**Appendix A**

**Report to Adults, Health and Active Lifestyles Scrutiny Board: 5th October 2021**

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| **Title of report**: | Update on the Adult Inpatient Stroke Rehabilitation Ward move and the status and development of a vision for Stroke services in Leeds |
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## BACKGROUND

Colleagues from the Leeds Teaching Hospitals NHS Trust (LTHT) attended a Scrutiny Board Working Group on 26 April 2021 to inform the Board of plans to relocate the inpatient stroke rehabilitation service from Leeds General Infirmary (LGI) to Chapel Allerton Hospital (CAH).

A further update paper was sent to Scrutiny Board members in June to update on progress against the engagement plan.

The NHS Long Term Plan (2019) identified Stroke as a national clinical priority, with an ambition to improve stroke care along the whole of the pathway, including prevention, early diagnosis and management from the onset of stroke, urgent and acute care, rehabilitation and life after stroke. These improvements are being implemented across Leeds and the rest of West Yorkshire and Harrogate and a city-wide vision for Stroke services in Leeds is being developed.

Based on discussions at the 26th April meeting, Scrutiny Board members wished to receive a further update on the stroke rehabilitation ward move, and be updated on the overall priorities and vision in relation to Stroke services in Leeds**.** This paper is split into two sections to provide these updates.

## A. INPATIENT STROKE REHABILITATION WARD MOVE FROM LEEDS TEACHING HOSPITALS

### 1. Background

1.1. The following stoke services are currently provided at Leeds General Infirmary (LGI):
- Urgent/emergency treatment including thrombectomy or surgery
- Inpatient care for those not suitable for inpatient rehabilitation
- Inpatient rehabilitation (rehab), to facilitate discharge from hospital

1.2. Stroke rehabilitation is provided in a 27-bedded unit at the LGI. The services on this unit are limited by the estate. There is not enough room to expand or to provide modern day rehabilitation facilities. It is recognised by partners in the city that whilst the care provided is good, an improved environment would facilitate much better outcomes for patients and facilitate timely discharge.

1.3. During the height of the Covid-19 pandemic, the ward was repurposed as a COVID ward in March 2020 and stroke rehabilitation patients were moved to non-specialist, non-Covid wards across Leeds Teaching Hospitals NHS Trust and the Nuffield Trust hospital. In addition, a time-limited opportunity arose to utilise capital funding as part of the Trust's response to Covid-19. This opportunity accelerated plans to improve the provision of stroke rehabilitation, giving a unique opportunity to create a purpose-built stroke rehabilitation unit with enhanced rehab facilities and access to outdoor space.

1.4. As a result, space was identified in a previously unused ward at Chapel Allerton Hospital, maximising use of the hospital estate and enabling the co-location of rehabilitation services.

1.5. The new unit at Chapel Allerton Hospital has 22 beds alongside an 'independence living assessment flat' which will allow assessment and support with practicing independent living, an important way of supporting patients to regain their confidence after stroke and help them to relearn skills to promote independence for everyday living.

1.6. Chapel Allerton Hospital already provides specialist rehabilitation medicine including on ward C1 which is a complex neuro rehabilitation ward. It is also the National Demonstration Centre for Neuro-Rehabilitation. It is anticipated that this closer alignment of stroke rehabilitation will bring benefits to quality of care, reduced length of stay and improved patient outcomes.

1.7. Hyper acute stroke care and acute inpatient care will remain at Leeds General Infirmary.

### 2. Current Status

2.1. The target date for moving the service to Chapel Allerton Hospital was June 2021. The building works are fully complete, but the movement of the service will now be implemented at the end of September 2021. This delay is because implementation has been dependent on successful appointment to a consultant post. This appointment has now been made and the new consultant appointment will commence in post in September, and work with the wider team to select the most appropriate patients to move across to the new ward.

2.2. An update on how the ward move has progressed as planned will be provided at the meeting on 5th October.

## 3. Patient, Public and Staff Engagement

3.1. An equality impact assessment (EQIA) was undertaken to determine whether the plans to relocate the service would have any detrimental impact on patients or carers from any of the "Protected Characteristics" groups as identified by the Equality Act 2010. The EQIA concluded the groups most likely to be affected by changes to stroke services were Older people, Carers, Black and Minority Ethnic (BME) groups, most notably Black, Asian and Eastern European populations and people living in deprived areas.

3.2. Online survey – An online survey was advertised to engage former stroke patients, carers, relatives and the public. 16 responses were received. 8 respondents thought the move is a good idea and 8 were undecided. Example reflections from patients are included within Appendix 1.

3.3. Leeds Voices Focus Groups - a series of focus groups were co-ordinated by Leeds Voices and took place during June 2021 and engaged with 116 people. The full engagement report is included within Appendix 2 and some summary points raised include:

- People were happy with the proposed Chapel Allerton hospital environment compared to Leeds General Infirmary both inside and outside and valued the green surroundings.
- The use of a video to give a visual representation of what the hospital was like alleviates the 'unknown'. Some suggestions were made to dub a voice over or create subtitles. Lots of participants suggested this should be shown to all patients and families before admission.
- The provision of items to make people feel at home if they didn't have family support is really important.
- The importance of staff who can help the patient emotionally was emphasised, and the reassurance that staff will behave in a way that respects cultural diversity.
- Carers and family members wanted to receive more information and education around how to look after the patient once they had been discharged from the rehab unit. It was also important for them to be offered mental health support and regular updates on the state and progress of the patient; something that had not been accessible in the LGI.
- The national FAST campaign is unknown to many focus group participants. The imagery could be more powerful and language more accessible (please see appendix 3, for more details regarding the FAST campaign).
- Information about the service should be widely available in different languages (although we recognise that it is not possible to provide translation for all languages some suggestions for the Stoke Association materials were: French, Arabic, Kurdish, Tigrinya, Farsi, Swahili and Amharic).
- Most participants said that a shop in the hospital would be important for them, even with shops nearby.

3.4. Staff engagement - Staff within Leeds Teaching Hospitals NHS Trust (LTHT) have also been fully engaged with on the ward move, with all staff sent letters explaining the proposal, with the opportunity to meet with their Matron on a 1-1 basis to discuss any personal concerns. A number of meetings were arranged to support staff, together with HR and representatives from staff unions.

3.5. Next Steps - All of the feedback received to date will be reviewed alongside further planned work with Carers Leeds, and the continued collation of patient experience as the new ward becomes fully utilised. This will be collated by the LTHT Patient, Carer

and Public Involvement (PCPI) team and all findings will be incorporated within a final experience report, by the end of 2021, with an action plan aligning with wider stroke service ambitions (as covered within the rest of this paper).

## B. STROKE SERVICES IN LEEDS

### 1. Providers

The following NHS services are provided in Leeds. In addition, some services for patients after stroke are provided in collaboration with General Practice and charities including The Stroke Association

1.1. Leeds Teaching Hospitals NHS Trust (LTHT)

Leeds Teaching Hospitals specialise in the early diagnosis, treatment and rehabilitation of people who have had a stroke. LTHT serves the Leeds metropolitan area providing initial emergency stroke care. In addition, LTHT receives approximately 70% of the acute stroke patients from the Harrogate catchment population following closure of the Harrogate Hyper Acute Stroke Unit (HASU) facility in 2019. As a regional specialist neuroscience centre, LTHT provides mechanical thrombectomy services and neurosurgical support to the West Yorkshire and Harrogate population of approximately 2.8 million people.

