Health Wellbeing and Local Government Committee

HWLG(3)-22-09-paper 2

Inquiry: Stroke Services in Wales

Memorandum

To: National Assembly for Wales
From: Andrew Jenkins, Consultant Paramedic on behalf of Alan Murray Chief Executive Officer
Date:14 October 2009

Re:The Ambulance Service in Wales' provision of care to stroke sufferers

1. Purpose

1.1 This paper outlines the developments in the Welsh Ambulance Services NHS Trust relating to Stroke services in Wales.

2. Pre-hospital Management of Acute Stroke

2.1 The pre-hospital management of acute stroke by the Trust is consistent with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Guidelines (2006) (Appendix 1). When an emergency call is received by ambulance control, Trust call-takers use the Advanced Medical Priority Dispatch System (AMPDS) to ensure that the caller is asked specific questions to determine the patients chief complaint. Where a chief complaint of Stroke is identified/confirmed, the call-taker will allocate an AMPDS code of 28. There are a total of 9 stroke related code 28 AMPDS determinants which are allocated according to the patients priority symptoms (28C01 = Not Alert, 28C02 = Abnormal Breathing, etc). It should however, be noted that regardless of which specific determinant is allocated, all AMPDS code 28 calls are categorised as emergency calls.

2.2 The Trust currently categorises all Stroke related emergency calls as category 'B'. The main purpose of this is to ensure that all stroke patients are allocated a double crewed emergency ambulance, rather than allocating a rapid response vehicle (RRV). This decision was endorsed by the all -Wales Stroke Partnership after the Trust was able to provide data which identified that the vast majority of the Stroke patients it manages are at hospital within 90 minutes of receiving the call. It should however be noted that where information from the caller highlights immediately life-threatening priority symptoms, a RRV will be dispatched if it is closer than the responding ambulance. Furthermore, the Clinical Review Panel have recently reviewed the AMPDS codes for stroke. As such, this will serve to provide a more clinically appropriate response. Nine codes / determinants have been upgraded from Amber to Red '8' minute response.

2.3 The current picture in Wales is that all patients who suffer an acute stroke, are transported to their nearest accident and emergency (A&E) department as there are no Acute Stroke Units operating in Wales. As identified above, all patients should be assessed by the attending ambulance clinician using the Face, Arm, Speech test (FAST). The Trusts ambulance clinicians have been using this method of neurological clinical assessment for two years. The findings of the FAST must form part of the hospital pre-alert and must also be recorded on the Trusts Patient Clinical Record (PCR). There is currently no specific area on the PCR to record the FAST (as a tick box), so ambulance clinicians must record the findings in the narrative section (22). Findings are recorded as Normal or Abnormal. The Trust recommends they are recorded thus;

FACE = A or N ARM = A or N SPEECH = A or N

2.4 Inclusion of a specific FAST section on the Trusts PCR would be a very positive step towards ensuring the findings of the FAST are accurately recorded by ambulance clinicians.

3. Regional Update - South East Region

3.1 A Clinical Support Officer is currently working in partnership with all the existing Hospital Trust`s in the SE to develop agreed fast-track protocols (appendix 1). They are also a member of the South East Wales Stroke Network. The first hospital to formally agree a Stroke fast-track protocol with the Trust, was the Royal Glamorgan Hospital, Llantrisant. This protocol is now considered as the baseline template on which all other protocols in the SE will be based. The pathway has also been incorporated locally, into the Map of Medicine.

3.2 The Clinical Support Officer is engaged with Cwm Taf, Cardiff & Vale and Gwent LHB's, to support them in their aims to develop Acute Stroke Services / Thrombolytic therapy by March 2010.

4. Current Progress by Hospital:

4.1 The Royal Glamorgan Hospital, Llantrisant, began providing a Monday to Friday, 09:00 to 17:00 Acute Stroke/ Thrombolysis Service in partnership with the Trust (first pilot in Wales), in September 2008). All patients are currently conveyed to A&E.

