Terms of Reference

Central Region Stroke Network: 1 July 2018 – 30 June 2019

Background

Stroke is the second most common cause of death worldwide and the most common cause of long-term adult disability in high income countries such as New Zealand[1]. In New Zealand, it is estimated that 50,000 people live with stroke and 8,500 have a new stroke each year with an annual cost of $750 million to the New Zealand health sector[2]. A substantial proportion of this overall cost results from long term disability following stroke. About 20% of stroke sufferers require long-term institutionalised care following stroke with stroke patients representing 1 in 6 rest home residents[3] costing NZ$47,450 per patient per year[4][5].

The key evidence-based interventions that have been shown to reduce the burden of stroke include:

- organised acute and rehabilitation stroke services
- rapid assessment and management of transient ischaemic attacks
- provision of acute stroke thrombolysis to eligible stroke patients.

Key recommendations from the 2010 New Zealand Stroke Guidelines[6] which drive the work programme for the Central Region Stroke Network are shown in Figure 1.

[1] Johnston SC, Mendis S, Mathers CD. Global variation in stroke burden and mortality: estimates from monitoring, surveillance, and modelling. Lancet Neurol. 2009; **8**(4): 345-54.

[2] Brown P. 2009. Economic burden of stroke in New Zealand. *Three decades of Auckland regional community stroke (ARCOS) studies: What have we learned and what is next for stroke care and stroke research?* AUT University. Auckland

[3] Cowman S, Royston M, Hickey A, Horgan F, McGee H, O'Neill D. Stroke and nursing home care: a national survey of nursing homes. BMC Geriatr. 2010; **10**: 4.

[4] Luengo-Fernandez R, Paul NL, Gray AM, Pendlebury ST, Bull LM, Welch SJ, et al. Population-based study of disability and institutionalization after transient ischemic attack and stroke: 10-year results of the Oxford Vascular Study. Stroke; a journal of cerebral circulation. 2013; **44**(10): 2854-61.

[5] Pharmac. Cost Resource Manual for PFPA. Version 2.11 ed; 2012.

[6] Stroke Foundation of New Zealand. 2010. *New Zealand Clinical Guidelines for Stroke Management*. Wellington: Stroke Foundation of New Zealand.

Figure 1: Key recommendations from the New Zealand Clinical Guidelines for Stroke Management 2010

Recommendations	Grade
All District Health Boards (DHBs) should provide organised stroke services	✓
All people admitted to hospital with stroke should expect to be managed in a stroke unit by a team of health practitioners with expertise in stroke and rehabilitation	✓
Large and medium sized DHBs should provide an acute stroke thrombolysis service for their populations	✓
All DHBs should provide a transient ischaemic attach (TIA) service in accordance with the NZ TIA Guideline (2008)	✓
Large DHBs can provide organised stroke-specific community teams	✓
Maori and Pacific participation in decision-making, planning, development and delivery of stroke services should be supported. Stroke services should work, where possible, with Maori and Pacific providers	✓
Community services should be equally accessible for stroke patients under 65 tears as those 65 years and over. Community services for stroke patients under 65 years should be responsive to the needs of Maori and Pacific providers.	✓
Health practitioners and others providing stroke care should receive training and support in delivering culturally competent, patient-centred care; including understanding the impact of culture on illness and rehabilitation.	✓
Grade description A Body of evidence can be trusted to guide practice B Body of evidence can be trusted to guide practice in most situations C Body of evidence provides some support for recommendation(s) but care should be taken in its application D Body of evidence is weak and recommendations must be applied with caution ✓Consensus based recommendation	

A significant amount of work has been done to implement these recommendations across the central region, including:

- refining the data collected in relation to stroke, including identifying Maori and Pacific patients who have experienced a stroke
- the region consistently exceeding the 8% thrombolysis target set by the Ministry of Health
- the implementation of Telestroke, which has improved access to thrombolysis and reduced door to needle time for patients.

The Central Region Stroke Network will continue to drive the implementation of these recommendations throughout the six Central Region DHBs.

