UK STROKE FORUM

Hosted by Stroke association

12th **UK Stroke Forum Conference**

28 – 30 November 2017
ACC Liverpool

Delegate programme

#UKSF17

Kindly supported by

BAYER · Bristol-Myers Squibb · Pfizer · Daiichi-Sankyo · GE

Stroke-Specific Education Framework

UK Stroke Forum Education & Training

Map your learning at the conference

The Stroke–Specific Education Framework (SSEF) consists of 16 'elements of care' which reflect the different parts of the stroke pathway. To help you see which parts of the pathway you are learning about, sessions within the UKSF programme have been mapped against the SSEF elements of care. The 16 elements of care have been grouped into four areas of stroke care, as follows:

Symbol	Area being covered	SSEF elements of care
■	Prevention and managing risk	E1 – Awareness raising E2 – Managing Risk E3 – Information E4 – User Involvement
II	Hyper-acute and acute care	E5 – Assessment (TIA) E6 – Treatment (TIA) E7 – Urgent response E8 – Assessment (stroke) E9 – Treatment (stroke)
>>	Hospital care & rehabilitation	E10 – Specialist rehab E11 – End of life care E12 – Seamless transfer of care
>	Post-discharge care	E13 – Long term care E14 – Review E15 – Participation in community E16 – Return to work

Learn more about the SEEF at the Conference

The SSEF website is a professional development tool which enables health-care professionals to assess their knowledge and skills against the SSEF, identify their training needs, and be directed to courses matching those needs. Training providers can enter details about their courses, map them to the SSEF and have them registered on a searchable database, increasing accessibility to those looking for training. The site, which has over one thousand users, won the Guardian University Award for Digital Innovation in March 2016.

Visit the SSEF team at: Stand A in the exhibition arena to see how registration can benefit you and your organisation.

Visit the SSEF site at: **www.stroke-education.org.uk**

UK Stroke Forum Conference 2017

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Dear Colleague,
Welcome to the 12th UK Stroke Forum Conference.

I am delighted to welcome you to the 12th UK Stroke Forum in Liverpool. It has been my honour and pleasure, in my first year as Chair, to work with the Scientific Programme Conference Committee to bring you a varied programme designed specifically for our broad multidisciplinary audience.

This year we welcome eminent speakers from across the UK, Australia, Germany and United States of America who will share the latest in stroke research, education, service delivery and examples of best practice.

This year we have made a number of changes to ensure the conference continues to develop and to meet the needs of the stroke community. We have further developed the Primary Care and Adult Social Workers streams which complement our other well established BASP, Nursing & Rehabilitation and Stroke Research streams. We received a record number of high calibre abstract submissions this year enabling us to host over 180 research posters and various poster tours covering all aspects of stroke care.

In order to recognise and reward excellence within the stroke community we award a variety of prizes throughout the programme including awards for the Life Time Achievement, the BASP Warlow Prize, National Stroke Nursing Forum, AHP Stroke Abstract, Stroke Rehabilitation SRR Prize and Patient, Carer, Public and Involvement Awards to name a few.

We have enhanced the 'soapbox science' platform which will showcase the industries' latest developments; the subjects and timings for these are in the programme. The knowledge hub has grown to allow you the opportunity to meet up with speakers and the UKSF Coalition. We are thrilled to have over 60 exhibitors who have supported the conference this year. Please do take time to visit the stands and corporate exhibits. The support our loyal sponsors and exhibitors offer is simply outstanding and, without it, our conference would not be possible.

I look forward to welcoming all delegates to the Welcome Drinks Reception on Tuesday evening from 17:00 within the exhibition arena. We are delighted to host the Katumba Drummers and the North West Stroke Survivors Art Exhibition. After the drinks reception The Stroke Association are hosting a 'sing along' movie in the auditorium from 18:00, more details can be found in the programme. Also, if you have not purchased your ticket for our '70's' themed Gala Dinner on Wednesday evening please do visit the enquiries desk.

In order to plan your agenda, view the programme and abstracts online - download the UKSF App from the App Store or Google Play Store, simply search UKSF in either store.

The conference is here to educate and inspire professionals and we always welcome your ideas and feedback. Please remember to complete our online evaluation after the event to ensure you receive your CPD certificate. This link will be sent to you on Thursday afternoon.

I would like to take this opportunity to thank my excellent colleagues in the UK Stroke Forum 'office', the members of the Steering Group and Scientific Programme Conference Committee, and the abstract reviewers who scored several hundreds of abstracts.

Best wishes,

Professor Peter Langhorne
Chair of UK Stroke Forum
Professor of Stroke Care
University of Glasgow

Acknowledgements

All UK Stroke Forum Coalition organisations have played a part in planning the conference programme and special thanks go to the following representatives:

Professor Peter Langhorne, UK Stroke Forum Chair
Professor Dame Caroline Watkins, UK Stroke Forum Chair Elect
Professor Avril Drummond, UK Stroke Forum Outgoing Chair

UK Stroke Forum Conference Scientific Programme Committee:

Dr Ulrike Hammerbeck, Association of Chartered Physiotherapists Interested in Neurology

Professor Rustam Al-Shahi Salman, British Association of Stroke Physicians

Dr Ann Needle, British Dietetic Association

Claire Howard, British and Irish Orthoptic Society

Dr Shirley Thomas, British Psychological Society

Joseph Dent, College of Paramedics

Hannah Waterhouse, Education for Health

Alex Hoffman, Intercollegiate Stroke Working Party

Professor David Werring, NIHR Stroke Research Network

Dr Patricia Gordon, Northern Ireland Multidisciplinary Association of Stroke Teams

Dr Katie Gallacher, Royal College of General Practitioners

Professor Pip Logan, Royal College of Occupational Therapist Specialist Section - Neurological Practice

Professor Marian Brady, Royal College of Speech & Language Therapists

Liz Topliss, Service User Representative
Robin Cant, Service User Representative

Dr Jacqui Morris, Scottish Stroke Allied Health Professionals Forum

Professor Audrey Bowen, Society for Research in Rehabilitation

Dr Kate Holmes, Stroke Association

Dr Chris Price, UK Stroke Forum Education and Training

Dr David Smithard, UK Swallowing Research Group

Dr Tal Anjum, Welsh Association of Stroke Physicians

UK Stroke Forum Steering Group:

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Pete Rumbold, ARNI Institute

Dr Ulrike Hammerbeck, Association of Chartered Physiotherapists Interested in Neurology

Professor Helen Rodgers, British Association of Stroke Physicians

Professor Thompson Robinson, British Association of Stroke Physicians

Dr Fiona Rowe, British and Irish Orthoptic Society

Dr Shirley Thomas, British Psychological Society

Mark Ballard, Chest Heart and Stroke Scotland

Joseph Dent, College of Paramedics

Brin Helliwell, Different Strokes

Hannah Waterhouse, Education for Health

Alex Hoffman, Intercollegiate Stroke Working Party

Professor Gillian Mead, Later Life Training

Professor Christine Roffe, NIHR Stroke Research Network

Dr Liz Lightbody, National Stroke Nursing Forum

Dr Patricia Gordon, Northern Ireland Multidisciplinary Association of Stroke Teams

Declan Cunnane, Northern Ireland Chest Heart and Stroke

Dr Katie Gallacher, Royal College of General Practioners

Professor Pip Logan, Royal College of Occupational Therapist Specialist Section - Neurological Practice

Professor Marian Brady, Royal College of Speech and Language Therapists

Professor Frederike van Wijck, Scottish Stroke Allied Health Professionals Forum

Dr Lisa Kidd, Scottish Stroke Nurses Forum

Professor Audrey Bowen, Society for Research in Rehabilitation

Juliet Bouverie, Stroke Association

Dr Tal Anjum, Welsh Association of Stroke Physicians

UK Stroke Forum Event Management and Sponsorship Team:

Sammy Williams, UK Stroke Forum Relationship & Business Manager

Tracy Johnson, UK Stroke Forum Conference Manager

Carly Norton, Exhibitions and Sponsorship Manager

Jenna Bennett, UK Stroke Forum Event Administrator

Bernadett Tildy, Research Awards Officer

The UK Stroke Forum would like to thank the following organisations for supporting the 2017 UK Stroke Forum Conference:

Sponsors:

Bayer
BMS/Pfizer Alliance
Daiichi Sankyo
Firstkind Medical
GE Healthcare
Novacor
OMRON Healthcare UK
ReNeuron
Stryker

Exhibitors:

Academic Unit of Elderly Care and Rehabilitation, Bradford
ACNR (Advances in Clinical Neuroscience & Rehabilitation) and The Primary Care Neurology Society
ACPIN
Allergan
Alzheimer's Society
Amgen
ARNI
Bayer
BMS/Pfizer Alliance
Boehringer Ingelheim
British and Irish Orthoptic Society
British Association of Stroke Physicians
British Heart Foundation
British Journal of Neuroscience Nursing
Cyclone Mobility
Daiichi Sankyo
DCC
Different Strokes
Dorset Orthopaedic
Edinburgh Stroke Trials
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Firstkind Medical
Fresenius Kabi
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Kora Healthcare
Jobskin
Knowledge Hub
Lancashire Clinical Trials Unit / NIHR GCRG Improving Stroke Care
Later Life Training
London South Bank University - Acupuncture and Stroke
Medtronic
MEYTEC GmbH Medizinsysteme
Mindmaze
Myoroface
Nihon Kohden
NIMAST - Northern Ireland Multidisciplinary Association of Stroke Teams
Novacor
NSNF - National Stroke Nursing Forum
OMRON Healthcare UK
Penumbra
PJ Care
Royal College of Occupational Therapists Specialist Section - Neurological Practice
Royal College of Speech and Language Therapists
Sage Products
Silverlink
SRR - The Society for Research in Rehabilitation
SSNAP / Royal College of Physicians
Stroke Association
Stroke Association Voluntary Groups
Stroke Research Centre, Institute of Neurology, UCL
Stroke Research in Stoke
Stroke-Specific Education Framework
Stryker
Summit Medical and Scientific
TICH-2 & RIGHT-2 Trials
University of Glasgow
Virtual Ware
Vision Research Unit
Wisepress Medical Bookshop

Venue services

Wifi internet access is available throughout the conference centre and is free of charge.

Join the debate! Why not tweet your thoughts on the event #UKSF17

Download the UK Stroke Forum 2017 app from the App Store or Google Play Store. Search UKSF in either store. On downloading the app you will then be prompted to enter your email address to access the full features of the app, please make sure you use the email address used when registering for the event.

The app includes various features to enhance your time at the event such as:

Full programme details

Exhibition information

Documentation

Floor plans

Social Media feeds

Business facilities – the ACC Business Centre is located at Ground Level (to the left as you enter via the Cityside Entrance) and is open throughout the event.

First Aid – delegates requiring first aid are asked to report to a member of ACC or UKSF staff for assistance.

Taxis – taxis can be booked at the ACC Guest Relations adjacent to the Business Centre at Ground Level.

Conference Information

Conference Rooms

All conference rooms are located on the Upper Level

Refreshments

Refreshments and lunch are included for all delegates and exhibitors each day and are available in the Exhibition Hall (Lower Ground level) at the times stated in the programme.

There is also a **coffee shop** at Ground Level where delegates can purchase additional refreshments and light snacks throughout the event.

Various **networking and seating areas** can be found in the Exhibition Hall (Lower Ground Level) where delegates can relax and network with colleagues.

Enquiries

The **delegate enquiries desk** is located at Ground Level near registration. On-site registrations are processed here and you can also buy Gala Dinner tickets (costing just £55), subject to availability. Please note that we cannot resell gala dinner tickets for you, but you are welcome to pass them onto colleagues.

The **exhibitor enquiries desk** is located at Ground Level near registration.

Exhibition Hall – Lower Ground Level

The UKSF Exhibition, **including research posters**, is located in one spacious hall on the Lower Ground Level. The exhibition features a wide variety of different stands and research so please make sure you investigate during the event. Ongoing trials posters can also be found in the exhibition hall.

Exhibition opening hours:

- Tuesday 28 November, 10.30 – 18.00
- Wednesday 29 November, 08.00 – 16.30
- Thursday 30 November, 07.00 – 13.00

Soapbox Science

Exhibitor supported sessions will be staged in the exhibition arena on the Soapbox Science area interspersed with Stroke Association fringe sessions. Check the programme for more information.

Speaker Preview Room

The speaker preview room is located on the Upper Level in Room 10. All speakers should report to this room at least one hour prior to their session. It will be open at the following times:

- Tuesday 28 November, 11.00 – 17.00
- Wednesday 29 November, 07.00 – 17.30
- Thursday 30 November, 07.00 – 13.00

Photography and Video

Our official multimedia producer will be present throughout the conference to take photos and film aspects of the event. Photos and videos will be used for promotional purposes (including our website and social media). Please let us know if you have any concerns about this.

Research and professional development

Abstracts

A copy of the Book of Abstracts is included in your delegate bag. Published by The International Journal of Stroke, delegates can also view it online at http://journals.sagepub.com/toc/wsoa/12/5_suppl

All **research posters** can be found in the Exhibition Hall (Lower Ground Level). Tours will take place on Wednesday and Thursday – see pages 39 and 56 for more details.

Speaker Presentations

Where permission has been given, slides from speaker presentations will be available on ukstrokeforum.org.uk and the Conference app by the end of January 2018.

CPD

Accreditation has been awarded from the Royal College of Physicians (18 points).

CPD certificates will be issued upon completion of the online conference evaluation (see below), and will be sent via email by 31 December 2017.

Conference Evaluation

Your feedback is extremely valuable as it helps us to improve the event each year. Evaluation forms can be completed via our online evaluation system. A link will be sent to you on Thursday afternoon and will also be available via the app.

This service is kindly supported by DCC Ltd

Talk To Us

If you have suggestions for future UKSF conferences, please visit the enquiries desk and we'll record your suggestion – we welcome any feedback or suggestions you may have!

Social Events

Welcome Drinks Reception – Tuesday 28 November, 17.00 – 18.00

All conference delegates are invited to enjoy a complimentary welcome drink in the exhibition hall (Lower Ground Level) and a chance to network and forge mutually beneficial relationships.

Charity Sing-along Cinema Screening – Tuesday 28 November, 18:00 – 20:00

Following the welcome drinks reception we are staging a charity sing-along cinema screening in the ACC auditorium. Log on to the UKSF app and vote for the movie you would like to sing-along to. *Mamma Mia* or *Grease!* Popcorn and cinema snacks will be available and remember to save your cinema ticket to be in for a chance to win a free place at next year's UK Stroke Forum Conference!

70's D I S C O themed Gala Dinner – Wednesday 29 November, 19.00 – midnight

Taking place at The Rum Warehouse, Titanic Hotel, Liverpool, guests will enjoy a drinks reception, scrumptious three course meal and an evening of entertainment. All tickets must be purchased in advance, and can be bought during the conference for £55 from the delegate enquiries desk (subject to availability). All tickets must be shown upon arrival to the venue (**The Rum Warehouse**, Titanic Hotel,Stanley Dock, Regent Road, Liverpool, L30AN). The dress code is smart evening wear (with a little D I S C O flare).

#UKSF17

Stroke association

UK Stroke Forum

Sing-a-long movie

Tuesday 28 November 2017

The auditorium

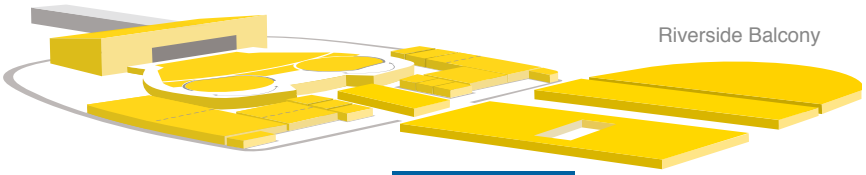
ACC, Liverpool

From 6.00pm

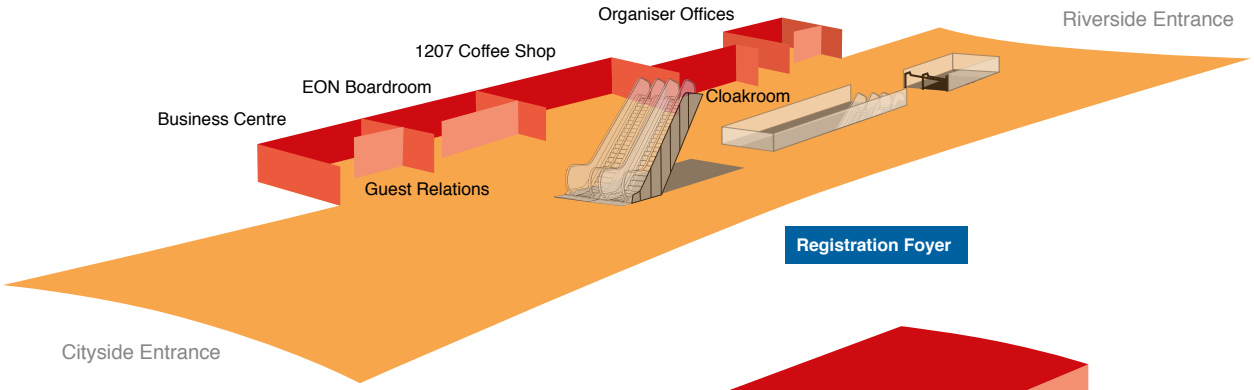
Please join us for our complimentary drinks reception and sing-a-long movie in the auditorium, ACC. The movie will start at 6pm – see you there!

Together we can conquer stroke

Venue Map

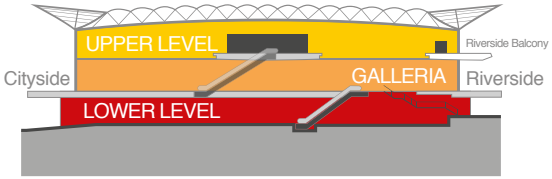


Conference Rooms

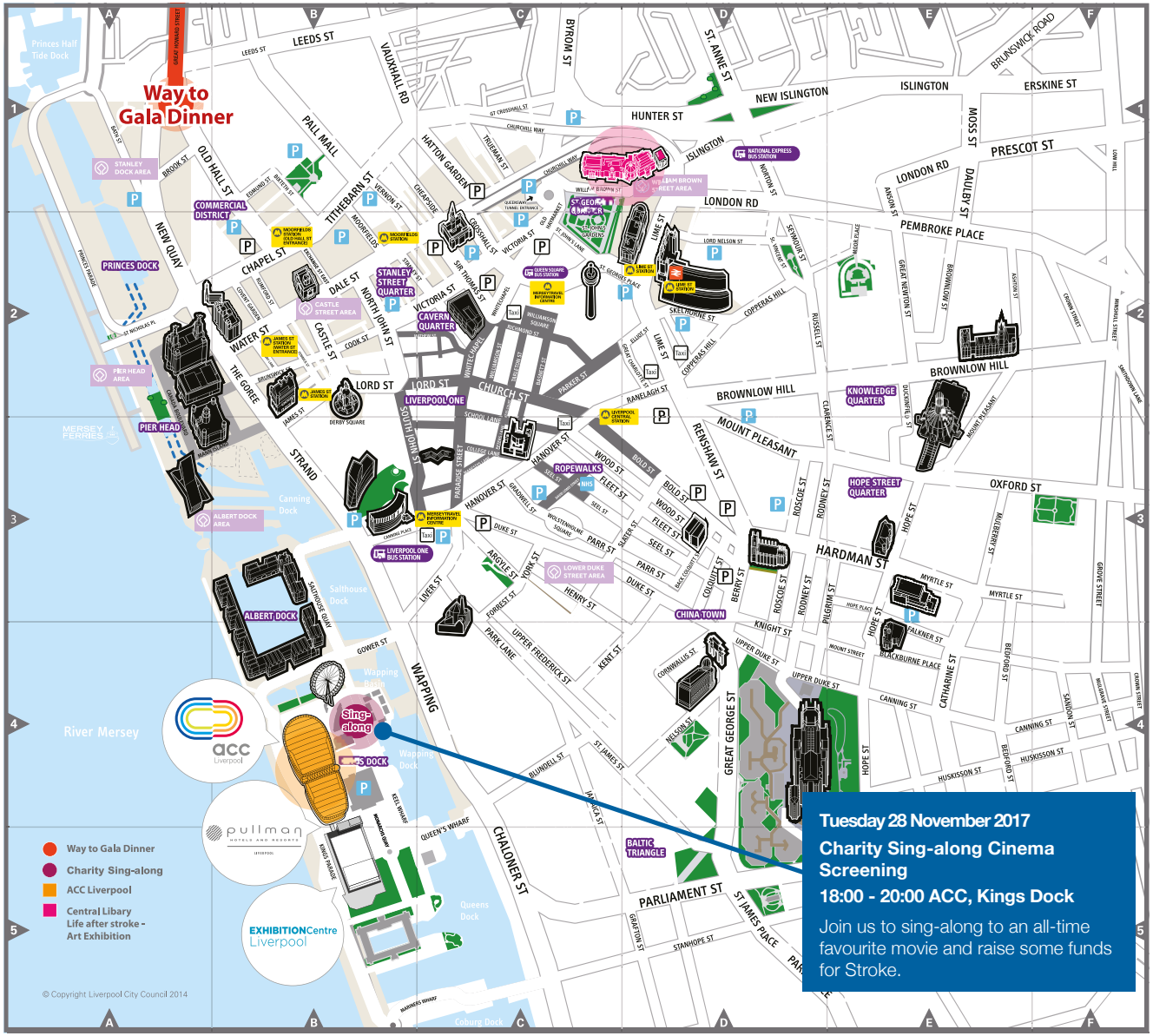


Registration Foyer

Exhibition, Poster Tours and Refreshments



ACC Location Map



For your eligible patients with NVAF:

ONCE-DAILY LIXIANA®▼

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- Superior reduction in major bleeding vs. well-managed warfarin[1]
- Proven efficacy – Comparable to well-managed warfarin in the prevention of stroke/SEE[1]
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The primary safety endpoint was the incidence of adjudicated major bleeding as defined by the International Society on Thrombosis and Haemostasis (ISTH)[1,5].
*Following initial use of heparin for at least 5 days in VTE.

