCOTQ4Ql8yOTYzMF8xNjU3NF8zMyYmZGVhZDgyNWY4ZjI1YWVhPTEyMjImJnVybD1odHRwcyUzQSUyRiUyRnd3dyUyRXZhc2N1bGFyc29jaWV0eSUyRW9yZyUyRXVrJTJGcHJvZmVzc2lvbmFscyUyRm5ld3MlMkYxMTMlMkZjb3ZpZDE5JTVGdmlydXMlMkUZhbmQlNUZ2YXNjdWxhciU1RnN1cmdlcnk=

- **Best Medical Treatment: https://www.bmj.com/content/bmj/364/bmj.l895.full.pdf**

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10. Document Control Information

It is the author's responsibility to ensure that all sections below are completed in relation to this version of the document prior to submission for upload.

Nominated Lead author:	Thom Luxon		Advanced Clinical Practitioner		
Lead author contact details:	0161 206 3171 0161 206 1901 0161 206 1903		Thom.luxon@srft.nhs.uk		
Lead Author's Manager:	Paula Beech		Consultant Nurse and as CG lead		
Applies to:	Please indicate which Care Organisation(s) this document applies to:				
	Salford CO				
Document developed in consultation with :	Stroke Services Emergency Department Stroke Operational Delivery Network.				
Keywords/ phrases:	TIA Transient Ischaemic Attack Mini Stroke Crescendo TIA Minor stroke				
Communication plan:	The policy will be made available on the trust intranet and will also be stored in the stroke specific shared drive. Each new starter within the stroke team will be given a handbook which directs to the policy with an expectation that the team member will have the opportunity to read this before starting.				
Document review arrangements:	This document will be reviewed by the author, or a nominated person, at least once every three years or earlier should a change in legislation, best practice or other change in circumstance dictate.				
Approval:	Add name of Committee and Chairpersons name and role: Dr Paula Beech, clinical governance lead				
	Insert full approval date: 02.04.2020				
How approved:	Chair's actions				

11. Equality Impact Assessment (EqIA) screening tool

Legislation requires that our documents consider the potential to affect groups differently, and eliminate or minimise this where possible. This process helps to reduce health inequalities by identifying where steps can be taken to ensure the same access, experience and outcomes are achieved across all groups of people. This may require you to do things differently for some groups to reduce any potential differences.

1a) Have you undertaken any consultation/ involvement with service users, staff or other groups in relation to this document? If yes, specify what.	*No* *Outline activity/method*
1b) Have any amendments been made as a result? If yes, specify what.	*No* *Outline changes made*

2) Does this policy have the potential to affect any of the groups listed below differently?
Place an X in the appropriate box: *Yes, No or Unsure*
This may be linked to access, how the process/procedure is experienced, and/or intended outcomes. Prompts for consideration are provided, but are not an exhaustive list.

Protected Group	Yes	No	Unsure
Age *(e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)*		X	
Sex *(e.g. is gender neutral language used in the way the policy or information leaflet is written?)*		X	
Race *(e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)*		X	
Religion & Belief *(e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered.)*		X	
Sexual orientation *(e.g. is inclusive language used? Are there different access/prevalence rates?)*		X	
Pregnancy & Maternity *(e.g. are procedures suitable for pregnant and/or breastfeeding women?)*		X	
Marital status/civil partnership *(e.g. would there be any difference because the individual is/is not married/in a civil partnership?)*		X	
Gender Reassignment *(e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)*		X	
Human Rights *(e.g. does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)*		X	
Carers *(e.g. is sufficient notice built in so can take time off work to attend appointment?)*		X	
Socio/economic *(e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)*		X	
Disability *(e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.*		X	

Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? *(e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)*		**X**	
3) Where you have identified that there are potential differences, what steps have you taken to mitigate these? *(what action has been taken or will be taken, who is responsible for taking a future action, and when it will be completed by – may include adjustment to wording of policy or leaflet to mitigate)* **4) Where you have identified adjustments would need to be made for those with disabilities, what action has been taken?** *(what action has been taken or will be taken, who is responsible for taking a future action, and when it will be completed by – may include adjustment to wording of policy or leaflet)*			
Will this policy require a full impact assessment? Yes / No (*a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - Please contact the Inclusion and Equality team for advice on* equality@pat.nhs.uk) Author: Ilse Burger Date: 02.04.2020 Sign off from Equality Champion: Date:			

Appendix 2 Referral documentation (print out complete and follow instructions below).

