BMA CYMRU WALES

Health and Social Care Committee

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Inquiry into Stroke Risk Reduction – Evidence from British Medical Association Cymru / Wales

British Medical Association Cymru / Wales

Written Evidence to the Health and Social Care Committee

Stroke Risk Reduction

INTRODUCTION

BMA Cymru Wales is pleased to provide evidence to the Health and Social Care Committees inquiry into Stroke Risk Reduction.

The British Medical Association represents doctors from all branches of medicine all over the UK. It has a total membership of almost 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, who speak for doctors at home and abroad. It is also an independent trade union. BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

Stroke is a common and devastating condition and is the third most common cause of death in the UK; 11,000 people have a stroke in Wales each year.

Strokes leave one third of patients permanently dependent on the help of others and is the biggest single cause of severe acquired disability.

The treatment and management of stroke is now supported by a good body of quality evidence and we have witnessed a number of medical advances in recent years. As a result stroke is increasingly becoming a treatable condition.

There has definitely been an increase in awareness of the symptoms of stroke and the fact that when a stroke occurs it requires an emergency response, however evidence is anecdotal – and much more could be done to promote health living.

Within the Annual Quality Framework 2011-12 there are specific targets for stroke acute care, rehabilitation and Transient Ischemic Attack (TIA). Although, it does not mention stroke risk reduction – this is however arguably harder to measure. However, targeted publicity and efforts to increase awareness of the risk factors in communities while mapping the prevalence of these factors and the incidence of stroke itself could be a useful long-term resource.

The Stroke Risk Reduction Action Plan does not mention risk reduction for a person who has already experienced a transient ischaemic attack (TIA) or stroke. This is an unfortunate omission since TIAs increases the risk of a future stroke. Sound evidence exists to show that patients who show symptoms of Transient Ischemic Attack (TIA) are at risk of having a stroke if they do not receive carotid endarterectomy – surgery of the neck arteries - as soon as possible; guidelines state this should ideally within 48 hours. The role of rapid access to carotid endarterectomy for patients having had a TIA needs to be considered in a any move to address the risk factors of stroke, also linked to this is ensuring that patients recognise the symptoms of a TIA and seek medical attention immediately.

The Risk Reduction Plan almost entirely focuses on raising public awareness. Whist this aim is laudable, important and necessary there are also specific steps that the Welsh Government could take to reduce risks and raise awareness - especially in relation to providing more information on the relationship, identification and treatment of both atrial fibrillation (AF) and transient ischaemic attack (TIA). The referral pathway also needs to be made clear in such cases for all partners.

Some people have argued for a systematic screening programme for atrial fibrillation (AF). Whilst the evidence is clear about the links between AF and stroke, the Committee will need to look at to what extent this is taking place already as there is a real risk of duplication of effort - the majority of the patients at risk are already targeted through existing services, especially smoking cessation, blood pressure checks and health reviews for other conditions in which cardiovascular risk is increased. It is reaching those at risk in harder-to-reach communities (e.g. some rural and valleys areas) or those who do not engage with the health service which need to be targeted. Opportunistic screening during other routine contact with the NHS or care services – for example, blood pressure / pulse checks when visiting the GP or pharmacy for flu vaccines or during medicines reviews – may be more productive and cost effective than systematic screening.

In addition the Welsh Government needs to be aware and willing to invest in new and emerging medical technologies and innovation. For example, the British Journal of General Practice recently contained an overview of a study of a new instrument that analyses finger-tip pulse in the detection of AF, it was undertaken on 594 patients, the study reliably concluded that the instrument provides an accurate and reliable screening too l for AF, filling a gap in the current process of early detection in the community[1]. We feel the Committees inquiry would definitely benefit from considering this study.

If we are to see real improvement in terms of prevention, treatment, and aftercare available to stroke patients across Wales, we need to look at the entire stroke pathway – BMA Cymru Wales has previously called for a Stroke Strategy to be designed to achieve that integration of stroke services across all health sectors.

There needs to be an effective, integrated emergency response to stroke – i.e. multi-disciplinary teams across primary and secondary care, a public campaign to raise awareness of the signs of stroke and that it requires a 999 response, referral to a stroke unit rather than general hospital ward – it is clear much more investment in the provision of specialist stroke care and a larger specialist workforce is needed in Wales.

We would be happy to talk to the Committee about how the UK Quality and Outcomes Framework (QOF) of the GP contract works in this area and the indicators for QOF 2012 proposed by NICE (based on the appraisal of evidence/best practice) should that be useful. QOF is based on NICE gold standard evidence, it currently provides that warfarin is only indicated for higher risk atrial fibrillation (CHADS2 score 2 or above). In addition, QOF contributes to risk reduction in an evidence based way in terms of lipids sugar, blood pressure and smoking cessation. Atrial fibrillation is often picked up during blood pressure checks and is managed by evidence based interventions. GPs work on the basis of clinical evidence of what is best for the patient.

<u>SYMPTOMS</u>

[1] BLGP January 2011 'Screening for Atrial Fibrillation: sensitivity and specificity of a new methodology' Malcolm Lewis, Dawood Parker, Clive Weston and Mark Bowes.