LTHT provide a 24/7 Brain Attack Team (BAT) of stroke specialist nurse cover for emergency admissions. In addition, there is also 24/7 specialist Stroke Consultant cover and support. The team aims to meet patients on arrive at the Accident and Emergency department in order to give patients the best possible outcome. The rapid assessment and management/intervention by BAT is time critical in terms of outcomes for patients with stroke and has significantly reduced the time from recognition of symptoms in the community to life saving, and life altering, interventions such as thrombolysis (clot busting drug administration) and mechanical thrombectomy (blood clot removal).

Leeds Teaching Hospitals also provides a Hyper Acute Stroke Unit (HASU) and an Acute Stroke Unit (ASU) for assessment and early rehabilitation. Patients requiring longer-term rehabilitation who are suitable are transferred to the Stroke Rehabilitation Unit, which is the provision moved to Chapel Allerton Hospital from the Leeds General Infirmary.

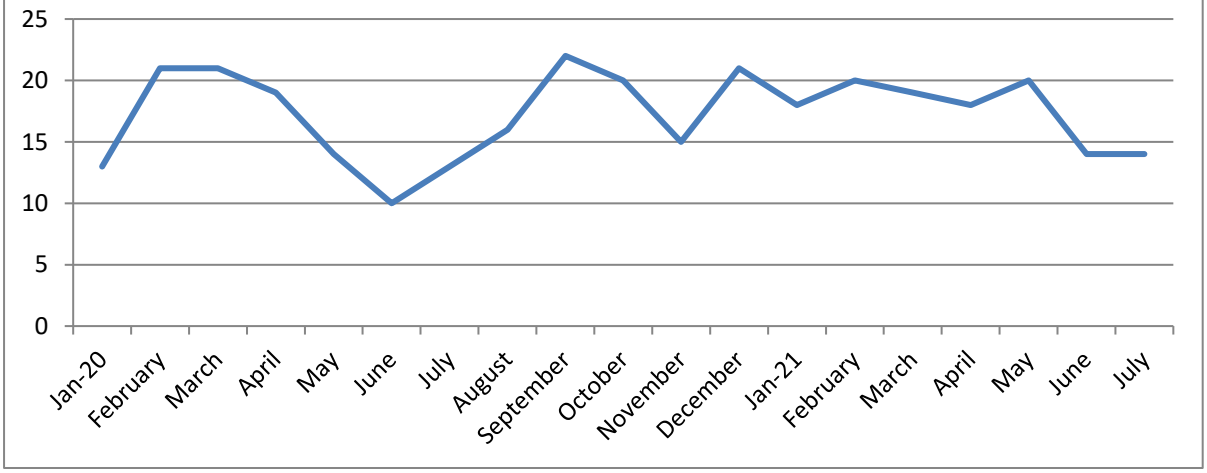
1.2. Leeds Community Healthcare (LCH)

Leeds Community Healthcare provide a seven-day service, delivering early stage stroke specialist rehabilitation in the community for up to twelve weeks. The team aims to maximise rehabilitation potential and improve quality of life for people following a stroke and support their carers. A multi-disciplinary team work with people who have had a stroke or subarachnoid hemorrhage to achieve their rehabilitation goals in their home. Leeds Community Healthcare also provide a Community Neurological Rehabilitation service, which aims to provide rehabilitation in community settings (home, leisure, community facilities, workplace, education facilities, etc). Some stroke patients from LTHT will enter this service if they have longer term rehabilitation needs. This service is currently being redesigned (with progress shared to Scrutiny).

## 2. Activity

Approximately 1500 acute stroke patients are treated in Leeds per year with an average length of stay outlined in Figure 1 below.

**Figure 1: Average Length of Stay for Stroke patients in LTHT (Jan 2020-July 2021)**




Admission numbers by month are provided for LTHT, with onward referral activity to LCH for community stroke care in Figure 2.

**Figure 2: Stroke patients admitted to hospital discharged to community stroke team**

| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2018/ 2019** | *LTHT stroke admissions | | | | | | | | | | 106 | 93 | 124 |
| | LCH stroke referrals | | | | | | | | | | 9 | 45 | 63 |
| | % of LTHT admissions referred to LCH | | | | | | | | | | 8% | 48% | 51% |
| **2019/ 2020** | LTHT stroke admissions | 112 | 119 | 128 | 117 | 112 | 117 | 132 | 130 | 121 | 132 | 127 | 123 |
| | LCH stroke referrals | 59 | 70 | 55 | 60 | 41 | 51 | 62 | 69 | 56 | 63 | 72 | 75 |
| | % of LTHT admissions referred to LCH | 53% | 59% | 43% | 51% | 37% | 44% | 47% | 53% | 46% | 48% | 57% | 61% |
| **2020/ 2021** | LTHT stroke admissions | 117 | 122 | 100 | 128 | 106 | 124 | 139 | 144 | 129 | 112 | 111 | 162 |
| | LCH stroke referrals | 48 | 40 | 51 | 57 | 51 | 52 | 58 | 59 | 46 | 49 | 47 | 87 |
| | % of LTHT admissions referred to LCH | 41% | 33% | 51% | 45% | 48% | 42% | 42% | 41% | 36% | 44% | 42% | 54% |
| **2021/ 2022** | LTHT stroke admissions | 121 | 141 | 145 | 134 | | | | | | | | |
| | LCH stroke referrals | 60 | 52 | 78 | 62 | | | | | | | | |
| | % of LTHT admissions referred to LCH | 50% | 37% | 54% | 46% | | | | | | | | |

*Please note LTHT stroke admission numbers include Harrogate/out of area patients, who are not subsequently referred to and managed by LCH Community Stroke services. Harrogate patients for example are managed by appropriate Harrogate community services.

## 3. Recent Service Developments

Leeds, as part of the West Yorkshire and Harrogate (WY&H) Integrated Care System, have for many years prioritised stroke services, with a WY&H Stroke Clinical Network in place which has now successfully transitioned into an Integrated Stroke Delivery Network (ISDN) in line with the National Stroke Service Model (May 2021). As a city, we have already undertaken significant stroke pathway improvement with a focus on continuous improvement in stroke services and patient outcomes, with the delivery of the Hyper Acute Stroke Unit (HASU) reconfiguration in 2018, across West Yorkshire and Harrogate providing one such example.

3.1. Atrial Fibrillation (AF) Medicines Optimisation Work (Stroke Prevention)

In 2019/2020, NHS Leeds CCG led a project funded by NHS England within the CCGs medicines optimisation team to review all patients with a diagnosis of AF not on an anti-coagulant in Leeds. Anti-coagulants are a medication prescribed to patients with AF, who are at increased risk of having a stroke (five times greater risk, than non-AF patients). By ensuring suitable people are on the correct medication it can reduce the risk of stroke by up to 50%. As part of the project, 2,752 patients were reviewed, with 486 patients placed on an anti-coagulant; therefore, reducing the conversion rate to stroke in future years. 1,194 were found not to be suitable for other medical reasons, with healthy lifestyles advice and education provided.

