Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Royal College of Physicians (Wales) -
Coleg Brenhinol y Meddygon (Cymru)
Regus House - Tŷ Regus, Falcon Drive
Cardiff - Caerdydd CF10 4RU
Tel - Ffôn: +44 (0)29 2050 4540

www.rcplondon.ac.uk/wales

Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE
Tel: +44 (0)20 3075 1560

www.rcplondon.ac.uk

Committee Clerk
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay CF99 1NA

HSCCommittee@wales.gov.uk

From The Registrar
O'r Cofrestrydd

Patrick Cadigan MD FRCP
patrick.cadigan@rcplondon.ac.uk

20 September 2013

STROKE RISK REDUCTION - FOLLOW-UP INQUIRY

Response from the Royal College of Physicians (Wales) to the National Assembly for Wales' health and social care committee follow up inquiry into stroke risk reduction

The Royal College of Physicians (Wales) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in Wales and across the world with education, training and support throughout their careers. As an independent body representing more than 28,000 fellows and members worldwide, including 1,000 in Wales, we advise and work with government, the public, patients and other professions to improve health and healthcare.

Mae Coleg Brenhinol y Meddygon (Cymru) yn arwain y ffordd o ran darparu gofal o ansawdd uchel i gleifion drwy osod safonau ar gyfer arferion meddygol a hybu rhagoriaeth glinigol. Rydym yn darparu addysg, hyfforddiant a chefnogaeth i feddygon yng Nghymru a ledled y byd drwy gydol eu gyrfa. Fel corff annibynnol sy'n cynrychioli mwy na 28,000 o gymrodorion ac aelodau ym mhedwar ban byd, gan gynnwys 1,000 yng Nghymu, rydym yn cynghori ac yn gweithio gyda'r llywodraeth, y cyhoedd, cleifion, a gweithwyr proffesiynol eraill i wella iechyd a gofal iechyd.

For further information

The RCP in Wales welcomes this opportunity to respond to your follow up inquiry into stroke risk reduction. We are happy to give oral evidence, if invited. If you would like more information, please contact Lowri Jackson, RCP senior policy adviser for Wales, at Lowri.Jackson@rcplondon.ac.uk or on 029 2050 4540.

Overview

The RCP in Wales believes that the prevention and treatment of stroke should be a key priority for the Welsh Government. There are an estimated 11,000 stroke events, including 6000 new strokes, every year in Wales. It is one of the top three causes of death, and a leading cause of adult disability.[1] The Welsh Government has recognised that:

> **'Stroke requires immediate comprehensive multidisciplinary assessment, acute care and rehabilitation … A significant number of stroke survivors need seamless, longer-term rehabilitation, follow up and support … A collaborative approach is required … along the whole stroke care pathway.'[2]**

However, following discussions with physicians working on the frontline of stroke medicine, while signs of improvement had been made in the treatment of acute and hyper acute stroke, we found that little progress had been made on stroke prevention since the publication of the December 2011 committee inquiry report into stroke risk reduction.

Our overarching recommendation is that a national, clinically led stroke network be established with the resources and accountability to drive the stroke agenda forward in Wales.

Key recommendations

1. The RCP in Wales recommends that a clinical lead in each health board be charged with implementing the recommendations in the 2012 Welsh Government stroke delivery plan, and that a national stroke network, with adequate funding and staff, be established to lead the stroke agenda and monitor the progress of the national and local stroke delivery plans.

2. The RCP in Wales recommends that a clinically led expert group, drawn from the membership of the proposed national stroke network, should be tasked with updating and taking forward the recommendations of the Halcox report (see appendix 3).

3. The RCP in Wales recommends that the Welsh Government develop clear guidelines for TIA management and assessment in Wales. This process must be clinically led, ideally by the proposed national stroke network.

4. The RCP in Wales recommends that the Welsh Government, the Wales Deanery, the proposed national stroke network and the seven health boards come together to develop a national workforce and education strategy for stroke physicians in Wales.

