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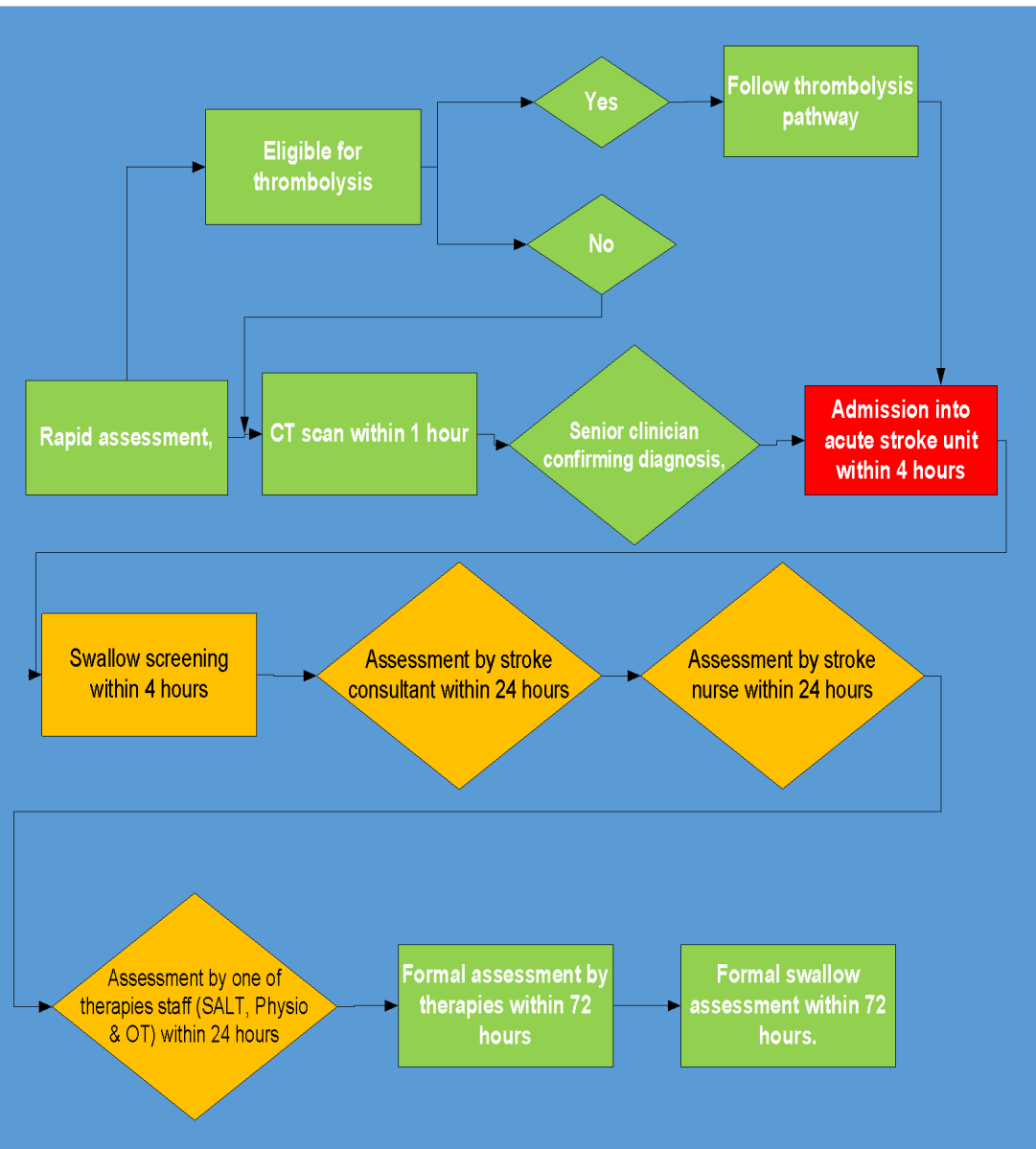
**Quality, Safety and Experience Committee  
(QSEC)  
22<sup>nd</sup> of June 2022  
Stroke Pathway Update**

# Situation

- Hywel Dda University Health Board (HDdUHB) provides stroke services to a total population of around 384,000 people throughout Carmarthenshire, Ceredigion and Pembrokeshire. Stroke care is provided in four stages: Hyper acute, Acute, Rehabilitation and Life after stroke. Stroke is described as being both preventable and treatable, however, in order to deliver the best outcomes a number of key elements must be addressed.
- Stroke services are provided across all four acute sites. The challenges in providing effective stroke services in rural locations are significant, with the need to balance multidisciplinary specialist care with care closer to home, and timely assessment and treatment with travel considerations across a wide geographical area.