12. Appendices

SALFORD ROYAL NHS FOUNDATION TRUST REFERRAL TO TIA SERVICES – PLEASE email to salford.tia@nhs.net or fax to (0161)206 0899 Please note if more than one episode within two weeks contact stroke registrar on (0161) 206 0070.	
NHS number:	
First name:	Last name:
Title:	Gender:
Date of Birth: / /	Contact number:
Address:	
Is an interpreter required? (If yes please state language required):	
Date and time of presentation to your service:	
STOP **– Does your patient take anticoagulants? If so they require urgent CT brain imaging and should be discussed with stroke registrar please contact (0161) 206 0070.**	
Has service user been informed that they are not to drive for four weeks / or until reviewed n TIA clinic? YES / NO This is a DVLA requirement. If you are unsure of guidelines please access them via: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals	
Has service user been given a stat dose of Aspirin 300mg or Clopidogrel 300mg if intolerant to aspirin? YES / NO	

Details of referring service.

Name of referring organisation	
Contact Information	

OFFICE USE ONLY Triage completed by:		
Triage outcome:		**Time/date of clinic**

TIA coordinator comments: (e.g. delays to attendance and / or triage comments to be signed and dated).

Presenting history Please include; presentation, examination findings, past medical history, drug history and if performed most recent BP, Pulse, blood glucose andECG.

Not just a funny turn

Your doctor or health professional thinks you may have had a **TIA**
(Transient Ischaemic Attack)
This is a type of stroke that **gets better within 24 hours.**
It is often called a **mini stroke** - there is more information over the page

You may have had some of these **symptoms** - weak arm or leg, difficulty thinking of words, strange vision, problems with speaking and understanding other people, difficulty with your balance.

Your doctor or health professional has **referred you to a stroke specialist for tests.** The specialist will talk to you about why you had your symptoms, and what you can do to reduce your risk of it happening again.

There are some things you must do now

- **Take aspirin** if you have been given it

- If your doctor or healthcare professional has given you a dose of aspirin (or another drug if you are allergic to aspirin) you **must** take this until you go to the clinic.

- **Carry on taking any medicine** you already take to reduce your risk of heart disease
- **Do not drive** at the moment
  - The specialist will give you more advice on driving when you see them – if not, ask them!
- **Watch out for signs** of a full stroke – there is information to help on the other side of the page. If your symptoms do come back, or if you have other symptoms of a stroke call 999 immediately
- **Go to your appointment** at the TIA clinic
- Without any treatment **1 in 8 people** will have a full stroke after their TIA

If you have a question about your appointment at the clinic please ring
0161 206 3171
We are open every day of the week contactable between 09:00 and 16:00.

What is a Transient Ischaemic Attack?
(TIA or mini stroke)

The **brain** controls **everything we do - movement, emotions, communication, thinking.** The **brain needs blood to work; if the blood supply is cut off the brain is damaged**. This can happen suddenly and is called a stroke.
For some people the **signs of a stroke go away** within 1 day (24 hours)
This mini stroke is called a **Transient Ischemic Attack** or **TIA**
Although your symptoms disappeared it is important that you get urgent help. We know that lots of people think they have had a funny turn that is not serious. A TIA can be a warning sign of a full stroke - it shows that you are **at risk**. You may still be **at risk** of having a further stroke while you are waiting to see the specialist.
The FAST test can help you identify signs of a stroke or TIA. Sometimes there are symptoms that look like stroke but later turn out to be another medical problem. **Ring 999** and the healthcare experts will decide what to do.