In most people, the symptoms of a stroke develop rapidly over a matter of seconds or minutes. The exact symptoms depend on the area of the brain affected.

There is usually little or no warning of a stroke. Immediate admission to hospital for assessment and treatment is essential so that a cause can be identified and treatment can begin. The after-effects of a stroke vary depending on the location and extent of the brain tissue affected. If the symptoms disappear within 24 hours, the condition is known as a transient ischaemic attack (TIA) which is a warning sign of a possible future stroke. Approximately 30 per cent of strokes are preceded by a TIA, or 'mini-stroke', and most subsequent strokes occur during the first few days after the initial warning event.

Drug treatment and prompt specialist care and rehabilitation are the greatest determinants of both survival and recovery.

Stroke symptoms can be hard to recognise and diagnose for those not specifically trained to do so. Unlike acute heart attacks for example where diagnosis is confirmed from the typical symptoms and an ECG, there is no such way of diagnosing a stroke. Some health conditions – e.g. migraine, seizure and Transient Ischamic Attack (TIA/co-called “mini-stroke”) – can mimic stroke symptoms of weakness and speech loss. Stroke has many mimics and many conditions mimic stroke.

Therefore, clot-busting thrombolysis treatments (which have a very high rate of adverse effects) can be given to the wrong patients. We would recommend that the diagnostic process is prioritised and every effort made to enhance the diagnostic skills i.e. for those who have early contact with potential stroke patients and in general medical training.

Although it is always difficult to measure the success of public health campaigns, more patients seem to be aware of the symptoms and indicators of stroke and the need for rapid healthcare attention. Anecdotally, it seems that more patients are presenting sooner with symptoms of stroke than has been the case in the past.

PREVENTION

Stroke can affect anyone; traditionally strokes have been associated with males over the age of 70 but this is becoming increasingly less so.

The risk factors for stroke are almost identical of those for cardiac disease – diabetes, smoking, hypertension, cholesterol – all of which are potentially modifiable through lifestyle changes. Strokes are therefore preventable, and like so many other health conditions, many are related to overall health and wellbeing. The National Service Framework for Older People states that “*about 40% of strokes could be prevented by regular blood pressure checks, treatment for hypertension and taking steps to improve overall health*”[2]

Urgent preventative treatment following the initial warnings of transient ischaemic attack (TIA) could avoid many thousands of strokes in Wales each year. Delays to assessment after TIA are significant, sometimes due to delays on the part of patients in seeking medical attention. Education is therefore required to enable the public to recognise the symptoms of TIA and minor stroke, and to encourage people to seek medical attention immediately.[3]

Primary prevention of stroke should be a priority and a central part of the overall policy on public health improvement (provision of information on healthy living, supporting healthy and active lifestyles, good nutrition, smoking cessation, access to green open spaces, active transport, exercise referral etc) which is also related to the prevention of a number of other critical illnesses – heart disease and diabetes for example.

[2] National Service Framework for Older People in Wales, 2006, p99
[3] Rothwell P, Giles M, Flossmann E, Lovelock C, Redgrave J, Warlow C, Mehta Z. A simple tool to identify individuals at high early risk of stroke after a transient ischaemic attack: the ABCD score. The Lancet 2005; 366:29-36.

Secondary prevention should start shortly after admission, and all patients should be offered lifestyle guidance. It is important for all local partners to be coordinated in their approach to reduce the risk factors for stroke and to realise that risk reduction does not only apply before a stroke takes place but during the entire care pathway.

It is clear that data collection and data quality are both important to the understanding of stroke prevalence in Wales, and the use of information on the risk factors (e.g. hypertesion; atrial fibrillation, cholesterol etc) can be put to better use and used to 'map risk' and direct resources.

A MEDICAL EMERGENCY

Stroke is now, rightly, being seen as a medical emergency which requires urgent and prompt specialist assessment and treatment.

Patients should be assessed at an acute hospital immediately after a stroke since hyperacute treatments such as thrombolysis must be administered within as little as three hours after stroke onset.

Most people who have suffered a stroke, should have a brain scan (CT or MRI) as soon as possible - within 24 hours / no later than 48 hours – of the onset of symptoms. When thrombolysis is being considered it is imperative that the patient is imaged immediately.

There is clear evidence that admission to a stroke unit reduces deaths and disability and prevents the onset of further complications.

Ambulance crews should be trained specifically in stroke care, and in screening. Emergency medical services in administering a first-line response should be trained and supported in recognising symptoms, ensuring initial stabilisation, possible administration of hyperacute therapies and communication with receiving hospitals/stroke units.

STROKE UNITS

Acute stroke units are paramount to the effective provision of stroke care. However stroke units need to be put into the wider context of acute services as a whole.

An acute stroke unit concentrates patients, healthcare staff, resources, and specialist expertise into one area, and such units provide a better outcome. Patients are twice as likely to survive a stroke, and have fewer complications, if treated in a dedicated unit. Therefore, treatment in a stroke unit is associated with earlier discharge - which along with overall improved recovery rates also delivers certain efficiency and cost-saving benefits to the NHS.