Indicated for:[2]

Prevention of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation (NVAF) with one or more risk factors, such as congestive heart failure, hypertension, age ≥75 years, diabetes mellitus, prior stroke or transient ischaemic attack (TIA)

Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adults

LIXIANA▼ (edoxaban) 60mg/30mg/15mg film coated tablets
See summary of product characteristics prior to prescribing for full list of adverse events

Presentation: 60 mg (yellow) / 30 mg (pink)/ 15mg (orange) edoxaban film coated tablets (as tosilate). **Indications:** Prevention of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation (NVAF) with one or more risk factors, such as congestive heart failure, hypertension, age ≥ 75 years, diabetes mellitus, prior stroke or transient ischaemic attack (TIA) and treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE), and prevention of recurrent DVT and PE in adults. **Posology and method of administration:** *NVAF* -The recommended dose is 60 mg edoxaban once daily with or without food. Therapy with edoxaban in NVAF patients should be continued long term. *VTE* - The recommended dose is 60 mg edoxaban once daily following initial use of parenteral anticoagulant for at least 5 days with or without food. Duration of therapy (at least 3 months) should be based on risk profile of the patient. For NVAF and VTE the recommended dose is 30 mg edoxaban once daily in patients with one or more of the following clinical factors: moderate or severe renal impairment (creatinine clearance (CrCL) 15 - 50 mL/min), low body weight ≤ 60 kg and / or concomitant use of the following P-glycoprotein (P -gp) inhibitors: ciclosporin, dronedarone, erythromycin, or ketoconazole. The 15 mg dose of edoxaban is not indicated as monotherapy, and should only be used during a switch from edoxaban to VKA (see SmPC for full details). Edoxaban can be initiated or continued in patients who may require cardioversion. For transoesophageal echocardiogram guided cardioversion in patients not previously treated with anticoagulants, edoxaban should be started at least 2 hours before cardioversion to ensure adequate anticoagulation. Cardioversion should be performed no later than 12 hours after the dose of edoxaban on the day of the procedure. Confirmation should be sought prior to cardioversion that the patient has taken edoxaban as prescribed. If a dose of edoxaban is missed, the dose should be taken immediately and then continued once daily on the following day. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients; clinically significant active bleeding. Hepatic disease associated with coagulopathy and clinically relevant bleeding risk. Lesion or condition, if considered to be a significant risk for major bleeding. This may include current or recent gastrointestinal (GI) ulceration, presence of malignant neoplasms at high risk of bleeding, recent brain or spinal injury, recent brain, spinal or ophthalmic surgery, recent intracranial haemorrhage, known or suspected oesophageal varices, arteriovenous malformations, vascular aneurysms or major intraspinal or intracerebral vascular abnormalities. Uncontrolled severe hypertension. Concomitant treatment with any other anticoagulants e.g. UFH, low molecular weight heparins, heparin derivatives (fondaparinux, etc.), VKA or NOACs except under specific circumstances of switching oral anticoagulant therapy or when UFH is given at doses necessary to maintain an open central venous or arterial catheter. Pregnancy and breast feeding. **Special warnings and precautions for use:** Haemorrhagic risk: Use with caution in patients with increased risk of bleeding such as elderly on ASA and should be discontinued if severe haemorrhage occurs. The anticoagulant effect of edoxaban cannot be reliably monitored with standard laboratory testing. A specific anticoagulant reversal agent for edoxaban is not available. Haemodialysis does not significantly clear edoxaban. Renal impairment: Renal function should be assessed prior to initiation of edoxaban and afterwards when clinically indicated. Not recommended in patients with end stage renal disease or on dialysis. Renal function and NVAF: A trend towards decreasing efficacy with increasing creatinine clearance was observed for edoxaban compared to well-managed warfarin. Edoxaban should only be used in patients with NVAF and high creatinine clearance after a careful benefit risk evaluation. Hepatic impairment: Not recommended in patients with severe hepatic impairment and should be used with caution in patients with mild or moderate hepatic impairment. Edoxaban should be used with caution in patients with elevated liver enzymes (ALT/AST > 2 x ULN) or total bilirubin ≥ 1.5 x ULN. *Surgery or other interventions*: discontinue edoxaban at least 24 hours before the procedure. If the procedure cannot be delayed, the increased risk of bleeding should be weighed against the urgency of the procedure. Edoxaban should be restarted as soon as haemostasis is achieved. *Prosthetic heart valves and moderate to severe mitral stenosis*: Not recommended. *Haemodynamically unstable PE patients or patients who require thrombolysis or pulmonary embolectomy*: Not recommended. *Patients with active cancer*: Not recommended. **Drug interactions:** The *P-gp inhibitive* ciclosporin, dronedarone, erythromycin, or ketoconazole result in increased concentration of edoxaban and a dose reduction of 30mg is required. Edoxaban should be used with caution with concomitant *P-gp inducers* (e.g. phenytoin, carbamazepine, phenobarbitol or St John's Wort). Concomitant high dose ASA (325mg) or chronic NSAIDs is not recommended. **Undesirable effects:** Common: anaemia, dizziness, headache, epistaxis, abdominal pain, lower GI haemorrhage, upper GI haemorrhage, oral/pharyngeal haemorrhage, nausea, blood bilirubin increased, gamma GT increased, cutaneous soft tissue haemorrhage, rash, pruritus, macroscopic haematuria/urethral haemorrhage, vaginal haemorrhage, puncture site haemorrhage, liver function test abnormal. Uncommon: hypersensitivity, intracranial haemorrhage (ICH), intraocular haemorrhage, other haemorrhage, haemoptysis, surgical site haemorrhage. Rare: anaphylactic reaction, allergic oedema, subarachnoid haemorrhage, pericardial haemorrhage, retroperitoneal haemorrhage, intramuscular haemorrhage (no compartment syndrome), intra-articular haemorrhage, subdural haemorrhage, procedural haemorrhage. **Legal category: POM Package quantities and basic NHS costs: 60mg / 30mg – 28 tablets £49.00 15mg – 10 tablets £17.50 Marketing Authorisation (MA) number: EU/1/15/993/001-16 MA holder: Daiichi Sankyo Europe GmbH, Zielstattstrasse 48, 81379 Munich, Germany**

Date of prep of PI: July 2017 I EDX/17/0140

Adverse events should be reported. Reporting forms and information can be found at yellowcard.mhra.gov.uk. Adverse events should also be reported to Daiichi Sankyo UK Medical Information on 0800 028 5122, medinfo@daiichi-sankyo.co.uk

References: 1. Giugliano RP *et al. N Eng J Med* 2013;369(22):2093–2104. **2.** LIXIANA® Summary of Product Characteristics. **3.** NICE Technology appraisal guidance [TA355]. September 2015. **4.** Scottish Medicines Consortium advice. SMC No. (1095/15). October 2015. **5.** Schulman S *et al. J Thromb Haemost* 2005;3(4):692–694.

www.lixiana.co.uk

Daiichi-Sankyo

Tuesday 28 November 2017 - Training Day

Times	EXHIBITION HALL	Auditorium	3B	1B, 3A, 4A+4B, 11B+C, 12
10:00	Registration, Exhibition & Refreshments			10:00-12:15 National Stroke CLAHRC Meeting Room 12 *(invitation only)*
11:45 - 12:30	Exhibition & Lunch			
12:30 - 14:30		BASP Training (Part 1)	Stroke Research Training Stream (Part 1)	Nursing and Rehabilitation Training Workshops – Research into Practice see pages 17-18 for more detail
14:30 - 15:00	Exhibition & Refreshments			
15:00 - 17:00		BASP Training (Part 2)	Stroke Research Training Stream (Part 2)	Nursing and Rehabilitation Training Workshops – Research into Practice see pages 17-18 for more detail
17:00 - 18:00	Welcome Drinks Reception	17:00 - 18:00: BASP AGM		17:00 - 18:00: NSNF AGM (Room 12)
18:00 - 20:00		Sing for Stroke: Sing Along Cinema Showing		

For the full Nursing and Rehabilitation Workshop schedule please see pages 17-18

Wednesday 29 November 2017 - Main Programme Day 1

Times	EXHIBITION HALL	Auditorium	Room 3	Room 11	Room 4	Room 12
08:00 - 08:50	Exhibition & Refreshments	Satellite Symposium: Bayer	Breakfast Session: BASP trainee abstracts	Breakfast Session: EuroHYP Investigator Meeting		
09:00 - 10:30		Welcome & Plenary 1: Stroke service reconfiguration: the challenges, the outcomes and the future?				
10:30 - 11:45	Exhibition & Refreshments (10:45 Poster Tours)		10:50 - 11:40: TRIDENT trial meeting	10:50 - 11:40: Involving the voices of the UK Stroke Assembly in research – the how and why?	10:50 - 11:40: GHRG for Improving Stroke Care in India	
11:45 - 13:00		Parallel 1A: Debate - further down the line: who is responsible for longer term stroke care?	Parallel 1B: Clot-busting: what you need to know about mechanical thrombectomy and its implementation	Parallel 1C: What's new in aphasia?	Parallel 1D: Brag and steal	
13:00 - 14:15	Exhibition & Lunch (13:30 SOAPBOX SCIENCE)		13:30 - 14:10: ATTEST-2, PISTE- AI, PRACTISE & TEMPO-2 - Joint Trials Meeting	13:30 - 14:10: CONVINCE Trial Investigators Update	13:30 - 14:10: Service delivery models for supporting patients after stroke	13:30 - 17:15 Primary Care and Adult Social Care Training Workshops - Long Term Care (PRE BOOKING ONLY)
14:15 - 15:30		Parallel 2A: Upper limb rehabilitation	Parallel 2B: High scoring abstracts	Parallel 2C: Trials of early mobility – beyond the headlines	Parallel 2D: Emotional wellbeing after stroke	
15:30 - 16:30	Exhibition & Refreshments (16:00 SOAPBOX SCIENCE)		15:40 - 16:20: FOCUS, RESTART, and SoSTART Investigators Meeting	15:40 - 16:20: Tenecteplase versus Alteplase for Stroke Thrombolysis Evaluation (TASTE) Trial	15:40 - 16:20: It couldn't happen to us - a short play	
16:30 - 17:15		Plenary 2: Princess Margaret Memorial Lecture - why clinical research is essential to high quality services				
17:20 - 18:00		17:20 - 18:00 Satellite symposium: Allergan		17:20 - 18:00: Joint TICH-2/RIGHT-2 Investigator meeting		
19:00 - midnight	Gala Dinner, Rum Warehouse					

Thursday 30 November 2017 - Main Programme Day 2

Times	EXHIBITION HALL	Auditorium	Room 3	Room 11	Room 4
08:00 - 08:30	Exhibition				
08:30 - 09:45		Parallel 3A: Diagnosis and prevention of pneumonia	Parallel 3B: Promoting and measuring self efficacy and self-management	Parallel 3C: State of the art in secondary prevention after ICH	Parallel 3D: Improving quality of life with post stroke visual impairment
09:45 - 10:45	(10:00 Poster Tours) Exhibition & Refreshments (10:25 SOAPBOX SCIENCE)		10:00 - 10:40: Stroke survivors' perspective: loss of the sense of self and social identity	10:00 - 10:40: Rates, Risks and Routes to Reduce Vascular Dementia' TSA/BHF/ Alz Soc ACTVaD study meeting	10:00 - 10:40: NIHR Industry Meeting
10:45 - 12:00		Parallel 4A: Pre-hospital stroke care	Parallel 4B: High scoring abstracts	Parallel 4C: Gait and Mobility Rehabilitation	Parallel 4D: Dysarthria after stroke – everything you wanted to know about impact, research and clinical practice
12:00 - 13:00	Exhibition & Lunch	12:10 - 12:50: Satellite symposium: Daiichi Sankyo	12:20 - 12:50: SSNAP quality improvement workshop	12:20 - 12:50: Impact of Visual Impairment after Stroke (IVIS) Study	12:20 - 12:50: Dysphagia: new horizons
13:00 - 14:30	CLOSED	Plenary 3: What's hot and what's next?			

Tuesday 28 November 2017 - Nursing and Rehabilitation Training Workshops

Times	Room 4	Room 12
Slot 1 12:30 - 13:25	Re-thinking falls risk and management after stroke	Relationship changes after stroke: psychological tips for the whole team
10 minute changeover		
Slot 2 13:35 - 14:30	Repeat of above workshops	
Refreshment Break: 14:30 - 15:00		
Slot 3 15:00 - 15:55	How can we promote plasticity after stroke? Motor and sensory adjuncts to therapy	Using apps and websites to rehabilitate post stroke visual impairments
10 minute changeover		
Slot 4 16:05 - 17:00	Repeat of above workshops	

– At a Glance

Room 11 B+C	Room 3A	Room 1B
Oral care: tailoring individual care needs	Upper limb neurorehabilitation	12:40 – 14:30 DEBATE Session: This house believes that machines have NO part to play in therapy
Recognising stroke and stroke mimics	‘I never felt this tired before’ Fatigue - is there anything clinicians can do?	15:10 – 17:00 Unilateral spatial neglect: a practical workshop on standardised functional assessment and prism adaptation training

Training Day – Tuesday 28 November

(The UKSF reserves the right to amend speakers and content within this preliminary programme)

10:00 – 17:00	**Registration open** Refreshments served from 10:00 in the Exhibition Hall (Hall 2 Lower Level) Lunch served at 11:45-12:30 in the Exhibition Hall (Hall 2 Lower Level)
10:00 – 18:00	**Exhibition open (Hall 2 Lower Level)**
10:00 – 12:15 Room 12	**National Stroke CLAHRC Meeting *(invitation only)*** **Chair:** Dr Rebecca Fisher *(Senior Lecturer, University of Nottingham)*

Training Stream 1

12:30 – 14:30	**British Association of Stroke Physicians Training (Part 1)** Auditorium
	Chairs: Dr Declan O'Kane *(Stroke Physician, Brighton, BASP Education and Training Committee Chair)* Professor Helen Rodgers *(President of British Association of Stroke Physicians & Clinical Professor of Stroke Care, Newcastle University)* Dr Iain McGurgan *(JRH, Oxford, BASP Education and Training Trainee Rep)*
	Case presentations Dr Mark Vettasseri *(Consultant Stroke Physician, Nottingham City Hospital)* Dr Gargi Banerjee *(Clinical Research Associate, UCL)* Dr Madan Meegada *(ST7, Sheffield Teaching Hospitals)*
	Evidence based update for Stroke Physicians Dr Ajay Bhalla *(Consultant Stroke Physician, St Thomas' Hospital)*
14:30 – 15:00	**EXHIBITION & REFRESHMENTS - Hall 2**
15:00 – 17:00	**British Association of Stroke Physicians Training (Part 2)** Auditorium
	Chairs: Dr Declan O'Kane *(Stroke Physician, Brighton, BASP Education and Training Committee Chair)* Professor Helen Rodgers *(President of British Association of Stroke Physicians & Clinical Professor of Stroke Care, Newcastle University)* Dr Iain McGurgan *(JRH, Oxford, BASP Education and Training Trainee Rep)*

Strokes in the brainstem
Dr Simon Hart *(Consultant Stroke Physician, University of Edinburgh)*

CTA and CT perfusion for stroke physicians
Dr Anthony Pereira *(Consultant Neurologist, St George's Hospital)*

Robotics related to stroke rehabilitation
Dr Hermano Igo Krebs *(Ph.D. IEEE Fellow, MIT, Mechanical Engineering Department)*

Training Stream 2

12:30 – 14:30	**Stroke Research Training Stream (Part 1) – Pre Booking Required** Room 3B

Chair: Dr Kate Holmes *(Assistant Director of Research, Stroke Association)*

Session Overview

The stream is aimed at those who want to get involved in research for the first time as well as those who have already started in a research career. Researchers at all career levels are welcome; we aim to provide engaging activities that are useful for all.

Speakers from different backgrounds will share their stroke research journey and share insight of the research profession. The interactive workshop will look at how to successfully engage stroke survivors in research, review and discuss posters and grant applications, and give the opportunity to share research ideas. The Stroke Association's Lecturers, Senior Lecturers and Readers will facilitate discussions. The aim is to provide a friendly, fun and supportive environment which will allow you to have an opportunity to practice critical assessment of research, discuss research ideas with experts, receive career advice and grow networks.

14:30 – 15:00	**EXHIBITION & REFRESHMENTS** **Hall 2**
15:00 – 17:00	**Stroke Research Training Stream (Part 2) – Pre Booking Required** Room 3B

Chair: Dr Kate Holmes *(Assistant Director of Research, Stroke Association)*

Training Stream 3 II >> >

Nursing and Rehabilitation Training Workshops – Research Into Practice

Delegates can choose to attend four workshops in total (one workshop from each set) Please note some workshops are repeated. These workshops feature practical activities to help you to support stroke survivors.

Spaces on these workshops are limited due to the nature of the sessions, therefore delegates are asked to arrive 5-10 minutes before the workshop begins and form a queue, spaces will be allocated on a first-come-first-served basis.

Please see the nursing/rehabilitation workshop timetable for a full schedule

A refreshment break is scheduled from 14:30-15:00 in the Exhibition Hall

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12:30 – 13:25

Re-thinking falls risk and management after stroke

Room 4

Chair: Professor Pip Logan *(Professor of Rehabilitation Research, Royal College of Occupational Therapists Specialist Section Neurological Practice)*
Speakers: Dr Mary Walsh *(Postdoctoral Research Fellow and Honorary Lecturer in Physiotherapy, Royal College of Surgeons in Ireland)*
Kate Robertson *(Assistant Professor, University of Nottingham)*

Repeated
13:35 – 14:30

Session Overview

The current evidence for methods of falls-prediction and prevention will be presented. Results from qualitative research around stroke survivors own experiences of living with falls-risk will also be described. Participants of this workshop will be challenged to reflect and discuss their understanding of falls-risk specifically in relation to stroke survivors living in the community. Problem-solving through different clinical scenarios will be facilitated. Participants will be encouraged to share their experience and knowledge of specific management strategies and to consider how they would work in practice.

12:30 – 13:25

Relationship changes after stroke: psychological tips for the whole team

Room 12

Chair: Dr Shirley Thomas *(Associate Professor in Rehabilitation Psychology, University of Nottingham)*
Speakers: Dr Posy Knights *(Lead Clinical Psychologist for Stroke, Nottinghamshire Healthcare NHS Foundation Trust)*
Dr Tabatha Kon *(Senior Specialist Clinical Psychologist In Neuropsychology, Nottinghamshire Healthcare NHS Foundation Trust)*

Repeated
13:35 – 14:30

Session Overview
It is easy for close relationships to deteriorate in the months following a stroke. This workshop draws upon both research in this area and couple's therapy to provide small interventions, questions that can be slipped into everyday conversations with patients, partners and carers that may help couples keep their relationships on track. Learn about relationship dynamics and how key communications can help to keep relationships strong through the challenges of a major unplanned life event.

12:30 – 13:25

Oral Care: Tailoring individual care needs

Room 11 B+C

Chair: Claire Fullbrook-Scanlon *(Matron Lead/Nurse Senior Lecturer, Royal United Foundation Trust, Bath and University of Western England)*
Speaker: Dr Heather Gray *(Senior Lecturer, School of Health and Life Sciences, Glasgow Caledonian University)*

Repeated
13:35 – 14:30

Session Overview
The World Health Organisation (2006) highlights that oral health is an essential element of general health and emphasises that trained non-dental healthcare professionals play an important role in oral healthcare. This workshop will take nursing and rehabilitation professionals through a comprehensive, evidence informed oral health care assessment and protocol that can be tailored for individual patients' requirements whether in hospital or community based settings. The assessment and protocol were developed for use in the Stroke Oral healthCare pLan Evaluation (SOCLE): phase II stepped-wedge cluster randomised controlled trial.