3.2. Transient Ischaemic Attack (TIA) Pathway Implementation

In early 2021 a new, clear, simplified pathway for clinicians in primary care to refer into for rapid access advice and support for patients with suspected TIA was created. The pathway went live to ensure review of patients within 24 hours by the Brain Attack Team via an email referral into LTHT. The new referral pathway has been well received by primary care and ensures prompt access to appropriate diagnostics for patients as required. Patients are contacted directly by the Brain Attack Team with a management plan agreed.

3.3. Progress towards improved SSNAP performance

Every year, providers of stroke care are required to submit key performance data concerning patient numbers treated and key indicators to the Sentinel Stroke National Audit Programme (SSNAP). Historically Leeds performance does not reflect standards of care locally because of technical challenges in reporting. Significant work has been undertaken to enhance reporting to improve our overall score. Improved performance is identified below in Figure 3.

**Figure 3: Leeds SSNAP Performance**

| Apr-Jun 2019 | Jul-Sep 2019 | Oct-Dec 2019 | Jan-Mar 2020 |
|---|---|---|---|
| X | X | X | D |
| . | . | . | 57.9 |

| Apr-Jun 2020 | Jul-Sep 2020 | Oct-Dec 2020 | Jan-Mar 2021 |
|---|---|---|---|
| X | C | C | C |
| . | 64.6 | 68.4 | 67.5 |

X = Data not submitted by Leeds due to reporting challenges

The best performance standard would attract an ‘A’ rating. Very few centres nationally achieve this standard overall. It was recognised at the most recent Stroke GiRFT review (Getting it Right First Time) that the data from Leeds was incomplete and, therefore, the overall rating was not fully reliable but that LTHT achieves an ‘A’ or ‘B’ rating in some domains.

3.4. An increase in the number of 6-month patient reviews completed in the community

A key recommendation from the National Stroke Guidelines is that every stroke patient should receive a patient led 6-month review. Nationally there is wide variation regarding if and how this is delivered. Historically, Leeds CCG funded the 6 month review of stroke

patients through the Stroke Association. This funding was discontinued in 2016/17 due to reprioritisation of funding resulting in a gap in the service. In 2019/20 the Community Stroke Rehabilitation Team utilised some available resource to develop and implement 6-month reviews for patients that access the Community pathway. This enabled 43% of Leeds patients who had had a stroke to be offered a 6-month review. The next phase for the city is to identify how a 6-month review can be offered to all patients that have had a stroke and will form a priority within our city vision for stroke services.

3.5. Improvements in the patient pathway from acute services to community; facilitated by improved relationships between therapists in the acute and community setting

In 2017/18 it was recognised across the system that the criteria and limitations of the Community Stroke Rehabilitation Team limited patient flow out of hospital. The tight criteria and 6-week model resulted in patients being kept in an acute hospital bed longer to have their rehabilitation needs met where, in fact, their needs could be met in the community if they were able to access the service and had the right length of input. Therapists and team managers across LTHT and LCH worked together to develop new accessible criteria to the community service. Alongside this funding was made available to improve the pathway from hospital to community, reduce length of stay in hospital, improve patient experience and for rehabilitation to be provided in the right place at the right time to meet patient needs. Staff from across the pathway worked together identifying where to allocate resource to have the biggest impact on the system. The success of this work was a result of staff and organisations coming together to share a joint vision of improving the patient journey for stroke patients in Leeds. They utilised and embedded opportunities to work in a more integrated way, improve relationships, learn from incidents together, create therapy rotations across acute and community to improve knowledge and experience across the pathway.

3.6. Taking on the Harrogate pathway for thrombolysis.

Leeds has adopted the Hyper Acute Stroke pathway from Harrogate and District NHS Foundation Trust after its service was closed in 2019. This enables faster access to hyperacute stroke treatments 24/7, including rapid access to assessment for thrombolysis, thrombectomy and admission to a Hyper Acute Stroke Unit. Approximately 30% of patients resident in Harrogate go to York whilst 70% are admitted in Leeds. The average door to needle time for thrombolysis in Harrogate prior to this move in July until September 2018 was approximately 110 minutes whereas Leeds' door to needle time average for January 2021 to March 2021 was 43 minutes.

## 4. 2021/22 Priorities for Stroke Services in Leeds

In Leeds we contribute to the Integrated Stroke Delivery Network (ISDN) led via the West Yorkshire and Harrogate Integrated Care System. The ISDN and delivery partners of Stroke services in Leeds strive to bring together stroke services, and to deliver the best possible care for the people of Leeds and WY&H, with the aim of reducing stroke mortality, disability and the impact of strokes on families, carers and health and social care providers. The ISDN is accountable for delivery of the National Stroke Service Delivery Model across West Yorkshire and Harrogate ICS.

Other priorities this year (which all align with national stroke priorities), in the delivery of stroke services in Leeds this year include:

4.1. Stroke Prevention

As outlined from the Stroke Rehabilitation Ward move engagement, more work needs to be undertaken on the awareness and prevention of stroke. As outlined by the engagement, the

national FAST campaign was unknown to many focus group participants, and we are confident that this is the case for much of the general public. We will strive in Leeds to publicise the FAST campaign and also highlight our services offered and routes into services for advice and emergency information as required. At all times we will work to tailor materials to different languages.

4.2. Managing stroke outliers within LTHT, with a review of all rehabilitation space

Due to the current prevalence of stroke and the existing capacity and demand restraints in the Trust, some stroke patients are managed outside the dedicated stroke bed base on non-stroke wards. This is always after their acute and hyperacute phase as they are embarking on the rehabilitation phase of their treatment and will occur whilst patients await a bed for stroke rehabilitation. During the pandemic, with the associated ward changes in response to changing Covid-19 inpatient demand, instances of stroke patients staying on non-stroke wards has grown. It is important that all outliers are mapped, tracked and resolved. The service is committed to improving overall bed utilisation and length of stay to ensure all stroke patients are managed within a dedicated stroke facility for as much of their in-patient stay as possible.

4.3. Improving thrombectomy access

A key priority of LTHT is to continue to improve access to thrombectomy. Approximately 80 patients have been treated in the last year with Mechanical Thrombectomy (MT) within the region, on a Monday to Friday, 08:00 – 16:00 basis. We aim to continue to increase this number in Leeds and regionally and are working towards a service delivery model that will provide 24/7 cover.

4.4. 6-month reviews and further improvements in SSNAP performance

As identified in the improvements section, significant improvement has been made in being able to offer 6-month reviews to all stroke patients in the community. The system aims to further improve this over the next 6 months and make improvements on our overall SSNAP performance and achieve a score of at least a ‘B’ rating.

4.5. Optimise CVD Prevent

Building on our prevention work to date in Leeds, in relation to AF optimisation, we will further optimise CVD Prevention (both primary and secondary). NHS Leeds CCG will support the roll-out of the national CVD Prevent programme, which is a national primary care audit that automatically extracts routinely held GP data covering diagnosis and management of six high risk conditions that cause stroke, heart attack and dementia: atrial fibrillation (AF), high blood pressure, high cholesterol, diabetes, non-diabetic hyperglycaemia and chronic kidney disease. The audit will provide an understanding how many patients with CVD and/or the high-risk conditions are potentially undiagnosed, or under or over treated. The audit will provide data to highlight gaps, identify inequalities, and opportunities for improvement. Progress made in improving the diagnosis and treatment of those at risk of CVD, will be monitored by the audit.

