1. Introduction

Stroke is the leading cause of adult disability in Wales, and the third most common cause of death, after cancer and heart disease.

Approximately 900 strokes occur every year in the Aneurin Bevan Health Board (ABUHB) area.

Our vision in ABUHB is to help people minimise the risk of having a stroke and, where stroke does occur, to provide the best quality care and support to maximise survival and return to independence as quickly as possible.

Our Local Stroke Delivery Plan reflects the principles set out in the Welsh Government National Stroke Delivery Plan and aims to:

- Prevent stroke
- Detect stroke quickly
- Deliver fast, effective, treatment and care
- Support life after a stroke
- Improve information
- Target research

**PREVENTION** - to help prevent people from having a stroke through raising awareness and helping them manage their risk factors.

**SPECIALIST CARE AND TREATMENT** - to provide ‘centre of excellence’ specialist stroke care and treatment to maximise patient outcomes and minimise the impact of stroke.

**EARLY SUPPORTED DISCHARGE** - to enable stroke patients to regain as much functionality, independence and wellbeing as possible, through early intensive rehabilitation and support wherever appropriate in their own home setting.

**ONGOING ASSESSMENT & CARE** - to ensure that those who need ongoing assessment and care following their stroke receive this in the most appropriate setting in accordance with their needs.

**LIFE AFTER STROKE** - to support and advise stroke survivors and their families and carers to meet the challenges of adapting to life after stroke, and to re-integrate into community life.
Significant improvements have been made to stroke care in ABUHB and across Wales in recent years through the provision of specialist, timely interventions that have undoubtedly helped to save lives and reduce the impact of stroke for many people. The public are also increasingly recognising that stroke is a medical emergency and seeking help quickly.

ABUHB aims to build on this success but in order to do so we need to use our valuable specialist resources differently to keep pace with the increasingly challenging standards of care identified by the Royal Colleges. This paper sets out how we are working towards our vision for stroke services through our clinical pathway and proposed model of care and poses a set of questions to help test and refine the service configuration options prior to formal public consultation.

2. Rationale for change

Many of the risk factors for stroke can be reduced through healthier lifestyle choices and/or through the use of primary and secondary stroke prevention interventions. This applies along the whole pathway of care but places a particular emphasis on the need for effective public health promotion and proactive management of risk factors in Primary Care.

Acute stroke care and inpatient rehabilitation in ABUHB is currently provided across seven hospital sites. Acute stroke care beds are located in the Royal Gwent and Nevill Hall Hospitals and inpatient rehabilitation is provided in Ysbyty Aneurin Bevan, St Woolos Hospital, Chepstow Community Hospital, County Hospital and Ysbyty Ystrad Fawr. Patients are managed by small teams of stroke specialist consultants, nurses and therapists often with small numbers of patients at each site and with limited post-discharge support available within the community.

Strong evidence suggests that stroke patients do better when admitted to a specialist stroke centre and then returning home as quickly as possible after the acute phase.

The Royal College of Physicians and Welsh Government are promoting a shift to community based Early Supported Discharge services as well as co-ordinated long term community support for stroke survivors. There are currently insufficient stroke specialist resources within the community to provide this support.

Life After Stroke programmes aim to enable stroke survivors to re-integrate into their community and to achieve and maintain their optimum quality of life.

Specialist care is needed enable quality requirements to be delivered. However, within the current configuration consistent compliance with exacting standards across the pathway for stroke care is extremely challenging.
3. Proposed new model for stroke services at Aneurin Bevan University Health Board

The key features of the ABUHB new model for stroke services in Gwent are:

- An increased focus on prevention
- One centre of excellence for hyper-acute care, acute care, and early rehabilitation
- Community based Early Supported Discharge services
- Fewer inpatient stroke rehabilitation units providing specialist rehabilitation
- Ongoing general rehabilitation, complex care planning and palliative care in a local hospital or home setting as appropriate
- Multi-agency support for life after stroke and secondary prevention

Aneurin Bevan Health Board Model for Stroke Services

![Diagram of the model](image)
3.1 PREVENTION - to help prevent people from having a stroke through raising awareness and helping them to manage their risk factors.

Evidence shows that many strokes are preventable through active management of the risk factors and changes to lifestyles. The ABUHB stroke pathway therefore includes a strong focus on prevention as set out in the Health Boards Public Health Strategic Framework including:

**Socially determined lifestyle risk factors**

- Smoking
- Alcohol
- Obesity
- Unhealthy diet
- Physical Inactivity

The Framework sets out the national and local initiatives that aim to tackle these lifestyle risks, such as Smoking Cessation services, local implementation of *Creating an Active Wales*, local Substance Misuse Strategy, Obesity Pathway and staff training in brief interventions with individuals to encourage them to make lifestyle changes.

**Clinical risk factors**

- Hypertension (high blood pressure)
- Atrial fibrillation (irregular heartbeat)
- High LDL Cholesterol
- Diabetes

Individuals with these clinical risk factors, including those who have had a stroke, will be identified and actively managed in primary care.

**Transcien Ischaemic Attack (TIA)**

TIA or ‘mini-stroke’ results in symptoms similar to a stroke but which resolve within 4 hours. A Tia is a warning sign that a full stroke may occur soon and without treatment there is a one in ten chance of having a full stroke within 4 weeks. It is therefore extremely important to treat TIA as a medical emergency and to initiate treatment which can greatly reduce the risk of further TIA or stroke. TIA assessment and treatment is provided by specialist hospital based services and it is vital that the public and GPs recognise the symptoms and refer to these services in a timely manner.
**3.2 SPECIALIST CARE AND TREATMENT** - to provide ‘centre of excellence’ specialist stroke care and treatment, to ensure the best outcomes for patients and minimise the impact of stroke.