12:30 – 13:25

Upper limb neurorehabilitation

Room 3A

Chair: Therese Lebedis *(Consultant AHP in Stroke, NHS Grampian)*
Speakers: Professor Nick Ward *(Professor of Clinical Neurology and Neurorehabilitation, The National Hospital for Neurology and Neurosurgery & UCL Institute of Neurology, Queen Square)*
Kate Kelly *(Consultant Occupational Therapist, National Hospital for Neurology & Neurosurgery, Queen Square)*
Fran Brander *(Consultant Physiotherapist, National Hospital for Neurology & Neurosurgery, Queen Square)*

Repeated
13:35 – 14:30

Session Overview
Management of the upper limb after stroke can be complex. Evidence is emerging that high intensity, high dose therapy, whilst avoiding complications, can have a clinically meaningful impact on the post-stroke upper limb. Here, we will explore the key factors important for delivering a step change in the recovery profiles of people suffering from stroke, and describe how we have begun to implement this in the Queen Square Upper Limb Neurorehabilitation Programme.

12:40 - 14:30

This house believes that machines have NO part to play in therapy

Room 1B

Chair: Professor Avril Drummond *(Outgoing Chair of UK Stroke Forum; Occupational Therapist and Professor of Healthcare Research, University of Nottingham)*
Speakers: Professor Jane Burridge *(President of ACPIN, Professor of Restorative Neuroscience, University of Southampton)*
Dr Rebecca Palmer *(Senior Lecturer, University of Sheffield)*

VS

Dr Louise Connell *(Reader in Rehabilitation, University of Central Lancashire)*
Professor Fiona Jones *(Professor of Rehabilitation, St George's University of London and Kingston University)*

Session Overview
Whilst we are all convinced that a key component of rehabilitation post-stroke requires therapy supported repetitive functional task practice, it is clear that in times of austerity and cuts that alternative approaches to providing therapy are required. Some people believe that robotics and other technologies may provide cost-effective solutions and so reduce the number of therapists required to deliver stroke rehabilitation. This house believes that machines have no part to play in the provision of therapy, and insist that therapy should be provided by, or at least supported by, therapists.

15:00 – 15:55

How can we promote plasticity after stroke? Motor and sensory adjuncts to therapy

Room 4

Chair: Dr Ulrike Hammerbeck *(Research Physiotherapist, University of Manchester)*
Speakers: Professor Frederike van Wijck *(Professor in Neurological Rehabilitation, Glasgow Caledonian University)*
Dr David Punt *(Senior Lecturer, School of Sport, Exercise and Rehabilitation Sciences, University of Birmingham)*

Repeated
16:05 – 17:00

Session Overview
Neuroplasticity is the brain's ability to change. Rehabilitation aims to capitalise on this plasticity to achieve the best possible recovery, i.e. by using an array of motor and sensory adjuncts to therapy. The aim of this workshop is to summarise the evidence for these priming techniques and promote discussion of how they may be integrated into clinical practice to optimise therapy outcomes.

15:00 – 15:55

Using apps and websites to rehabilitate post-stroke visual impairments

Room 12

Chair: Dr Lauren Hepworth *(Research Orthoptist, University of Liverpool)*

The use of technology in visual rehabilitation
Alexander Green *(Orthoptist in Stroke Care, Betsi Cadwaladr University Health Board)*

Repeated
16:05 – 17:00

Session Overview
Overview of the applications and websites which are available to provide therapy and information resources for patients, families, carers and professionals in the area of post stroke visual impairment.

15:00 – 15:55

Recognising stroke and stroke mimics

Room 11B+C

Chair: Dr Christopher Price *(Clinical Reader in Stroke Medicine, Newcastle University)*

Is it a stroke? Identification scores in practice
Dr Matthew Rudd *(ST7 Stroke Medicine / Geriatric Medicine / GIM, Health Education North East / Northumbria Healthcare NHS FT)*

But is it a mimic?
Graham McClelland *(Research Paramedic, North East Ambulance Service, NHS Foundation Trust)*

Interactive case presentations
Dr Louise Southern *(Stroke Fellow, Northumbria NHS Trust)*

Repeated
16:05 – 17:00

Session Overview
Stroke identification is challenging and there are a number of symptom checklists to help identify the commonest presentations. This session will present an overview of the pros and cons of different approaches to early stroke identification, and consider additional information which will specifically aid identification of stroke mimic conditions. There will be interactive case presentations to illustrate learning.

15:00 – 15:55

'I have never felt this tired before'
Fatigue - is there anything clinicians can do?

Room 3A

Chair: Professor Maree Hackett *(Professor of Epidemiology, UCLAN and The George Institute for Global Health, UNSW)*
Speaker: Professor Avril Drummond *(Outgoing Chair of UK Stroke Forum; Occupational Therapist and Professor of Healthcare Research, University of Nottingham)*

Repeated
16:05 – 17:00

Session Overview
Fatigue is common after stroke. However despite a wealth of publications and research on the topic, there are relatively few clinical recommendations for treatment and management. The aim of this session is to explore possible coping strategies and to provide practical guidance for clinicians.

15:10 – 17:00	**Unilateral spatial neglect: a practical workshop on standardised functional assessment and prism adaptation training**

Chair: Dr Charlie Chung *(Occupational Therapist, NHS Fife)*
Speaker: Dr Peii Chen (*Research Scientist, Kessler Foundation, United States of America)*
Dr Kimberly Hreha *(Post-Doctoral Fellow, University of Washington, United States of America)*

Session Overview
Spatial neglect commonly occurs after stroke. It is the failure or slowness to attend, orient, and/or make movements towards stimuli in the contra-lesional side of space. Prism adaptation treatment is one of the most promising interventions. We will highlight spatial neglect's clinical impact, demonstrate prism adaptation, and discuss our ongoing efforts in clinical implementation. In addition, we will introduce the KF-NAP, a standardized method using the Catherine Bergego Scale assessing neglect symptoms during daily activities.

17:00 – 18:00	**Welcome Drinks Reception - Hall 2**

An excellent opportunity to network with colleagues over a welcome drink and canapés whilst enjoying entertainment and the North West Stroke Survivors Art Exhibition.

17:00 – 18:00	**British Association of Stroke Physicians (BASP) AGM** Auditorium

Chair: Professor Helen Rodgers *(President of British Association of Stroke Physicians & Clinical Professor of Stroke Care, Newcastle University)*

17:00 – 18:00	**National Stroke Nursing Forum (NSNF) AGM** Room 12

Chair: Dr Liz Lightbody *(Chair of National Stroke Nursing Forum, Reader in Health Services Research, University of Central Lancashire)*

18:00 - 20:00	**Sing for Stroke: Sing Along Movie Showing – Grease or Mamma Mia!** Auditorium

Join us with your colleagues for a sing along cinema showing of a popular film with popcorn and light snacks. Delegates can vote on which film they would like to watch via the UKSF Conference App!

All audience members will be entered into a prize draw to win a free delegate place at the 13th UK Stroke Forum Conference, 4 - 6 December 2018 in Telford.

Main Conference Day 1 – Wednesday 29 November

08:00 – 18:00 **Registration and Exhibition open**

Registration is open from 08:00 in the Entrance Foyer
Refreshments served from 08:00 in the Exhibition Hall (Hall 2 Lower Level)

Breakfast Sessions

08:00 – 08:50 **Satellite Symposium: Bayer**
Auditorium

Chair: Dr David Hargroves *(Consultant Physician and Clinical Lead for Stroke Medicine at East Kent Hospital University Foundation Trust)*

Speakers: Dr Kneale Metcalf *(Consultant Stroke Physician, Norfolk and Norwich University Hospital)*
Ian Evans *(Consultant Nurse for Stroke, Somerset Partnership NHS Foundation Trust)*

08:00 – 08:50 **BASP – trainee abstract presentations**
Room 3

Chair: Professor Rustam Al-Shahi Salman *(Professor of Clinical Neurology, University of Edinburgh)*

08:00 - 08:05 **Welcome**

08:05 – 08:15 **Socioeconomic disparities in stroke incidence, quality of care and mortality: a nationwide registry based cohort study of 44 million adults in England**
Dr Ben Bray *(Public Health Registrar, Research Director, SSNAP)*

08:15 – 08:25 **Glyceryl trinitrate lowers blood pressure and blood pressure variability in acute stroke patients presenting with lacunar syndromes**
Dr Jason Appleton *(Clinical Research Fellow in Stroke Medicine, Stroke Trials Unit, University of Nottingham)*

08:25 – 08:35 **Clinical frailty is independently associated with poorer neurological recovery after stroke thrombolysis**
Dr Nicholas Evans *(Clinical Research Fellow, University of Cambridge)*

08:35 – 08:45 **Potentially avoidable morbidity associated with the lack of a 24/7 thrombectomy service in one healthboard: observational study of a prospective thrombolysis call log**
Dr Neil Hunter *(Specialist Registrar Stroke Department, Royal Infirmary of Edinburgh)*

08:45 – 08:50 **Questions and Answers**

08:00 – 08:50	**EuroHYP Investigator Meeting** Room 11
	Chair: Professor Nikola Sprigg *(Professor of Stroke Medicine, Faculty of Medicine and Health Sciences, University of Nottingham)*

Plenary 1

09:00 – 10:30	**Stroke service reconfiguration: the challenges, the outcomes and the future?** Auditorium
	Chairs: Professor Peter Langhorne *(Chair of UK Stroke Forum, Professor of Stroke Care, University of Glasgow)* Professor Tony Rudd *(National Clinical Director for Stroke NHS England)*
09:00 – 09:10	**Welcome from the UK Stroke Forum Chair** Professor Peter Langhorne *(Chair of UK Stroke Forum, Professor of Stroke Care, University of Glasgow)*
09:10 – 09:20	**NHS England update on the future of stroke care (via pre-recorded video)** Professor Sir Bruce Keogh *(Medical Director for NHS England)*
09:20 – 09:30	**Stroke survivor perspective** Michael Lynagh *(Retired Rugby Player, Stroke Survivor)*
09:30 – 09:45	**Stroke service reconfigurations: 'what works and at what cost?'** Professor Steve Morris *(Professor of Health Economics, UCL)*
09:45 – 10:00	**Stroke service reconfigurations: 'understanding implementation and sustainability'** Professor Naomi Fulop *(Professor of Health Care Organisation and Management, UCL)*
10:00 – 10:15	**Centralising stroke services in Greater Manchester - lessons learnt** Sarah Rickard *(Greater Manchester Stroke Operational Delivery Network Manager at Salford Royal Foundation Trust)*
10:15 – 10:30	**Questions and answers** *This session will include the Lifetime Achievement Award being presented to Dr John Bamford*
10:30 – 11:45	**REFRESHMENTS & EXHIBITION - Hall 2**
10:45 – 11:35	**POSTER TOURS**
10:50 – 11:40	**TRIDENT trial meeting** Room 3
	Chair: Professor Rustam Al-Shahi Salman *(Professor of Clinical Neurology, University of Edinburgh)*

10:50 – 11:40	**Involving the voices of the UK Stroke Assembly in research – the how and why?** Room 11
	Chair: Nirjay Mahindru *(Chief Executive, InterAct Stroke Support)* Find out what stroke survivors think about research, why you should be involving them in your studies, what are the do's and don'ts for involving the public, and discover what support is available to help you involve those affected by stroke in your research.
10:50 – 11:40	**GHRG for Improving Stroke Care in India** Room 4
	Chair: Professor Dame Caroline Watkins *(Chair Elect of UK Stroke Forum, Professor of Stroke and Older People's Care, University of Central Lancashire)*

Parallel Sessions 1

11:45 – 13:00	**Parallel Session 1A** **DEBATE: Further down the line: who is responsible for longer term stroke care?** Auditorium
>	**Chair:** Dr Martin James *(Consultant Stroke Physician, Royal Devon & Exeter Hospital)*
11:45 – 11:50	**Welcome**
11:50 – 12:50	**Primary care** Professor Jonathan Mant *(Professor of Primary Care Research, University of Cambridge)* Dr Deborah Lowe *(Consultant Stroke Physician and Geriatrician, Clinical Director for Medicine, Stroke Lead Northwest Coast Strategic Clinical Network, Wirral University Teaching Hospital NHS Foundation Trust)* **Secondary care** Dr Matthew Fay *(Medical Director of the NHS Practitioner Health Programme, GP, Westcliffe Medical Practice, Bradford)* Dr David Hargroves *(Consultant/Physician, East Kent Hospital, University Foundation Trust, Clinical Lead for Stroke South East Coast)*
12:50 - 13:00	**Questions and answers**

11:45 – 13:00	**Parallel Session 1B** **Clot-busting: what you need to know about mechanical thrombectomy and its implementation** Room 3
	Chairs: Professor David Werring *(Professor of Clinical Neurology, UCL, London, Consultant Neurologist, University College Hospitals NHS Foundation Trust)* Professor Martin Dennis *(Professor of Stroke Medicine & Consultant Stroke Physician, University of Edinburgh / Edinburgh Hospitals)*
11:45 – 11:50	**Welcome**
11:50 – 12:05	**A brief overview of the evidence** Professor David Werring *(Professor of Clinical Neurology, UCL, London, Consultant Neurologist, University College Hospitals NHS Foundation Trust)*
12:05 – 12:20	**Implementation: challenges for urban and non-urban (rural) settings** Dr Ian Rennie *(Consultant Interventional Neuroradiologist, Belfast Health and Social Care Trust)*
12:20 – 12:35	**Thrombectomy: current state of the art in practice** Professor Phil White *(Professor of Interventional and Diagnostic Neuroradiology, Newcastle University)*
12:35 – 12:50	**Thrombectomy: uncertainties and new frontiers** Professor Keith Muir *(SINAPSE Professor of Clinical Imaging & Consultant Neurologist, University of Glasgow)*
12:50 – 13:00	**Questions and answers**

11:45 – 13:00	**Parallel Session 1C** **What's new in aphasia?** Room 11
	Chair: Professor Sue Pownall *(Head of Speech and Language Therapy & Clinical Lead in Dysphagia, Sheffield Teaching Hospitals NHS Foundation Trust)*
11:45 – 11:50	**Welcome**
11:50 – 12:10	**New findings: Intensive speech and language therapy in patients with chronic aphasia after stroke (RCT)** Dr Stefanie Abel *(Clinical Senior Lecturer in Cognitive Neuroscience of Speech and Language, Neuroscience and Aphasia Research Unit (NARU), University of Manchester)*

12:10 – 12:30 **REhabilitation and recovery of peopLE with Aphasia after StrokE – an update on behalf of the RELEASE international collaboration**
Professor Marian Brady *(Professor of Stroke Care & Rehabilitation, Nursing, Midwifery and Allied Health Professions Research Unit, Glasgow Caledonian University)*

12:30 – 12:50 **The use of technology in aphasia therapy: EVA Park and virtual reality**
Professor Jane Marshall *(Professor, City, University of London)*

12:50 – 13:00 **Questions and answers**

11:45 – 13:00 **Parallel Session 1D**
Brag and steal
Room 4

Chair: Professor Marion Walker *(Professor in Stroke Rehabilitation, Associate Pro Vice-Chancellor, Equality, Diversity and Inclusion, University of Nottingham)*

11:45 – 11:48 **Welcome**

11:48 – 12:00 **Acute stroke referral and triage: a 6 month review of a nurse led service**
Jonathon Britton *(Brain Attack Nurse Specialist, Leeds Teaching Hospitals)*

12:00 – 12:12 **The effects of stroke severity on door-to-needle time delays – A retrospective analysis**
Dr Melanie Turner *(Stroke Association Postdoctoral Research Fellow, University of Aberdeen)*

12:12 - 12:24 **Cardiac monitoring methods to detect paroxysmal atrial fibrillation (PAF) following acute ischaemic stroke: A UK wide survey of stroke physicians**
Dr Philip Thomas *(Senior Clinical Fellow Stroke, Greater Manchester Comprehensive Stroke Centre, Department of Medical Neurosciences, Salford Royal Foundation Trust)*

12:24 – 12:36 **An effective model to improve outcome in TIA clinic**
Dr Amy Hillarious *(Registrar, Department of Stroke Services, Nottingham City Hospital)*

12:36 – 12:48 **The Queen Square intensive upper limb rehabilitation program – what's in the box?**
Fleur Vella *(Physiotherapist, St Pancras Hospital, London)*

12:48 – 13:00 **A collaborative community and acute services pilot project to explore the impact of a two week stroke review on the outcomes for patients discharged from a hyperacute stroke unit (HASU) without identified ongoing rehabilitation needs**
Jennifer Crow *(Clinical Specialist Occupational Therapist in Stroke, Imperial College Healthcare NHS Trust)*

13:00 – 14:15 **LUNCH & EXHIBITION - Hall 2**

13:30 – 13:45 **SOAPBOX SCIENCE - Bayer**

Speaker: Dr Sadia Khan *(Consultant Cardiologist, Chelsea and Westminster Hospital NHS Foundation Trust)*

13:30 – 14:10 **ATTEST-2, PISTE- AI, PRACTISE & TEMPO-2 - Joint Trials Meeting**
Room 3

Chair: Professor Keith Muir *(SINAPSE Professor of Clinical Imaging & Consultant Neurologist, University of Glasgow)*

13:30 – 14:10 **CONVINCE Trial Investigators Update**
Room 11

Chair: Dr Christopher Price *(Clinical Reader in Stroke Medicine, Newcastle University)*

13:30 – 14:10 **Service delivery models for supporting patients after stroke**
Room 4

Chairs: Kate Charles *(Deputy Head of Operations - North West, Life After Stroke Services, Stroke Association)*
Dr Mark Griffiths *(Consultant Lead Clinical Psychologist, Aintree University Hospital)*

13:30 – 17:15 **Training Stream**
Primary Care Training Workshop – PRE-BOOKING REQUIRED
Room 12

13:30 – 13:40 **Welcome and introductions**
Dr Katie Gallacher *(General Practice and Primary Care, University of Glasgow)*

13:40 – 14:15 **Patient experiences of stroke care in the community and the implications for primary care**
Professor Jonathon Mant *(Professor of Primary Care Research, University of Cambridge)*

14:15 – 14:55 **A practical guide to primary and secondary prevention of stroke**
Dr Matthew Fay *(General Practitioner, The Willows Medical Practice, Trustee AF Association, Trustee Thrombosis UK)*

14:55 – 15:30 **Diagnosis of stroke**
Dr Peter Humphry *(Consultant Neurologist, Walton Centre for Neurology and Neurosurgery, Liverpool)*

16:00 – 17:00 **Interactive Workshops**
Cognitive problems after stroke
Dr Terry Quinn *(Joint Stroke Association/Chief Scientist Office Senior Clinical Lecturer)*

Psychological difficulties experienced by stroke survivors
Dr Fergus Doubal *(Stroke Association, Garfield Weston Foundation Senior Clinical Lecturer)*

17:00 – 17:15 **Q&A and closing remarks**

13:30 – 17:15 **Training Stream**
Social Care Training Workshop – PRE-BOOKING REQUIRED
Room 13

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13:30 – 13:40 **Welcome and introductions**

13:40 – 14:00 **Communication strategies**
Dr Rebecca Palmer *(Speech and Language Therapist, University of Sheffield)*
An exploration of the three main types of communication difficulty and how to select the best strategies and techniques to overcome them

14:00 – 15:30 **Let's communicate**
Josh Murphy *(Stroke Training Officer, Stroke Association)*
A practical session to explore the communication chain and what it feels to have a communication difficulty.

16:00 – 16:20 **Key components of the goal setting process: What are they and why are they important?**
Dr Lesley Scobbie *(HRH The Princess Margaret Stroke Association Clinical Lecturer, Glasgow Caledonian University)*
Goal setting is recommended in stroke clinical guidelines and routinely implemented in practice, but we all tend to do it differently. Using case studies, this talk will explore the key components of goal setting practice and show why they are important.

16:20 – 17:00 **Putting it in motion**
Stroke Training Officers *(Stroke Association)*
This second practical session will show you how to implement best practice strategies and supported conversation techniques to set reablement and recovery goals with communication impaired stroke survivors.