In addition, we must strengthen the education and guidance that is given to patients following a TIA or stroke, to avoid further occurrences. This will be considered over the next 6 months and will form a key component of the longer-term strategy. As highlighted in the engagement work from the stroke ward move, carers and family members have asked for more information and education around how to look after patients once home, along with wider mental health support.

4.6. Covid recovery

The Stroke teams continue to recover and manage patient need within the constraints of the continuing pandemic. Covid-19 is linked to changes in clotting, with services having seen an increase in the incidence of stroke in patients following their Covid illness. An increase in stroke numbers is also currently evident and may potentially be associated with behaviour changes during lockdown, with the general public taking less exercise and following a less healthy diet. In addition, reallocation of stroke rehabilitation beds to Covid care during the height of the pandemic impacted staffing resource and treatment available to patients needing stroke rehabilitation. This has caused a consequential rise in demand for community services and some patients who received less therapy than we would have wanted, with increased complexity, meaning that resources are spread more thinly within the community team. Leeds Community Healthcare are working to ensure that patients with lower risk presentation have alternative offers of support including referral directly to the Stroke Association, including 'After Stroke' Education Groups for patients who benefit from support with self-management. These areas of development align also with some of the recommendations from the ward move engagement and shall be further explored and developed as work on the vision for stroke services in Leeds is developed.

## 5. The development of a Leeds Vision for Stroke Services

NHS Leeds CCG, Leeds Teaching Hospitals and Leeds Community Healthcare have all committed to developing a vision for stroke services for the next five years. The vision document (a strategy) will set out our citywide ambitions formally in terms of our vision and ambition, as this stocktake of activities for scrutiny has allowed us to reflect on the many successes and progress we've made to date, however a firm plan and ambition is needed. We intend the vision and ambitions to be consistent with the framework adopted for diabetes services in Leeds: https://www.leedsccg.nhs.uk/publications/leeds-diabetes-strategy-2019-2024/, with clear accountability plans for achievement.

Development of the vision will commence in October 2021, via the formation of a 'Stroke Vision Task Group' which will meet monthly. The vision/strategy will be a live document, developed with patients, carers, staff and the public. We also recognise the importance of aligning the vision with wider city work including developing rehabilitation strategies, workforce competency frameworks and Discharge to Assess. It is also vital that the vision forms a joint ambition with Leeds City Council as prevention and social care, equipment and adaptation services are considered. There are all areas where we recognise improvement is required and if Scrutiny Board members can help assist/support dialogue in these areas it would be welcomed. Strategy development will also involve development with the Stroke Association and other third sector organisations.

The Leeds strategy will align with the National Stroke Strategy and clinical service strategies produced as part of the West Yorkshire and Harrogate ICS. We intend to publish a first draft of the Stroke Vision by April 2022.

## 6. Conclusion

Scrutiny members are asked to note the changes proposed, progress made and plans for strategy development included within this paper.

**Appendix 1: Patient Comments Received via LTHT Stroke Ward Move Survey**

*“There was a little family room but not many facilities for carers and obviously city centre parking is not ideal when your relative is in for a long time. My dad was in for 7 months before transfer to Chappell Allerton so very costly in parking."*

*"During intensive care stages the staff and care was incredible. After that, it was difficult to discuss progress with staff and rehab wasn’t occurring in line with NICE guidelines - this was a real stress factor caring for a relative who was young (62) and who we desperately wanted to get rehab for. Increased rehab and communication for relatives would really help."*

**"***Chapel A has better facilities and, due to capacity, increased access to rehab. Consistent Rehab in the earlier stages of recovery is so vital and chapel a would be better equipped to offer this. Also better facilities for stroke patients and easier parking for carers (they offered 2 passes for close relatives which helped with the cost as we were visiting daily)"*

*"Anyone who doesn’t have access to a car would have a more difficult journey but I think the benefits of rehab and facilities far outweigh this"*

*"The staff at chapel a during my dad’s stay were incredible, supportive and accessible. I’ll never forget each individual who played a part in supporting us and him during his stay. I think the more people who can access these staff and the facilities they have there would be invaluable. Ultimately we paid for treatment at Motion Rehab, access to better equipment on the chapel a ward would really help to rehabilitate and prevent long term disability, considering more state of the art equipment at an earlier stage in recovery I’m sure would have resulted in a different outcome for My dad."*

**Report: Stroke Rehabilitation Engagement**

**Leeds Voices**

**Iona Lyons, Connor Craig-Jackson, Claire Graham and Helen Farrell**

**June 2021**

## Summary

In June 2021 Leeds Voices spoke to 116 people, in 8 focus groups from South Asian, Black Caribbean, Black African and Eastern European communities about the move of Stroke Rehabilitation Services from LGI to Chapel Allerton Hospital.

Overall, participants were positive about the changing the Stroke Services from LGI to Chapel Allerton. The Hospital was seen as easier to get to, more welcoming, less stretched and that it was a hospital with *"a lot of potential"*.

The communities we spoke to had reported negative experiences with staff where they had experienced *"prejudice"*, with some staff being *"aggressive"* when faced with a language barrier. More therefore needs to be done to make hospitals inclusive.

These communities also felt the main reasons they are less likely to use stroke rehab services is mainly down to a lack of awareness or education about the services. Therefore these communities need to be more targeted in any information that is sent out about the services.

Barring some minor additions such as community languages/dubs and a more thorough display of how the equipment works, participants were positive about the LTHT Stroke Rehabilitation video when it was shown to them and that it was *"really positive"* when they saw how the hospital looked.

The new Stroke Rehab Unit in Chapel Allerton overall is a service that different communities would use and find more accessible than the LGI. However, from the feedback gained, more can be done to help make this service inclusive and to spread awareness of its existence.

## Recommendations

- The FAST campaign was unknown to many focus group participants. The imagery could be more powerful and language more accessible.

- Information about the service should be widely available in different languages (Although we recognise that it is not possible to provide translation for all languages some suggestions for the Stoke Association materials were: French, Arabic, Kurdish, Tigrinya, Farsi, Swahili and Amharic).

- Most participants said that a shop in the hospital would be important for them, even with shops nearby.

- The use of a video to give a visual representation of what the hospital was like alleviates the 'unknown'. Some suggestions were made to dub a voice over or create subtitles. Lots of participants suggested this should be shown to all patients and families before admission.

- People were happy with the hospital environment compared to LGI both inside and outside and valued the green surroundings.

- The provision of items to make people feel at home if they didn't have family support is really important.

- The importance of staff who can help the patent emotionally was emphasised, and the reassurance that staff will behave in a way that respects cultural diversity.

- Carers and family members wanted to receive more information and education around how to look after the patient once they had been discharged from the rehab unit. It was also important for them to be offered mental health support and regular updates on the state and progress of the patient; something that had not been accessible in the LGI

## 1. Background

In June 2021 Leeds Voices were tasked with carrying out a short engagement using focus groups to speak to 55 people seeking their opinion about the relocation of all stroke Rehabilitation Services from LGI to Chapel Allerton Hospital.

## 2. Description of the Engagement & Method

The aim of the Leeds Voices Involvement work was to: 'to support the relocation by engaging with communities most likely to be affected by a stroke'

We were asked to seek the opinions of people from South Asian, Black Caribbean, Black African and Eastern European communities and their carers because we know that people from those communities are more likely to suffer from a stroke.