The Face, Arm, Speech Test (FAST)
…to help you recognise the symptoms of a stroke

F	A	S	T
Facial weakness Can the person smile? Has their mouth or eye dropped?	**Arm weakness** Can the person raise both arms equally?	**Speech problems** Can the person speak clearly and understand what you say?	**Time** **to call 999**

For more information go to www.stroke.org.uk/resources/transient-ischaemic-attack-tia

Produced together with the Greater Manchester Stroke Operational Delivery Network

Appendix 4 TIA clinic information leaflet (Aphasia friendly version).

Salford Care Organisation
Northern Care Alliance NHS Group

Not just a funny turn

Your doctor or health professional thinks you may have had a **TIA** (**Transient Ischaemic Attack or mini stroke**)

This is a type of stroke that **gets better within 24 hours**

There is more information on page 3

You may have had some of these **symptoms**

weak arm or leg

drooping face

strange vision

difficulty thinking of words, speaking and understanding other people

difficulty with your balance

Your doctor or health professional has **referred you to a stroke specialist for tests.**

The specialist will talk about **why** you had your symptoms,
and how to **reduce your risk** of it happening again

There are some things you must do now

Take aspirin if you have been given it
You may be told to take aspirin or another drug if you are **allergic** to aspirin
You **must** take this until you go to the clinic

Carry on taking any medicine you already take to reduce your risk of heart disease

Do not drive at the moment
The specialist will give you advice on driving when you see them

Watch out for symptoms of a full stroke
There is information to help on page 4

If your **symptoms do come back**,
or you have other symptoms of a stroke

call 999 immediately

Go to your appointment at the TIA clinic

Without any treatment 1 in 8 people will have a full stroke after their TIA

Ring if you have a question about your appointment at the clinic
0161 206 7209
We are open every day between 09:00 and 16:00.

What is a Transient Ischaemic Attack? (TIA or mini stroke)

The **brain** controls **everything we do -**

movement

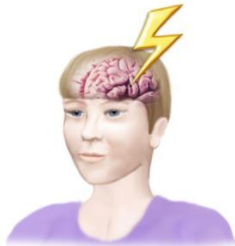
emotions

communication

thinking

The **brain needs blood**

Blood keeps the **brain working**



The **blood supply** can **stop**

Then the brain is **damaged**

This can happen **suddenly**

This is called **a stroke**

For some people the **signs of a stroke go away** within 1 day (24 hours)

This mini stroke is called a **Transient Ischemic Attack** or **TIA**

A TIA can be a warning sign of a full stroke

So…although your symptoms have gone you need urgent help

You may be **at risk** of a full stroke… even while you are waiting to see the

specialist

Watch out for any symptoms

Use the FAST test (below) to help

Sometimes there are symptoms that look like stroke but later turn out to be another medical problem

Ring 999 and the healthcare experts will decide what to do

The Face, Arm, Speech Test (FAST)

…to help you recognise the symptoms of a stroke

F	A	S	T
Face weakness	**Arm weakness**	**Speech problems**	**Time**
Can the person smile? Has their mouth or eye dropped?	Can the person raise both arms equally?	Can the person speak clearly and understand what you say?	**…to call 999**

For more information go to www.stroke.org.uk/resources/transient-ischaemic-attack-tia

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Appendix 5 Contact information for TIA services in other areas.

Greater Manchester TIA referral contact details

Please include Name, DOB, Address and NHS Number on all referrals.

Salford Royal Hospital

Fax: 0161 206 0899

Coordinator telephone – 0161 206 3171

Fairfield General Hospital

Includes Oldham, North Manchester and Heywood, Middleton and Rochdale patients.

Email: pah-tr.adminsupportteam@nhs.net .

Fax 0161 918 8551

Call: 0161 778 2233 (option 2 – booking team – for patients who have queries).

Manchester Royal Infirmary

Fax: 0161 276 3541 (FAO Carolie)

Tel: 0161 276 4568

Royal Bolton Hospital

No longer accept fax, only NHS.net emails to Boh-tr.boltonstrokeunit@nhs.net

Stepping Hill Hospital

Stockport and also Eastern Cheshire residents.