5. The RCP in Wales recommends that the proposed national stroke network leads on joint work with other organisations, including the RCGP, Community Pharmacy Wales and the Royal Pharmaceutical Society, to develop education and training on stroke risk reduction in primary and community care.

[1] Welsh Government, Together for Health - Stroke Delivery Plan, December 2012
[2] Ibid

Our response

Our response is informed by our fellows and members in Wales.

The RCP in Wales also hosted a roundtable meeting with key physicians in Wales to discuss the RCP response to this inquiry on 20 August 2013. These discussions have also informed our response and a list of participants can be found in appendix 2 of this document.

The National Assembly for Wales' health and social care committee last reported on stroke risk reduction in December 2011 (referred to in this response as 'the 2011 committee report'). Below we have taken the five recommendations from that report and commented on where progress has been made, and where progress is still required.

Recommendation 1: We recommend that the Welsh Government undertake a full and robust evaluation of the implementation of the Stroke Risk Reduction Action Plan, involving all stakeholders. The evaluation should be published, and the results used to inform the development of the National Stroke Delivery Plan.

While an evaluation of the implementation of the stroke risk reduction action plan was carried out by Public Health Wales, we found that the report itself was not made publically available until very recently.

A key issue which was repeatedly raised by our physicians was the lack of a clear line of accountability at the national government level on stroke services in Wales. There is no clear Welsh Government lead with responsibility for the delivery of past action plans and the current stroke delivery plan.

We spoke to the national clinical lead for stroke, Dr Anne Freeman, who told us that she is contracted to work only three sessions a week in this role, but frequently does more. The role has a wide ranging remit which includes stroke prevention, acute treatment, rehabilitation and life after stroke. It has also evolved to include developing sustainable support structures, encouraging clinical innovation, and quality improvement for stroke in NHS Wales. However, she told us that time and resource constraints have made her role quite difficult at times, and she would welcome more support, especially staff.

Our physicians recommended the establishment of a national stroke network in Wales, linked to a government lead, with adequate funding and staff, which would be able to lead the stroke agenda and monitor the progress of the national and local stroke delivery plans.

> **'What we would like to see is a stroke network developed in Wales, which would really drive the stroke programme forwards. We've got this in cancer, we've got this in cardiology … The three biggest killers are cancer, cardiac disease and stroke, and yet we haven't got the same infrastructure that cancer and cardiac have got.'**

> **'Scotland has got 14 managed clinical [stroke] networks. Each managed clinical network has got a clinical lead; they've got managers; they've got teams to look at audit, research, education, and the clinical aspects.'**

> **'These reports keep coming out with action and timetables, and nothing gets achieved. Here we have [the 2010 stroke risk reduction action plan] … Why hasn't that been done? Is it because the will is not strong enough? Is it a resource issue? What is the problem? These actions and recommendations keep coming back, and they're not [being] delivered.'**

The RCP therefore recommends that a clinical lead in each health board be charged with implementing the recommendations in the 2012 stroke delivery plan, and that a national stroke network be set up to oversee the progress of this work.

Recommendation 2: We recommend that the Welsh Government includes within the National Stroke Delivery Plan clear references to the prevention of secondary strokes and the treatment and diagnosis of TIAs as they relate to stroke risk reduction work.

Our physicians recommended a number of areas where work could be undertaken to prevent strokes in both primary and secondary healthcare settings. A full list of recommendations we received from our physicians is available at appendix 1 of this response. We have also submitted the 2010 'Vascular Risk Management in Wales' report commissioned by the Welsh Government from Professor Julian Halcox as appendix 3 to this response. This is because our physicians told us that the original 2010 stroke risk reduction action plan does not adequately consider secondary prevention of stroke.

> **'Most of the risk factors for stroke are actually missing … I'm not sure if there's mention of hypertension. There certainly isn't a mention of diabetes … it's all to do with public health measures. We should be inviting individuals for cardiovascular checks to prevent them from diabetes, stroke, kidney, heart disease. The cardiovascular diseases together are responsible for more premature deaths than cancer or infections.'**

Participants in our roundtable meeting were also concerned about a lack of progress on the treatment and diagnosis of TIAs.