Objectives

The objectives of Central Region Stroke Network are to:

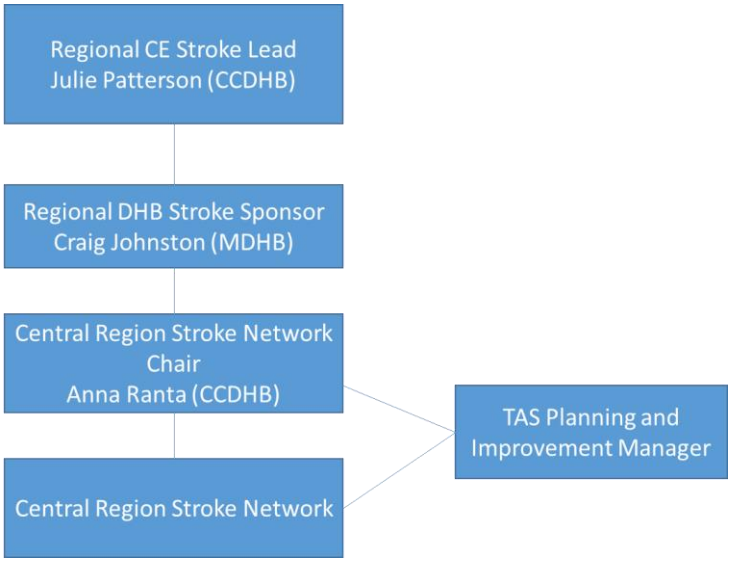
- meet the milestones and measures for Stroke in the 2018/19 Regional Services Plan (attached as Appendix 1)

- fully implement the New Zealand Clinical Guidelines for Stroke throughout the region, aiming for equitable and timelier access for all patients
- provide a governance structure for stroke service development and leadership across the region
- monitor key performance indicators and ensure quality assurance to achieve and maintain a high standard of care for all patients
- provide accountability to the Regional CEs and COOs / GMs P&F
- achieve objectives by 30 June 2019.

Accountability and governance

The Project Sponsor has key accountability for the Central Region Stroke Network on behalf of the Central Region Chief Executive. Governance is provided by the Central Region Chief Executives and Chief Operating Officers / General Managers Planning and Funding (refer to Figure 2).

Figure 2: Project structure for stroke



Membership

The membership of the Central Region Stroke Network will comprise representation from the six Central Region District Health Boards and will include:

- Neurologist
- General Physician or Geriatrician with interest/expertise in acute stroke
- Rehabilitation Physician or Geriatrician with interest/expertise in stroke rehabilitation
- Stroke Nurse
- Allied health professional
- Primary care
- Māori Representative
- Ambulance.

The group can co-opt expertise as seen necessary, including a consumer representative, to progress project work as required, for example ambulance services representation.

Quorum

The quorum will be six members and does not need to be DHB/Provider specific.

Term of membership

The term of membership will be two years with the option of a further reappointment.

Chair and deputy chair

The Clinical Lead will be appointed chair of the Central Region Stroke Network. A Deputy Chair will be nominated by the Network. The term of chair and deputy chair will be two years with the option of a further appointment.

Frequency of meetings

Central Region Stroke Network meetings will be held quarterly, with teleconferences between meetings if required.

An attendance record of each meeting will be maintained.

Decision-making

The Central Region Stroke Network will progress the project objectives aligned to the Regional Services Plan. Recommendations and decisions will be made at Central Region Stroke Network meetings and ratified through the Chair. Decisions will be made by consensus or by a clear majority. If a member is not able to attend a meeting, their views and comments can be provided to the group via the Planning and Improvement Manager or Chair at least one week before the meeting.

Recommendations or decisions will be signed off through the Regional Decision-making Framework.

Papers

A call for agenda items will occur two weeks before a meeting is scheduled. Agenda and papers will be circulated approximately one week in advance. Draft minutes will be approved by the Chair and circulated one week after the meeting. Items may be tabled at the discretion of the Chair.

The Central Region Stroke Network will be able to share information and documents via email.

Reporting

Progress of the Central Region Stroke Network work programme will be reported via quarterly reports through the performance monitoring framework to the Ministry of Health. These will be prepared by the TAS Project Manager.

Funding

Participation will be funded by each participating DHB/Provider.

Support

TAS will work in collaboration with the Central Region Stroke Network, providing project

management and co-ordination. This will include facilitating and co-ordinating communication within and between regional groups. Organising resources to support meetings, for example presentation tools, refreshments, minute taking, distributing meeting information and analytical support.