The National Sentinel Audit for Stroke (2006) stated that: "*Action required: Wales needs to identify systems to raise the quality of stroke across the whole patient pathway, particularly through the development of stroke units.*" The 2010 Audit stated that "100% of hospitals in England and Northern Ireland and 93% of hospitals in Wales now have a stroke unit. This is a major improvement for Wales". However there is still a stark difference in the availability of thrombolysis 24/7 between England (57%), Northern Ireland (25%), and Wales (0%). This is very concerning data.

We believe that nobody in Wales should be further than a travel-time of 30 minutes from a dedicated stroke unit, but this might not mean that an acute stroke unit is needed in every hospital in Wales. A network of 'hyperacute' units in centres with expertise for thrombolysis and its complications; coupled with rehabilitation units closer to home might be one model to consider.

The development of acute stroke centres and systems of care may revolutionise the medical community's ability to treat patients with stroke. The obviously need to be closely linked to local primary and tertiary care teams for clear and appropriate referral, rehabilitation and monitoring of patients.

REHABILITATION

The principal aims of rehabilitation are to restore function and reduce the effect of the stroke on patients and their carers. Rehabilitation should start early during recovery with assessment and mobilisation while the patient is in the stroke unit.

Optimal care is multidisciplinary: doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, dieticians, psychologists, and social workers all have a role. Mental well-being plays a large part in the recovery process for stroke survivors, mental health support should start early and community based provision needs to be supported to form part of the multidisciplinary care pathway.

The role of social services in delivering stroke care is often overlooked; and the potential of social services to join up care provision is often not realised. 53% of stroke units in Wales have a social worker attached to the multidisciplinary stroke team, this compares to 73% in England and 100% in N.Ireland.[4]

BMA Cymru has always supported the view that people should be treated as close to home as possible – as long as it is effective and safe to do so. In relation to stroke, this is where ensuring that a dedicated stroke team in the community is available and fully resourced to enable appropriate early supported discharge. National Sentinel Stroke Audit 2010[5] found that early supported discharge teams are rarely available in Welsh Hospitals (England 45% Northern Ireland 83% and Wales 7%) however it reported that there has been an increase in Wales with hospitals with a specific community stroke rehabilitation team.

RECOMMENDATIONS

Alongside the points made elsewhere in this paper, we have a number of other recommendations the Committee may wish to consider:

We believe that a positive step would be for the new LHBs to take ownership of the action plan. They could, for example, do this by:

- Identifying a Public Health practitioner within their locality to lead a team on implementation and data collection / reporting;
- Develop local links with the broader health improvement initiatives such as Health Challenge Wales to champion improvements and innovation;
- Prioritise how to engage hard-to-reach individuals;
- Review their workforce planning mechanisms and ensure that staff levels and support for the workforce in delivering stroke treatment and care are adequate;
- Strengthen and formalise their links with local authorities and others community services to create multi-disciplinary care partnerships ensuring joined up working and continuous care provision;
- Facilitate research and data gathering through, for example, local clinical research networks, reporting data nationally;
- Utilise the new Professional Forums and Stakeholder Reference Group as a mechanism to highlight stroke risk factors and services;
- Facilitate public awareness and education campaigns.

National and Local public awareness campaign is needed to highlight the prevalence and severity of stroke, espacially how to recognise the symptoms, and that it requires a 999 response. The FAST (Face, Arms, Speech, Time) campaign did some good work in relation to this but needs to be built on – for example, the ways to recognise transient ischaemic attacks (TIA), the risk factors such as high blood pressure and diabetes, high cholesterol, smoking, excess alcohol intake and recreational drug use should also be highlighted. Many people still do not realise that strokes are preventable, do not know the symptoms or risk factors, or how to manage them.

The opportunities for training and education on Stroke for medical, nursing and therapy staff at all levels needs to be reviewed on an all Wales basis – it may be worth considering those areas which we know contain hard-to-reach populations as a priority. A training programme should be developed for stroke

[4] National Sentinel Stroke Audit Phase II (clinical audit) 2008
[5] 2010 Sentinel Stroke Audit http://www.rcplondon.ac.uk/sites/default/files/easy_access_version_2010_1.pdf

treatment across the multi-disciplinary teams working within the primary and secondary care sector to ensure efficiency and confidence when treating or managing stroke. Training should also be extended to carers.

Every person in Wales should have access to a Stroke Unit within 30 minutes travel distance from their home, the Unit should:

- Offer high quality 24 hour care - including 24hour access to thrombolysis and scanning equipment. There should be no unnecessary delay in undertaking a brain-scan. Without a brain scan, treatment cannot commence safely or effectively;
- Be of a similar high standard to other Units across Wales;
- Have adequate staffing levels (doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, dieticians, psychologists, and social workers) – including sufficient sessions dedicated to stroke care;
- Have adequate bed capacity;
- Have strong links with rehabilitation and support services.

The long-term impact of stroke on families and carers needs to be considered in any new policy.