Stroke is a medical emergency and the pathway for stroke admission is :

1. Rapid assessment
2. CT scan immediately for thrombolysis, within 1 hour for all others. Consideration for THROMBECTOMY
3. Experienced clinician confirming diagnosis
4. Admission into acute stroke unit within 4 hours
5. Swallow assessment / screening within 4 hours
6. Assessment by stroke consultant within 24 hours
7. Assessment by stroke nurse within 24 hours
8. Assessment by therapies staff (SALT, Physio & OT) within 24 hours
9. Formal assessment by therapies within 72 hours
10. Formal swallow assessment within 72 hours



# How do we measure our stroke performance?

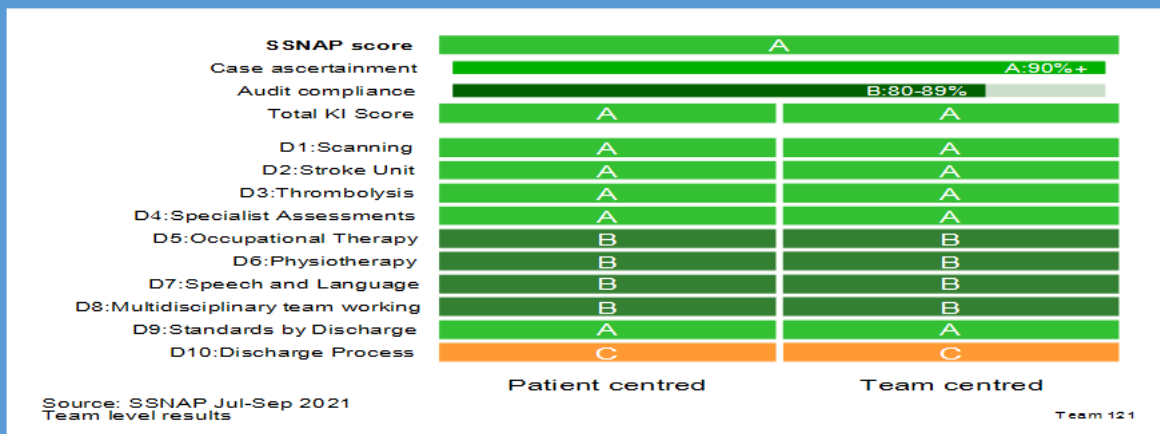
We measure our stroke performance using the Sentinel Stroke National Audit Programme (SSNAP) data which is collated every month. The clinical audit collects a minimum dataset for stroke patients in England, Wales and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of 6 month assessment.

The aims of the SSNAP clinical audit are:

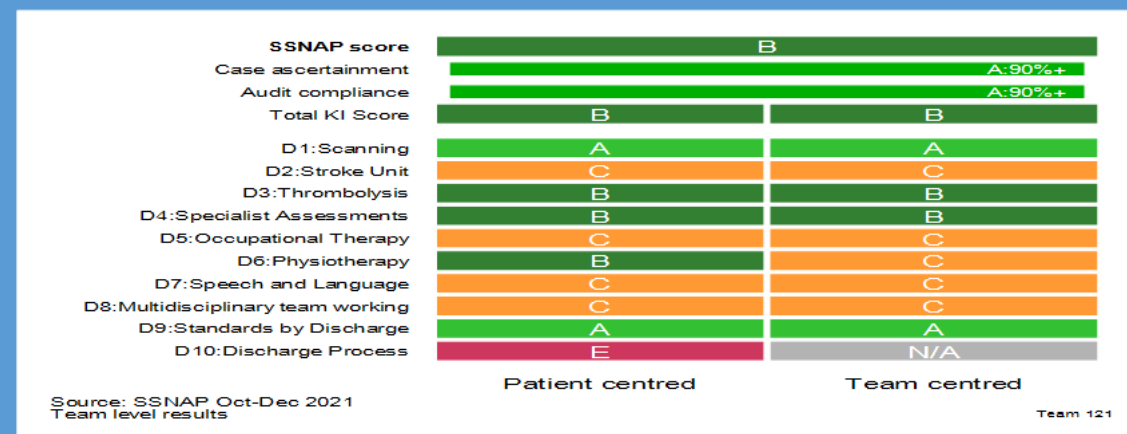
- to benchmark services regionally and nationally.
- to monitor progress against a background of organisational change to stroke services and more generally in the NHS.
- to support clinicians in identifying where improvements are needed, planning for and lobbying for change and celebrating success.
- to empower patients to ask searching questions.