Fax: 0161 419 2181

Tel: 0161 419 5299

Trafford General Hospital

TIA Referral email to: bookingoffice.t36@nhs.net

Fax: 0161 746 2071

Tel: 0161 746 2130

Tameside General Hospital

Fax: 0161 922 6339 (FAO Lisa Collins).

Wythenshawe Hospital

Fax: 0161 291 6075

Email: Elaine.french@uhsm.nhs.uk

Tel: 0161 291 6374

Wrightington, Wigan and Leigh

Fax: 01942 778 760 they will book the appointments.

Tel: 01942 822 596

Warrington Hospital

Fax 01925 662 042

The next section is the Compliance Checklist for the author to complete prior to submission for approval. It will be removed from the document by Document Control department prior to publication.

Compliance checklist for authors	
This sheet must be completed **by the author prior to approval** and will be removed by Document Control prior to publication.	Tick/Comment
1. Have you registered your document with Document Control? If your document affects both SRFT and PAT it will need a specific reference number allocated.	YES
2. Have you fully completed the document's header box at the top of each page?	YES
3. Is the official NCA logo displayed correctly at the top of the title page & the document summary sheet if used?	YES
4. If you have not used the document summary sheet have you removed it?	YES
5. Have you removed all of the template instructions? (the guidance text in grey)	YES
6. Have you indicated the correct document type on the title page? (i.e. Policy, Guideline)	YES
7. Is your title clear, appropriate and with the subject first?	YES
8. Have you adhered to the style and format as described in the policy template: font size, colour and type?	YES
9. Is all text left aligned (with the exception of the title page, figures, & tables)?	YES
10. Has 'Title case' been used which means that only 1st letter of the title words are in block capitals - Whole words should not be put in block capitals; italics should not be used, & underlining should not be used apart from for hyperlinks.	YES
11. Have you been explicit where this document is to be used being clear which Care Organisation/s it affects?	YES
12. Have all the core sections been included?	
1) What is the policy/Guideline for?	YES
2) Where will this document be used?	YES
3) Why is this document important?	YES
4) What is new in this version?	YES
5) Policy/Procedure/Guideline?	YES
6) Roles and responsibilities.	YES
7) Monitoring document effectiveness.	YES
8) Abbreviation and definitions.	YES
9) References and supporting documents.	YES
10) Document control information	YES
11) EqIA screening tool	YES
	YES
13. Is Section 5 and its subsections the main area that contains all the relevant policy information and instruction?	YES
14. Have you fully completed Section 10 the Document Control Information?	YES
15. Is it clear where the document has been for consultation/endorsement?	YES
16. Are you able to evidence that all stakeholders have been consulted and provided the opportunity to contribute to the document?	YES
17. Are all dates within the document written as dd/mm/yyyy?	YES
18. What dissemination & training arrangements have been made? (If	YES

applicable, please state arrangements other than the policy being made available on the Document Management System)	
19. Have you added relevant key words to support searching for the document?	YES
20. Is the correct Disclaimer in the document footer present? (See policy template for correct wording)	YES
21. Are page numbers in the format of 'page x of y'?	YES
22. Has a contents page been completed and page numbers match the actual contents?	YES
23. Are the monitoring methods in Section 7 measurable and achievable? (E.g. would you be able to provide evidence to demonstrate what you have said?)	YES
24. Have all abbreviations used, including within the appendices, been listed and explained in Section 8?	YES
25. Have you completed the EqIA form and has it been countersigned by your Equality Champion?	YES
26. Have you used consistent terminology throughout? (i.e. if something is called a policy is it referred to as a policy throughout)	YES
27. Do all hyperlinks contained in the document work? (I.e. take the reader to where they should go)?	YES
28. If used, are images sourced & acknowledged appropriately? (i.e. copyright permissions checked & source acknowledged as per source request)	YES
29. Have you carried out a spelling and grammar check?	YES
30. Have you ensured there are no ‘embedded’ documents as the reader will not be able to open them once the document is published?	YES
31. Have you carried out a final proof read to ensure that your document makes sense?	YES