Greater Manchester
Neurorehabilitation & Integrated
Stroke Delivery Network

Stroke and TIA Toolkit for Primary Care Clinicians in Greater Manchester

VERSION 1.1

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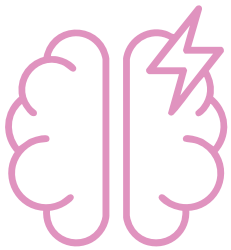
All information can be found on the network's Primary Care webpages

1 Understanding Stroke

1.1. Definitions



- **Stroke:** Sudden neurological deficit caused by focal brain, spinal cord, or retinal vascular injury
- **Transient Ischaemic Attack (TIA):** A transient episode of neurological dysfunction without acute infarction, typically resolving within an hour

1.2. Impacts

- **Physical:**
  Muscle weakness affecting upper and/or lower limbs, speech, balance, vision, swallowing, bladder and bowel control

- **Psychological:**
  Depression, anxiety and emotionalism

- **Hidden Deficits:**
  Not always obvious but significantly impact daily life including booking/attending healthcare appointments and accessing services. Impairments include:
  - Cognition – memory, concentration and thinking skills
  - Communication (aphasia) – speech, comprehension, ability to read/write or use the phone
  - Fatigue and pain - common and disabling

1.3. Statistics

- Stroke is the biggest cause of adult disability
- 80% of stroke are preventable
- 25% of strokes occur in working-age people
- 85% of strokes are ischaemic; 15% are haemorrhagic
- 26% of stroke survivors experience another within 5 years
- Nearly 50% of the 90-day stroke risk following a TIA occurs within the first 48 hours

USEFUL RESOURCES

- Stroke Association: What is a stroke? and Stroke Association: What is a TIA?
- Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network Stroke Pathway Training for Primary Care – register/log in to access
- Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network Stroke Care Pathway