# Bronglais General Hospital (BGH)- Stroke results

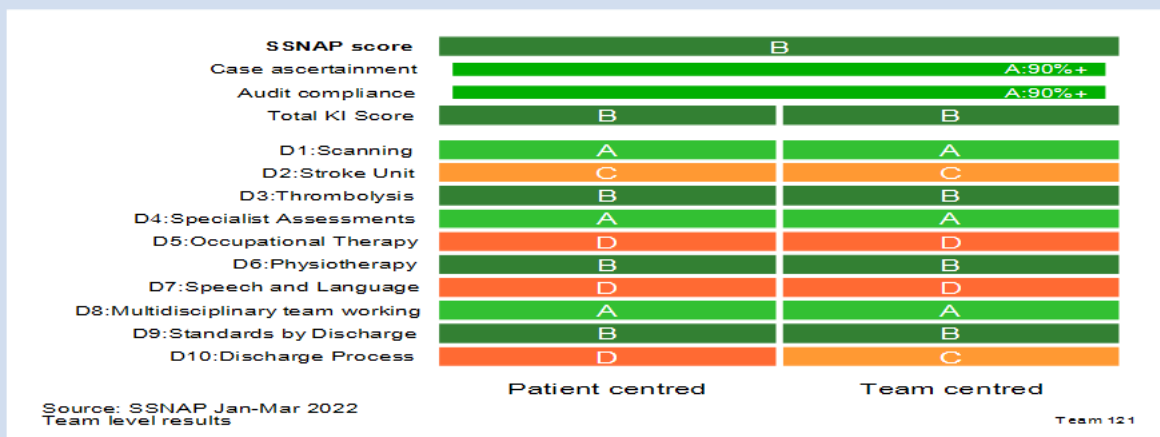
## SSNAP Jul-Sep 2021



## SSNAP Oct-Dec 2021



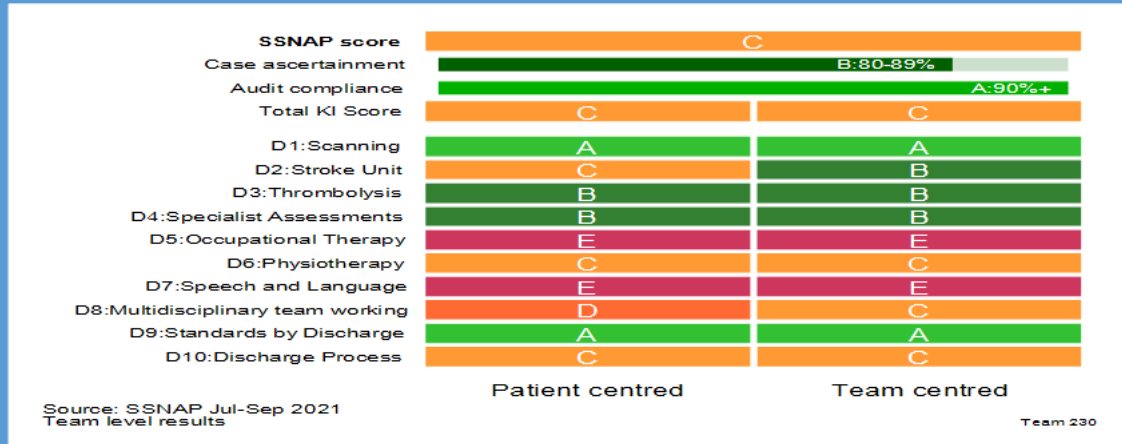
## SSNAP Jan –Mar 2022



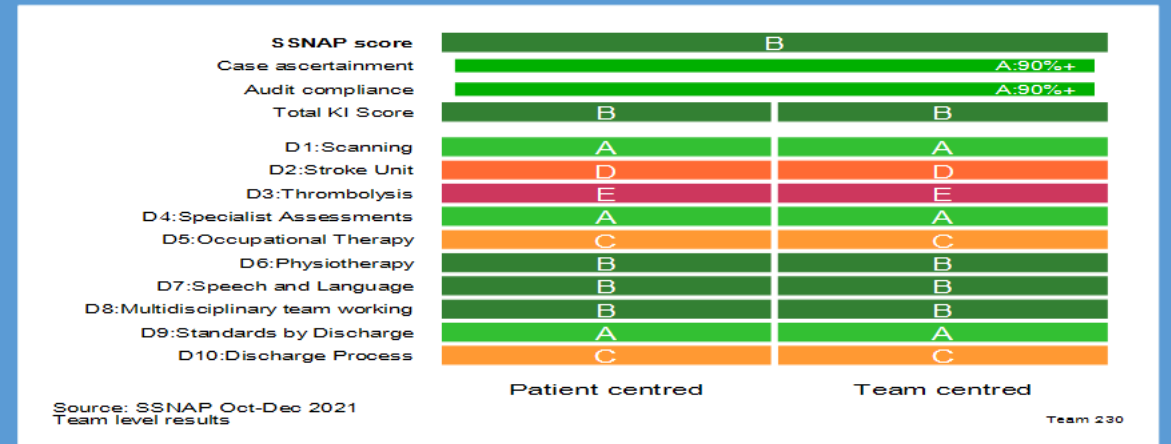
BGH Stroke unit/team have been able to sustain high standards of care for the last 8 months. Have seen a dip in some therapy input.