We wanted to know what barriers people might face getting to Chapel Allerton Hospital, what they thought about the local area and amenities, what facilities they may need inside the hospital and how the hospital can make their stay as welcoming and comfortable as possible to the patients and visitors. The focus groups were asked a series of questions based on the information above, and were shown a video of the new unit.

We worked closely with the Stroke Association and used the FAST material to talk to groups about recognising the signs of a stroke. This information will be shared with the Stroke Association and is included here as it gives useful insight into public health material for these communities.

Despite the disproportionate number of people from Black, South Asian and Eastern European background who experience strokes, the Stroke Association users are predominantly white British, we included this question with participants and have recorded their feedback.

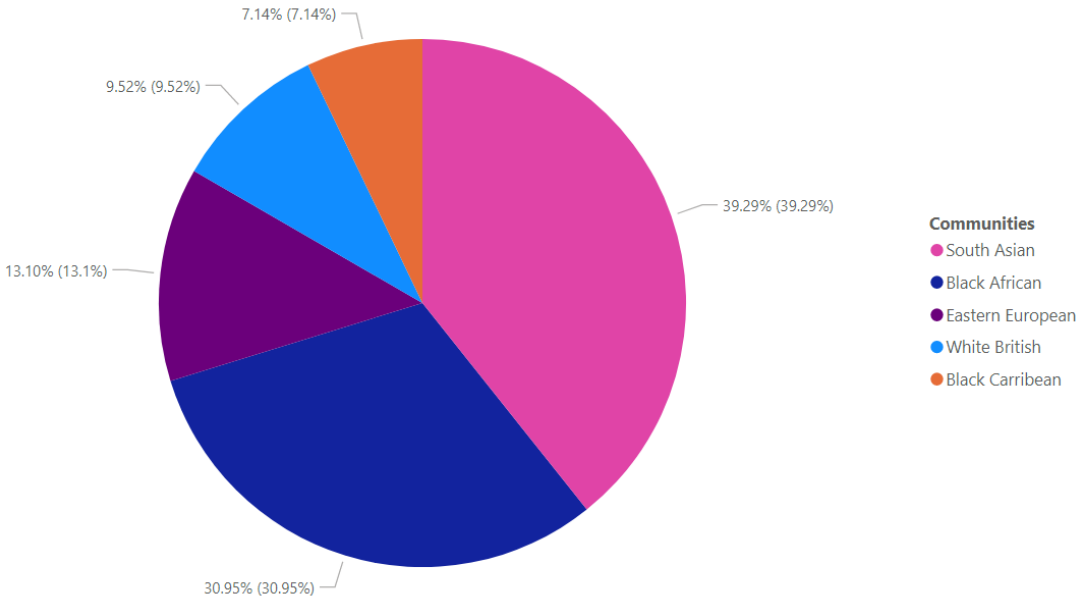
## 3. Who was involved?

We ran 8 focus groups with a total number of 116 people from the following community organisations.

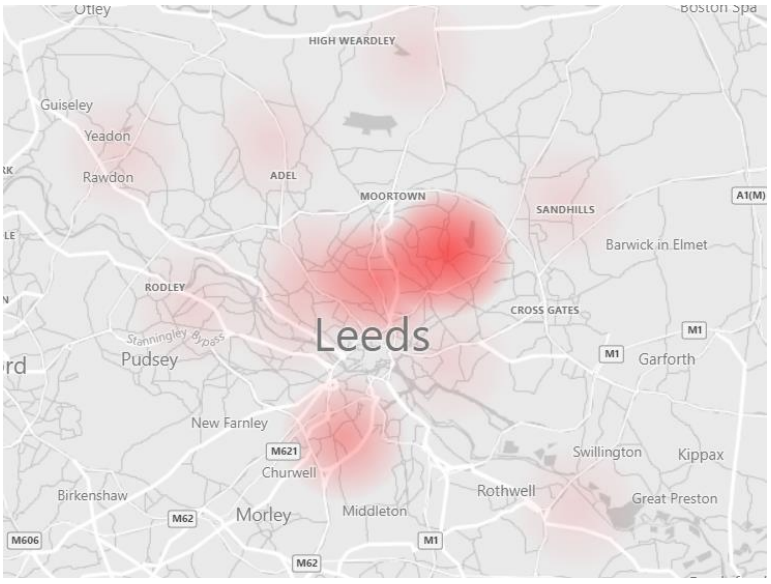
Feel Good Factor
Shantona Womens Centre
AME Roma
Peaceful Mind
Circles of Life
Hamara Healthy Living Centre
Leeds Refugee Forum
The Stroke Association

Seven of the focus groups we ran took place with groups that were already established and met regularly. Most of the groups were formed as communities of interest by ethnicity, geography or culture. The Stroke Association group was the only group that met up due to their experience of stroke.  It was also valuable to get the opinions of staff at the Stroke Association focus group, which has been recorded in the findings.

## Participant Communities Pie Chart




## Participant Postcodes Heatmap



A large number of attendees had lived experience of a stroke. This included two women who were under 40 at the Roma group and one woman, from an African background who had lost all 6 of her siblings and her mother to stroke and suffered 5 strokes herself.

**Main Findings**

1. **FAST Campaign Poster**

Groups were shown a poster which was part of the FAST Campaign from the Stroke Association. When asked about what they knew from the campaign and the poster shown they had the following feedback:

**Campaign distribution**

While some participants who had strong English had seen the FAST campaign on television, many of them hadn't seen the poster, with participants from all communities expressing that there was a lack of visibility for the campaign amongst their communities.

*"I know about FAST but haven't seen that particular poster...we (the organisation) have been supporting someone that had a stroke a year and a half ago, but throughout the LGI stroke unit I have never seen this poster."*

*"(the campaign) is not publicised enough in our communities (Black African & South Asian)"*

When speaking about how best to get this information out to all communities, it was recommended that the Stroke Association should link up directly with organisations such as the ones included in this report to run zoom sessions where they can distribute information to communities.

*"The approach (to sending guidance out) is a big problem...using flyers and emails etc. doesn't work with the majority of these communities because they don't think these methods of communication are for them due to language and cultural barriers. From covid we've learned that zoom is a good way of letting communities use their voice. So I think with more consultancy and more communication with these people, we will be able to capture the right way."*

It was also expressed that there needs to be a targeted campaign for participating communities so that the information can reach those who have experienced a “lack of education” or are new to the country and therefore aren’t engaged in the services. Participants suggested that community radios would also be a good platform to get this information out, due to it being in the communities’ own languages and a verbal method of communication.

*“To my mind it’s a problem of a lack of awareness, which I think needs to be addressed with a specific campaign targeting black communities to make them more aware of what’s available in terms of facilities and also the symptoms and danger of having a stroke.”*

## Key points

- The poster needs to be distributed to **all** hospitals and GPs across Leeds
- The Stroke Association can link up with the organisations included in this report to see how they can get information directly to their service users
- There needs to be a targeted campaign to target Black British, Caribbean, African, South Asian and Eastern European communities to better engage them with the Stroke services

## Changes to make to the poster

Multiple groups expressed that some of the language used in the poster was not clear enough. The term ‘Facial Weakness’ seemed vague and unhelpful for spotting a stroke, therefore it was suggested ‘**Facial Drooping’** should be used as the main ‘F’ title, while ‘Facial Weakness’ should be moved to the smaller print.