Appendix 1: Regional Services Plan Work Programme for Stroke 2018/19

Ref	Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
Regional priorities					
-	Regional engagement and collaboration	Central Region Stroke Network Chair to meet twice per year with other regional networks in the region to identify common solutions to shared challenges	Relevant regional networks identified and twice yearly meetings take place	Q2 and Q4	Central Region Stroke Network Chair/Manager
	Implement a regional endovascular clot retrieval service	Implement an in-hours accessible service at CCDHB Develop regional pathways and guidelines including transport	Implementation of a regional endovascular clot retrieval service progressed	Q4	CCDHB / Central Region Stroke Network
National priorities					
4.6	Equitable access to acute stroke services across the Central Region	Central Region Stroke Network to monitor stroke data and produce a KPI report for review	10% or more of potentially eligible stroke patients thrombolysed 24/7	Q1 – Q4	Central Region Stroke Network
			80% of patients with acute stroke are admitted to a stroke unit or an organised stroke service with a demonstrated stroke pathway	Q1 – Q4	

Ref	Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
	Equitable access to inpatient and community rehabilitation		80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation are transferred within 7 days of acute admissions	Q1 – Q4	
		Explore regional solutions for rehabilitation, to ensure equity of access for all patients regardless of age, ethnicity and geographic location	60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge	Q1 – Q4	Central Region Stroke Network
Enablers					
1.8	Equity	Central Region Stroke Network is engaged in the REGIONS care project to help identify and address ethnic and geographic disparity	Completion of audit data collection and analysis by Central Region DHBs	Q1-3	Central Region Stroke Network
2.8	Workforce	Identify current demand for acute and rehabilitation stroke services in both the hospital setting and the in the community; and identify regional ability to meet these demands	Continue to monitor data in relation to access to acute and rehabilitation stroke services and assess regional ability to meet demands	Q1-Q4	TAS / Central Region Stroke Network
		Develop and implement a workforce plan to ensure training, recruitment, retention	A workforce plan is developed which identifies workforce issues and opportunities to address them	Q4	TAS / Central Region Stroke Network

Ref	Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
		and other relevant workforce issues are addressed and are ongoing			
		Seek new and innovative ways of addressing service delivery in environments where health professionals work primarily in isolation or where the workforce is limited in its ability to meet recommended service delivery	Continue to explore opportunities for service improvement	Q1-Q4	Central Region Stroke Network
3.8	Technology and digital services	Support the delivery of regionally consistent systems across DHBs to deliver telestroke services for acute stroke service intervention in a safe and timely manner, and support participation in the thrombolysis register	Telestroke implemented across the Central Region	Q4	Central Region DHBs
			Central Region DHBs participate in thrombolysis register data collection processes	Q1-4	
4.6	Quality	Work regionally and collaboratively to support DHBs to ensure stroke patients are admitted to a stroke unit or organised stroke service, with a	80% of patients with acute stroke are admitted to a stroke unit or an organised stroke service with a demonstrated stroke pathway	Q1 - Q4	Central Region Stroke Network

Ref	Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
		demonstrated stroke pathway			
5.8	Clinical leadership	Stroke Network Chair to represent the Central Region at National Stroke events and facilitate implementation of regional priorities	Chair attends National Stroke Network meetings and annual data & quality meetings	Q1-4	Central Region Stroke Network Chair
		Nursing and medical stroke leadership roles in regional DHBs are supported	Regional nursing, medical and allied health leaders are identified in relation to their contribution to the regional stroke network and regional representation in the national stroke network	Q1-4	Central Region DHBs
		The importance of allied health stroke service activity is identified	Central Region DAHs group actively involved in the Central Region Stroke Network to support the role of allied health in stroke service activity	Q1-4	Central Region Stroke Network
		Stroke clinical leaders support and provide regular regional stroke education programmes and encourage participation	• Annual study day hosted by a DHB in the Central Region and stroke teams are supported to attend • Central Region Stroke teams are supported to attend the National Acute Stroke Reperfusion Data and Quality Meeting • Central Region Stroke teams are supported to attend the National Stroke Rehabilitation Quality Meeting	Q1-Q4	Central Region Stroke Network / Central Region DHBs
6.6	Pathways	Improve acute and rehabilitation stroke pathways across primary, community, and secondary services for patients	Data from BPAC and NMDS is collected and monitored to assess how the BPAC TIA diagnostic tool is being utilised in primary care and impacting on hospital admission and readmission rates for TIA and stroke.	Q1-Q4	TAS / Central Region Stroke Network

Ref	Key area of focus	Actions to deliver	Measures	Timeframe	Accountable roles
		with ischaemic stroke and TIA	Data on stroke patient admission to ASU or acute stroke pathway continues to be monitored and strategies developed to support DHBs who do not meet the 80% target	Q1-Q4	TAS / Central Region Stroke Network