> **'I think the issue for me is that there isn't a specific piece of work looking at TIAs at the moment … There are TIA bundles, but they were handed over to the health boards.' / 'They were never performance managed. There were never any targets set for compliance … It was for the health boards to take them on and then to monitor continuous improvement.'**

Once again, our physicians told us that they believe a national stroke network with a government lead was needed to drive the stroke agenda forward. They were also very keen to ensure that the Halcox report (see appendix 3) and its recommendations not be overlooked.

> **'[This] recommendation is to look at the whole issue of primary and secondary prevention, which encompasses everything that we are talking about … Within that recommendation, you've got to drill it down – you've got to look at the actual primary causes of stroke, the secondary causes, and then take action … and have a mechanism whereby you can bring the whole of stroke prevention together'. / 'Do you think … that anybody is actually doing that?' / 'No.'**

> **'Basically the only way we're going to really address stroke risk reduction is if we can get … stroke, cardiac, diabetes, vascular surgery, general practice, public health, all working together in their different strands, bringing it together cohesively. We're all working at it a bit piecemeal, somebody going off doing a bit of this and a bit of that [and] we've got to bring it together with the aim that we reduce the incidence of stroke.'**

The RCP therefore recommends that a clinically led expert group, drawn from the membership of the proposed national stroke network, should be tasked with updating and taking forward the recommendations of the Halcox report.

Recommendation 3: We recommend that by April 2012 and in line with its published expectation, the Welsh Government ensures patients have access to seven day TIA clinics and that clinical guidelines in relation to carotid endarterectomies are adhered to across Wales.

Our physicians do not believe that this recommendation is currently being met. They felt that the current advice on delivering a TIA service was unclear, and that the wording of 'seven day TIA clinics' should be replaced with 'a seven day TIA service'. One physician told us that without significant financial investment, there is no way that rural health boards would ever be able to provide this kind of service:

> **'The local approach [in my health board] has been to train all front end doctors in the recognition and management of acute stroke [including TIA]. In this way, all patients can be considered for thrombolysis and all can be offered appropriate secondary prevention immediately. There are two rapid access stroke clinics each week at which TIA referrals are seen … [If] a seven day a week service [becomes] mandatory, then that will require significant investment. Even if a telemedicine service is considered there would need to be a local person to examine the patient … Maybe we should be pragmatic about this, and be clear that the objective of the seven day service is to exclude haemorrhage, arrange carotid imaging, ECHO, 24 hour rhythm recorder and lipids, and other investigations and most importantly, to offer immediate antiplatelet therapy to reduce stroke risk as soon as possible. Wales (or at least, rural Wales) will be set up to fail if a seven day a week service is demanded without additional resource to the rural area.'**

The RCP therefore recommends that the Welsh Government develop clear guidelines for TIA management and assessment in Wales. This process must be clinically led, ideally by the proposed national stroke network.

We also believe that there is a real problem with data collection around the clinical guidelines in relation to carotid endarterectomise. The RCP Stroke Programme in London has tried to collect data from cardiovascular surgeons about this, with a varying degree of success in Wales. However, even where the data is available, nobody has the responsibility for monitoring and auditing that data, which leads to a lack of accountability. We believe that this situation supports our first recommendation.