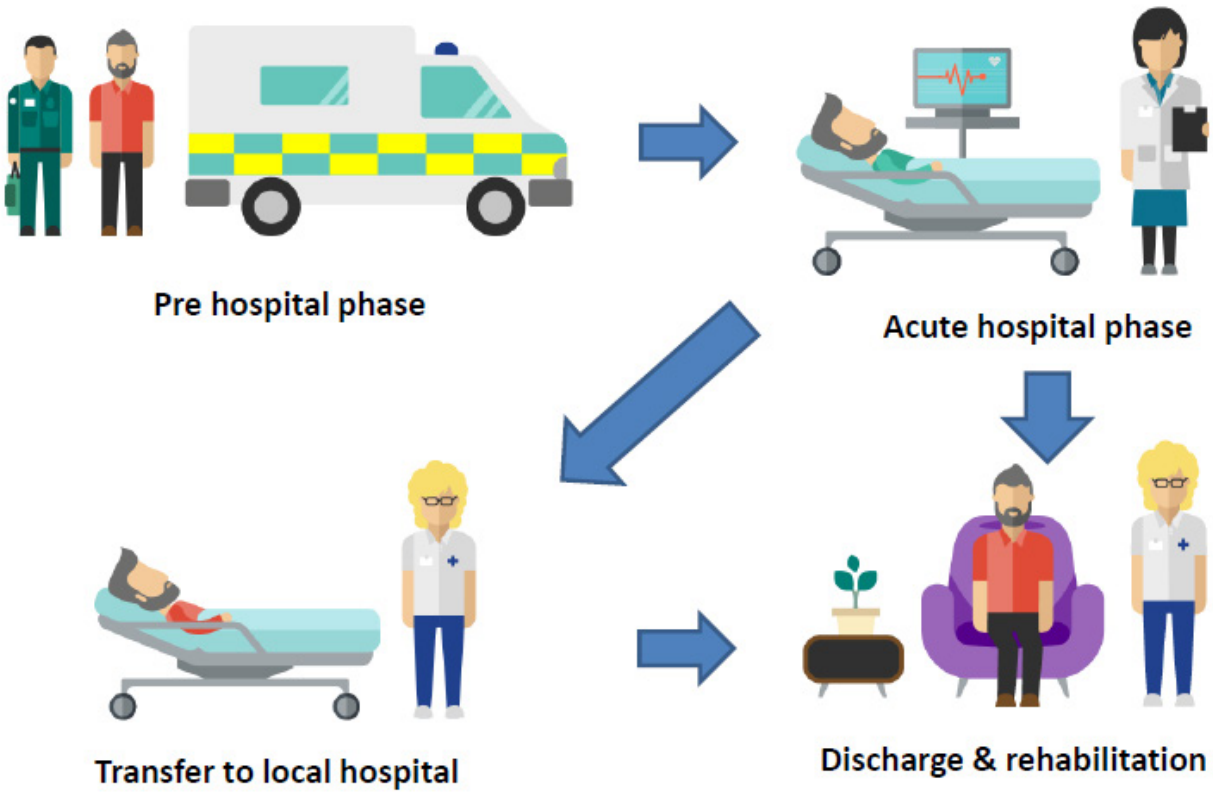
2 Acute Management of Stroke and TIA

2.1. Recognition and Initial Management for Suspected Stroke

- Assess immediately using F.A.S.T. (Face, Arms, Speech, Time):
  - **F**ACE WEAKNESS:
    Can they smile? Has their mouth or eye drooped?
  - **A**RM WEAKNESS:
    Can they raise both arms fully and keep them there?
  - **S**PEECH PROBLEMS:
    Can they speak clearly and understand what you say?
    Is their speech slurred
  - **T**IME:
    Dial 999 immediately if any of these symptoms are observed

- **Additional Symptoms:** Sudden onset of numbness, confusion, severe headache, dizziness, or visual disturbances

- **DO NOT administer aspirin until ischaemic stroke is confirmed. Anticoagulants such as warfarin or DOACs should also be suspended until haemorrhagic stroke is excluded**
- **Hyper Acute Care:** Greater Manchester operates a centralised hyper-acute pathway. Patients are taken by ambulance to the nearest, open Hyper Acute Stroke Unit (HASU) at Salford Royal, Fairfield General, or Stepping Hill Hospitals. Dialling 999 triggers this pathway



2.2. Recognition and Initial Management for Suspected TIA

- **Key Signs:**
  TIA symptoms typically resolve within an hour. If symptoms persist, treat as a potential stroke and dial 999.
  - If in doubt, treat as TIA
  - Do not use ABCD2 score for risk assessment as all patients should be seen by a specialist team within 24 hours

Then:

1. Pulse check for AF or other arrhythmias
2. **Offer aspirin 300mg daily immediately**
   (if no contraindications; clopidogrel as second-line, dipyridamole third-line).
3. Immediately refer for specialist assessment at their local stroke service
4. Patients should be assessed by a stroke specialist clinician before a decision on brain imaging is made, except when haemorrhage requires exclusion in patients taking an anticoagulant or with a bleeding disorder when unenhanced CT should be performed urgently
5. Direct to Stroke Association website for further information and support
6. Provide safety netting advice: If any recurrence of symptoms, dial 999 immediately

2.3. Driving advice (if relevant):

1. Advise patients not to drive post-stroke or TIA until assessed
2. Provide DVLA and Stroke Association guidance
3. Refer to Regional Driving Assessment Centres as needed