4.2 Prince Chares Hospital, Merthyr - meetings with the Trust and working towards a possible Monday to Friday, 09:00 to 17:00 Thrombolysis Pilot in Autumn 2009. All patients currently conveyed to A&E.

4.3 Royal Gwent Hospital, Newport - care pathway in place Monday to Friday, 09:00 to 17:00. Thrombolysis not currently provided, but working towards this for autumn 2009. Patients conveyed to A&E

4.4 Neville Hall Hospital, Abergavenny - meetings with the Trust on-going, working towards providing thrombolysis October 09. Direct admission to ward being considered on a Monday to Friday, 09:00 to 17:00 basis.

4.5 University Hospital of Wales Cardiff - Dr Shetty has been undertaking opportunistic thrombolysis of stroke patients on a Monday to Friday 09:00 to 17:00 basis for some months, though no formally agreed fast-track protocol in place with THE TRUST. All patients currently conveyed to A&E.

4.6 University Hospital Llandough, Penarth - meetings with Cardiff and Vale NHS Trust on-going. No fast-track protocol in place, working towards implementing Thrombolysis on a Monday to Friday, 09:00 to 17:00 basis. All patients currently conveyed to Medical Emergency Admissions Unit.

4.6.1 Note; Cardiff and Vale are currently considering a 24/7 thrombolysis service. The most likely location for this would be University Hospital of Wales, Cardiff.

4.7 As can be seen from the above, the Clinical Support Officer is fully engaged with all relevant NHS Trusts and Health Board's in the South East. This local engagement should ensure that the Trust is able to support the Health Board's in their progress towards fully meeting what is required of them in the National Service Framework for Stroke by the end of March 2015.

5 Regional Update - Central & West Region

5.1 The interface between pre-hospital and secondary care services for stroke patients within the Central and West Region has been slow to progress with only one example of a limited service at Morriston Hospital, Swansea. The Trust has had some initial involvement in developing services across the Region but with the reorganisation of the Trusts this has somewhat stalled.

6. Morriston Hospital, Swansea

6.1 The current pathway in operation covers patients from the Swansea area with these patients being taken to Moriston Hospital. The service operates Monday to Friday between 0900 and 1700hrs and provides the potential for thrombolysis for those patients who meet the criteria (this is consistent with the Royal Glamorgan Model). The consultant in charge is however looking to expand the hours. Currently the Trusts representative in this area is a Senior Education and Development Lead who continues to be a member of the Stroke Partnership Project.

7. Hywel Dda Trust

7.1 The Trust has formed a local stroke group to look at standardising stroke protocols and pathways, but this is in its infancy. A Clinical Support Officer is actively seeking to join this group as the Trusts representative and has made initial contact.

8. Bronglais General Hospital, Aberystwyth

8.1 Currently, the Trusts Stroke patients are taken to the A&E Department where they are then assessed for thrombolysis. The patient is managed in A & E for the 1st hour / day with admission to the stroke ward for a further 7 days. There is a designated 4 bed Stroke ward at the hospital for acute admissions with a further 14 beds for rehabilitation purposes.

9. Withybush General Hospital, Haverfordwest

9.1 All 999 Stroke patients are taken to A & E. There is no agreed fast-track protocol, but patients are managed by the Trust as per JRCALC guidelines.

10. West Wales General Hospital, Glangwili, Carmarthen

10.1 All 999 Stoke patients from the catchment area are taken to A&E. There is no agreed fast-track protocol, but patients are managed by the Trust as per JRCALC guidelines. GP referred patients are admitted via the Clinical Decision Unit within A & E.

http://www.wales.nhs.uk/sites3/news.cfm?orgid=808&contentid=11229

11. Hereford County Hospital

11.1 All 999 Stroke patients are taken to A&E. There is no agreed fast-track protocol but patients are managed by the Trust as per JRCALC guidelines.

12. Royal Shrewsbury Hospital (Shrewsbury and Telford NHS Trust)

12.1 All 999 Stroke patients are taken to A&E. There is no agreed fast-track protocol but patients are managed by the Trust as per JRCALC guidelines.

