# Cross Party Group on Stroke held on 28 January 2014 at Ty Hywel

**Present:**

Guest Speaker: Dr Shakeel Ahmad (SA), Cardiff and Vale LHB

Joyce Watson (JW), Chair of Cross Party Group
Dr Anne Freeman MBE (AF), Clinical Lead for Stroke in Wales
Yaqoob Bhat (YB), Clinical Lead Stroke, ABHB representing WASP
Ana Palazon (AP), Director of Stroke Association in Wales
Dr Alison Cooper (AC), Older People and Ageing Research Network, Swansea University
Ruth Crowder (RC), College of Occupational Therapists
Phillipa Ford (PF), Chartered Society of Physiotherapy
Lowri Jackson (LJ), Royal College of Physicians, Wales
Fay McCaffer (FM), Chair RCSLT Stroke Expert Group and Speech & Language Therapist Cardiff and Vale ULHB
Dr Julie Wilcox (JWil), Consultant Clinical Psychologist, Cardiff and Vale
Lowri Griffiths (LG), Corporate Events Manager, Stroke Association
Claire O'Shea (CO), Regional Information and Campaigns Officer, Stroke Association
Gareth Davies (GD), Stroke Association Volunteer
Nitesh Patel (NP), Communications Officer to Joyce Watson AM

**In Attendance:**
Jillian Haynes, Minute Secretary, Stroke Association

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**Item 1: Welcome and Apologies**

The Chair welcomed members and noted the apologies which included David Melding AM, Lindsay Whittle AM, Kirsty Williams AM, Mark Drakeford AM.

**Item 2: Presentation: Year 1 of the Implementation of the Stroke Delivery Plan (SDP); a Health Board (HB) perspective from Dr Shakeel Ahmad, Cardiff and Vale (C&V) University Health Board**

Dr Ahmad began by outlining the demographics of stroke in Wales. The cost of stroke in Wales is estimated to be £2.8 million per year, consuming 5% of healthcare resources.

The Stroke Delivery Plan of December 2012 had at its core: prevention, detection, treatment and life after stroke. It also addresses inequalities and the research culture in Wales. The Local Delivery Plan (LDP) determines local needs and the first Annual Report had been published.

Dr Ahmad discussed each element in turn explaining how the service operates in Cardiff and Vale (C&V) and the scoring system that records and prioritises risk. Over the first year, 991 patients had been referred, and 1450 had been followed up during September

2012 to August 2013. Seventy per cent of high risk cases were seen within the first 24 hours and 80% of low risk patients were seen within a week.

He explained that modifications in stroke medicine had been incalculable and described the advances in thrombolysis, the accepted treatment for acute ischemic stroke, clot retrieval and decompressive surgery. The UHB runs a daily TIA service and provides 24/7 cover, including an out of hours and weekend thrombolysis cover. He included impressive evidential statistics and stated that the LHB aimed to reduce door to needle time from 80 minutes to 32 minutes, in order to reduce the loss of brain function during the critical period.

Dr Ahmed related two patient cases and Members were able to appreciate the processes involved at each stage. He concluded by stating that there were still many improvements that could be gained eg improving patient flow through the system, but the headway made in the treatment of the condition in recent years was inspiring, and the first year of the delivery plan was successful.

A new rehabilitation unit had been opened in Llandough Hospital. Forty seven beds had been reduced to 35 to accommodate it. An Early Supported Discharge (ESD) team had been appointed and 38 patients had been referred for ESD ie 3-4 per week. A community care support service assisted survivors needing further support.

For research purposes, thirty patients' conditions had been studied. He continued that if it were possible in Wales to set up a research base, with a Chair in Stroke, it would raise standards of stroke education and the opportunity for new ideas would be evaluated more fully..

It was stated that there are 25-30 centres in the UK which offer clot retreival treatment and it is regarded as standard practice in Europe. The cost is approximately £5-6,000 per patient. In Wales, there are two neurologists who can perform this treatment. AF suggested that recruitment of more interventionalists was required in Wales. JW stated that it was perceived that Wales cannot recruit stroke professionals, as it was understood that resources are scarce and SA agreed that all professionals compete for one resource centre compared to other areas where there are very specialised, and more abundant, resources. SA stated however that communications in Wales is very good, and every Wednesday afternoon a teleconference is held in which nine or ten centres participate.

YB agreed that recognition of stroke is the main problem. Given the advances in Wales however, it would be wise to consider all options imminently. AF stated that stroke patients in north Wales are referred to Liverpool Hospital for treatment. Stoke on Trent Hospital had offered their services but this offer was under review.

GD asked what would be required in order to raise thrombolysis rates to 20% from 12%. SA confirmed that recognition of stroke, the process of getting the patient to hospital and assisting patient flow were all contributing factors. Patient handover can take up to twenty minutes and a fast track system would greatly reduce this delay, and propel the patient towards assessment, scan, review and treatment much more quickly. Process time was previously more than 100 minutes from door to needle, but this has now been reduced to 32 minutes, as each process has been reviewed and modified. One patient had experienced the whole process within 12 minutes.

YB agreed that efficiency in patient flow was crucial as was public awareness in dialling 999 immediately. One patient in eight experienced thrombolysis, but this figure should be higher. AF reported that in England the figure was also lower than it could be, with 11.8% of patients experiencing thrombolysis. In Wales the figure is 11.68%. She continued that a researcher from Newcastle was studying stroke processes in Wales, in order to deduce what is required to improve services and reduce door to needle time.

AC asked what occurred in cases of severe stroke, if mild to moderate cases progress to ESD. SA replied that most patients return home quickly in this system, leaving inpatients with more complex conditions which can be studied in detail. The stroke outreach team assists patients with more severe strokes. Community facilities included daily hospitals that are useful in monitoring patients' ongoing requirements.