*"Instead of saying 'facial weakness' it could say 'facial drooping', because the symptom isn't that the face becomes 'weak', but that there's actually a shift because the mouth starts to droop."*

*"I would say 'facial droop' or 'facial drooping' is a better way to describe the effects of a Stroke (than 'facial weakness')."*

*“I feel ‘droop’ or ‘drooping’ is better because it has more of a meaning already attached to the word when compared to ‘weakness’.”*

Participants felt the poster was missing images of real-life people that demonstrated the signs of a stroke and each aspect of 'FAST' such as facial defects, or checking for numbness of arms etc. Using these pictures would be more *"eye-catching"* and make people more likely to take notice of the information in the posters.

*"I think especially with the BAME community they say 'a picture paints thousand words'… I would say that if you got the images correct then language is not a barrier, it doesn't really matter what terminology you use or what text is on there, it already tells us a story, it gets people engaged and they will read through- whether it's someone from a BAME community and it takes them a few extra minutes to read through."*

*"If you have actual pictures of people from different ethnic backgrounds it catches your eye when you see a real person, the way the adverts (on TV) do it to capture an image like that would probably be quite striking, you'd probably take more notice of it"*

The colours used on the poster was also seen as not conveying a sense of urgency or being eye-catching. This was an important aspect as it would stand out more with a colour such as red that conveyed danger and would be more likely to be picked up and read by communities.

*"I think colour needs to be more eye catchy, the colour is a little bit dark, it needs to be like an emergency so maybe a red colour."*

*'I agree that this F.A.S.T bit does not stand out, maybe it should be in another colour from the rest of it, so that it sticks out? But really for me there is nothing that draws you into the picture, it's a bit dull."*

*"It looks more like a sign that you have over your sink saying 'Wash your hands'…you glaze over it without giving it a second thought."*

**Key points**

- Change the wording on the poster from **'Facial Weakness'** to **'Facial Drooping'** to make it more clear
- Include pictures of people from diverse backgrounds displaying the stroke symptoms as with the TV advert in order to make it more eye-catching

- The colour should be altered from blue to something that communicates danger such as red

## 2. Getting to Chapel Allerton Hospital

Participants were positive about getting to Chapel Allerton Hospital when compared to the LGI. Those who had experienced both said getting to Chapel Allerton Hospital was easier as it is “much quieter with less traffic”.

In terms of parking, Chapel Allerton was also seen as more favourable than LGI. Participants who had been to Chapel Allerton said that parking was “not an issue, as “there is lots of parking literally on-site”. The parking was also described as “not as compact as at LGI”, with “better wheelchair access”.

One issue however that was raised by a participant was the pricing and having to top up the car parking charge due to the doctor running late. The participant had in the past had to go and top up the money they had spent parking due to this but at the same time this risked them missing their appointment if the doctor suddenly came to call them whilst they were topping up their parking payment. It was suggested that this could be resolved if the hospital could somehow use your registration number to see if your appointment had been late and provide a discount to instead charge you what you originally would have paid if the appointment had been on time. This would reduce anxiety and be reassuring for patients during their appointment.

Some participants who were based in South Leeds did mention that getting to Chapel Allerton Hospital “could be a bit of an issue” for their family members who don’t drive as it would “probably be a bus into Leeds city centre and then out of it” rather than one bus to the LGI, while getting a taxi “could be quite expensive” due to the further distance.

### Key points

- Most participants saw Chapel Allerton as easier to get to than LGI. Those who had experience of the hospital said that there is less traffic and more spacious parking as well as nearby on-street parking.
- One participant suggested using patients’ car registration number to give them a parking discount if their appointment is running late.
- Chapel Allerton would be more difficult to get to for those living in South Leeds that use public transport

## 3. Chapel Allerton as an area

Participants were familiar with the area around Chapel Allerton hospital, with pictures also shown during the groups to give them an idea of what was there.

There were positive views expressed about the area when comparing it with the LGI.

*"I know that area, it's less busy (than LGI) and I think it would be good to help a patient relax".*

The area around the LGI meanwhile was seen as *"a concrete jungle"* and therefore not as relaxing for rehab patients.

The local shops such as Lidl and Tesco Express were also seen as much cheaper and convenient in Chapel Allerton.

*"You don't have to spend a mortgage to get something to eat".*

Some participants however did feel that the walk to the shops may be difficult for those recovering from a stroke, therefore they may not be able to use the local shops or their family members may have to go and get items for them.

*"It's quite a busy road to get to the Tesco Express and if you're a but unsteady on your feet then that might be a factor (in stopping people from using the shops)"*

### Key points

- Chapel Allerton overall is seen as a better area than the area around the LGI. It is quieter, more relaxing and the shops are cheaper, so this is a positive change
- There are some concerns however that patients will not be able to use the shops or at least will find difficulty getting there due to the shops being on a busy road with lots of crossings

## 4. LTHT Stroke Rehabilitation Video

### Positive Aspects

During focus groups participants were shown a video released by Leeds Teaching Hospitals to give patients an insight into the Rehabilitation unit at Chapel Allerton and what to expect.

Overall participants were positive about this video, finding it *"very informative"* about how different aspects of the care will benefit patients and were reassured that *"they do look like they're making improvements"*.

*"The video is very good very informative."*

*"The good part about it too is that they actually extended it to home care, in that the experience that the patient would have in the bays they are in with the various equipment would familiarise themselves with this equipment, so that when they go home they are familiar with it…the patient leaves the hospital familiar with what the new home situation is going to be."*

The visual aspect was also seen as very beneficial for patients, with one participant saying *"It's amazing, there still some language barriers but it's good to have something visual where you can see it and imagine what is there".*

**Improvements/Adjustments**

Some participants felt that the video could have been improved if viewers could *"see the use of the hoists"* to paint a clearer picture of how they will operate.

Communities were also keen to have the video available in different community languages, with the Roma Community in particular expressing that for them it would need to be dubbed in Romanian as most of the community do not read.

More information could have been provided "*about the length of stay and what the rehabilitation process is"* as there was one participant who was confused about this.

One participant also felt that the video should have included more details about childhood strokes as they *"can be quite common and often misdiagnosed as epilepsy, which was the case for me, so there should be something in the video about childhood strokes"*.

**Key Points**

- The overall format, look and content of the video was well received by participants who were happy for it to be used as a way of informing patients about life in the hospital
- The video needs to be translated in different community languages, with Roma Communities requiring a Romanian dub due to not being able to read

- The video could include a demonstration of how to use the hoists, a segment on child stroke services and details about the length of stay or rehabilitation process

## 5. Feeling at home in the hospital

### Overall Environment of Chapel Allerton Hospital compared to LGI

Those who had stayed at the LGI reported many negative experiences of it, with one patient describing the ward they stayed in as a *"dungeon"*, situated on a lower floor with the windows high up so they couldn't see outside.