USEFUL RESOURCES

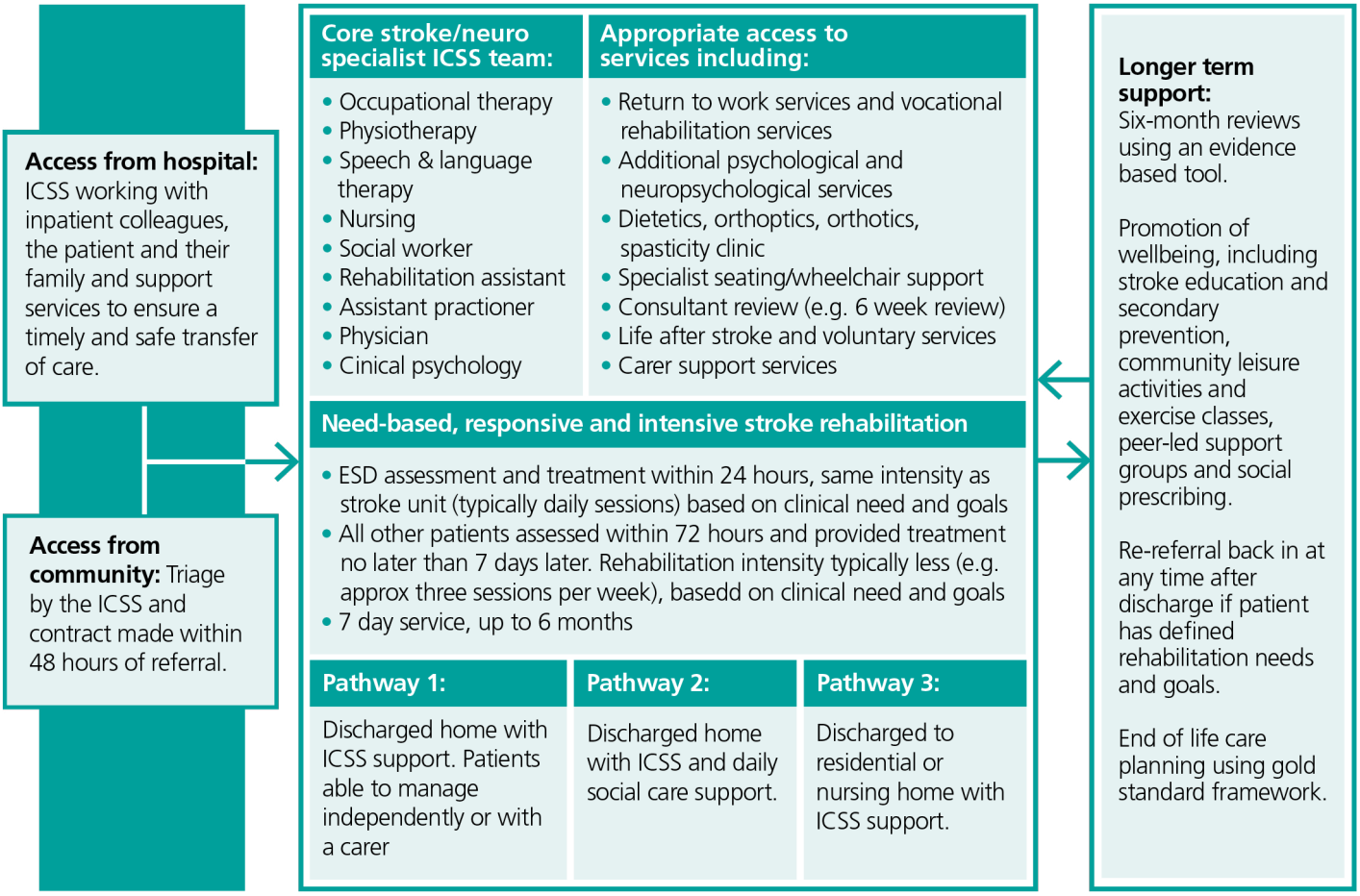
- National Stroke Clinical Guideline (2023) – Assessment and diagnosis (section 3.2) & treatment and vascular prevention (section 3.3)
- Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network TIA Services – register/log in to access
- Stroke Association: What is a TIA?
- Stroke Association: Support Services
- Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network Driving Advice for Professionals – register/log in to access

3 Coordinated Stroke Care and Follow-Up

3.1. Greater Manchester Stroke Discharge and Community Care Pathway

1. **Discharge from Stroke Unit:** To local Community Stroke Team (CST) who typically support for up to 6 months - longer if required depending on rehabilitation goals
2. **Initial Review by CST:** Within 72 hours of discharge from hospital
3. **6-Week Review by Local Stroke Unit:** Conducted by a Stroke Consultant
4. **6-Month Review:** Comprehensive evaluation by CST or Stroke Association

Pro-active coordination between CSTs and primary care is essential to streamline the patient journey and ensure continuity of care