17:00 – 17:15 **Q&A and closing remarks**

Parallel Sessions 2

14:15 – 15:30	**Parallel Session 2A** **Upper limb rehabilitation** Auditorium
>>	**Chair:** Professor Pip Logan *(Professor of Rehabilitation Research, Royal College of Occupational Therapists Specialist Section Neurological Practice)*
14:15 – 14:25	**Welcome**
14:25 – 14:45	**Assessment and rehabilitation for people with upper limb apraxia** Therese Lebedis *(Consultant AHP in Stroke, NHS Grampian)*
14:45 – 15:05	**Implications of the proportional recovery rule for upper limb recovery after stroke** Professor Nick Ward *(Professor of Clinical Neurology and Neurorehabilitation, The National Hospital for Neurology and Neurosurgery & UCL Institute of Neurology, Queen Square)*
15:05 – 15:25	**Performance improvement after proximal arm training in chronic stroke** Dr Ulrike Hammerbeck *(Research Physiotherapist, University of Manchester)*
15:25 – 15:30	**Questions and answers**
14:15 – 15:30	**Parallel Session 2B** **High scoring abstracts** Room 3
II	**Chair:** Professor Rustam Al-Shahi Salman *(Professor of Clinical Neurology, University of Edinburgh)*
14:15 – 14:18	**Welcome**
14:18 – 14:30	**The impact of tenecteplase compared to alteplase in patients without mismatch** Dr Andrew Bivard *(Senior Lecturer, Departments of Neurology, John Hunter Hospital, University of Newcastle, Newcastle, Australia)*
14:30 – 14:42	**How does real world thrombectomy data in England, Wales and Northern Ireland compare to RCTs?** Victoria McCurran *(SSNAP Senior Data Analyst, Royal College of Physicians)*
14:42 – 14:54	**Impact of treatment delay on the effect of glyceryl trinitrate, a nitric oxide donor, on global outcome after acute stroke: a systematic review and meta-analysis of individual patient data from randomised trials** Lisa Woodhouse *(Medical Statistician Stroke, Division of Clinical Neuroscience, University of Nottingham)*

14:54 – 15:06	**Blood pressure variability: The methodological heterogeneity in quantifying the prognostic value in acute stroke** Karen Osei-Bonsu Appiah *(PhD Student, University of Leicester)*
15:06 – 15:18	**Impairment of white matter cerebrovascular reactivity is associated with increased white matter hyperintensity and perivascular space burdens in patients with minor ischaemic stroke presentations of small vessel disease** Dr Gordon Blair *(Clinical Research Fellow, Centre for Clinical Brain Sciences, University of Edinburgh)*
15:18 – 15:30	**A simple clinical score identifies stroke risk in medically treated asymptomatic carotid artery stenosis** Professor Alison Halliday *(Professor of Vascular Surgery, Nuffield Department of Surgical Sciences, John Radcliffe Hospital, University of Oxford)*
14:15 – 15:30	**Parallel Session 2C** **Trials of early mobility – beyond the headlines** Room 11
II >>	**Chair:** Professor Anne Forster *(Head of the Academic Unit of Elderly Care and Rehabilitation, University of Leeds, Bradford Teaching Hospitals NHS Foundation Trust)*
14:15 – 14:20	**Welcome**
14:20 – 14:40	**Lying flat: people's concerns** Professor Dame Caroline Watkins *(Chair Elect of UK Stroke Forum, Professor of Stroke and Older People's Care, University of Central Lancashire)*
14:40 – 15:00	**Exploring the trials: beyond the headlines** Professor Peter Langhorne *(Chair of UK Stroke Forum, Professor of Stroke Care, University of Glasgow)*
15:00 – 15:20	**Implementation of "new" protocols in acute stroke care: the challenges** Professor Maree Hackett *(Professor of Epidemiology, UCLAN and The George Institute for Global Health, UNSW)*
15:20 – 15:30	**Questions and answers**

14:15 – 15:30	**Parallel Session 2D** **Emotional wellbeing after stroke** Room 4
II >> >	**Chair:** Dr Shirley Thomas *(Associate Professor in Rehabilitation Psychology, University of Nottingham)*
14:15 – 14:20	**Welcome**
14:20 – 14:40	**Psychological adjustment after stroke** Professor Reg Morris *(Clinical Psychologist, Cardiff University/Cardiff & Vale UHB)*
14:40 – 15:00	**Prevention and treatment of emotional problems after stroke in people with aphasia** Professor Ian Kneebone *(Head of Discipline Clinical Psychology, University of Technology Sydney, Australia)*
15:00 – 15:20	**Accelerating Delivery Of Psychological Therapies after Stroke (ADOPTS): Preliminary Results** Dr Liz Lightbody (*Chair of National Stroke Nursing Forum, Reader in Health Services Research, University of Central Lancashire)*
15:20 – 15:30	**Questions and answers**
15:30 – 16:30	**REFRESHMENTS & EXHIBITION - Hall 2**
15:45 - 16:00	**Meet the UK Stroke Forum Coalition in the Knowledge Hubb (Stand C6)**
16:00 – 16:15	**SOAPBOX SCIENCE** GE Healthcare St George's Hospital is at the helm of thrombectomy service expansion in the UK, as the first fully staffed 24/7 thrombectomy service in the country. It is also the site with the largest number of thrombectomies across England with a procedure volume that has trebled within the past year. The organisation of regional stroke networks, patient care pathways, hospital stroke teams, as well as the use of imaging for both patient triage and endovascular guidance, were deeply transformed to enable this development.
15:40 – 16:20	**FOCUS, RESTART, and SoSTART Investigators Meeting** Room 3
	Chairs: Professor Martin Dennis *(Professor of Stroke Medicine & Consultant Stroke Physician, University of Edinburgh / Edinburgh Hospitals)* Professor Rustam Al-Shahi Salman *(Professor of Clinical Neurology, University of Edinburgh)*

15:40 – 16:20	**Tenecteplase versus Alteplase for Stroke Thrombolysis Evaluation (TASTE) Trial** Room 11
⏸	**Chair:** Professor Hugh Markus *(Professor of Stroke Medicine Honorary Consultant Neurologist, University of Cambridge)*
15:40 – 16:20	**'It couldn't happen to us' - a short play** Room 4
	Chair: Nirjay Mahindru *(Chief Executive, InterAct Stroke Support)*

Plenary 2

16:30 – 17:15	**Princess Margaret Memorial Lecture** Auditorium
	Chair: Professor Peter Langhorne *(Chair of UK Stroke Forum, Professor of Stroke Care, University of Glasgow)*
	Welcome and prizes*
	The challenge of delivering realistic, tailored, evidence based stroke care Professor Martin Dennis *(Professor of Stroke Medicine & Consultant Stroke Physician, University of Edinburgh / Edinburgh Hospitals)*
	Questions and answers **This session includes prizes being awarded for the:* *Princess Margaret Memorial Lecture - Professor Martin Dennis* *Abdul Majid Basic Neuroscience and Translational Research Prize - Professor Philip Bath* *Patient, Carer, Public and Involvement Winner - Victoria Fleming* *Patient, Carer, Public and Involvement Highly Commended - Dr Stefan Tino Kulnik and Dr Karolina Gombert*
17:20 – 18:00	**Satellite symposium: Allergan** Auditorium Allergan
	Speakers: Dr Ed Gamble *(Stroke Consultant)* Dr Bhaskar Basu *(Neuro Rehabilitation Consultant)*
17:20 – 18:00	**Joint TICH-2/RIGHT-2 Investigator meeting** Room 11
	Chairs: Professor Philip Bath *(Stroke Association Professor of Stroke Medicine, Chair and Head of the Division of Clinical Neuroscience, University of Nottingham)* Professor Nikola Sprigg *(Professor of Stroke, Faculty of Medicine and Health Sciences, University of Nottingham)*

19:00 – Midnight '70's' Gala Dinner, themed evening of dining and entertainment

The Rum Warehouse at the Titanic Hotel

Dust off your bell bottoms, throw on your love beads and join us for our themed 70's D I S C O gala dinner! An evening of scrumptious food and excellent entertainment at the uber funky Rum Warehouse.

The evening begins at 7pm with a drinks reception, followed by a three-course dinner and dancing to an incredible band. The dress code is smart evening wear or optional groovy 70's attire! Entrance with ticket only.

Wednesday 29 November 2017 Poster tours - 10:45–11:35

Tour 1
Cognitive, Emotional and Psychological 1

001
Anxiety after stroke and TIA: subtypes, predictors, and patient outcomes at 3 months
Chun Y, Carson A, Mead G, Dennis M, Whiteley W

002
Avoidant behaviour in anxious people following stroke and transient ischaemic attack
Chun Y, Carson A, Mead G, Dennis M, Whiteley W

003
Delirium and long-term cognitive impairment after stroke: a longitudinal cohort study
Barugh AJ, Davis DHJ, Shenkin SD , MacLullich AMJ, Mead GE

004
Correlates and predictors of apathy, depression and fatigue post-stroke
Carroll C, Burgess GH, Hulbert S, Smithard D

005
The NOTtingham Fatigue After STroke (NotFAST) study: factors associated with fatigue severity at 6 months
Drummond A, Hawkins L, Sprigg N, Ward N, Mistri A, Tyrrell P, Worthington E, Lincoln NB

006
The NOTtingham Fatigue After STroke (NotFAST) study: a qualitative evaluation of the experiences of participants
Worthington E, Hawkins L, Lincoln NB, Drummond A

Tour 2
Secondary Prevention and TIA, and Translational Research 1

007
Promoting Recruitment using Information Management Efficiently (PRIME): a stepped wedge cluster randomised trial of a complex recruitment intervention embedded within the REstart or STop Antithrombotics Randomised Trial (RESTART)
Maxwell AE, Parker RA, Drever J, Rudd A, Dennis M, Weir CJ, Al-Shahi Salman R

008
Patch-based cardiac monitoring for stroke - trial results of Early Prolonged Ambulatory Cardiac monitoring in Stroke (EPACS)
Teo J, Kaura A, Sztriha L, Piechowski-Jozwiak B, Gall N

009
Improving Detection of Atrial Fibrillation (AF) in patients after transient ischaemic attack (TIA): ID-AF
Kee YK, Lochrie N, Mahmood S, Lawrence E

010
Early or later anticoagulation after atrial fibrillation (AF)-related stroke – a survey of UK stroke physicians
Munn D, Abdul-Rahim A, Werring D, Robinson T, Fischer U, Dawson J, and the ELAN Investigators

011
Early versus late anticoagulation administration for cerebral ischaemic events secondary to atrial fibrillation (AF): multicentre cohort study
Wilson D, Banerjee G, Ambler G, Shakeshaft C, Cohen H, Yousry T, Al-Shahi Salman R, Lip GYH, Brown MM, Muir KW, Jäger HR, Werring DJ, on behalf of the CROMIS-2 collaborators

012
Thiazolidinediones and risk of bone fractures: a systematic review and meta-analysis of randomised controlled trials
Azhari H, Macisaac R, Dawson J

013
Remote platelet function testing using measurement of platelet surface P-selectin expression in patients with acute stroke or TIA and who are taking clopidogrel
Bath PM, Appleton JP, Clarke J, Dovlatova N, May J, Heptinstall S

Tour 3
Complications, and Acute Care 1

014
Microbiological aetiologies of stroke associated pneumonia (SAP): a systematic review
Kishore AK, Jeans A, Vail A, van de Beek D, Westendorp W, Roffe C, Kalra L, Chamorro A, Montaner J, Meisel A, Smith CJ, on behalf of the Pneumonia In Stroke ConsEnsuS (PISCES) Group

015
A systematic review of molecular biomarkers to predict early neurological deterioration following acute ischaemic stroke
Martin AJ, Price C

016
Glyceryl trinitrate improves early neurological outcome in acute stroke patients presenting with lacunar syndromes and acute lacunar infarction
Appleton JP, Woodhouse LJ, Law ZK, Sprigg N, Wardlaw JM, Bath PM, for the ENOS Investigators

017
Clinical outcomes by diagnosis in the Rapid Intervention with Glyceryl trinitrate in Hypertensive Trial-2 (RIGHT-2): an interim analysis
Bath PM, Appleton JP, Scutt P, Law ZK, Dixon M, Howard H, Havard D, Sprigg N, for the RIGHT-2 investigators

018
Association between surgery and survival after cerebellar intracerebral haemorrhage: results of a single centre retrospective observational study
Aljohar F, Patel HC, Parry-Jones AR

019
Stroke post-transcatheter aortic valve insertion (post-TAVI): risk factors, management and outcomes
Bennett J, Lucio DA, Frame A, Demir OM, Banerjee S, Mikhail G, Sen S, Petraco R, Sutaria N, Ariff B, Kanaganayagam G, Gopalan D, Kelshiker M, Malik I

020
Development of a prehospital stroke mimic identification tool: a focus group study with healthcare professionals
McClelland G, Flynn D, Rodgers H, Price CIM

021
Outcomes after thrombectomy in Belfast: a comparison of drip and ship versus mothership paradigms
Wiggam MI, Adams K, Hunter A, Diamond A, O'Reilly S, McKenna B, Flynn P, Rennie I, Smyth G, Kerr E, Fulton A, Gordon P, Patterson C, Roberts G, Watt M, Burns P

Tour 4
Rehabilitation 1

022
Reading in people with aphasia: the relationship between assessment of ability and perception
Morris J, Webster J, Howard D, Garraffa M, Malone J

023
Identifying barriers and enablers of adherence to self-directed aphasia computer therapy: a patient and carer perspective
Harrison M, Palmer R, Cooper C

024
What are the factors influencing the implementation of self-managed computerised therapy for people with long term aphasia following stroke? A qualitative study
Burke J, Palmer R, Harrison M

025
Listen-In: high-dose home-based auditory comprehension therapy is achievable and effective
Fleming V, Krason A, Leach R, Leff A, Brownsett S

026
Virtual reality to support patient discharge after stroke: results from a feasibility study and subsequent pilot randomised controlled trial
Threapleton K, Worthington E, Sutton G, Newberry K, Drummond A

027
Stroke related factors associated with discharge to care homes after inpatient stroke unit rehabilitation
Thornton D, Bowen E, Dutta D

028
Factors influencing re-referral to specialist care in stroke survivors: insights from focus groups on long-term care after stroke
Lim L, Pindus D, Mullis R, Moore C, Kreit E, Mant J

029
Clinicians' experience of identifying and managing patients with cognitive impairment and dementia in stroke rehabilitation
Longley V, Bowen A, Peters S, Swarbrick C

030
Long-term life satisfaction in persons who have had stroke and their partners
Ytterberg C, Nilsson MI, Fugl-Meyer K, von Koch L

Tour 5
Brag and Steal 1

031
Enabling people with aphasia to make life changing decisions
Gray J, Harding S

032
Ward-based, mobile simulation can improve technical and non-technical skills for common stroke related complications
Styles J

033
The implementation of a stroke continence assessment and care pathway at the Royal Bournemouth Hospital (RBH)
Young M, Jones S

034
Improving services for weight management after stroke: a co-production approach
Clifford J, Wostenholme D, Grindell C, Tod A, Ryan T, Homer C

035
Evaluation of a community-based peer support group following discharge from a Stroke Early Supported Discharge Service: a pilot study
Graham M, Rahim M, Sands L, Banks S

036
Positive working relationships in stroke rehabilitation: what makes the difference? Implementing a Stroke Survivor Forum to generate service objectives
Vidal M

037
Setting up a keyworking scheme on an inpatient stroke unit
Julien C, Ghosh M, Alecock N, Esposito M, Hall K, Kee YK

038
Every day counts: provision of a speech and language therapy swallowing assessment service on Sunday mornings within acute stroke unit, Royal Victoria Hospital
Keys A, McLaughlin C, Donnelly C

039
Improving oral care in a stroke unit
Marshall L, Markram A, Sivakumar R

040
Experiences using a mobility assessment course (MAC) to assess adaptation to post-stroke hemianopia
Howard C, Rowe F

Tour 6
Rehabilitation 2, Assistive Technology, and Translational Research 2

041
A systematic review of self-directed therapy programmes for upper limb rehabilitation after stroke
Da Silva R, Moore S, Price CI

042
Using low cost sensors to augment an upper limb trainer with automated movement feedback
Collins R, Tarfali G, Kerr A

043
The effects of Lycra sleeves on acromion-greater tuberosity (AGT) distance, muscle activity and scapula position in people with post-stroke hemiplegia
Kumar P, Macleod L, Mohan P, Wai Tse G, Wheeler C

044
Assessment approaches for hemiplegic shoulder pain – a scoping review
Kumar P, Hugman J, Owen C, Redfern M, Smith E, Trenouth S

045
'If it works, fine. If it doesn't, have hope.': A qualitative study to explore individuals' experiences of managing their severely affected arm after stroke
Kulnik ST, Mohapatra S, Gawned S, Shamah S, Amo K, Jones F

046
Improving variable selection for modelling recovery of upper limb function post-stroke
Al-Shallawi A, Blana D, Pandyan A

047
What cut-off is indicative of no upper limb function in Action Research Arm Test?
Al-Shallawi A, Blana D, Pandyan A

048
Time – frequency spectrum analysis of motor evoked potential (MEP) using transcranial magnetic stimulation for extensor digitorum communis muscle
Singh N, Kumar N, Anand S, Srivastava P, Mehndiratta A

Tour 7
Brag and Steal 2

049
Acute research team go 24/7
Maguire H, Grocott J

050
Acute research team night coverage
Grocott J, Maguire H

051
Young stroke what do we do and is it worth it? Diagnostic yield of investigation in patients under 55 who have ischaemic strokes
Mohan S, Endean K, Lindert R

052
Causes of delay in admission to hyper-acute stroke unit
Alakbarzade V, Corns J, Zhang L

053
Moving innovation to operation
Gower M, Chambers K, Davies T, Heath S, Johnson S, Jupp R, Manns N, Parker A, Stalley S, Thavanesan K, Young M

054
Impact of an 8am–8pm 7 day a week consultant led stroke service on CT scanning, thrombolysis times and length of stay in a tertiary neurosciences centre
Marigold JRG, Weir NU, Crawford PJ, Evans SR, Battersby-Wood EJ, Lovett JK, Colchester NT, Morris RJ, Slaght SJ

055
Impact of an advanced stroke nurse practitioner training programme to request acute CT head scans on acute admission to scan times
Sanders C, Rafael S, Fox F, Ferreira M, Ashman G, Silva L, Sage W, Wooding D, Bailey T, Smith, T, Marques, J

056
Mechanical thrombectomy: the Leeds story
Waldmeyer W, Hicken L, Cooper J, Bailey A

Tour 8
Brag and Steal 3

057
'CREATE' Collaborative Rehabilitation Environments in Acute sTrokE – an Experience-Based Co-Design approach (EBCD) to improving activity experiences of stroke patients in 2 hospitals in England
Jones F, Clarke D, Honey S, Gombert K, Harris R, Robert G, McKevitt C, Macdonald AS, Cloud G

058
"Living with aphasia" carers days
Cunningham L, Coutts E

059
4 trusts, 1 CCG; 1 vision for stroke care in Dorset. Sharing experiences from a vanguard programme redesigning Dorset stroke services
Clark L, Stalley C, Ragab S

060
7-day therapy on the acute stroke unit
Turner N, Patridge L, Wardle I, Starkie H, Cooke E

061
Development and evaluation of a telemedicine clinic service for CADASIL
Walsh J, Markus HS

062
Is the FAST TV campaign effective?
Rengasamy ER, Rees SC, Shetty H

063
Should non-thrombectomy hyper-acute stroke units be shut down?
Povlsen SD, Sivagnanaratnam A, Abdul-Saheb M, Devine J, Cohen DL, Bathula R

064
Using the Patient Activation Measure (PAM) to design tailored follow-up services for people with TIA across Dorset
Heath S, Gleave L, Johnson L, Shave A, Leggett J, Thavanesan K, Jupp B, Jenkinson D, Gower M, Ragab S

065
Developing real-time online indicators for stroke care using the SSNAP audit
Dunn G, Kavanagh M, Paley L, Hoffman A, Bray B, Tyrrell P, James M, Rudd A, on behalf of the Inter-Collegiate Stroke Working Party (ICSWP) and the SSNAP Collaboration

066
New standard, new service, no money: setting up a new spasticity clinic in a time of austerity
Brodie F, McInnes C, Gardiner P, Spence M, McWhirter G, Brennan K

Tour 9
Brag and Steal 4

067
Bridging the gap between inpatient and community physiotherapy stroke services
Richards C, Stevenson V

068
The use of animal assisted therapy in stroke rehabilitation
Winter JM, Dudley D

069
Young mums have strokes too…
Prior J

070
FeSTivAPP – an innovative method for delivering functional strength training exercises for upper limb impairment after stroke
Mares K, Gilbert L, Hodgson S, Bell S, Pomeroy V

071
Rebuilding your life after stroke: positive steps to well-being – a self-management book
Morris R, Falck M, Miles T, Wilcox J, Fisher-Hicks S

072
Use of portable diagnostic ultrasound to inform treatment choices for hemiplegic shoulder pain in people with chronic stroke – a case series
Kumar P, Brouwers J