Furthermore, a key part of ensuring seven day access to stroke services, including TIA clinics, is having enough trained specialist doctors to do the work. However, the British Association of Stroke Physicians (BASP) believes that 'the present availability of [stroke] training posts is woefully inadequate to redress the

current shortfall in consultant posts within a realistic timescale'.[3] Dr Freeman, the clinical lead for stroke in Wales told us that:

> **'Some time ago [I carried out] a survey of all consultants in Wales working in stroke either full-time or part-time and there is a shortfall ... [Each health board is responsible for planning] its own stroke consultant session requirements and recruiting as appropriate … However, [I feel that we need] to look at what is needed in Wales as a whole, as well as by health board, to get a Wales-wide overview of the shortfall. [Then we could] assess the need for additional sessions, where they should be, the numbers of specialist registrar posts required in the future [and] the need for academic consultant posts.'**

The 2011 committee report asks the Welsh Government to 'consider the shortfall in trained stroke physicians through the use of effective workforce planning.' We believe this proposition is still highly relevant. The RCP therefore recommends that the Welsh Government, the Wales Deanery, the proposed national clinical stroke network and the seven health boards come together to develop a national workforce and education strategy for stroke physicians in Wales.

Recommendation 4: We recommend that the Welsh Government develops clear guidance for primary care and community resource teams on the diagnosis, treatment and management of atrial fibrillation and clearly identifies professional responsibilities in each area.

Recommendation 5: We recommend that the Welsh Government ensures that pulse checks are offered as standard to patients presenting stroke risk factors when attending primary care. Any necessary treatment which then follows should comply with NICE guidelines, and further action by the Welsh Government is needed to ensure that this takes place. Compliance should be monitored through Public Health Wales' audits of primary care record data.

Our physicians considered these two recommendations together. They expressed surprise that the fourth recommendation does not mention the role of hospital specialists in the diagnosis, treatment and management of atrial fibrillation. It was strongly felt by our physicians that to be cost effective, these tests should be combined with other screening programmes. It was noted that some GPs may not feel confident in prescribing medication for atrial fibrillation:

> **'I think it's a matter, really, of training, in the same way that ten years ago, GPs in my area were scared of prescribing insulin, and now every practice does it. It's education and training … I think we really need to start breaking down these barriers between secondary and primary care. I spend a lot of my time doing education and training in primary care, and in the long run, it saves me from having packed clinics.'**

It was also suggested that there could be a greater role for community pharmacies in this work.

[3] British Association of Stroke Physicians, *Specialist stroke services: Consultant workforce requirements*, available at http://bit.ly/15b2OOL

'I have been talking to community pharmacists in Wales and they are very keen to get involved in cardiovascular risk prevention to carry out these checks, particular in areas of socio-economic deprivation.'

The RCP therefore recommends that the proposed national stroke network leads on joint work with other organisations, including the RCGP, Community Pharmacy Wales and the Royal Pharmaceutical Society, to develop education and training on stroke risk reduction in primary and community care.

If you have further questions, please contact Lowri Jackson, RCP senior policy adviser for Wales, at Lowri.Jackson@rcplondon.ac.uk or on 029 2050 4540.

Yours faithfully,

Dr Patrick Cadigan
Registrar / Cofrestrydd

Royal College of Physicians (Wales)
Regus House
Falcon Drive
Cardiff Bay CF10 4RU

Tel: +44 (0)29 2050 4540
Email: Wales@rcplondon.ac.uk

www.rcplondon.ac.uk/uk/wales

Coleg Brenhinol y Meddygon (Cymru)
Tŷ Regus
Falcon Drive
Bae Caerdydd CF10 4RU

Ffôn: +44 (0)29 2050 4540
Ebost: Wales@rcplondon.ac.uk

www.rcplondon.ac.uk/cymraeg/cymru

Further information about the RCP's Stroke Programme

The Stroke Programme at the Royal College of Physicians has been at the forefront of quality improvement programmes in stroke since 1996. The Intercollegiate Stroke Working Party, made up of senior representatives from all the professional bodies involved in stroke care, including the voluntary sector and patient representation, oversees the work.

The programme sets evidence based standards in the National Clinical Guideline for Stroke, now encompassed within the NICE Quality Standards and measures compliance in the organisation and delivery of stroke care in comparison to these with national audits and encourages service improvement through peer review, workshops and links with the Welsh Government and health boards.

