Y Gymdeithas Feddygol Brydeinig
British Medical Association
0300 123 1233 bma.org.uk
Wales National Office
Swyddfa Genedlaethol Cymru

Fifth Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, Cardiff CF10 4DQ
T 029 2047 4646 **F** 029 2047 4600
Pumed Llawr, 2 Pentir Caspian, Ffordd Caspian, Bae Caerdydd, Caerdydd CF10 4DQ
Ffôn 029 2047 4646 **Ffacs** 029 2047 4600

18 September 2013

FOLLOW-UP INQUIRY INTO STROKE RISK REDUCTION

Consultation by National Assembly for Wales' Health and Social Care Committee

Response from BMA Cymru Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the follow-up inquiry into stroke risk reduction by the National Assembly for Wales' Health and Social Care Committee.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 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, which speaks 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

Please see below the BMA Wales Cymru view on progress made since December 2011in addressing each of the recommendations of the Committee's original report:

Recommendation1: 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.

It is the view of BMA Cymru Wales that there has been a leadership problem within NHS Wales which led to problems in implementing the Stroke Risk Reduction Action Plan. This stemmed for instance from the lack of a clear timetable being put in place, as well as a lack of clear definitions being provided regarding the roles of individuals responsible for implementation of both the action plan and the implementation strategy. We therefore believe there was a lack of clarity regarding when targets were to be achieved and who was tasked with the responsibility for ensuring they were met.

Furthermore, the plan itself did not appear to be comprehensive and, in our view, contained notable gaps. This would suggest it was drawn up without sufficient involvement of clinicians.

Ysgrifennydd Cymreig/Welsh Secretary:
Dr Richard JP Lewis, CStJ MB ChB MRCGP Dip IMC RCS (Ed) PGDip FLM

BMA Cymru Wales fully supports the undertaking of a high-level, full and robust evaluation of the implementation of any plan in the NHS. Indeed, we are aware that an evaluation of the action plan was undertaken by Public Health Wales in 2012[1].

On this occasion, it appears to our members that the plan has not yet been effectively implemented.

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.

Preventing secondary strokes is a separate issue from the treatment and diagnosis of transient ischaemic attacks (TIAs). In our view, we should be careful not to treat the two concepts as being one and the same.

Primary prevention of TIAs and strokes means that we need to work on identifying the risk factors for strokes and TIAs, and try to prevent them from occurring by focusing on these risk factors. If a stroke nonetheless occurs, then the relevant risk factors should be identified and managed more actively as there is always a high risk within those patients who have suffered from a stroke that they will go on to have another one. (The risk in such cases is about 30-40% after a year if the risk factors remains unidentified and have not been dealt with.)

Transient ischaemic attacks (TIAs) are different. While there is no treatment for TIAs, most clinicians would agree that the risk factors should be investigated thoroughly to help ensure their prevention. That is exactly why we need a daily TIA clinic. In addition, we need to be careful with the diagnosis of TIA as, from clinical experience in South Wales, about 50% of those referred to the TIA clinic are ultimately diagnosed with a different condition, known as a TIA mimic.

Recommendation 3: Government ensures patients have access to seven day TIA clinics and that clinical guidelines in relation to carotid endarterectomies are adhered to across Wales.

Establishing a seven day TIA clinic is not an easy task. There is currently no health board in Wales which is running a TIA clinic on a seven-days-a-week basis. The main reason for this is a lack of sufficient staffing resource. As such, provision of even Monday-Friday TIA clinics is not yet routine in some parts of Wales, including in North Wales where staffing issues also mean there are problems in providing a thrombolysing service for ischaemic stroke patients. Members feel that access to thrombolysis is patchy across Wales. It should however be noted that it is possible to have a TIA assessment service outside of the provision of a dedicated TIA clinic, and this could for instance be provided on weekends and bank holidays alongside a dedicated TIA clinic operating Monday-Friday.

The role of GPs in diagnosing patients with TIA and then referring such patients to a TIA clinic is also a vital part of the process. However, quick access to a TIA assessment service may be required for this to be effective. GPs feel that they require clearer and simpler guidance to enable them to deal with suspected strokes in a primary care setting, and on the urgency and appropriateness of treatments such as anticoagulation.

An audit carried out by the Royal College of Surgeons regarding the endarterectomy procedure[2], as well as local Welsh studies, have shown that there is a need for more to be done regarding operating on stenotic internal carotid arteries in patients who are judged to be at risk of TIA or stroke.

Recommendation 4: 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

[1] http://www.wales.nhs.uk/document/220816/info/?02FB00BB-CB24-F842-E58895262220CDEB

[2] http://www.rcseng.ac.uk/news/docs/UK%20Audit%20of%20Vascular%20Surgical%20Services.pdf/view?searchterm=stroke

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.

We would note that a manual pulse check conducted as part of a primary care consultation would be sufficient to diagnose persistent atrial fibrillation (AF) but is not always adequate for the diagnosis of paroxysmal AF. In fact guidance published in 2012 by the Royal College of Physicians (*National Clinical Guidelines for Stroke - fourth edition*)[3] differentiates clearly on clinical ground between paroxysmal AF and persistent AF but suggests anticoagulation should be given to patients with either condition as they are both a risk factor for stroke.

The use of a Holter monitor, or 24 hours tape, is important and we would note that the diagnosis of AF is often done in a hospital setting (although, as indicated above, some types of AF are diagnosed by GPs in a primary care setting.) Some GPs report, however, that waiting lists for these procedures may currently be unacceptably long, as may be the wait for TIA assessments.

Recommendation 5: We recommend that the Welsh Government develops clear guidance for primary care and community resource teams on the diagnosis, treatment and management of AF and clearly identifies professional responsibilities in each area.

Such guidance is part the Royal College of Physicians guidelines that we have already referred to in our response to recommendation 4.

We would certainly agree that better identification of professional responsibilities in relation to the diagnosis, treatment and management of AF is required but, in our view, there has been a problem with such a requirement being addressed. This relates to views we have expressed earlier in this response that the issue of leadership needs to be addressed through the establishment of clearer timetables, clearer definitions regarding roles for the individuals involved in implementing the Stroke Risk Reduction Action Plan and clearer allocation of responsibilities for meeting targets. We would further stress that we believe this needs to be done as a matter of priority.

Contact for further information:
Rodney Berman
E-mail: RBerman@bma.org.uk
Tel: 029 2047 4620
Fax: 029 2047 4600
Mobile: 07867 356106

[3] http://www.rcplondon.ac.uk/resources/stroke-guidelines