073
Driving advice following a stroke
Thomas R

074
Not just a tick box exercise! A patient collaboration – enhancing the goal setting process for the stroke pathway
Roman L, Greenman P, Kalev V

Poster Tour Map - Wednesday 29 November 10:45am – 11:35am

Poster tour titles:

Poster Tour 1 – Cognitive, Emotional and Psychological 1

Poster Tour 2 – Secondary Prevention and TIA, and Translational Research 1

Poster Tour 3 – Complications and Acute Care 1

Poster Tour 4 – Rehabilitation 1

Poster Tour 5 – Brag and Steal 1

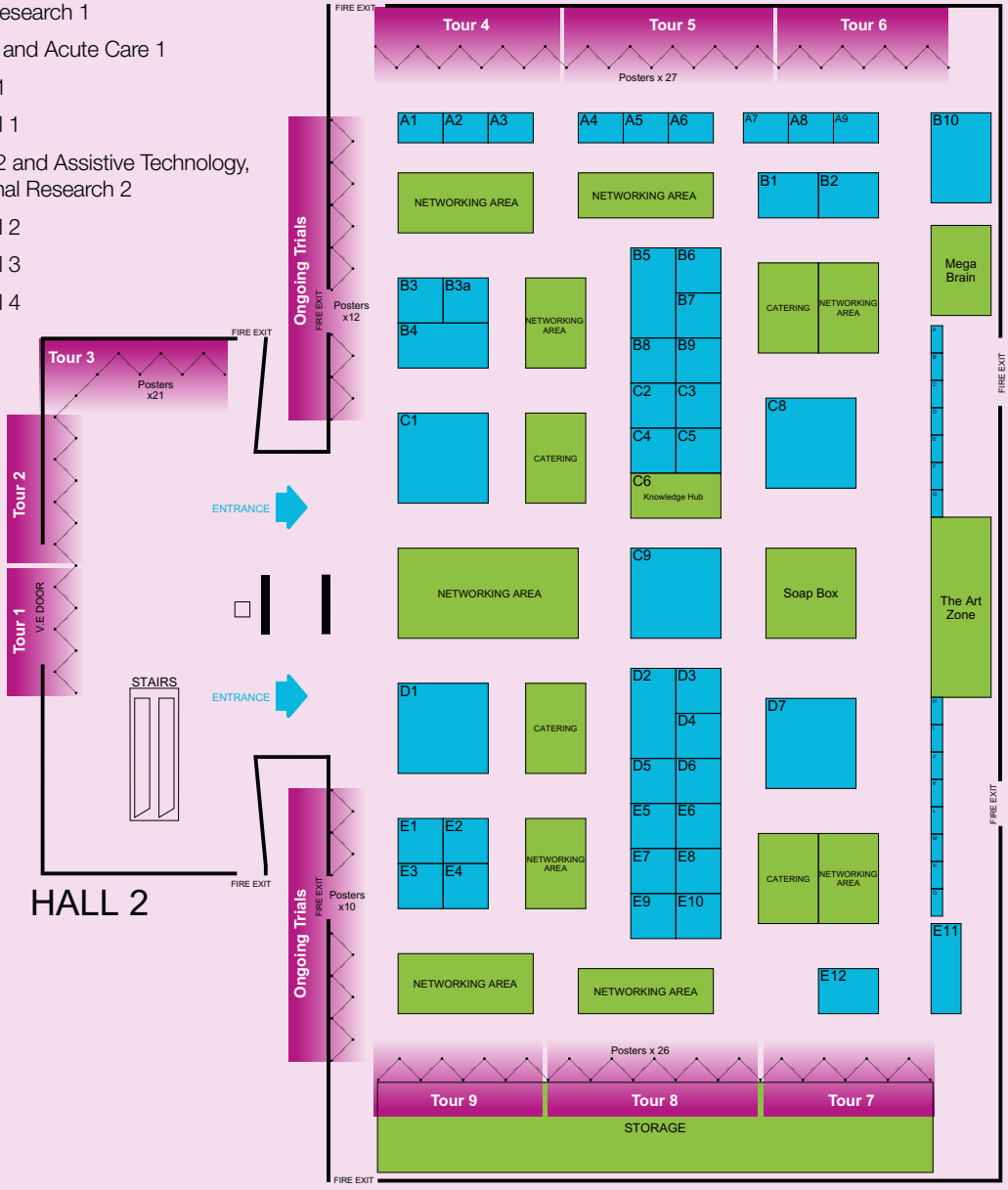
Poster Tour 6 – Rehabilitation 2 and Assistive Technology, and Translational Research 2

Poster Tour 7 – Brag and Steal 2

Poster Tour 8 – Brag and Steal 3

Poster Tour 9 – Brag and Steal 4

Ongoing trials (no tour)



Soapbox Sessions

Stroke association

Join the Stroke Association interactive sessions on the Soapbox in the Exhibition Hall to hear from experts and stroke survivors about aphasia, research, training and case studies.

Q&A on the benefits of stroke-specific training

with the Stroke Association Training team

Tuesday 28 November

2.35 - 2.50pm

The Stroke Association is committed to ensuring that stroke survivors receive high quality care from a well-trained and well-skilled workforce. Join us at the Soapbox in the exhibition arena for a question and answer session with healthcare professionals who have benefited from stroke-specific training. Find out more about the training and qualifications we offer and how we can help develop the knowledge and skills within your team.

Tackling the co-morbidity challenge – a Stroke Association and Alzheimer's Society case study

with Sue Clarke, Operations Manager, Alzheimer's Society and Kate Charles, Head of Stroke Support - North, Stroke Association.

Wednesday 29 November

10.35 - 10.50am

The Alzheimer's Society and the Stroke Association are building an approach to collaboration across multiple areas of their work. Representatives from both organisations will share how they have identified common aims and shared values on which to build a partnership. Taking you through the journey so far, we will explore some of the challenges to establishing partnership working, some of the foundations that are ensuring success and our future ambitions for this innovative new approach.

Listening, watching, learning – unlocking the aphasia experience

with Melanie Derbyshire, Assistant Director - Aphasia, Stroke Association

Wednesday 29 November

1.05 - 1.20pm

Hear from people with aphasia about working with the Stroke Association.

Patient and Public Involvement in research: what is it?

with Laura Piercy, Research Engagement Officer, Stroke Association

Wednesday 29 November

3.35 - 3.50pm

Find out what Patient and Public Involvement (PPI) in research is, why you should be doing it, and the Stroke Association's expectations for PPI in funding applications.

Main Conference Day 2 – Thursday 30 November

08:00 – 13:00 **Registration and exhibition open**

Parallel Sessions 3

08:30 – 09:45	**Parallel Session 3A** **Diagnosis and prevention of pneumonia** Auditorium
II >>	**Chair:** Dr David Smithard *(Princess Royal University Hospital, King's College Hospital NHS)*
08:30 – 08:35	**Welcome**
08:35 – 08:55	**Stroke-associated pneumonia: aetiology and diagnostic challenges** Professor Craig Smith *(Professor of Stroke Medicine, Manchester Academic Health Science Centre, University of Manchester and Salford Royal NHS Foundation Trust)*
08:55 – 09:15	**Which aspects of early dysphagia assessment and management reduce aspiraion?** Professor Sue Pownall *(Head of Speech and Language Therapy & Clinical Lead in Dysphagia,Sheffield Teaching Hospitals NHS Foundation Trust)*
09:15 – 09:35	**Strategies for the prevention of pneumonia** Professor Christine Roffe *(Professor of Stroke Medicine, Royal Stoke University Hospital)*
09:35 – 09:45	**Questions and answers**

08:30 – 09:45	**Parallel Session 3B** **Promoting and measuring self-efficacy and self-management** Room 3
>> >	**Chair:** Professor Pip Logan *(Professor of Rehabilitation Research, College of Occupational Therapists Specialist Section Neurological Practice)*
08:30 – 08:35	**Welcome**
08:35 – 08:55	**What do people really want? How to make self-management support right for everyone post stroke** Professor Fiona Jones *(Professor of Rehabilitation, St George's University of London and Kingston University)*

08:55 – 09:15	**Understanding and measuring the burden of supported self-care rehab for people with stroke and their families** Dr Sara Demain *(Lecturer in Physiotherapy, University of Southampton)*
09:15 – 09:35	**Interpreting and implementing stroke self-management support in practice: the importance of context** Dr Lisa Kidd *(Reader, University of Glasgow)*
09:35 – 09:45	**Questions and answers**
08:30 – 09:45	**Parallel Session 3C** **State of the art in secondary prevention after ICH** Room 11
■ >> >	**Chair:** Professor Nikola Sprigg *(Professor of Stroke Medicine, Faculty of Medicine and Health Sciences, University of Nottingham)*
08:30 – 08:35	**Welcome**
08:35 – 08:50	**(Re)starting antiplatelet drugs** Professor Rustam Al-Shahi Salman *(Professor of Clinical Neurology, University of Edinburgh)*
08:50 – 09:05	**State of the art in secondary prevention after ICH: Lowering blood pressure** Professor Thompson Robinson *(Head of Department of Cardiovascular Sciences and Professor of Stroke Medicine, University of Leicester)*
09:05 – 09:20	**(Re)starting anticoagulants** Professor Roland Veltkamp *(Professor of Neurology, Imperial College, London)*
09:20 – 09:35	**Other medical therapy, including statins** Professor David Werring *(Professor of Clinical Neurology, UCL, London, Consultant Neurologist, University College Hospitals NHS Foundation Trust)*
09:35 – 09:45	**Questions and answers**
08:30 – 09:45	**Parallel Session 3D** **Improving quality of life with post stroke visual impairment** Room 4
>> >	**Chair:** Claire Howard *(British and Irish Orthoptic Society Lead for Stroke and Neuro Rehabilitation)*
08:30 – 08:35	**Welcome**
08:35 – 08:55	**E-therapies to support post-stroke reading impairments** Professor Alexander Leff *(Professor of Cognitive Neurology, University College London)*

08:55 – 09:15	**Seeing solutions after stoke: Durham reading and exploration (DREX) training** Dr Stephen Dunne *(Postdoctoral Research Associate / DREX Project Manager Durham University)*
09:15 – 09:35	**Returning to work with visual impairment following stroke** Stevie Johnson *(Clinical Lead, Royal National Institute of Blind People)*
09:35 – 09:45	**Questions and answers**
09:45 – 10:45	**REFRESHMENTS & EXHIBITION - Hall 2**
10:00 – 10:35	**POSTER TOURS**
10:25 - 10:40	**SOAPBOX SCIENCE - Bayer** **Speaker:** Sharron Gordon *(Consultant Pharmacist in Anticoagulation, Hampshire)*
10:00 – 10:40	**Stroke survivors' perspective: loss of the sense of self and social identity** Room 3
	Chair: Joyce Booth *(Life After Stroke Coordinator, Stroke Association)*
10:00 – 10:40	**Rates, Risks and Routes to Reduce Vascular Dementia' TSA/BHF/Alz Soc ACTVaD study meeting** Room 11
	Chair: Professor Joanna Wardlaw *(Professor of Applied Neuroimaging, University of Edinburgh)*
10:00 – 10:40	**NIHR Industry Meeting *(Invitation only)*** Room 4
	Chairs: Professor Thompson Robinson *(NIHR CRN National Specialty Lead for Stroke)* Joy Liao *(Assistant Cluster Lead, Cluster A: Cardiovascular Disease, Diabetes, Metabolic & Endocrine Disorders, Renal Disorders and Stroke)*
10:45 – 12:00	**Parallel Session 4A** **Pre-hospital stroke care** Auditorium
	Chair: Dr Martin James *(Consultant Stroke Physician, Royal Devon & Exeter Hospital)*
10:45 – 10:50	**Welcome**
10:50 – 11:10	**Mobile stroke units – why and where?** Professor Heinrich Audebert *(Head of Department of Neurology, Campus Benjamin Franklin, Charité University Medicine, Berlin)*

11:10 – 11:30	**Pharmacological intervention in the ambulance** Professor Philip Bath *(Stroke Association Professor of Stroke Medicine, Chair and Head of the Division of Clinical Neuroscience, University of Nottingham)*
11:30 – 11:50	**Early but accurate identification** Dr Christopher Price *(Clinical Reader in Stroke Medicine, Newcastle University)*
11:50 – 12:00	**Questions and answers**
10:45 – 12:00	**Parallel Session 4B** **High Scoring Abstracts** Room 3
>> >	**Chair:** Dr Liz Lightbody *(Chair of National Stroke Nursing Forum, Reader in Health Services Research, University of Central Lancashire)*
10:45 – 10:48	**Welcome and prize***
10:48 – 11:00	**Adoption of stroke rehabilitation technologies by the user community** Dr Andrew Kerr *(Lecturer, Biomedical Engineering, University of Strathclyde, Glasgow)*
11:00 – 11:12	**Which hospital-level organisational factors contribute to the variation in mortality for stroke patients?** Lizz Paley *(Stroke Programme Intelligence Manager, Royal College of Physicians)*
11:12 – 11:24	**Foot and ankle impairments as predictors of mobility and balance after stroke (FAiMiS study)** Dr Mary Cramp *(Associate Head, Department of Allied Health Professions, University of the West of England)*
11:24 – 11:36	**A systematic review and meta-analysis of the effectiveness of biofeedback in dysphagia therapy** Jacqueline Benfield *(Speech and Language Therapist/PhD Student, Derbyshire Community Health Services NHS Foundation Trust & School of Medicine, University of Nottingham)*
11:36 – 11:48	**Cardiac rehabilitation for people with sub-acute, mild to moderate stroke: results from a mixed methods feasibility study** Nicola Clague-Baker *(Physiotherapy Lecturer/Practitioner, University of Leicester)*
11:48 – 12:00	**Exploring stroke survivor and informal carer need: informing a new primary care model** Dr Caroline Moore *(Research Associate, University of Cambridge)*

**This session will include the AHP Stroke Abstract Prize being awarded to Jacqueline Benfield*

10:45 – 12:00	**Parallel Session 4C** **Gait and Mobility Rehabilitation** Room 11
>> >	**Chair:** Professor Frederike van Wijck *(Professor in Neurological Rehabilitation, Glasgow Caledonian University)*
10:45 – 10:50	**Welcome**
10:50 – 11:10	**The use of technologies in gait and mobility rehabilitation** Professor Jane Burridge *(President of ACPIN, Professor of Restorative Neuroscience, University of Southampton)*
11:10 – 11:30	**Repetitive task practice for lower limb function: A Cochrane Review** Dr Louise Connell *(Reader in Rehabilitation, University of Central Lancashire)*
11:30 – 11:50	**Improving mobility after stroke with cycling** Dr Andrew Kerr *(Lecturer, Biomedical Engineering, University of Strathclyde, Glasgow)*
11:50 – 12:00	**Questions and answers**
10:45 – 12:00	**Parallel Session 4D** **Dysarthria after stroke – everything you wanted to know about impact, research and clinical practice** Room 4
>> >	**Chair:** Professor Audrey Bowen *(Stroke Association /John Marshall Memorial Professor of Neuropsychological Rehabilitation, University of Manchester)*
10:45 – 10:50	**Welcome**
10:50 – 11:10	**Why is dysarthria treated as the poor relation to aphasia?** Annette Dancer *(Stroke Survivor and Co-producer of Dysarthria Research)* Claire Mitchell *(Research Speech and Language Therapist, University of Manchester)*
11:10 – 11:30	**Service provision for people affected by post-stroke dysarthria: a United Kingdom perspective** Professor Nick Miller *(Professor of Motor Speech Disorders, University of Newcastle)*
11:30 – 11:50	**New frontiers in the management of dysarthria** Dr Rebecca Palmer *(Senior Lecturer, University of Sheffield)*
11:50 – 12:00	**Questions and answers**

12:00 – 13:00	**LUNCH & EXHIBITION - Hall 2**
12:20 – 12:50	**Satellite symposium: Daiichi Sankyo** Auditorium
12:20 – 12:50	**SSNAP quality improvement workshop** Room 3
	Chairs: Dr Ben Bray *(SSNAP Research Director)* Mr Mark Kavanagh *(SSNAP Programme Manager)*
12:20 – 12:50	**Impact of Visual Impairment after Stroke (IVIS) Study** Room 11
>	**Chair:** Dr Fiona Rowe *(Reader in Orthoptics and Health Services Research/NIHR Fellow, University of Liverpool)* The aims of the IVIS study were to find out how often visual impairment happens following stroke, what types of visual problems occur, what issues these visual problems cause for stroke survivors and how best to identify these visual problems.
12:20 – 12:50	**Dysphagia: new horizons** Room 4
	Chairs: Lauren Longhurst *(Research and Development Officer - Royal College of Speech and Language Therapists)* Kathy Tier *(Research Manager, Identification - NIHR)*

Plenary 3

13:00 – 14:30	**What's hot and what's next?** Auditorium
	Chairs: Professor Rustam Al-Shahi Salman *(Professor of Clinical Neurology, University of Edinburgh)* Professor Dame Caroline Watkins *(Chair Elect of UK Stroke Forum, Professor of Stroke and Older People's Care, University of Central Lancashire)*
13:00 – 13:10	**Welcome and prizes***

What's hot?

13:10 – 13:25 **The PRESERVE trial (perfusion substudy): intensive blood pressure lowering and cerebral blood flow in small vessel disease**
Professor Hugh Markus *(Professor of Stroke Medicine, Honorary Consultant Neurologist, University of Cambridge)*

13:25 – 13:40 **Behavioural activation therapy for depression after stroke (BEADS): a feasibility randomised controlled pilot trial of a psychological intervention for post-stroke depression**
Dr Shirley Thomas *(Associate Professor in Rehabilitation Psychology, University of Nottingham)*

13:40 – 13:55 **Preventing cognitive decline and dementia from cerebral small vessel disease: the LACI-1 trial**
Dr Gordon Blair *(Clinical Research Fellow, Centre for Clinical Brain Sciences, University of Edinburgh)*

What's next?