Regarding prevention, LG asked how YB and SA perceived the feedback on the work with GPs. SA stated that his job is to meet all referrals for assessment and scan, and his position involved diagnosing whether the condition was actually a TIA, so he felt that education is a key feature in determining a vascular event. While anti-coagulant tablets were discussed, there was no data to determine efficacy.

YB added that the average care cost for a stroke patient is approximately £6,000 as opposed to £200-300 for thrombolysis treatment, so thrombolysis was both effective and economical.

PF asked about the effect of the drop in number of beds. SA stated that the resources would remain in the stroke service. The decommissioned beds were made available for ESD. The system had worked well until November, and then in December, with the winter resource pressures, there were issues with patient flow as the beds were used for the winter influx. This meant that the number of beds was reduced back to 35 which caused a backlog in the stroke patient flow. In October and November, between 35 and 38 admissions were processed, but in December fewer were processed. SA suggested that change capacity for stroke beds could be discussed ie increasing numbers of beds at certain times of year.

PF asked if the stroke bundles were working well. SA confirmed that the bundles are the drivers and are evidenced based. Standards were implemented to drive performance, and this had been the case in Cardiff with improved data obtained as a result. The SSNAP audit also collected useful data. As healthcare staff were entering data however, this administrative action transferred their attention away from their patients. SA advised that there were IT solutions available, but these may have a prohibitive cost eg electronic record collection which could transfer data automatically to SSNAP. North-east England use this facility.

Following a question from NP, SA stated that screening targets for C&V were set at 60-80%, with a 24 hour limit for high risk patients and a week for low risk patients. AF stated that the performance management tool was not operating properly as yet, so the data was not as currently as useful as it would be in the future.

YB stated that the bundles were operating very well and helped with attaining the 100% target achieved in low risk patients. High risk patients could be admitted to the ward and

be examined even if there was no immediate capacity. Every low risk and high risk patient would be reviewed within 24 hours. SA agreed that the problem was getting them into the ward in the first place in order to take the assessments.

JW asked the healthcare professionals how the service could be standardised throughout Wales, with every region aiming to upgrade to the highest standards. SA reported that the higher the population the more efficient the centre becomes at patient processing. He also reminded Members that the telestroke teleconference tool was very useful for sharing expertise and delivering services to the regions.

JW asked whether all HBs were signed up to the telemedicine conference and whether it was fully developed. AF replied that Betsi Cadwaladr was signed up to telemedicine but that Hywel Dda was not at the present time, although Hywel Dda did possess stroke carts. One in four centres does not have a cart. Healthcare professionals would eventually be able to obtain group advice over the telephone, but she explained that this goal had not yet been reached. AP queried whether claiming that there was 24/7 provision was accurate in the circumstances. SA stated that public funds were used to buy the carts and therefore they should be used. Telestroke was available for rural areas on a 24/7 basis, but the quality differed greatly. AF explained that at Bronglais, there was an independent service, but if the stroke was a complex situation, this needed further medical advice.

AF reported that Tom Hughes had offered Betsi Cadwaladr his advice and clot retrieval services for a weekend, but they had declined his offer. Services of the Stoke on Trent centre had also been refused on contractual issues, so the situation was not yet resolved.

LG asked whether the LDP had been useful to shape services. SA replied that good progress had been apparent but improvements could still be made. AF stated that every HB had developed its own action plan; this had been featured in the delivery plan. There was a six month window to decide if the model should be altered. AP stated that ESD was still in its early days and was being evaluated; the patient is followed for up to six weeks and if medical attention is required, the patient is referred.

AF advised that the first public quarterly report was due to be published that day and would be made public on 11 February. The first 72 hour period would be analysed and each HB's performance would be scrutinised.

**Item 3: Health Committee Response on One Day Inquiry on Stroke Risk Reduction**

LG referred Members to the letter from the Health and Social Care Committee to Mark Drakeford AM, revisiting the recommendations from the December 2011 enquiry and requesting a response within six weeks. AF summarised the key points highlighted in the letter:

i) leadership and the role of a national clinical network
ii) data collection – a stroke register for Wales
iii) stroke workforce
iv) access to TIA services
v) carotid surgery
vi) atrial fibrillation
vii) public awareness.

JW reported that an event around atrial fibrillation would be held in March.

YB stated that he engaged the press to inform public knowledge and that short messages repeated often were more effective.

LG reminded Members that the 'Action On Stroke Month' at the Stroke Association would be held again in May and this year would concentrate on TIA. Work was ongoing between the Stroke Association and pharmacies. She noted that high blood pressure and vascular issues had not been mentioned in the letter.

LJ suggested that the costs of implementation were prohibitive, but YB replied that when looking at costings, the long term benefits were the relevant benchmark.

As Adam Cairns is the lead on stroke and diabetes, LJ suggested liaising closely with him and suggested that school children and businesses be taught about stroke. AF stated that she would be in contact with Adam Cairns shortly and would meet the new vascular surgeons the following day to strengthen the pathway.

SA noted that legislation had been effective in reducing smoking, and suggested that funds spent on public campaigns may have been wasted to an extent, as legislation had a more effective and immediate result. NP suggested sending information to JW by letter.

LG stated that work was ongoing with pharmaceutical companies at the Stroke Association with research, prevention and risk reduction at its core. She enquired whether JW would support the initiative. JW stated that she would require further information before committing and NP suggested inviting groups to future meetings to discuss the initiative.

JW invited Members to email their questions to her and stated that she intended to work alongside SA at C&V to understand the processes and pressures experienced at the unit.

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