Socioeconomic deprivation and post-stroke care in the community

**INTRODUCTION**

Low socioeconomic status (SES) is associated with an increased incidence of stroke.1 People who live in more deprived areas present with more severe strokes at a younger age and are more likely to become disabled as a result.2 Worryingly, socioeconomic deprivation in childhood has been associated with an increased risk of stroke and stroke mortality as an adult, irrespective of socioeconomic circumstances in adult life.3 While there is an abundance of evidence that the most deprived populations are disproportionately affected by the stroke burden, the reasons behind this are less clear.

**RISK FACTORS**

The UK is a country with high levels of urbanisation and a universal healthcare system. Most UK studies have not found inequalities in access to healthcare services in relation to SES.3 On the other hand, lifestyle factors such as smoking, diet, and exercise significantly contribute to the excess risk of stroke in patients with low SES.2 Socioeconomic factors also seem to play a role in stroke recovery. Stroke survivors who work, have 13 or more years of education, and have adequate income before stroke are less likely to be disabled 3 months after stroke.4 Surprisingly, stroke prevention medication does not seem to diminish the risk of severe stroke in patients with low education levels compared to patients with high education levels.5

**CLINICAL CARE**

One of the aims of the Quality and Outcomes Framework (QOF) has been to address inequalities in healthcare provision.6 When first introduced, QOF incentivised managing stroke risk factors such as smoking and high cholesterol; however, high QOF scores did not always reflect adherence to guideline recommendations.7 Further, associations between practice QOF scores and health outcomes were found to be small and inconsistent, while the relationship between socioeconomic deprivation and health was much stronger.8 Over time, some of the QOF indicators for ongoing management of stroke were moved to other domains or removed completely. Current indicators focus on managing blood pressure and prescribing antplatelets or anticoagulants.9 Given that medication does not appear to alleviate the increased risk of severe stroke in patients with lower SES,9 it seems unlikely that even high QOF achievement would help to diminish health inequalities in secondary stroke prevention.

Unfortunately, despite the QOF incentives, many stroke survivors and their caregivers felt abandoned by the healthcare system after discharge from secondary care.10 One of the contributing factors might have been suboptimal communication between specialist stroke services and general practice.11 GPs might have been unaware of unmet patient needs, gaps in service provision, or required follow up. Particularly, patients with low SES might have lacked the knowledge or skills necessary to re-engage with appropriate services.

**NEW MODELS OF CARE**

The national service model for an Integrated Community Stroke Service (ICSS) was introduced in February 2022 in response to some of these concerns. It aims to improve the quality of stroke services in the community and address health inequalities.12 Prior to the introduction of ICSS, early supported discharge was shown to reduce long-term dependency and admission to institutional care, but this service was only provided up to 6 weeks and was suitable for up to 40% of patients.12 Unfortunately, it excluded patients with severe strokes and data show that it is patients with low SES who have a higher risk of severe stroke.2 Where implemented, ICSS aims to provide multidisciplinary support to all stroke patients up to 6 months after stroke with an option to re-refer.12 The service aims to be available to all stroke survivors regardless of their SES, stroke severity, or care setting so that patients would not be left without access to specialist services during the period of time that is crucial for their recovery.

Integrated Stroke Delivery Networks (ISDNs) are responsible for designing and delivering optimal stroke pathways including ICSS. Patients with low SES were identified as one of the target groups within the Stroke Specific Health Inequalities Framework published in the Getting It Right First Time (GIRFT) Programme’s National Specialty Report for Stroke.13 The RightCare Stroke Toolkit recommended that each ISDN should coordinate their health inequalities work with the Integrated Care System (ICS) Health Inequalities Lead.14 This creates an opportunity for specialist and primary care services to work more closely in order to provide better post-stroke care to the most vulnerable patient groups. However, it is not yet clear what the role of GPs will be within this model. ‘Physician’ was mentioned as a part of the multidisciplinary core team in the ICSS guidance, but the document does not clarify the role of GPs specifically.12 Hopefully, this omission will not result in GPs being left out of communications and service planning, which could perpetuate existing gaps in care.

**CONCLUSION**

Socioeconomic deprivation is a complex issue and there is no straightforward solution in any branch of medicine. Based on current evidence, addressing lifestyle

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“Patients with low SES [socioeconomic status] are disproportionately affected by the stroke burden. The liaison between ISDNs [Integrated Stroke Delivery Networks] and ICSs [Integrated Care Systems] might help to target this patient group more effectively.”

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