13:55 – 14:00 **Acute medical care in less than 5 minutes**
Dr Ajay Bhalla *(Consultant Stroke Physician, St Thomas' Hospital)*

14:00 – 14:05 **Acute nursing care in less than 5 minutes**
Dr Liz Lightbody *Chair of National Stroke Nursing Forum, Reader in Health Services Research, University of Central Lancashire)*

14:05 – 14:10 **Rehabilitation in less than 5 minutes**
Professor Marion Walker *(Professor in Stroke Rehabilitation, Associate Pro Vice-Chancellor, Equality, Diversity and Inclusion, University of Nottingham)*

14:10 – 14:15 **Primary and secondary prevention in less than 5 minutes**
Dr William Whiteley *(Senior Research Fellow and Consultant Neurologist, University of Edinburgh and NHS Lothian)*

14:15 – 14:20 **Patient support in less than 5 minutes**
Fiona Greene *(Director of Care and Secondary Prevention, Northern Ireland Chest Heart and Stroke)*

14:20 – 14:30 **Questions and answers**

**This session will include prizes being awarded for the:*
British Stroke Research Group Prize – Professor Hugh Markus
Stroke Rehabilitation SRR Prize – Dr Shirley Thomas

CONFERENCE CLOSES

Thursday 30 November 2017 Poster tours - 10:00–10:35

Tour 1
Communication

075
A novel cognitive intervention for functional communication in global aphasia
Adjei-Nicol S, Beeke S, Sacchett C

076
People with aphasia's experience of therapeutic alliance construction and maintenance in aphasia rehabilitation post-stroke
Lawton M, Haddock G, Conroy P, Sage K, Serrant L

077
Interventions to support Internet use with aphasia: preliminary evidence for a tailored approach
Menger F, Morris J, Salis C

078
Development and preliminary evaluation of a tool to support person centred, medicines-focused consultations with stroke survivors
Dodds L, Da Costa D, Corlett SA

Tour 2
Primary Prevention & Risk Factors for Stroke, and Other

079
Stroke in haemodialysis (HD): incidence, risk factors and outcomes from national datasets
Findlay MD, Mark PB, Dawson J

080
Multimorbidity and comorbidity in atrial fibrillation and effects on survival: findings from UK Biobank cohort
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Poster Tour Map - Thursday 30 November 10:00am – 10:35am

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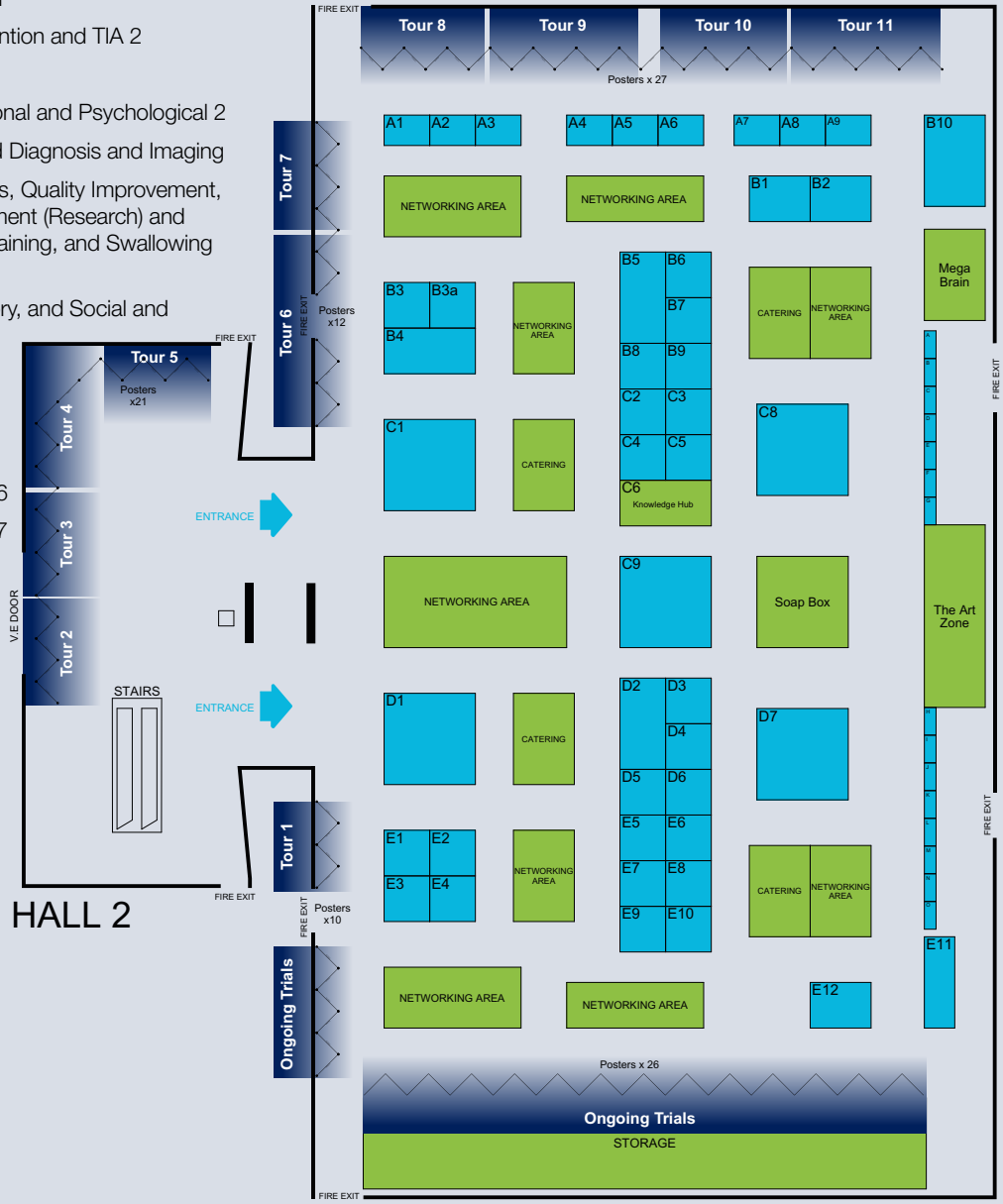

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OG01

A stroke or not a stroke – that is the question

Negansan C, Kee YK, Mahmood S, Lawrence E, Ghosh M
Croydon University Hospital, Stroke Medicine, Croydon, UK

Introduction: Transient ischaemic attack (TIA) clinics have seen an increase in the number of patients with non-stroke pathology due to the ability to see patients in a timely manner. We present an interesting case which was referred to the TIA clinic which highlights the importance of investigating all patients in a thorough manner to ensure prompt treatment for all patients regardless of pathology.
Methods: A young woman presented to the TIA clinic with recent onset of severe headache followed by episodic confusion, memory loss and occasional slurred speech. She triggered a TIA referral as the GP was concerned about the slurred speech. She described feeling vague and unwell for the preceding few months. Her past medical history include Bell's palsy a year ago.
Results: MRI Brain showed white matter lesions affecting pons, left hippocampus, right cerebellum and bilateral external capsules without diffusion restriction. Contrast scan showed meningeal-enhancement of these lesions leading to the possibility of neurosarcoidosis. Sarcoidosis is a multisystem disorder affecting around 5% of nervous system. The most common manifestation is cranial neuropathy. Less frequently it can present as meningoencephalitis, hydrocephalus, seizure, myopathy and peripheral neuropathy.
Conclusion: This case shows the diversity of the different diagnoses that may present to TIA clinic. It also highlights the need for rapid access service for a range of other TIA and stroke mimics that present to the service. It will be important to ensure that future designs of services ensure these patients are not left waiting for their diagnoses to be made.

OG02

Bilateral posterior cerebral artery infarction resulting in Anton's syndrome: a case report

Oklopčić A, Menezes BF
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Introduction: Anton's syndrome describes the condition in which patients deny their blindness despite objective evidence of visual loss, and moreover confabulate to support their stance. It is a rare extension of cortical blindness and in addition to the injury of the occipital cortex, other cortical centres may be affected with patients typically behaving as if they were sighted.
Methods: Case report.
Results: We report a 66 year old gentleman who initially presented with an unresponsive episode with quadrantonopia. His clinical signs evolved insidiously to hemianopia and eventually to cognitive impairment, agitation and cortical blindness which on further investigation was shown to have resulted from bilateral posterior circulation infarction secondary to bilateral posterior cerebral artery thrombus. Despite his obvious blindness, the patient denied visual loss and demonstrated confabulation consistent with a diagnosis of Anton's syndrome. 2 months after his event, although his cognitive issues have

improved, he remains cortically blind and visually anosognosic.
Conclusion: A suspicion of cortical blindness and Anton's syndrome should be considered in patients with atypical visual loss and evidence of posterior circulation territory injury. Cerebrovascular disease is the most common cause of Anton's syndrome, as in our patient. Recovery of visual function depends on the underlying aetiology with cases due to occipital infarction after a cerebrovascular event being less likely to result in complete recovery.

OG03

Bilateral thalamic stroke from a basilar thrombus, and good recovery following thrombectomy

Underwood A, Hervey S, Thompson P, Poitelea M
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Introduction: A 74 year old man was admitted to the Royal Sussex County Hospital after being found on his bathroom floor unresponsive. He had last been seen well 7 hours prior to admission.
Methods: On examination, he had a GCS of 4, with fixed and dilated pupils and decerebrate posturing. An initial CT head and CT angiogram of neck and intracranial vessels demonstrated a basilar artery thrombus. With this information, an MRI brain and MRI angiogram were arranged to establish the degree of infarction within the brainstem to prognosticate before attempting thrombectomy. This confirmed distal basilar artery occlusion with acute bilateral thalamic and mid-brain infarcts. A successful thrombectomy was performed at 10:30pm, resulting in recannalisation of the basilar artery. He was transferred to ITU. Engagement of all limb muscles was present on day 1 post thrombectomy and a repeat CT head showed no post-operative intracerebral haemorrhage. High dose aspirin was started.
Results: Extubation took place on Day 5 of admission. His main neurological impairments were characterised by bilateral cranial nerve III palsy, dilated pupils, variable GCS (8–14) and dysarthria. He was transferred to the stroke unit where he received neurorehabilitation and subsequently transferred to the Sussex Rehabilitation Centre for longer term, goal-centred, therapy.
Conclusion: This case highlights the importance of considering basilar artery thrombus in a patient who presents unresponsive with fixed dilated pupils. It also supports recent evidence that thrombectomy can provide favourable outcomes for patients with delayed presentation.

OG04

The Adult SPasticity International REgistry (ASPIRE) study: treatment utilization patterns in patients with stroke treated for spasticity

Bavikatte G[1], Francisco GE[2], Bandari DS[3], Jost WH[4], Manack Adams A[5], Largent J[6], Esquenazi A[7]
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Introduction: OnabotulinumtoxinA treatment for spasticity is individualized, variable, and dependent on numerous factors. This analysis examines onabotulinumtoxinA treatment utilization in patients with stroke treated for spasticity (1-year interim data).
Methods: A prospective, observational registry conducted at select international sites (NCT01930786), examining adults with spasticity treated with onabotulinumtoxinA at the physician's discretion. Assessments include treatment utilization and patient/physician satisfaction.

Results: Patients (n = 731) were on average 54 years old; majority female (52%) and continuing onabotulinumtoxinA treatment (63%). 411 patients (56%) had an aetiology of stroke. Among stroke patients, the most common upper limb presentation was clenched fist (71%); flexor digitorum superficialis (85%) was most commonly injected. The most common lower limb presentation was equinovarus foot (53%); gastrocnemius (75%) was most commonly injected. OnabotulinumtoxinA doses ranged between 5–600U (upper limb) and 15–1,100U (lower limb). Overall (n = 731), patients (82%) and physicians (91%) expressed extreme satisfaction/satisfaction that their recent onabotulinumtoxinA treatment helped their spasticity. Patients (90%) and physicians (97%) indicated they would definitely/probably continue onabotulinumtoxinA treatment for spasticity. Overall, 211/731 patients reported 559 adverse events (AEs). 23 AEs in 17 patients were considered treatment-related; most common was muscular weakness (n = 6). 75 patients reported 136 serious AEs. 5 serious AEs in 2 patients were considered treatment-related; most common was muscular weakness (2 events in 1 patient).
Conclusion: Results provide insight into real-world onabotulinumtoxinA treatment patterns in patients with stroke treated for spasticity. Current data demonstrate effectiveness and safety of onabotulinumtoxinA treatment for spasticity across multiple aetiologies; future analyses will evaluate this data in the stroke population.

OG05

Organising Support for CARers of Stroke Survivors (OSCARSS): a work-in-progress cluster randomised controlled trial (RCT) with embedded process evaluation

Patchick E, Rothwell K, Woodward-Nutt K, Rhodes S, Bowen A, on behalf of the OSCARSS trial management group
NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester, Manchester, UK

Introduction: Informal carers, typically family members, provide invaluable support for stroke survivors but this can affect their own health and well-being. This study aims to explore and compare to standard practice the implementation and the clinical- and cost-effectiveness of an approach (co-developed with service users) to identify, assess and support carers' needs. The components of the approach include: staff training, needs assessment guidance; review and action planning; plus implementation considerations.
Methods: Mixed-methodology, longitudinal, multi-site cluster randomised controlled trial (cRCT) with embedded qualitative study, health economic analysis and process evaluation (PE). Clusters are Stroke Association services randomised to the new approach (intervention) or standard practice (control). Intervention clusters are trained. Adult carers referred to participating services are invited to participate. cRCT carer participants provide demographic data at study entry and outcome data at 3 and 6 months, through self-reported postal questionnaires. Outcomes are: caregiver strain and burden, mood, experience of caring, satisfaction with services, and economic burden (care provision and service utilisation). A sub-sample of carers are invited to a telephone interview to enrich quantitative findings. The PE is collecting quantitative and qualitative data from staff to explore: training acceptability; how practice changes over time; intervention fidelity; and staff experiences of intervention and control.
Results: Ethics is secured (16/NW/0657) with 35 clusters randomised and participating (18 intervention; 17 control). To date, 114 carers have been recruited to cRCT; 69 staff have participated in the first round of PE questionnaires. Interviews, cRCT recruitment and outcome assessment, and additional PE questionnaires are underway.
Conclusion: Results will be available in 2018.

OG06

The Metoclopramide and selective oral decontamination for Avoiding Pneumonia after Stroke (MAPS-2) trial: a 2x2 double-blind, randomized controlled trial of metoclopramide and selective oral decontamination for the prevention of pneumonia in patients with dysphagia after an acute stroke

Roffe C[1,2], Warusevitane A[1,2], Smith C[3], Gosney M[4], Knox E[1], Buttery A[1], Sim J[5], Jeans A[3], Barton P[6], Harrison M[7], Bray B[8], Helliwell B[9]

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[2]University Hospitals of North Midlands NHS Trust, Stoke-on-Trent, UK
[3]Royal Salford University Hospital, Salford, UK
[4]University of Reading, Reading, UK
[5]Faculty of Medicine and Health Sciences, Keele University, Keele, UK
[6]University of Birmingham, Birmingham, UK
[7]Anglia Ruskin Clinical Trials Unit, Cambridge, UK
[8]King's College London, London, UK
[9]Stroke Survivor, Birmingham, UK

Introduction: Pneumonia is a common complication of stroke, and associated with high mortality and morbidity. It is most likely to occur in severe patients with dysphagia, with the highest risk in patients fed via nasogastric tubes. 2 small pilot studies showed that both metoclopramide and selective oral decontamination using an antibiotic paste, significantly reduce pneumonia in stroke patients with dysphagia. The aim of MAPS-2 is to confirm this in a larger study and to determine whether these interventions also reduce mortality.
Methods: Metoclopramide and/or selective oral decontamination in patients with severe acute stroke (NIHSS ≥ 10) and dysphagia, within 9 hours of symptom onset will enrol 1,160 patients from over 40 acute stroke units in the UK over 2 years. The intervention will be given for 21 days or until a nasogastric tube is no longer needed (metoclopramide arm) or until patient is able to swallow normally (selective oral decontamination arm). A daily log recording symptoms of pneumonia, treatments and complications will be completed for 14 days. Participants will be followed in person at 30 days and via telephone at 90 days. Vital status will be assessed for every patent until the end of end of the study (maximum 24 months) for the primary outcome.
Results: Blinded demographic data of patients included in the study will be presented.
Conclusion: This study will provide important data for prevention of pneumonia after stroke.

OG07

Segmented infarct characteristics in acute stroke following ischaemia reperfusion using MR diffusion-weighted and quantitative T2 imaging

Gupta Sah R[1,2], Sitaram A[1], d'Esterre CD[1,2,3,4,5], Hafeez M[1,2], Tariq S[2,4], Forkert ND[3,4], Barber PA[1,2,3,4]

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[4]Hotchkiss Brain Institute, University of Calgary, Calgary, Canada
[5]Department of Clinical Neurosciences, University of Calgary, Calgary, Canada

Introduction: In acute ischaemia, diffusion weighted imaging (DWI) is considered the pre-eminent examination to demonstrate cytotoxic oedema. However, measurement of free-water with quantitative T2 (qT2) relaxometry is generally ignored.

Methods: 42 ischaemic stroke patients (age: 71.5 ± 17) with intracranial vascular occlusion involving MCA, were PCA or ACA territory were imaged within 4 hours (baseline) and at 24 hours on a 3 T MR scanner. ADC and qT2 maps were calculated from DWI and multi-echo T2 datasets using ANTONIA software. Volumetric segmentation of qT2 lesion was performed using a threshold -12.5% of the mean contralateral side value. ADC lesions were segmented using a threshold of 630 x 10^{-6} mm^2/s. Lesion overlap of qT2 and ADC segmented volumes was also calculated using DICE coefficient.
Results: Time from stroke onset to MRI was 4.64 ± 1.42, and recanalization was confirmed. Treatment was provided with tPA in 20/40 (50%) or endovascular therapy 9/40 in (23%) or both 13/40 in (33%). Ischaemic lesions were identified in 27/40 (67.5%) at baseline and 28/35 (80%) at 24 hours based on ADC, QT2 lesions were observed in 22/32 (68.8%) at baseline and 23/30 (76.7%) at 24 hours. QT2 and ADC volume overlap were 8.5% at baseline and 16.7% at 24 hours. The percentage change in qT2 lesion was 173.8%, compared to ADC lesion growth of 88.2%. Lesion growth was more frequently demonstrated by qR2 than ADC (Fisher's exact $p < 0.05$).
Conclusion: Acute lesion growth was more frequently demonstrated by qT2 than by ADC. ADC underestimates the severity of acute ischaemia and infarct growth. QT2 imaging has utility in acute stroke imaging.

OG08
Adjustment post-stroke and aphasia: protocol for the SUpporting well-being through PEeR-Befriending (SUPERB trial)

Hilari K[1], Behn N[1], Marshall J[1], Simpson A[1], Thomas S[2], Flood C[1], Northcott S[1], Goldsmith K[3], McBicker S[1]
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[2]University of Nottingham, Nottingham, UK
[3]King's Clinical Trials Unit, London, UK

Introduction: Stroke and aphasia can have a profound impact on people's lives. There is a need to systematically evaluate interventions that aim to improve psychosocial wellbeing for people with stroke and aphasia, who are often excluded from stroke studies. SUPERB will evaluate the feasibility of a study on the clinical and cost-effectiveness of one-to-one peer befriending for people with aphasia post-stroke and provide the necessary parameters to plan a definitive trial.
Methods: Single blind, mixed methods, parallel group Phase II RCT comparing peer-befriending vs. usual care, starting at discharge from hospital. The design has been informed by the MRC framework for complex interventions. The study will deliver on 4 work packages: development phase; RCT; qualitative study; economic evaluation. Participants (n = 60) will be assessed 4 times up to 10 months post-randomization.
Results: We will assess feasibility of recruitment to a definitive trial (proportion screened who meet criteria; proportion who consent; rate of consent); participant, significant other, peer befriender views on acceptability of procedures (qualitative study); number of missing/incomplete data on outcome measures; attrition rate at follow-up; potential value of conducting main trial using value of information analysis (economic evaluation); description of usual care; treatment fidelity of peer-befriending. Patient-reported outcomes will include mood, confidence, participation, social support, quality of life.
Conclusion: This study will provide evidence for one-to-one peer befriending; and provide the necessary parameters and information to plan a definitive trial. Peer befriending is worth exploring as it has the potential, pending positive outcomes of a definitive trial, to improve service provision for people with stroke and aphasia.

OG09

Biopsychosocial Intervention for informal Stroke Carers (BISC): a feasibility randomised controlled trial (work-in-progress)

Condon L[1], Walker MF[1], Fisher R[1], Thomas S[1], Kontou E[1], Whitehead PJ[1], Sprigg N[2], Benford OM[1], Birchall S[1], Cobley C[3], Fletcher-Smith J[1], Greensmith C[4]
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[3]University of Sheffield, Sheffield, UK
[4]Nottinghamshire Healthcare NHS Foundation Trust, Nottingham, UK

Introduction: Informal caregivers of stroke survivors are at increasing risk of experiencing deterioration in their physical and mental health, due in part to the increased load attributed to caring responsibilities. Current service provision doesn't prioritise the needs of stroke carers. The aim of this research is to assess the feasibility of delivering a biopsychosocial intervention to informal stroke carers in the community.
Methods: We are conducting a feasibility randomised controlled trial with a concurrent qualitative study. We aim to recruit 40 stroke survivor/carer dyads where the survivor is within 1 year of first stroke and being cared for in the community. Dyads are randomised to either treatment (6-week intervention) or control group (usual care). Treatment will ideally be delivered in a group or, on exception, on a 1:1 basis. Treatment sessions are manualised and cover: stress and coping, recognising normal emotions, problem solving, and strategies for dealing with negative emotions. Outcomes are assessed at 6 months and include measures of anxiety and depression (HADS), cognitive function (MOCA), activities of daily living (Barthel), caregiver burden (CBS), and quality of life (EQ-5D). Ethical approval, REC (ref: 14/EM/1264).
Results: Recruitment is complete and intervention delivery is currently underway in a group-based format alongside 6 month outcome data collection. Full trial results are due in January 2018.
Conclusion: The trial findings, along with a concurrent qualitative study addressing recruitment, implementation and treatment fidelity will determine whether it is feasible to conduct a powered study of this type in this population.

OG10

'Big CACTUS' cost effectiveness of self-managed computer therapy at home: a UK multicentre RCT

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Introduction: One third of stroke survivors experience aphasia, making it difficult to speak, understand spoken language, read, and write. Evidence suggests that aphasia can continue to improve for many months and years with intensive speech and language therapy. However, NHS resources are rarely available to provide ongoing intensive intervention. The development of computer software for language practice enables independent intensive therapy. Big CACTUS investigates the clinical and cost effectiveness of a computerised approach to long-term aphasia therapy post stroke.
Methods: Adults with aphasia at least 4 months post-stroke were randomised to: usual care; computerised intervention in addition to usual care or attention/activity control in addition to usual care. Outcome measures are made at baseline, 6, 9 and 12 months after randomisation by blinded speech and language therapist assessors. Primary outcomes

are the change in number of words (of personal relevance named correctly at 6 months and improvement in functional conversation of personally relevant topics. A cost-utility analysis will be undertaken from the NHS and personal social service perspective.

Results: 21 speech and language therapy departments across the UK have recruited people with aphasia to the study. The study has recruited 278 participants and more than 170 carers. The intervention has been completed and participants are currently in follow-up. Results will be available in 2018.