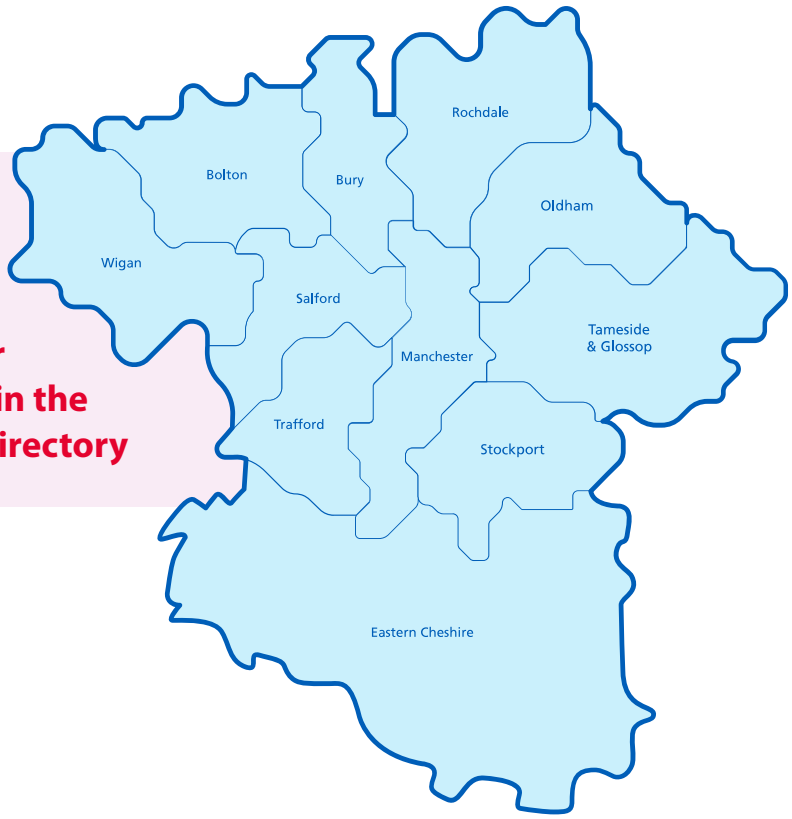


NHS England Integrated Community Stroke Service model (ICSS). In Greater Manchester our CSTs follow the ICSS model.

3.2. Community Stroke Team Support

- Teams are based in each borough (with three in Manchester - North / Central / South) and provide specialist rehabilitation and support for stroke survivors, including:
  - **Rehabilitation:** Mobility, upper limb function, spasticity, falls prevention, cognitive and communication issues, and activities of daily living e.g. dressing, washing etc
  - **Secondary Prevention:** Risk factor management including lifestyle advice / support, BP management and joint care planning
  - **Emotional Wellbeing:** Depression, anxiety and adjustment
  - **Social Support:** Carer training, social interaction, driving advice and vocational rehabilitation (including return to work)
  - **Specialist Input:** Swallowing, nutrition, pain, sensory and visual impairments, and home adaptations
- Each locality also commissions a Stroke Association Recovery Service that patients can be referred to for support. NB: Wigan also funds Think Ahead. Both also accept self-referrals.

Referral information and contact details for all community and voluntary sector teams can be found in the Network's Contact Directory



USEFUL RESOURCES

- Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network Contact Directory for Primary Care
- Stroke Association Recovery Service

4 Long-Term Management by Primary Care

4.1. General Responsibilities

- **Coordinate Care:**
  - Liaise with CST for specialist stroke rehabilitation expertise and advice
  - Act promptly on CST clinical updates/requests (e.g. hypertension medicine changes) and discharge letters

- **Ensure Accessibility:**
  - Consider how to support hidden deficits - especially cognition, communication and fatigue - that may affect ability to engage online or by phone
  - Ask patient how best to communicate and offer alternatives e.g. via trusted contacts or carers, using written materials or email

  - Train staff to recognise and understand reasonable adjustments for patients with hidden deficits
  - Implement Reasonable Adjustment Flags in EMIS/SystemOne with SNOMED CT codes:
    - 1326341000000105 for "Impairment with substantial and long-term adverse effect on normal day-to-day activity (Equality Act 2010)."
    - 1108111000000107 for "Requires reasonable adjustment for health and care access (Equality Act 2010)."
  - Regularly review and update accessibility records

- **Addressing Missed Appointments (DNAs):**
  - Hidden deficits may hinder attendance
  - Use communication flags to tailor appointment notifications e.g. telephone follow-ups instead of SMS
  - Liaise with carers or trusted contacts to help ensure appointments are attended

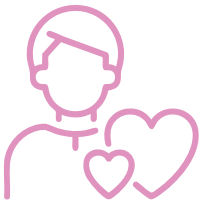
4.2. Post-Stroke Monitoring and Review *(Bio-Psycho-Social Framework)*

Liaise with the patient's local CST to co-ordinate care and access their neurorehabilitation expertise.

- **Biological Needs:**
  - **Secondary Prevention:** Ensure adherence to targets for BP, cholesterol, and diabetes management
  - **Mobility and Physical Health:** Assess for spasticity, pain management, fatigue and other functional issues
  - **Pain Management:** Identify and address stroke-related pain (neuropathic/spasticity) and initiate appropriate management or referrals
  - **Other Medical Conditions:** Screen for complications such as recurrent stroke risk or sleep apnoea

4 Long-Term Management by Primary Care

- **Psychological Needs:**
  - **Cognitive and Neuropsychological:** Screen for memory issues using tools like GPCOG and address neuropsychological deficits
  - **Mental Health:** Identify signs of anxiety, depression, or emotional instability, and refer to services such as Talking Therapies or mental health specialists as needed



- **Social Needs:**
  - **Carers' Support:** Consider carers' needs as they may not recognise their role or appreciate the impact on themselves. Include carers in reviews to assess their ability to cope and provide adequate care. Offer and signpost support and resources e.g. training, peer support groups, social prescribing services and Stroke Association resources
  - **Community Integration:** Promote social prescribing and connect patients with local community services for exercise, social activities, or support networks
  - **Social Isolation:** Identify and address barriers to social engagement and access to services

- **Annual Review Integration:**
  - Combine Bio-Psycho-Social elements into a structured annual review tailored to the patient's evolving needs. It should address ongoing challenges and provide anticipatory care to mitigate future issues. Patients are likely to have had a 6 month review post stroke conducted by their CST or Stroke Association.