In order to deliver the proposed model of care and to create centres of excellence for stroke patients it is proposed that the number of inpatient stroke facilities in ABUHB is reduced and that community services, to enable early return home, are developed.

An options appraisal, started on the 1st May 2013, has thus far defined 7 potential options. The first option is to maintain the status quo with the others showing the hyper-acute admitting unit at Royal Gwent Hospital supported by rehabilitation at up to three additional hospitals sites.

**One hyper-acute unit stroke unit**
Moving to the Clinical Futures model of one hyper-acute unit will concentrate our expert acute stroke staff in a ‘centre of excellence’ able to deliver consistent high quality care in the most efficient way for patients 24 hours a day.

The preferred site, before the SCCC is built, for delivery of hyper acute specialist care is the Royal Gwent Hospital for the following reasons:

- Larger centre of population
- Availability of neurologist support and access to regional neurology rota
- Radiology resilience (2 x CT scanners)
- Availability and suitability of facilities, with particular respect to space and appropriateness for rehabilitation
- Cost of any capital alterations required
- Alignment with the broader re-configuration plans for Aneurin Bevan University Health Board services
- Strategic fit with regional planning and assumptions about patient flow

**Specialist Stroke Rehabilitation Unit(s)**
Approximately 17% of stroke patients will require an extended period of inpatient stroke rehabilitation. The clinical view is that these patients should be transferred to a specialist stroke rehabilitation unit, rather than continue their rehabilitation in the acute hospital.

Following a period of specialist rehabilitation the majority of patients should be discharged home with Early Supported Discharge/community stroke rehabilitation. Others will be transferred to their local hospital for ongoing care, complex discharge planning or palliative/end of life care.
3.3 EARLY SUPPORTED DISCHARGE - to enable stroke patients to regain as much functionality, independence and well being as possible, through early intensive rehabilitation and support wherever appropriate in their own home setting.

Evidence from early supported discharge trials suggest that up to 41% of stroke patients could benefit from returning home early with appropriate support. The ABUHB stroke pathway includes the introduction of community-based Early Supported Discharge (ESD) neuro rehabilitation teams to ‘pull’ appropriate stroke patients back home from the stroke unit and to provide intensive rehabilitation within the person’s home or in their locality.

3.4 ONGOING ASSESSMENT AND CARE - to ensure that those stroke patients who require ongoing assessment and care receive this in the most appropriate setting in accordance with their needs.

Some patients unfortunately have such a dense stroke that they will never achieve full recovery or a significant level of independence. Such patients do not respond to rehabilitation but require ongoing care and will need to be assessed for their continuing healthcare needs.

Appropriate provision needs to be made for such patients in our community hospitals whilst longer term care options are being planned.

Some will need palliative and end of life care which should be delivered in accordance with the Last Days of Life Integrated Care Pathway.

3.5 LIFE AFTER STROKE - to advise and support stroke survivors and their families and carers to meet the challenges of adapting to life after stroke and re-integration into their chosen community life.

The national Life After Stroke programme follows the care bundle approach and requires stroke survivors to have a formal review at 6 weeks, 6 months and annually thereafter. The reviews look at their goal plan, medication, lifestyle and information needs, follow up of any referrals made or required, and ongoing goal /next steps planning.

The Early Supported Discharge and community stroke services will be central to initiating life after stroke support in partnership with local authorities, the Stroke Association and other voluntary sector agencies.

4. COMMUNICATION AND ENGAGEMENT

This proposed model for stroke services has been developed by the multi-disciplinary Stroke Board and through broader engagement achieved in a series of clinical workshops during 2013. We now want to engage more widely with stakeholders who have an interest in stroke care including
stroke survivors, carers and partner agencies to consider the vision and proposed stroke service reconfiguration in ABUHB.

Your views, questions and comments will help us shape this service model that aims to provide the best possible services for stroke patients in Gwent and South Powys through the development of a service of excellence.

Questions we are asking staff and stakeholders to comment on are:

a) **VISION** – do you agree with this vision for stroke services at ABUHB?

b) **RATIONALE FOR CHANGE** – do you agree that there is a need to change our stroke model in order to further improve stroke care?

c) **PREVENTION** – how can we engage the public in the prevention agenda? What should be the priorities to address in primary care?

d) **PROPOSED MODELS** – what are your views on the proposed model?

e) **ACUTE** – do you agree with the reasons and criteria we have used to select the preferred DGH site for the acute unit?

f) **EARLY SUPPORTED DISCHARGE** – do you agree that developing such a service would be beneficial to stroke patients and their carers?

g) **ONGOING ASSESSMENT & CARE** – do you agree that some stroke patients are not appropriate for active specialist rehabilitation, but require alternative care provision? Where do you think their needs are best met?

h) **PATIENT FLOW** – how do we ensure efficient patient flow so that patients are in the right place at the right time?

i) **LIFE AFTER STROKE** – what specific services do we need to have in place to support patients and carers after stroke? How can we ensure these services are well co-ordinated?

j) **ANY OTHER COMMENTS** – other comments, questions or ideas?

Comments and views will be gathered through a number of stakeholder meetings. Should you wish to submit written comment please write to:

**Samantha Crane**
Head of Partnerships & Networks, Blaenau Gwent & Caerphilly/ABUHB Lead for Stroke
sam.crane@wales.nhs.uk

**ABUHB Stroke Board – March 2014**