Conclusion: Challenges overcome include: establishing excess treatment costs and service support costs for AHPs; research training of speech and language therapists to become principal investigators; recruitment of hard to reach patients; consenting people with language difficulties, and large scale implementation of rehabilitation technology.

OG11

Experiences of health inequalities by stroke survivors with visual impairments

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Introduction: A systematic literature review revealed that there is very little documented regarding the health inequalities experienced by the visually impaired stroke population in the UK. It was found that vision services for stroke survivors are inconsistent nationally, with many receiving inadequate or no visual input to their stroke care. In order to investigate the true health inequalities facing this population, focus groups and interviews were conducted with stroke survivors suffering from subsequent visual impairments.

Methods: 2 focus groups and 5 individual interviews were conducted with stroke survivors (n = 13) and 1 spouse across the North West of England. The transcripts were coded and a thematic analysis was undertaken using NVivo 10 software package.

Results: Health inequalities were identified in relation to transport, area of residence, access to eye/stroke services, occupation, income and expenses, education and information provision. Additional possible inequalities identified from the literature were posed to the stroke survivors. They reported no previous experiences of inequalities in relation to race/ethnicity, gender and age.

Conclusion: Consideration of these inequalities must be made when planning future eye/stroke services. Recommendations from these research include:

1. To widely advertise the available resources, visual therapies, support, alternative transport means and financial aid to stroke survivors.
2. To educate the general public and non-visually trained hospital staff of the visual signs of stroke.
3. For clinicians to motivate patients to comply with treatments, attend their appointments.
4. For clinicians to revisit the patient's most problematic symptom at each visit and prioritise rehabilitation goals.
5. To ensure orthoptic input is included within the stroke service.

OG12

The LACunar Intervention trial 2: LACI-2. Feasibility phase trial to assess safety and efficacy of cilostazol and/or isosorbide mononitrate to prevent cerebral small vessel disease

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Introduction: 25% of ischaemic strokes are lacunar, due to intrinsic, non-atheromatous, non-cardioembolic cerebral small vessel disease (SVD). There are no specific treatments: antiplatelet drugs may be ineffective or hazardous long-term;

antihypertensive treatment had limited benefit. Endothelial dysfunction, which contributes to SVD pathogenesis, might be improved by drugs that affect nitric oxide or prostacyclin systems. Licensed drugs, isosorbide mononitrate (ISMN) and cilostazol have relevant effects and data: ISMN is widely used in cardiovascular disease; randomized trials of cilostazol in all-stroke prevention (n > 6,000) show promise.
Methods: Purpose: To assess feasibility of recruitment, drug tolerability, trial procedures, safety and confirm event rates, to estimate power for a future Phase III trial.
Design: Prospective, randomised, open label, blinded-endpoint, multicentre, 2x2 partial factorial trial.
Comparators: Oral, ISMN 25 mg bd, cilostazol 100 mg bd, both, or neither, for one year.
Participants: Patients with lacunar ischaemic stroke.
Sample size and power: LACI-2 is powered for safety to detect deaths of 2.0% p.a. and will stop if deaths reach 4% (upper 95% CI of 2% in 400 patients).
Results: Primary Endpoint: Feasibility of randomisation and follow-up of 400 patients across 20 sites.
Secondary Endpoints: At 1 year, tolerability, safety (haemorrhage, death), recurrent stroke, MI, dependency, cognitive impairment.
Conclusion: This phase of the LACI trials assesses feasibility, tolerability, safety and vascular event rates in up to 400 patients recruited in the UK and followed-up to one year, preparatory to a large Phase III trial aiming to prevent recurrent lacunar stroke, and physical and cognitive impairment.

OG13

Prevention Of Hypertensive Injury to the Brain by Intensive Treatment after IntraCerebral Haemorrhage (PROHIBIT-ICH): a pilot randomised trial of home telemetry-guided treatment

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Introduction: Intracerebral haemorrhage (ICH) accounts for about 10% of all strokes in the UK, and is often fatal or disabling. Although blood pressure (BP) lowering is proven to reduce future stroke risk after ischaemic stroke, data on reduction after ICH remains limited. Observational data strongly suggest that intensive and sustained BP lowering could improve secondary prevention of ICH, but there are no current trials to guide the optimum strategy or intensity for BP lowering after ICH. Telemetric home BP monitoring is a promising intervention to improve BP control.
Methods: About 112 participants from multi-centres will be randomised to either standard care using current RCP guidelines (control), or intensive Telemetric Bluetooth home BP monitoring and adjustment of BP medications (intervention) to achieve a target of < 120/70 mmHg. Medication changes will be notified to the research team and participant's GP. Participants will be followed up at 3 months and 1 year to collect outcome data.
Results: a) Consent rate, drop-out rate, patient approval of the home monitoring process.
b) Difference in systolic BP between arms at 3 months.
c) Difference in proportion of individuals who develop new cerebral microbleeds at 1 year between arms.
d) Quantification of white matter damage and cognitive decline at 1 year.
e) Clinical outcomes, including recurrent stroke at 1 year.
Conclusion: To determine whether a strategy of intensive treatment guided by telemetric monitoring versus standard treatment of BP after spontaneous ICH attributed to small vessel disease is feasible, safe, and associated with reduced cerebral injury compared with standard BP treatment.

OG14

Xanthine oxidase inhibition for Improvement of Long-term Outcomes Following Ischaemic Stroke and Transient ischaemic attack (XILO-FIST)

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Introduction: XILO-FIST is a randomised double-blind placebo controlled clinical trial. It is evaluating the effect of allopurinol 300 mg twice daily on white matter hyper-intensity (WMH) progression and arterial blood pressure (BP) in patients with recent ischaemic stroke. The trial is funded by the British Heart Foundation and the Stroke Association via a joint programme grant. Allopurinol, a xanthine oxidase inhibitor, lowers serum uric acid and reduces oxidative stress in the vasculature. It reduced progression of carotid-intima media thickness and lowered blood pressure in a small clinical trial of patients with previous ischaemic stroke. XILO-FIST aims to assess benefit of a longer course of treatment on robust surrogate markers of risk and to establish whether it helps control BP after stroke.
Methods: XILO-FIST will include 464 participants aged greater than 50 years with ischaemic stroke within the past month. Participants are randomised on a 1:1 basis to 2-years treatment with allopurinol or placebo. Participants will undergo brain MRI, detailed cognitive assessment, ambulatory blood pressure monitoring and blood sampling at baseline and after 2 years treatment. The primary endpoint is WMH progression, measured using the Rotterdam Progression Scale. Secondary endpoints include change in WMH volume, mean day-time systolic BP and measures of cognitive function. Up to 100 participants with left ventricular hypertrophy will undergo additional cardiac MRI.
Results: The first participant first visit was in May 2015. By 1st June 2017 the trial was open in 16 sites across the UK. 286 patients were enrolled with 239 were randomised (most of remainder are in the trial run-in phase). On average 12 participants per month are being randomised. 95 participants have completed 1 year follow-up.
Conclusion: We aim to finish recruitment by May 2018.

OG15

A comparison of national guidelines for secondary prevention of ischaemic stroke

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Introduction: National guidelines for secondary prevention of ischaemic stroke are developed independently, and could therefore offer different recommendations based on the guideline body's interpretation of evidence and local economic or contextual factors. To compare recommendations on the use of statins, antiplatelet drugs and antihypertensive drugs from national guidelines on the secondary prevention of ischaemic stroke.
Methods: A grey literature search for national clinical guidelines on secondary prevention of ischaemic stroke. A systematic comparison of guideline recommendations with regard to indication, choice of drug and outcome targets.

Results: Guidelines from National Institute for Health and Care Excellence (NICE), Royal College of Physicians (RCP), Scottish Intercollegiate Guidelines Network, American Heart Association, National Stroke Foundation and Canadian Stroke Best Practice Recommendations were identified. All guidelines recommend antiplatelet therapy and statins, but differ with regard to choice of antiplatelet drug and lipid targets. More substantial variation exists within the recommendations for anti-hypertensive therapy, with no agreement on the threshold to initiate treatment, choice of drug and target blood pressure. Only NICE and RCP recommend selection of antihypertensive drugs according to age and ethnicity.
Conclusion: The differences in the guidelines highlight the need for further research, and suggest that in some instances, individual guidelines are more didactic than is warranted. Where evidence is equivocal, patient preference could be prioritised in the selection process.

OG16

The use of neuromuscular stimulation of calf muscles for prevention of venous thromboembolism in patients with acute stroke

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Introduction: Venous thromboembolism (VTE) is a well-recognised, and potentially fatal complication of stroke. Intermittent pneumatic compression (IPC) is recommended by NICE for VTE prophylaxis after acute stroke. We introduced neuromuscular stimulation devices activating the calf pump (GEKO) as an alternative for patients who do not tolerate IPC. The aim of this audit is to assess the effect of this prevention strategy.
Methods: The audit included every patient admitted to the Acute Stroke Unit at Royal Stoke University Hospital from 1st November 2016 to 31st May 2017. Patients with both ischaemic and haemorrhagic stroke were included. Data gathered included the method of VTE prophylaxis used, duration of use, how it was tolerated, and the incidence of symptomatic VTE 90 days after discharge.
Results: 409 patients (205 (50.0%) males, mean age 74 years) were included. 241 (76.8%) were initially given IPC devices and 47 (15.0%) were started on or changed to the GEKO device due to contraindications to IPC. 53 22.0% of patients did not tolerate IPC and 8 (7.1%) did not tolerate GEKO. 1 (0.4%) patient developed a deep vein thrombosis and 3 patients (1.2%) developed a pulmonary embolism within 90 days following discharge from hospital. All 4 (1.7%) of these were prescribed IPC, compared to 0 (0%) of patients prescribed a GEKO device.
Conclusion: The incidence of VTE was low using IPC as primary prevention and GEKO devices when these were not tolerated or contraindicated. A prospective randomized study is needed to test effectiveness of the GEKO device.

OG17

REstart or STop Antithrombotics Randomised Trial (RESTART)

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Introduction: For adults surviving stroke due to spontaneous (non-traumatic) intracerebral haemorrhage (ICH) who had taken an antithrombotic (i.e. anticoagulant or antiplatelet) drug for the prevention of vaso-occlusive disease before the ICH, does a policy of starting antiplatelet drugs result in a beneficial net reduction of all serious vascular events over at least 6 months compared with a policy of avoiding antiplatelet drugs? Do brain microbleeds modify the effects of antiplatelet drugs?

Methods: Participants: Adults surviving ICH who had taken an antithrombotic drug for the prevention of vaso-occlusive disease before the ICH.
Intervention: Start antiplatelet drugs (aspirin, clopidogrel or dipyridamole; chosen at investigator's discretion). Optional sub-study of brain magnetic resonance imaging (MRI) to assess microbleeds before randomisation.
Comparator: Avoid antiplatelet drugs.
Outcomes: recurrent symptomatic ICH (primary); vaso-occlusive events, symptomatic stroke of uncertain type, other fatal events, modified Rankin Scale score, and adherence to antiplatelet drugs (secondary).
Randomisation: Central, web-based system using a minimisation algorithm, with 1:1 treatment allocation to which central research staff are masked.
Follow-up: Central: annual postal or telephone questionnaires to participants and their GPs. Local: medical records and any brain imaging relating to outcomes. Administrative data: Death certificates and Hospital Episode Statistics.
Sample size: At least 720 participants in the main trial (at least 550 in the MRI sub-study).
Results: 416 participants have been recruited by 7th June 2017. Recruitment closes 31 May 2018. Follow-up ends 30 November 2018.
Conclusion: Registration: ISRCTN71907627. Website: www.RESTARTtrial.org

OG18

Start or STop Anticoagulants Randomised Trial (SoSTART)

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Introduction: For adults surviving spontaneous (non-traumatic) symptomatic intracranial haemorrhage with persistent/paroxysmal atrial fibrillation/flutter (AF), does starting full treatment dose oral anticoagulation (OAC) result in a beneficial net reduction of all serious vascular events compared with not starting OAC?
Methods: Participants: Spontaneous symptomatic intracranial haemorrhage, AF and a CHA2DS2-VASc score ≥ 2.
Intervention: Start long-term ($\geq$ 1 year) full treatment dose OAC (either a non-vitamin K antagonist direct oral anticoagulant [DOAC] or warfarin if a DOAC cannot be used), chosen by the patient's physician before randomisation.
Comparator: Do not start OAC (standard clinical practice without OAC may include antiplatelet drug(s) or no antithrombotic drugs).
Outcomes: Primary outcome: All symptomatic serious vascular events (i.e. major adverse cardiac or cerebrovascular events [MACCE]) including non-fatal stroke, non-fatal acute coronary syndrome, vascular death, sudden death, or death of unknown cause. Secondary outcomes: individual symptomatic vascular events; individual types of fatal events; dependence according to the modified Rankin Scale.
Randomisation: Central, web-based randomisation, with 1:1 allocation of intervention: comparator, using a minimisation algorithm.
Follow-up: At least 1 year after randomisation, using annual questionnaires to participants and their GPs, including review of any medical records and brain imaging relating to outcomes.
Results: Recruitment will begin by the end of 2017. We plan for a pilot phase, followed by a main phase.
Conclusion: Registration: NCT03153150. Website: www.SoSTART.ed.ac.uk

OG19

The Triple therapy prevention of Recurrent Intracerebral Disease EveNts Trial (TRIDENT)

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Introduction: Survivors of acute intracerebral haemorrhage (ICH) are at high risk of recurrent stroke and other serious vascular events including cognitive decline. Blood pressure (BP) lowering is an effective prevention strategy for ICH, but BP control is sub-optimal or non-existent in many populations and there is uncertainty over the optimum systolic BP target. TRIDENT aims to determine reliably the effectiveness of a novel, fixed, low-dose 'Triple Pill' approach to BP lowering treatment on top of standard care for the prevention of recurrent stroke and other serious vascular events after ICH.
Methods: This is an investigator-initiated and conducted, international, multi-centre, double-blind, placebo-controlled, randomised trial involving 4,200 participants from 150+ sites in up to 9 countries. Patients with an ICH within 6 months and a systolic BP of 130–160 mmHg, who successfully complete a 2 week active run-in phase, will be randomised to receive low-dose triple combination (telmisartan, amlopidine, indapamide) or matched placebos. Follow-up assessments are 6-monthly for an average of 3 years. The study has 90% power to detect a 40% reduction in time to recurrent ICH.
Results: Establishment of coordinating centres, country networks and clinical sites, began in January 2017, and participant recruitment from June 2017. We plan a UK pilot phase involving 10 sites participating in the RESTART trial, followed by a main phase after confirming feasibility and funding.
Conclusion: Registration: NCT02699645. Website: http://www.georgeinstitute.org/projects/triple-therapy-prevention-of-recurrent-intracerebral-disease-events-trial-trident

Thursday:

OG20
Identifying priorities for end-of-life care after stroke

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Introduction: Despite recent advances in the treatment and management of stroke, death rates from stroke remain high. 1 in 8 patients die within the first 30 days after having a stroke. These mortality rates are anticipated to continue to increase because of the aging population. A review published in 2007 highlighted key provisions that need improving in palliative care for stroke patients (symptom control, psychosocial support, accessibility of information for informal carers about patient's condition, support surrounding caring experience and systematic provision of palliative care based on need). However, recommendations from that review are now dated as changes to policy and practice have been made. Therefore, there is a need to identify current priorities for End-of-Life Care (EoLC) after stroke. The aim of this study was to explore current evidence underpinning EoLC after a stroke.
Methods: We conducted a scoping review of the literature with a focus on EoLC after stroke. We used agreed search terms: 'end-of-life care' AND 'stroke'. We searched 3 databases (Medline, CINAHL and Cochrane library) to identify key papers published.
Results: We identified a number of key issues, which lacked evidence from the literature. These were supportive needs of carers, recognising dying, symptom management, clinical-decision making, communication and education.
Conclusion: The key issues identified from this scoping review will inform the development of further research in this area (e.g. guidelines, surveys and interventions) that aim to improve EoLC after stroke.

OG21
Relationship between duration of mechanical thrombectomy and outcome

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Introduction: Mechanical thrombectomy has been approved by NICE as a treatment option for acute ischaemic stroke. While most interventions take no longer than 90 minutes after groin puncture, some are prolonged due to difficult access, complications, or occlusions in multiple vessels.
Methods: Data extracted from the University Hospital of North Staffordshire (UHNM) thrombectomy register included procedure duration (groin puncture to final catheter angiogram, intra-procedural complications, symptomatic intracranial haemorrhage within 24–36 hours, and functional outcome at 90 days.
Results: 281 patients were included between 1st December 2009 and 14th April 2016 (median age 64 years, 157 (57%) males, median National Institutes for Health Stroke Scale score 18). The procedure duration was < 1 hour in 116, < 2 hours in 105, < 3 hours in 42, < 4 hours in 11, and ≥ 4 hours in 2. The median modified Rankin Scale Score was 2, 2, 4, 4, and 6 and mortality; 13 (11%), 17 (16%), 10 (24%), 10 (18%), and 2 (100%) for these timings respectively. Patients with longer intervention times were more likely to have additional procedures (angioplasty, stent placement) and to have peri-procedural complications (clot propagation, dissection, subarachnoid haemorrhage).
Conclusion: Thrombectomies with longer procedure duration are less likely to have good outcomes, and are more often associated with complications.

OG23

Baseline characteristics of patients in the Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial-2 (RIGHT-2): an interim analysis

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Introduction: High blood pressure (BP) is common in acute stroke. Glyceryl trinitrate (GTN), a nitric oxide donor, is a candidate treatment for acute stroke; it lowers blood pressure, does not alter cerebral blood flow or platelet function, and is neuroprotective in experimental stroke. A meta-analysis of trials showed that GTN improved functional outcome when administered early (within 6 hours of stroke onset). The Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial-2 (RIGHT-2) trial aims to assess the safety and efficacy of ambulance-based, paramedic-delivered GTN when administered within 4 hours of stroke onset.
Methods: The RIGHT-2 trial is a multicentre UK-based prospective randomised sham-controlled outcome-blinded parallel-group trial in patients with presumed stroke who present to the ambulance service following a 999 emergency call. The primary outcome is the modified Rankin scale (mRS) measured by central telephone follow-up at 90 days. Secondary outcomes include: BP, impairment, recurrence, discharge disposition, length of stay, death, disability, cognition, quality of life and mood.
Results: As of April 2017, 486 patients were recruited from 7 ambulance services to 39 centres across the UK. Baseline characteristics collected by paramedic in the ambulance include: age 72 (14.8), male 50%, Glasgow coma scale 14 (1.6), FAST score 2.6 (0.5), SBP 162 (26). Time from stroke onset to randomisation 66 [42, 106] minutes.
Conclusion: The ongoing RIGHT-2 trial aims to assess the safety and efficacy of transdermal GTN in hyper-acute stroke, delivered in the pre-hospital setting. It aims to recruit 850 patients by November 2017.

OG24

Stroke mimics in the Rapid Intervention with Glyceryl trinitrate in Hypertensive Trial-2 (RIGHT-2): a comparison of pre-hospital stroke screening tools

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Introduction: The ongoing Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial (RIGHT-2) trial aims to assess the safety and efficacy of paramedic-delivered transdermal glyceryl trinitrate (GTN) in patients with ultra-acute stroke. Based on previous data the predicted stroke mimic rate was 10%, but this is much higher in RIGHT-2 to date (23.6%). We assessed differing screening tools used in pre-hospital stroke trials to potentially reduce the number of stroke mimics without impacting upon overall recruitment and scientific validity.
Methods: RIGHT-2 is an ongoing prospective randomised single-blind blinded-endpoint parallel group trial enrolling 850 patients with suspected stroke (Face Arm Speech Time (FAST) $\geq$ 2/3) within 4 hours of onset. Comparisons were made between the inclusion/exclusion criteria of RIGHT-2 with FAST and modified Los Angeles Pre-hospital Stroke Screen (mLAPSS) used in the FAST-MAG trial.
Results: As of June 2017, 577 patients were recruited into the trial. RIGHT-2 inclusion/exclusion criteria and mLAPSS differences include: age; blood glucose; seizure history; symptom duration; pre-stroke disability; assessment of neurological deficit and conscious level. Compared with the RIGHT-2 inclusion/exclusion criteria, mLAPSS would have led to 39 fewer mimics being recruited 97 (16.8%) vs 136 (23.6%). However, mLAPSS would also have excluded 33 (9.0%) stroke and 3 (5.5%) transient ischaemic attack participants compared with current RIGHT-2 inclusion/exclusion criteria.
Conclusion: Pre-hospital trials are feasible and may be the most effective design for testing ultra-acute time-dependent interventions. Pragmatic pre-hospital trial inclusion/exclusion criteria and safety data on mimics may ultimately ease implementation of interventions into clinical practice.