# Prince Phillip Hospital(PPH)- Stroke Results

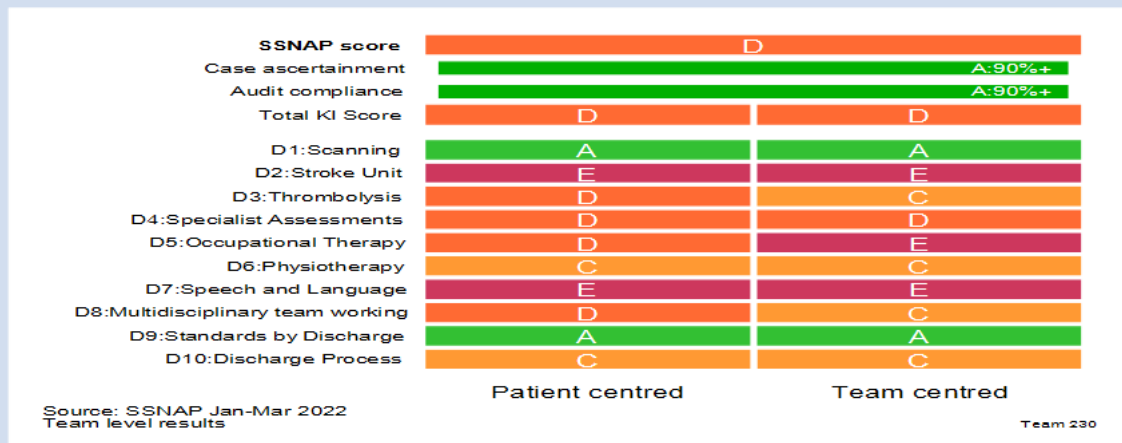
## SSNAP Jul-Sep 2021



## SSNAP Oct-Dec 2021



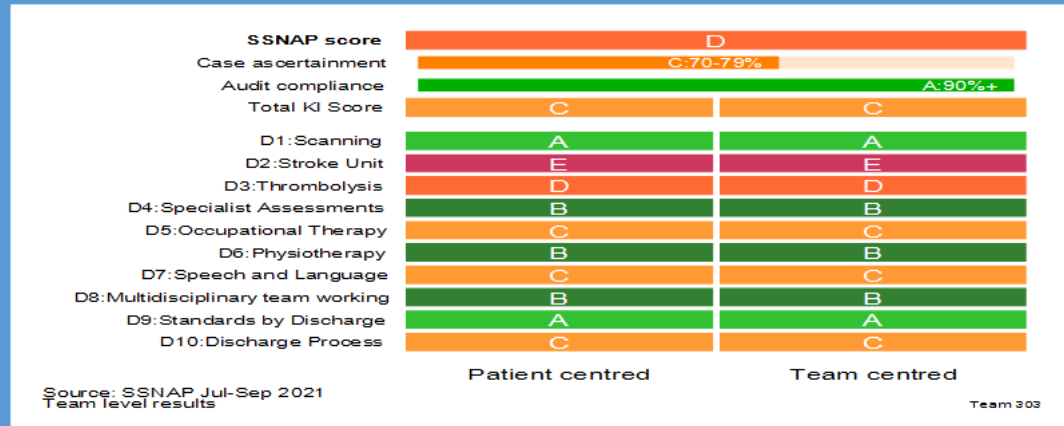
## SSNAP Jan-Mar 2022



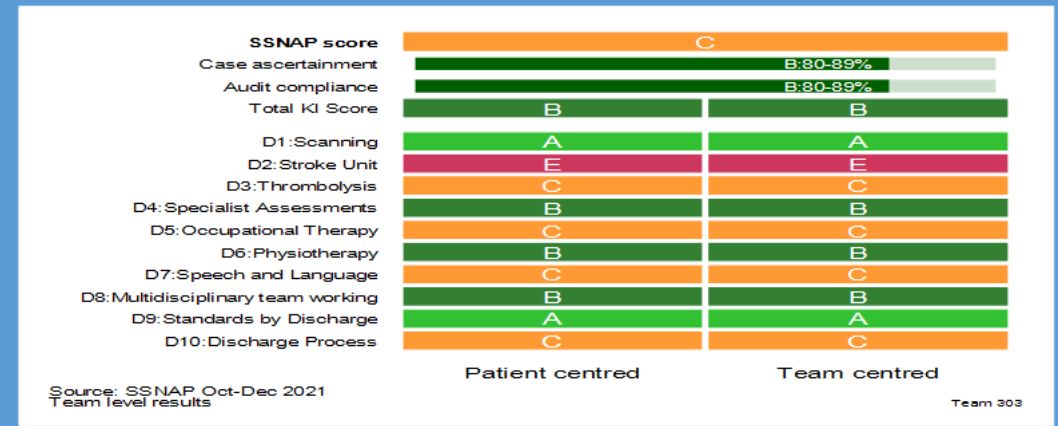
PPH have seen some improvement in performance but have found it difficult to sustain.

