

INTRODUCTION

There has been much progress made in specialist stroke services over the last decade; however, increasing volumes of ongoing care occurs in the community, as stroke-survival rates are increasing and patients are living longer independently. Following specialist care, it is important to note that the long-term needs of stroke survivors are not being adequately addressed.¹ Further, nearly half of all stroke patients feel abandoned after they leave hospital.² The physical consequences post-stroke are often addressed as the highest priority due to their impact on dependency and practical care needs, with recognised routes of community referral, for example, to physiotherapy or occupational therapy. However, there are also less obvious and emotional effects such as depression, fatigue, and importantly, post-stroke cognitive changes.² In fact, nine in ten stroke survivors surveyed reported that they experienced at least one cognitive effect, which is the same number experiencing at least one physical effect.³ It is not always clear how best to manage or who to refer these individuals to even if they do present to their GP upon specialist discharge.

The key questions for primary care are: what more can be done for stroke survivors at risk of cognitive difficulties that might progress to a dementia illness; whose responsibility is it to manage these individuals; and could we find new improved care pathways to address this growing need?

THE SCALE OF THE PROBLEM: COGNITIVE DIFFICULTIES POST-STROKE

In the first-year post-stroke, as many as four in ten patients have some degree of cognitive impairment.⁴ At 6 months, this is associated with lower levels of independence, worse quality of life, greater informal care provision and a greater chance of developing depressive symptoms up until 5-years post-stroke.⁵ Further, in the year after a major stroke, the incidence

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of dementia can be nearly 50 times higher compared to that in the general population.⁶ This creates a significant burden of both cognitive impairment and dementia in the community that may be hidden if not actively assessed. Patients may also experience both personal and organisational barriers, which means that they are less likely to seek help for their ongoing problems such as memory deficits.⁷

CURRENT CARE

National clinical guidelines recommend that stroke patients have a review 6-months post-stroke.⁸ Once in the community, primary care is responsible for an annual review that normally includes risk factor management (to reduce recurrent stroke) and providing access to clinical and social care services if needed. However, there is no formal requirement to assess for any subsequent cognitive deficit or indeed a possible dementia illness. The previous dementia direct enhanced service did provide an incentivised way for GPs to opportunistically offer an assessment to at-risk groups, such as stroke patients aged ≥ 60 years, but this has subsequently been discontinued. Cognition is not the only consequence post-stroke, for example, depressive symptoms can often present many years after the initial stroke, particularly if there is cognitive impairment 6-months post-stroke.⁵ However, without a formal mechanism to identify these common non-physical post-stroke sequelae and then provide the necessary support and intervention, patients and their families may struggle in the community.

STROKE CARE IN THE COMMUNITY

There is increasing recognition that new approaches are needed to provide better care for stroke survivors, particularly once they are in the community. A previous systematic review looking at different models of stroke follow-up care found that there was a need for high-quality trials in this area, in order to develop primary care-based interventions.⁹ One trial hoping to address this is the Improving Primary Care After Stroke (IPCAS) trial.¹⁰ Here, patients are randomised to either an intervention consisting of a structured review of care needs, a self-management programme, optimised communication between patients and services and a direct point of contact at the GP surgery, or usual care.¹⁰ It is hoped that this new multicomponent intervention can help to address the long-term needs of stroke survivors living in the community. Although the trial is not addressing cognitive needs specifically, a checklist is used as part of the structured review of care needs, which could help identify important cognitive deficits. Further, the increased primary care support and improved communication pathways will hopefully reduce some of the barriers associated with patient help-seeking behaviour. While awaiting publication of the trial results, other options should be considered for research or service improvement and evaluation. There could be opportunities to develop more formal pathways between stroke, community, and memory clinic services, particularly if significant cognitive decline post-stroke has been detected. It might also be possible to identify stroke patients to participate in trials of long-term cognitive rehabilitation, and examine whether less service support is needed.

CONCLUSION

Given the significant effects of stroke, primary care needs to find ways to improve and adopt new ways of working

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so that patients do not continue to feel 'abandoned'. Evidence-based interventions need to be developed in order to address some of these concerns, but GPs in general need to be aware of the long-term visible, and more importantly invisible, effects of stroke.

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Competing interests

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