National Assembly for Wales

Health and Social Care Committee

Stroke risk reduction – follow-up inquiry

Evidence from Royal College of Nursing – SFU 8

Royal College Of Nursing

Response to Health and Social Care Committee's Follow up Inquiry into stroke risk reduction.

ABOUT THE ROYAL COLLEGE OF NURSING (RCN)

The RCN is the world's largest professional union of nurses, representing over 400,000 nurses, midwives, health visitors and nursing students, including over 23,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

HSCC 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.

The Welsh Government published Together For Health- Stroke Delivery Plan in 2012. At the consultation phase the Royal College of Nursing had a number of concerns:

- The plan failed to discuss the workforce required to deliver services to a high standard. We urged the Welsh Government to look at guidance issued by the Royal College of Nursing on safe Staffing for Older People's wards[1]. This guidance states that there should be at least 1 registered nurse for 5 patients (depending on acuity) and never exceeding 1 registered nurse for 7 patients. The National Sentinel Stroke Audit 2010 showed that Staffing levels in Wales are somewhat lower than in England

[1] http://www.rcn.org.uk/__data/assets/pdf_file/0010/439399/Safe_staffing_for_older_people_V3.pdf

and Northern Ireland[2]. Thrombolysed patients need 1:1 nursing for first 24 hours so staffing levels need to reflect this.

- The plan failed to discuss the value or the role of nursing in stroke prevention or care. Evidence from Millar 2010[3] suggests that nurses are the most likely professional group to take prominent leadership role in the primary and secondary prevention of strokes. Millar emphasises the importance of prevention on all inpatient and outpatient units and establishing workplace staff health promotion programs to reduce modifiable stroke risk factors, given the increasing incidence of stroke in younger adults. At present there is a lack of training and education opportunities in Wales for Stroke for medical and nursing and therapy staff at all levels, and where courses are available there is insufficient cover so staff are not able to be released.

- We were concerned that the proposed performance indicators for the NHS were too broad and far reaching and would have liked to see measurable actions for Health Boards, e.g. Are GPs in the locality clear of referral pathways for AF, have primary care practices been offered education and training on AF. Stroke specific educated staff at all levels will provide better care and outcomes for patients.

- The plan fails to address the critical need for thrombolysis within a 4.5 hour period for under 80's and 3 hrs and at medical discretion for over 80's based on current guidance, instead the plan makes reference to LHBs providing timely access. We suggested that achieving the care bundle targets is instead clearly set out.

- LHBs are also asked to provide timely access to diagnostic procedures, vascular surgery and tertiary services. The RCN is concerned about the impact of the various reconfiguration plans on this.

HSCC 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.

HSCC Recommendation 3

[2] https://audit.rcplondon.ac.uk/sentinelstroke/website/files/generic%20report%202010%20(incl%20appendices).pdf

[3] Rehabilitation Nursing Vol35 no.3 May/June 2010

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.

Welsh Government Delivery Plan states on p5 that LHBs should ensure to fully functional services for stroke and TIA. SENTINEL Audit 2012 shows that most areas are providing a robust 5 day a week service however our members tell us that there are areas that do not have access to specialists or scanning 7 days per week.

HSCC 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 AF and clearly identifies professional responsibilities in each area.
HSCC 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.

The Welsh Government accepted these in principle but stated that they would ask officials to consider the findings of the UK National Screening Committee were current review into systematic screening for atrial fibrillation (The review process began in Jan 2010 and is estimated to be completed by Nov 2013).

In our original submission we called for:

- A specialist nurse should be championing AF detection in each LHB.

- GP services in each LHB area should have knowledge of how to refer patients with AF and the importance of this.

- Practice nurses and HCSWs may need education in stroke risk reduction. Even if this is provided by the LHB the employees the GP may not be released to attend. LHBs could examine this provision and need in their area.

- The Chronic Conditions team in each LHB should consider AF as a chronic condition.

- Prompt treatment is needed for people once AF has been diagnosed.

Screening could be carried out cost effectively by the nursing/ primary care team. This could simply be done by carrying out manual pulse checks when doing other routine work for example during flu clinic or routine health check.

We recommended the Committee examine the service recently developed in Cwm Taff. An AF Specialist Nurse is developing a nurse led clinic and works closely with Cardiologists and Stroke Physician. Referrals come from Primary Care and from within the Hospital.

Other area of best practice from which evidence may be drawn are the SAFE project study - a small study which investigated the role of practice nurses systematically screening practice population or the pilot study conducted by 2 arrhythmia nurse specialists in North Wales looked at integrating manual pulse checks into a routine chronic conditions clinic within General Practice[4].

Stroke specialists from across the United Kingdom called for a national screening programme for all people over 65 to be developed as a matter of urgency to improve detection of atrial fibrillation and prevent up to 2000 premature deaths a year at a two day consensus conference organized by the RCP in 2012[5]

In terms of the prevention and public health agenda the RCN believes that more could be done to inform the public of the benefits of lifestyle change in relation to stroke. Risk factors such as smoking, lack of physical activity, high blood pressure etc are recognised as relating to cancer and heart disease but not to strokes. Preventative activity by health professionals needs to be joined up and not disease specific.

[4] Both of these examples are taken from Keeping our finger on the Pulse August 2010

[5] *BMJ 2012;344:e1644*