# Glangwili General Hospital (GGH) - Stroke results

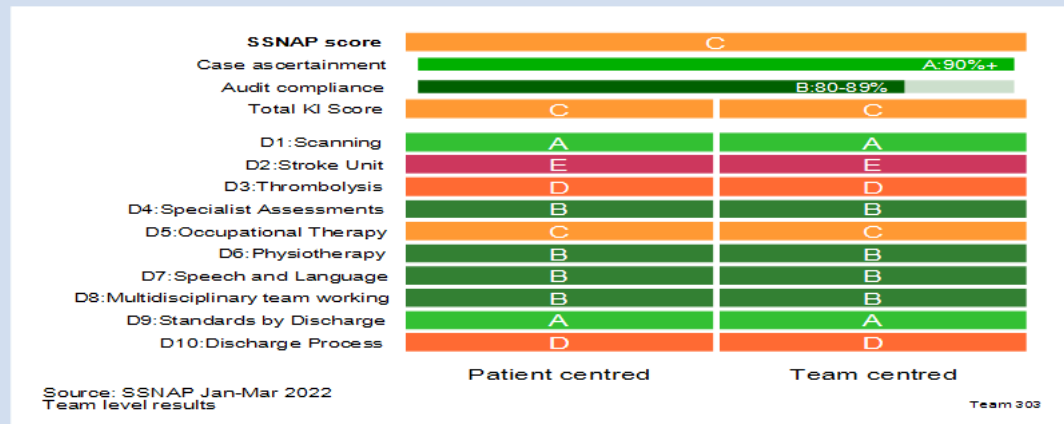
## SSNAP Jul-Sep 2021



## SSNAP Oct-Dec 2021



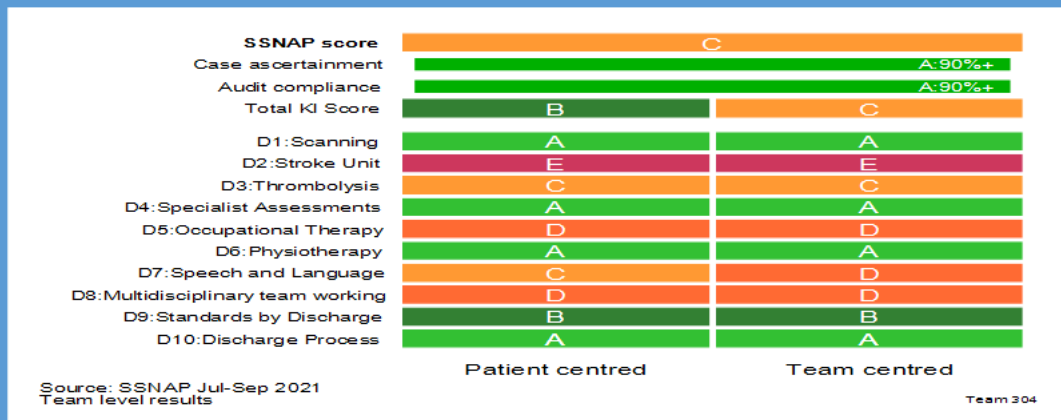
## SSNAP Jan –Mar 2022



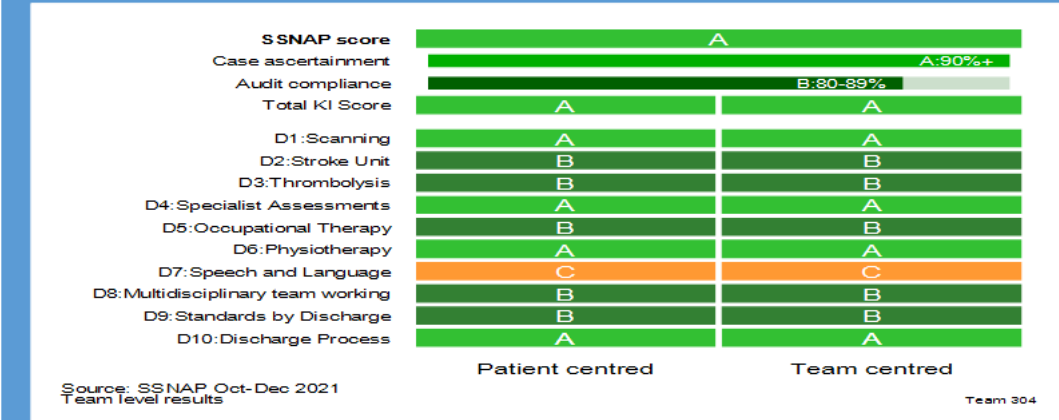
GGH have has some difficulties in maintaining standards throughout this last 8 months.