*"As soon as I saw the door (to the room) I cried my eyes out."*

*"That place was so depressing, and if you've had a stroke, you don't want to be there."*

*"I believe, well I know that there was a lot of prejudice going on. There was just abuse to me all the time, especially at night. I did say to them ''Please I haven't slept all night, can I have another room please? They said '' sorry you cant'' But the at the end I discharged myself, I said I don't want to stay here any longer I'd rather stay at the hotel. But in the end my memory was down, I was depressed and there was nobody there who I could speak to."*

By contrast views about Chapel Allerton, especially compared to LGI were positive, reflecting this change as a well-received one for stroke rehab patients.

*"(my wife) was in Chapel Allerton for five months and the service she got there was of a far higher standard than the LGI. At the LGI they were stretched with physios, therapists, everything and she was getting physiotherapy maybe twice a week. At Chapel Allerton it was every day, they make you feel so welcome.*

*"as an in-patient it's got a lovely garden, it's just a lovely place to be"*

From the Leeds Teaching Hospitals Video that was shown during the group, participants were very reassured that the ward would provide a nicer environment that was *"worlds apart"* from their previous experiences.

*"Looking at (the video) now the process that they have got is worlds apart, so thank God that we've got somewhere like that."*

*"It's amazing....great to have something visual where you can see it and imagine what is there."*

One participant whose wife had used the hospital's neuro rehab services was full of praise for Chapel Allerton hospital comparing it very favourably to LGI. One factor that particularly helped with recovery was that the return back home was more gradual, with the patient returning on the weekend and then going back to the hospital during the week. This was *"a massive part of her recovery"* as it was easier to adjust to life back outside and meant that she could *"see the light at the end of the tunnel"* and would therefore be a very important feature of the Stroke Rehab service in Chapel Allerton.

Some participants from multiple groups did point out that Chapel Allerton Hospital no longer had a shop inside whereas LGI did, therefore this was a negative factor as it meant patients couldn't have a short walk down from their ward to pick up some items and would have to rely on family members bringing it to them.

*"When my mum was in LGI I was able to go and get her stuff from the shop...it's good practice as well for people when they're preparing to go back to normal life."*

There was also a slight concern raised by some about whether the Stroke Rehabilitation unit would cause Chapel Allerton to lose its standard of service, therefore eliminating the positive experiences that people had reported about the hospital. It would therefore be useful to acknowledge this risk in any communications sent out and provide some reassurance that the hospital will have this under control or at least in mind.

**Key Points**

- The inside of Chapel Allerton Hospital is also seen as a nicer environment than LGI
- Participants had positive views about Chapel Allerton Hospital describing it as *"welcoming"* and *"of a much higher standard"* than the LGI, which was described as being *"stretched"* and *"depressing"*, therefore this is seen as a positive change
- The lack of an inside shop at Chapel Allerton was seen as a concern, with suggestions that they could bring in people who had stalls as a quick substitute for a shop
- Some were concerned this new service could make the hospital more stretched, therefore there needs to be some reassurance provided around this

**Helping Family members/carers to be part of their loved ones' recovery**

Participants who had English as their second language felt much more comfortable having a close family member/friend able to attend the hospital with them in order to provide interpretation for them.

*"If it's my husband or my cousin (interpreting), then I feel a lot more confident."*

Similarly, family members/carers wanted to be able to accompany the patient to the hospital and interpret for them, so that they can make sure the doctors could understand their family members' condition.

*"I want to interpret for my wife because I don't want her condition being exploited by someone else."*

In terms of how the change in hospital would affect family members/carers, all participants who had experienced both the hospitals said that they felt the care received at Chapel Allerton was *"of a much higher standard"* than the LGI and would be reassured that their family member or friend would have stringer rehabilitation in Chapel Allerton.

*"As a carer (Chapel Allerton) kept me well informed with what was going on and everything that I needed to expect when (my wife) came back out. It was a lot easier for me to get to than the LGI and on a great bus route."*

The mental health of family members was also an important aspect for participants due to the distress felt at having a family member having to recover from a stroke. One community leader spoke about the struggles that members of the South Asian community had faced when their family member had suffered a stroke.

*"I have had so many calls because of distressed family members that have not been able to go and see loved ones in hospital. I think it's going take a long time to help them and it's sad to say that we have lost so many members. The question is now how are we going to support these people who have had such distressing times and how can we now support our community and safely say 'right, we have got all this information, all protocols are in place and you don't need to be intimidated'."*

Education about what precautions to take in order to avoid a stroke is also important for family members and carers, as it would they can continue to support the patient once they are discharged from the rehab unit.

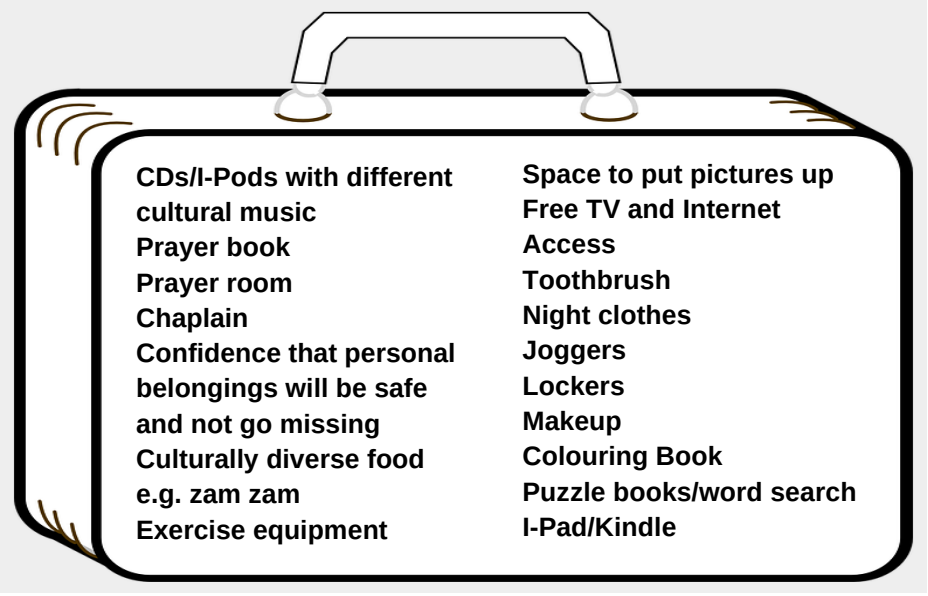
*"When the patient returns home there will be a continuation of the patients care at home, so family members need to be part of this process so they can then learn things like what to eat and what not to eat in order to avoid triggering a stroke."*

## Key Points

- Chapel Allerton hospital was received more positively from carers/family members who had experienced the hospital as they felt informed and involved in the patient's recovery.
- Those with language barriers would prefer to have their carer/family member interpret for them in hospital as they are more comfortable and trusting towards them than a hired interpreter.
- Education needs to be provided fromt eh hospital to family members/carers about what measures to make in order to minimise the risk of future strokes for the patient.
- If visits are restricted then there needs to be regular communication to the family members from the hospital about the treatment their family member is receiving and what the next steps will be.
- Mental health support should also be an option to family members/carers to help them with the distress involved with having the patient in the rehab unit.