13. Regional Update - North Wales Region

13.1 North Wales Regional Director represents the Trust as a member of the North Wales Stroke Forum.

13.2 In February 2009, Stroke/TIA patients that would previously have been admitted to Llandudno General Hospital are now admitted directly to either Ysbyty Glan Clwyd, or Ysbyty Gwynedd Bangor, dependent on their proximity to the aforementioned hospitals.

14. Ysbyty Gwynedd, Bangor

14.1 All 999 Stroke patients are taken to A&E. There is no formally agreed fast-track protocol but patients are managed by the Trust as per JRCALC guidelines. There is a co located stroke ward, but CT scanning is currently not possible within three-hours. There is no identified location for Stroke thrombolysis currently. Currently one Physician and nurse are trained to provide treatment (not specified)

15. Wrexham Maelor

15.1 All 999 Stroke patients are taken to A&E. There is no formally agreed fast-track protocol but patients are managed by the Trust as per JRCALC guidelines. Acute Stroke Unit developed. There is a co located stroke ward for acute strokes and rehabilitation. Currently there is a stroke team functioning. Two Physicians are trained for stroke thrombolysis. A three hour CT scan is possible but requires formal arrangements with the radiologist? The location for thrombolysis has not been identified.

16. Ysbyty Glan Clwyd

16.1 All 999 Stroke patients are taken to A&E. There is no formally agreed fast-track protocol but patients are managed by the Trust as per JRCALC guidelines. There is a co located stroke bed facility with monitoring facilities and 3-hour CT scanning is available Monday to Thursday from 09:00 to 17:00 hours. Resource implications re thrombolysis / post thrombolysis care provision.

17. Future requirements for North Region

17.1 Due to geographical restraints and the requirement to administer thrombolysis within three hours all three hospitals will need to provide thrombolysis treatment for stroke. Given this there are implications for each hospital, as funding will need to be found to support the development of Acute Stroke Units and the necessary infrastructure to support them.

17.2 The option of providing one centre of excellence is being considered. If this were to be developed, it would have significant implications for the Trust, because it would "pull" ambulance resources out of area, thereby reducing emergency cover.

18. Conclusions

18.1 At this time, no DGH in Wales is providing a 24/7 Acute Stroke Service and only two, the Royal Glamorgan Hospital, Llantrisant and Morriston Hospital, Swansea, operate agreed fast-track protocols with the Trust. Provision of thrombolysis for stroke is again only formally operated by these same two hospitals, but there are examples of this intervention being provided on an opportunistic 09:00 to 17:00 hours basis in other hospitals, namely Bronglais General Hospital, Aberystwyth, University Hospital of Wales Cardiff, the Wrexham Maelor and Ysbyty Glan Clwyd.

18.2 As previously mentioned in the Pre-hospital Management section of this paper (page 1), patients identified as an acute Stroke (AMPDS code 28) are currently allocated a category 'B' status, the aim being to ensure a transporting ambulance is allocated to the call, rather than sending a RRV. Whilst this aims to ensure patients are provided the correct resource appropriate to their need, at times of high demand, it is possible that the responding ambulance could be reallocated a higher priority (category A) call, which could result in the patient experiencing an undue delay in their subsequent assessment and treatment (3-hour window of opportunity for thrombolysis). Whilst the rationale for allocating Stroke calls as category B is a sound one, consideration could perhaps be given to making all 999 responses to Stroke as "non stand-down" calls?

18.3 The National Sentinel Audit of Stroke 2008 Clinical Audit Report acknowledges that the observations made by ambulance clinicians can be invaluable in evaluating the patient. The report strongly supports incorporation of the FAST assessment into the PCR and sees this as an opportunity to greatly improve communication of the patient's clinical assessment in the early stages of their Stroke. Whilst it is acknowledged that the Trust is currently exploring the option of introducing an electronic Patient Clinical Record, in the short-term, inclusion of the FAST assessment into the Trusts PCR should be seriously considered.

18.4 In an effort to improve the use and recording of FAST by the Trusts paramedics, the 2009/2010 Continuous Professional Development Programme (CPD) programme for paramedics includes a session on the use of FAST.