# Withybush General Hospital (WGH) -Stroke results

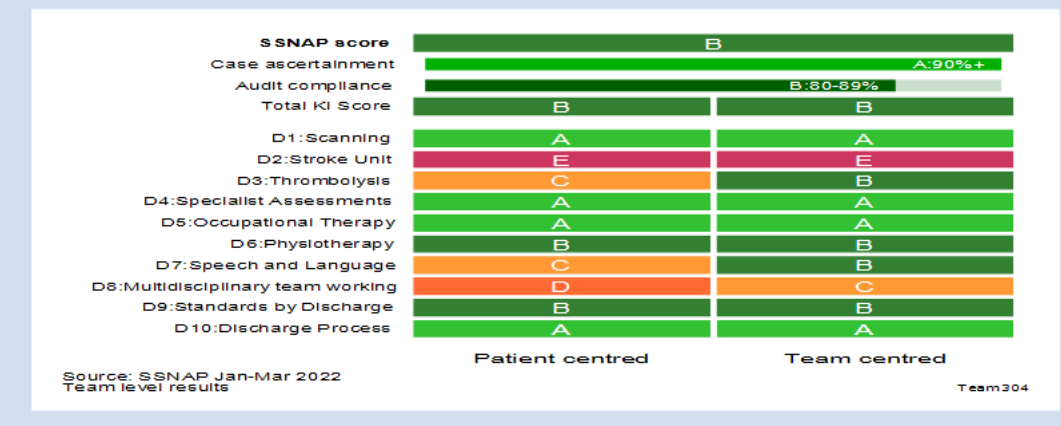
## SSNAP Jul-Sep 2021



## SSNAP Oct-Dec 2021



## SSNAP Jan –Mar 2022



WGH have seen an on going improvement in standards. One of the biggest issues is getting to the stroke unit within the allotted time (Percentage of patients directly admitted to a stroke unit within 4 hours of clock start)



# Risks and Mitigation

- **Risk**- All 4 units have had difficulty in patients directly admitted to a stroke unit within 4 hours of clock start. Unable to ring fence beds due to site pressures.

**Mitigation** – All stroke patients will be seen and reviewed by the stroke team, all medical on call teams are trained in stroke care. Any patient deemed suitable for thrombolysis treatment will start (not bed dependant).

- **Risk** – Low rates for Thrombolysis (as per national average, tends to be an issues out of hours)

**Mitigation** – Any patient deemed suitable for thrombolysis treatment will start (not bed dependant). All new medical staff are trained by the stroke team regarding stroke care and thrombolysis. All 4 units review and complete an exception report on the number of stroke patients and the mitigation of why they are not thrombolysed. This is then discussed in the Stroke Steering Group (SSG). Teams are reporting patients miss the target time due to a number of wake up strokes and the arrival time in ED.

# Risks and Mitigation (cont'd)

- **Risk** – The team have been at times struggling to maintain the therapy input for the stroke patients. There are a number of issues regarding this. Sickness (through COVID-19), vacancies and recruitment.

**Mitigation** – This has been recognised by the Heads of Therapy, staff have been moved to help with gaps but this has lead to issues in other services. Nursing staff are working very closely with the therapy team and will follow rehabilitation/therapy care plans.

- **Risk** - Poor discharge profile for complex stroke discharges

**Mitigation** – Teams are constantly working with the Joint Discharging Teams (JDTs) to help add in discharges. Early Supported Discharge (ESD) team have helped greatly with one unit.

# All-teams mortality results( results available if requested)

- The SSNAP mortality data for Stroke is published (2019- 2020). #None of Hywel Dda sites are outliers or anywhere in the region of concern.
- As the clinician led data input, SSNAP mortality report easily surpasses any other data like RAMI, CHKS etc. It takes into account the various patient characteristics which makes lot of sense with standardisation.
- However it is suggested to the clinical group via our Stroke Steering Group to use the other data (RAMI, CHKS etc) to highlight any coding issues and also to react to any unusual patterns emerging, so we can act then and there.
- In summary the recommendation would be to use SSNAP mortality data as the gold standard, while not totally ignoring the other scores.

# Next Steps

- The team are engaged in internal and regional service development meetings, however, significant improvement cannot be achieved without whole service/whole region re-design and investment/re-investment in parts of the pathway.

# Recommendation

For QSEC to be assured that the service is addressing the risks associated with the delivery of stroke services, acknowledging that further actions still are required, which sit outside the ability of the service to progress independently.