The purpose of the ICSWP is to set evidence based standards, measure compliance in the organisation and delivery of stroke care and encourage service improvement. The stroke programme carries out commissioned work through several projects listed below:

- Stroke Improvement National Audit Programme (SINAP)
- Sentinel Stroke National Audit Programme (SSNAP)
- UK Carotid Interventions Audit
- National Sentinel Stroke Audit
- National Clinical Guideline for Stroke
- Stroke Peer Review Scheme

Appendix 1: Recommendations for stroke prevention

Primary prevention

1. Families who have history of stroke should be targeted for primary prevention. Genetic factors are important in the development of common risk factors such as hypertension, diabetes, and hyperlipidemia. Familial sharing of life style may also contribute to stroke risk.

2. Non-invasive screening for unruptured intracranial aneurysms in patients with >2 first-degree relatives with subarachnoid haemorrhage or intracranial aneurysms should be considered.

3. Further work should be carried out to reduce alcohol consumption and promote smoking cessation. Facilities to promote exercise should be developed further and made accessible to all sections of society. Reduced salt consumption and healthier diet to prevent obesity should be promoted.

4. Hypertension is the most important risk factor for stroke and treatment of hypertension is probably one of the most effective strategies for preventing both ischaemic and haemorrhagic strokes. The higher the blood pressure, the greater the risk of stroke and the risk increases progressively with increasing blood pressure. Although blood pressure control is one of the QOF targets, consideration should also be given to improve control and to reduce variability of blood pressure.

5. Treatment with a statin in addition to lifestyle changes should be recommended for primary prevention of ischemic stroke in patients with coronary heart disease and diabetes.

6. Atrial fibrillation is associated with a 4- to 5-fold increased risk of ischemic stroke. Greater recognition of atrial fibrillation in the community and more effective use of anticoagulant therapy in appropriately selected patients is likely to have a positive impact on the incidence of stroke.

7. Drugs of abuse, including cocaine, amphetamines, and heroin, are associated with increased risk of stroke. Abuse of these drugs can result in acute and severe hypertension, cerebral vasospasm, vasculitis, infective endocarditis and intracerebral haemorrhage. Measures should be taken to educate young people about the dangers of drug abuse.

8. Every encounter with high risk age group of people both in primary and secondary care should be used for opportunistic screening for stroke risk factors and health education.

Secondary prevention

1. Every patient who has had a TIA or stroke should be assessed by a stroke specialist as soon as possible.

2. High risk TIA patients should be assessed within 24 hours in a specialist stroke prevention clinic.

3. Educational initiatives aimed at general public should include recognition of TIAs.

4. Rapid access pathways should be set up to facilitate early treatment (within 2 weeks) of symptomatic carotid stenosis.

5. Stroke and TIA patients should be counselled about the importance of adherence to secondary preventive treatments.

6. Every health board should ensure that there is easy access to investigations such as neuroimaging, Carotid Doppler, cardiac rhythm monitoring, and echocardiogram.

7. Similar principles apply as in primary prevention in the management of risk factors such as hypertension, hypercholesterolemia, smoking, alcohol misuse, obesity and atrial fibrillation.

Appendix 2: List of attendees at the RCP (Wales) roundtable meeting to discuss an RCP response to the National Assembly for Wales stroke risk reduction inquiry

Attendees

Dr Meurig Williams	RCP service adviser for Wales
Dr Anne Freeman	National clinical lead for stroke in Wales
Dr Amer Jafar	Stroke physician, Royal Gwent Hospital
Dr Shakeel Ahmed	Training programme director for stroke in Wales
Andrew Jones	Performance manager, NHS Wales Delivery Unit
Lowri Griffiths	Head of communications and external affairs, Stroke Association Cymru
Lowri Jackson	RCP senior policy adviser for Wales

Could not attend but contributed detailed written evidence

Dr Hamsaraj Shetty	Regional specialty adviser for stroke in Wales

Appendix 3: Vascular Risk Management in Wales

Please see the attached report by Professor Julian Halcox at Cardiff University, developed with the Vascular Project Group, which reported to the Welsh Government in March 2010.