4.3. Medical Management and Secondary Prevention

Antiplatelet Therapy:	Blood Pressure Management:	Cholesterol Management:	Diabetes Management:	Lifestyle Modifications:
• First-line: Clopidogrel 75mg daily. • If intolerant: Aspirin 75mg daily. • Dual Antiplatelet Therapy (DAPT) or alternative therapy should be at the advice of a specialist.	• Target: <130 mmHg systolic in clinic settings • Home/ambulatory BP target: 5/5 mmHg lower. • Lower targets may also be required for CKD with significant proteinuria.	• High-intensity statin (e.g. atorvastatin 80mg daily). • Follow the GM Secondary Prevention of Lipids Pathway • Statins should not be discontinued following a new diagnosis of haemorrhagic stroke • Initiation of statin should not be delayed if there are other indications for statin therapy	• Optimise diabetic control as per the Greater Manchester Hypertension Pathway	• Smoking cessation • Moderate alcohol intake • Regular physical activity • Cardiorespiratory rehabilitation • Healthy / balanced diet • Weight management • Ensure information is culturally relevant and tailored to patient

5 QOF Indicators for CVD prevention 2025/26

Blood Pressure Management

ID	Lower threshold (2024/25)	Upper threshold (2024/25)	QOF points (2024/25)	Lower threshold (2025/26)	Upper threshold (2025/26)	QOF points (2025/26)
CHOL003	70%	95%	14	70%	95%	38
CHOL004	20%	35%	16	20%	50%	44
HYP008	40%	77%	14	40%	85%	38
HYP009	40%	80%	5	40%	85%	14
STIA014	40%	73%	3	40%	90%	8
STIA015	46%	86%	2	46%	90%	6
CHD015	40%	77%	12	40%	90%	33
CHD016	46%	86%	5	46%	90%	14
DM0362	38%	78%	10	38%	90%	27

Hypertension

- HYP008: Percentage of patients aged 79 years or under with hypertension in whom the last BP reading is ≤140/90 mmHg.
  - Threshold Change: 40%-77% (2024/25) → 40%-85% (2025/26)
  - QOF Points Change: 14 → 38
- HYP009: Percentage of patients aged 80+ with hypertension in whom the last BP reading is ≤150/90 mmHg.
  - Threshold Change: 40%-80% (2024/25) → 40%-85% (2025/26)
  - QOF Points Change: 5 → 14

Stroke

- STIA014: Percentage of stroke/TIA patients aged ≤79 with BP ≤140/90 mmHg.
  - Threshold Change: 40%-73% (2024/25) → 40%-90% (2025/26)
  - QOF Points Change: 3 → 8
- STIA015: Percentage of STIA patients aged 80+ with BP ≤150/90 mmHg.
  - Threshold Change: 40%-73% (2024/25) → 40%-90% (2025/26)
  - QOF Points Change: 12 → 33

5 QOF Indicators for CVD prevention 2025/26

CHD

- CHD015: Percentage of CHD patients aged ≤79 with BP ≤140/90 mmHg.
  - Threshold Change: 40%-77% (2024/25) → 40%-90% (2025/26)
  - QOF Points Change: 12 → 33
- CHD016: Percentage of CHD patients aged 80+ with BP ≤150/90 mmHg.
  - Threshold Change: 46%-86% (2024/25) → 46%-90% (2025/26)
  - QOF Points Change: 5 → 14

Lipid Management & Statin Therapy

- CHOL003: Percentage of CHD, PAD, Stroke/TIA, or CKD patients prescribed a statin.
  - Threshold Change: Maintained at 70%-95%
  - QOF Points Change: 14 → 38
- CHOL004: Percentage of CHD, PAD, or Stroke/TIA patients with most recent cholesterol measurement in target range.
  - Threshold Change: 20%-35% (2024/25) → 20%-50% (2025/26)
  - QOF Points Change: 16 → 44

USEFUL RESOURCES

- National Stroke Clinical Guideline (2023) – Long term management and secondary prevention (section 5)
- Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network CVD Prevention
- Greater Manchester Hypertension Pathway
- Greater Manchester Secondary Prevention of Lipids Pathway

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