## Resources that the hospital can provide

Participants were all asked what provisions people from their community would require in the rehab unit to make them feel at home during their stay and ultimately recover quicker. The overall results are compiled below along with quotes from participants who suggested items:



*“Music has got to be a must and with technology now it is limitless. Easy to provide for all backgrounds and promote familiarity as well as stimulation.”*

*“As a people we are very religious, so greater access to our religious beliefs (prayer rooms, Bible, pastor) if we are going to have a long-term stay”*

*“(access to African food) made me feel like I am getting better and I am ready to go home, something was happening in my mind like I am ok and I am getting better”*

## Experiences of culturally diverse communities in the hospital

- **Discrimination from staff**

All communities had participants who reported negative experiences in the hospital that were caused by a language barrier and not feeling like the hospital staff were being understanding about this.

*“Sometimes I feel straight away when (staff) treat me this way. When I don’t understand something a staff member has said they then shout it at me and it feels aggressive towards me.”*

*"I didn’t say thankyou for my cup of tea because I couldn’t speak the language – the lady shouted at me that she’s like my mum’s age and I should be grateful – I was shocked/nervous. I didn’t know what to do"*

There was a suggestion from multiple groups that staff could undergo culturally sensitive training or have staff screening dedicated to addressing cultural barriers experienced by communities. That way it would at least be reassuring for patients to know that they were in an environment that is addressing these issues and trying to create a more inclusive environment regardless of the attitudes of some staff.

*“You can’t change people’s opinions overnight. But what you can do is say ‘look, keep your opinions to yourself or take it outside, but in the hospital the patient is our customer and the customer’s always right’.”*

*“They just need to think to themselves, if they were in hospital how would they like to be treated?”*

## Key points

- When faced with language barriers staff often display a lack of sensitivity to this, sometimes shouting, talking too fast and making the patient feel uncomfortable and upset.
- While racism is still an issue in hospitals, communities would find it reassuring to know if staff had received culturally sensitive training as it would at least display that the hospital are acknowledging and confronting it.

- **Interpreters in the hospital**

Communities that faced language barriers were reluctant to use interpreters in the hospital, partly due to having to pay for them, meaning *"they tend to avoid them because of the cost."*. However a larger factor was that communities were often uncomfortable with explaining their symptoms to a stranger to interpret it on their behalf due to the very private nature of it. Therefore it is much preferred to use a family member who can speak English and interpret for them as there is more trust.

*"It's degrading (explaining health issues to a hired interpreter) so friends/family are always preferred for interpreting."*

This is still a barrier however, as participants reported that staff at hospitals, including Chapel Allerton initially didn't allow them to interpret for one of their relatives as they would *"not interpret correctly"*. This made a lot of participants confused as to why they weren't being allowed to interpret and it also made them feel uncomfortable having to let their relatives rely on someone who they haven't met before to listen to and interpret their personal conditions to the doctor.

*"I don't understand why they don't accept that their husband is telling you what (their wife) is saying"*

*"I want to interpret for my wife because I don't want her condition being exploited by someone else"*

An alternative suggestion to this from one of the groups was that patients could use an interpreter from a community organisation, which would be a more trusted source than an interpreter from the council or hospital.

*"If (family interpreters) isn't an option you can arrange for someone from a place like Hamara to help with this."*

One group also suggested that volunteer interpreters from local communities could also help patients with rehabilitation as they would be able to be on hand to speak to them regularly as part of a befriending service to comfort and reassure them during their stay in the hospital if they are anxious. This is especially important as they recognised that hospital staff are *"stretched"* and therefore nurses aren't always on hand to help the patients in the ward.

*"There is a need for volunteers who speak the languages of the people who are in the hospital as a befriending service, because if you have had a stroke you need lots of stimulation, you need to have practice talking and thinking about things."*

*"Countless times you'd go into the ward (to visit a family member) but often in the opposite bed there would be somebody from the BAME Community and you'd end up going over to them and saying 'you're gonna be fine, look (my relative) has been in X weeks and look how far he's got.' and just encouraging them because you could see the fear on their faces. Nurses don't have time for that one-to-one."*

There was also a suggestion that hospitals could utilise the "third generation" medical professionals from diverse backgrounds as they are generally multi-lingual, having been brought up in the UK, therefore could provide trusted interpretation services.

*"A lot of the third generation (from our background) are really into medical occupations, so having doctors and nurses available would make it better because there's more trust there with a professional."*

Due to most interpreters in hospitals being women, this provided a large barrier for the male participants in the group, who said that they feel uncomfortable having to explain a very personal condition to a female who isn't a medical professional.

*"I find that 99.79% of interpreters are female, because male interpreters won't be accepted by females because of privacy…however If I had to explain a very personal bodily condition to a female, I would feel embarrassed and she would also be embarrassed, so I just think with interpreters in hospital than man should have man and female should have female."*

This was also the same for female participants when talking about male interpreters, with participants reporting that *"we feel shame if we have to ask a man to interpret our health issues in a hospital."*

## Key Points

- People with language barriers would like to be allowed to have a family member interpreting for them as it makes them feel more comfortable
- If family members aren't available then volunteers from local community groups could be used and assigned to patients as a befriending service
- Interpreters should be the same sex as the patient they are interpreting for due to the personal nature of the information the patients are sharing

- **Why participating communities are less likely to use the stroke services**

Throughout this engagement we have developed a positive working relationship with The Stroke Association who take referrals from the team at Chapel Allerton. The Stroke Association recognise that their membership does not reflect the diverse communities of Leeds.

When asked about the disparity between White British and Black British, Black African, South Asian, Eastern European communities of accessing community services, participants mainly pinned the disparity down to differences in culture and in education.

Culturally, both Black African and South Asian participants said that there is a *"duty of care"* amongst their communities for relatives who are ill. Therefore, rather than use the hospitals and seek professional help, they would rather stay at home and be cared for by family members in a familiar environment.

*"What I think is that our community have a duty of care to our elders, and as we know there are different generations living under one roof so if anybody had become ill there are different generations that can look after that person and maybe that is another reason why you won't find as many seeking to go into a home or rehab or things like that."*

As previously highlighted in the report, there is also a general lack of *"awareness"* and *"education"* in participating communities around Stroke Rehabilitation. Information and communications sent out about Rehab services therefore needs to be part of a campaign that specifically targets people from  backgrounds.

## Key Points

- There is a general lack of awareness amongst culturally diverse communities that Stroke Rehab services are available
- Those from South Asian and Black communities usually choose to have rehab in their home as it is a familiar environment with family members of multiple generations who can look after them
- There is a ‘cultural pressure’ for families to be seen to care for their loved ones at home.
- The Stroke Association has since presented to the Leeds Voices monthly drop-in to promote their service and also supplied all community groups who attended focus groups with translated booklets with information about Stoke and the services they offer.

**Appendix 3: FAST (Face, Arms, Speech, Time)**


The Act FAST campaign urges everyone to take immediate action on seeing any stroke symptoms to save lives – the NHS is open.

Stroke is a medical emergency and anyone experiencing symptoms should seek urgent help. Early treatment not only saves lives but results in a greater chance of a better recovery, as well as a likely reduction in permanent disability from stroke.

Stroke is a time sensitive condition which means that any hesitancy and delay in getting treatment kills brain cells and has sadly and unnecessarily proven to be fatal in the early phase of the pandemic.

**Think and act FAST**

The signs of stroke are:

- Face – has their face fallen on one side? Can they smile?
- Arms – can they raise both their arms and keep them there?
- Speech – is their speech slurred?
- Time – time to call 999