OG25

Paramedic Acute Stroke Treatment Assessment (PASTA) trial: study progress

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Introduction: Rapid treatment of stroke can improve the chances of recovery. It is important that patients are assessed quickly to decide if it is appropriate to deliver thrombolysis treatment. This study is evaluating whether an enhanced assessment by paramedics could speed up treatment.
Methods: Study design: Multicentre randomised trial with cost-effectiveness analysis and parallel process evaluation.
Setting: NHS ambulance services, emergency departments and stroke units within 3 geographical regions of England and Wales.
Study intervention: A Paramedic Acute Stroke Treatment Assessment (PASTA) pathway initiated by paramedics and continued initially in hospital to facilitate the speed of brain imaging and delivery of thrombolysis when clinically appropriate.
Study control: Usual care according to national and local guidelines for the pre-hospital and hospital assessment of suspected stroke.
Randomisation: Ambulance stations within each region randomised to delivering the PASTA pathway or continuing with usual stroke care.
Participants: Intervention paramedics deliver the PASTA pathway to adults within 4 hours of suspected stroke onset. Participants enrolled in the study are adults with confirmed stroke who were assessed by a study paramedic within 4 hours of onset.
Primary outcome: Proportion of participants receiving intravenous thrombolysis.
Process evaluation: Semi-structured interviews with a subsample of participants and staff to gain insight into perceptions and experience of the PASTA pathway.
Sample size: Allowing for 1% attrition, 1,297 participants provide 90% power to detect a 10% difference in the proportion of patients receiving thrombolysis.
Results: This study opened to recruitment in December 2015 and is currently running in 15 NHS Trusts. At submission of this abstract, 576 participants had been enrolled.
Conclusion: N/A.

OG26

A European, multicentre, Phase III, clinical trial of HYPothermia for acute ischaemic stroke: EuroHYP-1

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Introduction: Cooling is a promising neuroprotective intervention in experimental ischaemic stroke. Cooling to 35°C reduced infarct size by about one third. Cooling awake ischaemic stroke patients to 35°C has been shown feasible and safe, but whether this is safe and effective has not been tested in a large clinical trial. Aim:
To determine whether systemic cooling to target temperature of 34 to 35°C, started within 6 hours of symptom onset and maintained for 12 hours, improves functional outcome at 3 months in patients with acute ischaemic stroke.
Methods: Open, randomised, Phase III, multicentre, international clinical trial with masked outcome assessment testing the safety and efficacy of therapeutic cooling in 800 awake adult patients with acute ischaemic stroke. Cooling will be initiated within 6 hours of symptom onset with an intravenous infusion of 20 ml/kg cooled normal saline (4°C) over 30 to 60 minutes, followed by either surface or endovascular cooling to 34 to 35°C, maintained for 12 hours. Shivering and discomfort will be prevented and treated with anti-shivering drugs. All patients will receive best medical treatment, including alteplase, if indicated. The primary outcome is centrally adjudicated modified Rankin Scale at 90 days (shift analysis). A trial with 400 patients per arm has 80% power to detect a 7% absolute improvement in the mRS at the 5% significance level.
Results: As of 8th June 2017, 84 patients have been recruited across 20 sites in 6 countries. 27 patients have been enrolled in the UK; at Northwick Park, UCLH, Nottingham, Liverpool, Royal London, Surrey, Newcastle and Sheffield.
Conclusion: EuroHYP-1 is ongoing, funded by the European Commission 7th Framework Programme (FP7/2007-2013-278709).

OG27

TICH-2 Trial – Tranexamic acid for IntraCerebral Haemorrhage 2

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Introduction: To assess in a pragmatic Phase III prospective double blind randomised placebo-controlled trial whether tranexamic acid is safe and reduces death or dependency after spontaneous intracerebral haemorrhage (SICH). The results will determine whether tranexamic acid should be used to treat ICH.
Methods: Patients will be randomised (1:1) to receive either tranexamic acid or placebo (0.9% saline) within 8 hours of acute SICH. Randomisation will be computerised and minimised on key prognostics age; sex; time since onset; systolic blood pressure; stroke severity (NIHSS); presence of intraventricular haemorrhage and known history of antiplatelet treatment. Patients, investigators and outcome assessors will be blind to treatment allocation. The primary outcome is death or dependency (modified Rankin Scale) and telephone follow-up is at day 90.
Results: The start-up phase of the trial commenced on 1st March 2013, the main phase commenced 1st April 2014. The recruitment target was 300 participants in the start-up phase and 2,000 in the main phase. As of 30th May 2017, 2,191 patients have been recruited from 123 centres (UK, Georgia, Italy, Malaysia, Switzerland, Republic of Ireland, Turkey, Sweden, Denmark, Hungary, Spain and Poland). The objective was to have 80 UK centres and 40 international centres.
Conclusion: Disclaimer: The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the Health and Technology Assessment Programme, NIHR, NHS or the Department of Health. Contact information: E-mail: tich-2@nottingham.ac.uk, Telephone: +44 (0)115 823 1770

OG28

Mechanical thrombectomy for tandem occlusions of the internal carotid artery

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Introduction: Outcome of patients with tandem occlusion of the internal carotid artery (ICA) and an intracranial artery is poor if treated medically, with mortality up to 40%. We report the outcome of 59 cases treated with mechanical thrombectomy and/or angioplasty for tandem occlusions since 2009.
Methods: Data extracted from the University Hospital of North Staffordshire (UHNM) thrombectomy register included location of occlusion, treatment modality, procedural timings, complications, and functional outcome at 90 days.
Results: 59 out of 300 patients had tandem ICA occlusion and were treated with angioplasty and or stenting (mean National Institutes for Health Stroke Scale score 17, mean door to femoral puncture time 117 min). 9 patients had contraindications to intravenous alteplase, but the others received a standard 10% bolus of the maximum dose (0.9 mg/kg body weight). 8 (47%) patients were alive and independent at 90 days (mRS < 3). 13 (22%) died of a large haemorrhagic infarction and swelling of the brain. Peri- and post-procedural complications included: clot propagation (n = 10), distal embolization (n = 2), vertebral artery occlusion (n = 1), ICA dissection (n = 1), new infarct in unrelated territory (n = 1), vasospasm (n = 7), and subarachnoid haemorrhage (n = 1), reocclusion (n = 1). 33 patients (54%) had no complications.
Conclusion: Mechanical thrombectomy with stenting and/or angioplasty is associated with good outcomes in almost 50% of patients with tandem occlusion of the internal carotid artery.

OG29

Interim analysis of ambulance logistics and timings in patients recruited into the Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial-2 (RIGHT-2)

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Introduction: Stroke is a severe condition with high morbidity and mortality. Despite treatment effects in acute stroke being predominantly time dependent (e.g. thrombolysis and thrombectomy), proven treatments are hospital based and require prior brain scanning to identify intracerebral haemorrhage. Commencing treatment in the ambulance could dramatically reduce time to treatment.
Methods: The Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial-2 (RIGHT-2) is a multicentre prospective randomised single-blind blinded-endpoint parallel group trial assessing the safety and efficacy of ambulance-based, paramedic-delivered glyceryl trinitrate (GTN) when administered within 4 hours of stroke onset. Paramedics trained in RIGHT-2 procedures assess, take appropriate consent and enrol eligible FAST-positive patients and apply the first of 4 GTN or sham transdermal patches that are continued during hospital admission. Timings, vital signs and distances are recorded.
Results: 563 participants enrolled across 7 UK NHS ambulance services were assessed in this interim analysis. Median [interquartile range] timings in minutes were: symptom onset to 999 call 16 [5, 56], call-dispatch 2 [1, 5], onset-randomisation 64 [41, 105], arrive scene-randomisation 21 [14, 31] with no difference between participants scoring FAST 2 or 3, scene-departure 31 [25, 40]), departure-hospital 16 [10, 24]. All timings were comparable to a cohort of 49

stroke patients across East Midlands Ambulance Service who were not enrolled in to RIGHT-2, e.g. scene-departure 32 [23, 40].
Conclusion: Randomisation of participants to an ambulance-based stroke trial is possible. Paramedics can rapidly identify eligible patients, gain appropriate consent, randomise and commence treatment en route to hospital without prolonging time spent on scene.

OG30

Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial-2 (RIGHT-2): safety and efficacy of transdermal glyceryl trinitrate, a nitric oxide donor

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Introduction: High blood pressure (BP) is common in acute stroke and is associated with poor outcome. Previous hospital-based trials testing the effects of BP lowering on functional outcome have been inconclusive. The PIL-FAST and RIGHT pilot trials confirmed the feasibility of performing single-centre ambulance-based stroke trials in the UK. In both RIGHT and a subgroup of patients recruited within 6 hours into the large ENOS trial, transdermal glyceryl trinitrate (GTN, a nitric oxide donor) lowered BP and reduced death or disability. Based on these results, the Rapid Intervention with Glyceryl trinitrate in Hypertensive Stroke Trial-2 (RIGHT-2) is testing the safety and efficacy of transdermal GTN in the pre-hospital setting.
Methods: Over 1,100 paramedics from 7 UK ambulance services serving over 40 comprehensive or primary stroke care centres are screening, consenting, randomising and treating 850 patients presenting within 4 hours of FAST-positive stroke and with systolic BP > 120 mmHg. Treatment comprises GTN or similar sham patch, and is continued in hospital for 3 days. The primary outcome is the modified Rankin Scale at day 90. Secondary outcomes include vascular events, disability, quality of life, mood and cognition. Neuroimaging and biomarkers are examining potential mechanisms of action.
Results: Recruitment commenced in October 2015. As of Monday 5th June 2017, 579 patients have been recruited from 7 ambulance trusts conveying patients into 42 active stroke centres. Experiences with the trial and baseline characteristics of the recruited patients-to-date will be presented.
Conclusion: Website: http://www.right2-trial.org

OG31

PRACTISE Trial: Penumbra and Recanalisation Acute Computed Tomography in Ischaemic Stroke Evaluation

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Introduction: The use of multimodal brain imaging, including CTP and CTA provides valuable information on tissue viability and vascular anatomy that may be helpful in patient stratification for revascularisation therapy. However, it is currently unknown whether benefits from potentially improved patient selection outweighs the disadvantages of additional resource utilisation, radiation and contrast exposure, and treatment delay associated the use of additional multimodal CT imaging. This study aims to evaluate the effect of additional CT imaging on the number of acute stroke patients treated with intravenous rtPA and their outcomes.
Methods: PRACTISE is a prospective, multicentre randomised controlled trial (RCT) comparing current evidence based imaging (NCCT alone, control arm) with additional multimodal CT imaging (CT+CTA+CTP, experimental arm). Patients with acute ischaemic stroke, ≥ 18 years, and clinically eligible for intravenous rtPA treatment are randomised in the ratio of 1:1 into each arm. Primary endpoint is the proportion treated with rtPA. Secondary endpoints evaluate times to decision making, comparison of different image processing software and clinical outcomes at 3 months. Randomisation of a maximum of 400 patients is planned.
Results: By early June 2017, 9 sites are open for recruitment in the UK with 158 patients randomised.
Conclusion: Understanding the role of CTA and CTP in thrombolysis decision would guide their use in clinical practise. If additional diagnostic testing identifies a subgroup of patients that are more or less likely to respond to treatment and hence influences treatment decisions favourably, then these could be adopted as standard practice.

OG32

REmote ischaemic Conditioning After Stroke Trial-2 (RECAST-2): a pilot randomised controlled Phase II trial evaluating remote ischaemic conditioning (RIC) after hyperacute stroke

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Introduction: Remote ischaemic per-conditioning (RIC) in experimental ischaemic stroke is neuroprotective and is achieved by repeated transient occlusion of the blood supply to a limb. The mechanisms of protection are unclear but probably relate to the release of numerous neurohumoral mediators such as heat shock proteins or nitric oxide.
Methods: The REmote ischaemic Conditioning After Stroke Trial-2 (RECAST-2) is an ongoing pilot 2-centre blinded sham-controlled dose-escalation trial in patients with hyperacute ischaemic stroke, randomised 1:1 to receive RIC (4 5-minute cycles of cuff inflation and deflation) to the non-paretic upper limb in 3 blocks of increasing dose: the first 20 patients will receive RIC once, within 6 hours of onset; the second 20 patients undergo a second dose of RIC 1 hour later; the final 20 patients, twice daily dosing until day 4. The primary outcome is trial feasibility with secondary outcomes at day 4 and 90: tolerability, safety, putative biomarkers of mechanism and efficacy (plasma heat shock proteins and serum S100-beta) and clinical efficacy (impairment [NIHSS], dependency [modified Rankin Scale], disability [Barthel Index], mood and cognition) performed by blinded outcome assessors. Sponsored by the University of Nottingham.

Results: The trial commenced recruitment in August 2016 across 2 sites, Derby Teaching Hospitals NHS Foundation Trust and Nottingham University Hospitals NHS Trust. Recruitment rate runs at ~3 patients per month.
Conclusion: RECAST-2 aims to complete recruitment in Q2 2018 (n = 60). Data on compliance, feasibility and biomarkers after repeated dosing will inform the design of a larger trial.

OG33

Oxygen saturation in stroke patients at the time of arrival to hospital

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Introduction: Hypoxia is common but frequently intermittent in the first few days after stroke and associated with worse outcomes. UK Stroke Guidelines suggest that oxygen should be given if the oxygen saturation falls below 95%. The aim of this survey is to determine how common hypoxia is very early after the stroke, plus immediately after presentation to accident and emergency.
Methods: Baseline demographics and vital physiological parameters including oxygen saturation are recorded immediately after arrival for every patient who presents to the emergency department at the Royal Stoke University Hospital. These data were collected retrospectively for all patients with a confirmed diagnosis of acute stroke for this audit between 1st November 2015 and 31st March 2016.
Results: 274 sequential patients were included. The mean oxygen saturation on arrival was 96.9% (range 85–100%). Of these 244 (89%) had an oxygen saturation > 95%, 28 (10%) a saturation of 90–95%, and 2 (0.7%) a saturation below 90% (85 and 86% respectively). 4 patients (1.5%) were treated with oxygen at the time of arrival. Their oxygen saturations were 92% on 2 L/min, 2 with 93% on 4 L/min, 93%, and 95% on 4 L/min. Severe hypoxia (saturation less than 90% on air or < 95% on oxygen) occurred in 6 (2%).
Conclusion: Very early after acute stroke, most patients have normal or high normal oxygen saturation. Very few patients required supplemental oxygen prior to admission. Severe hypoxia therefore, is very uncommon in acute stroke patients on arrival.

OG34

Alteplase-Tenecteplase Trial Evaluation for Stroke Thrombolysis (ATTEST 2)

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Introduction: Intravenous (IV) thrombolysis with alteplase, the only medical treatment currently approved for acute ischaemic stroke, significantly increases the probability of excellent recovery. A recent trial has demonstrated that the modified tissue plasminogen activator tenecteplase at a dose of 0.4 mg/kg is of similar safety and efficacy to alteplase in acute stroke. In addition to having simpler administration, tenecteplase 0.25 mg/kg is also potentially superior to alteplase with respect to efficacy, based on meta-analysis of small trials. More data are required to establish the true risk-benefit profile compared with alteplase.
Methods: ATTEST-2 will establish whether tenecteplase is superior to alteplase by undertaking a prospective randomised open blinded end-point (PROBE) trial in patients eligible for IV thrombolysis based on non-contrast CT imaging. 60 UK

centres will recruit 1,870 patients.
Results: Primary outcome is the distribution of modified Rankin Scale (mRS) outcomes at day 90, determined by the Rankin Focused Assessment method, analysed by ordinal distribution ("shift") analysis of the of scores in intervention and control groups.
Conclusion: An agent with superior risk:benefit ratio to alteplase would further encourage treatment of a greater proportion of eligible patients than at present and strengthen the service reorganisation necessary to deliver acute care. Acute stroke treatment has established reperfusion as an achievable and clinically valuable treatment, but needs to move forward to optimise reperfusion strategies. This trial is a step towards this goal.

OG35

TEMPO-2: TNK-tPA for minor ischaemic stroke with proven acute symptomatic occlusion trial-2

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Introduction: Minor stroke and TIA with an intracranial occlusion are associated with a 20–30% risk of deterioration and disability. Tenecteplase (TNK-tPA) compared to alteplase is easier to administer, has a longer half-life, higher fibrin specificity and possibly less intracerebral haemorrhage (ICH). It may be an ideal thrombolytic agent in this population. A pilot study, TEMPO-1, showed feasibility and safety. TEMPO-2 (NCT02398656) examines tenecteplase for the treatment of minor stroke with imaging defined intracranial occlusion.
Methods: Multi-center, prospective, open-label, randomized controlled trial comparing tenecteplase to best standard of care. Patients with an NIHSS < 6, intracranial arterial occlusion on CTA, and within a 12 hour treatment window will be enrolled (expected sample size of 1,274 patients). Patients will be randomized 1:1 to receive 0.25 mg/kg intravenous tenecteplase or control, defined as the best standard of care and minimally must include immediate treatment with ASA. The primary outcome will be a responder analysis defined by the modified Rankin Scale score at 90 days. Safety will be assessed by the rate of symptomatic ICH. Secondary outcomes include complete neurological (NIHSS 0–1) and functional (mRS 0–1) recovery at 90 days, recanalization at 4–8 hours on CTA and minor bleeding.
Results: The study has received regulatory approval and is registered. The trial is currently running in Canada. Sites in Europe and Australia are expected to start enrolment in 2017. The first 93 patients have been enrolled. This study is in the site activation phase and is expected to continue for up to 5 years.
Conclusion: N/A.

OG36

Robot Assisted Training for the Upper Limb after Stroke (RATULS): intervention adherence

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Introduction: The RATULS trial is evaluating robot assisted training for upper limb (UL) recovery after stroke compared to an UL therapy programme of the same frequency and duration, and usual post-stroke care. Here we report intervention adherence for the 2 intervention therapy programmes over the first 3 years of recruitment.
Methods: The frequency and duration of the RATULS therapy programmes is 45 minutes, 3 times per week for 12 weeks (36 sessions). Robot-assisted training uses the InMotion robotic gym system (wrist and shoulder-elbow modules with/without the hand attachment). It is a prescriptive training programme which aims for participants to achieve above 1,000 movement attempts per session. The study robots record data about each session. Enhanced UL therapy uses task-orientation practice to work towards up to 4 UL rehabilitation goals. There is no repetition target for this programme. The study therapists record data about each session.
Results: By 1st February 2017, 161 participants had concluded robot-assisted training and attended 5,091/5,796 (88%) sessions. The median duration on the robot for attended sessions was 41 minutes [IQR 37–44] with participants achieving a median of 903 movement attempts [IQR 787–1,088] on the wrist module and 842 [IQR 735–925] on the shoulder-elbow module per session. 157 participants had concluded enhanced UL therapy and attended 4,845/5,652 (86%) sessions. The median session duration for enhanced UL therapy sessions was 45 minutes [IQR 45–45].
Conclusion: Currently intervention adherence is good for both therapy programmes. Study results, including a full description of compliance with interventions, will be published in 2019.

OG37

Stem cells: stroke survivor and carer views in relation to stem cell clinical trials using placebo neurosurgery

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Introduction: There are few studies that explore stroke survivor views and motivations towards stem cell therapy. This qualitative study explores the views and motivations of both stroke survivors and their partners/carers towards a proposed 2-arm Phase III randomised controlled trial (RCT) comparing intracerebral insertion of stem cells with placebo neurosurgery in stroke survivors with disability.
Methods: Data were collected via 5 Conversation Cafes with stroke survivors (age 40–75) and partners/carers between June–October 2016. Qualitative data were analysed using a thematic approach.
Results: Stroke survivor views and motivations reflect anticipation of personal and future benefit of regenerative medicine. Partners/carers sought to balance the value of stroke survivor hope with carrying the weight of hope as a carer, a conflict-burden adding to existing caregiver burden. This has significant implications for rehabilitation and support.
Conclusion: This study provides a rare opportunity to explore the views and motivations of stroke survivors and their partners/carers towards a proposed Phase III 2-arm RCT. This adds weight to qualitative evidence exploring rehabilitation and support needs, decision-making and perceptions of treatment risks.

OG38

The REduCing sedentaRy bEhaviour After sTrokE Study (RECREATE): development and evaluation of an intervention to improve outcomes

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Introduction: Evidence suggests that sedentary behaviour has detrimental effects on health and well-being. Stroke survivors are particularly sedentary compared to age-matched controls and at risk of associated negative effects including reduced physical function, increased mood problems and mortality. This NIHR-funded programme aims to develop and evaluate a complex intervention to reduce/break up sedentary behaviour after stroke.
Methods: The programme comprises 5 work-streams (WS). WS1 will update quantitative and qualitative evidence relating to sedentary behaviour through systematic reviews. WS2 is a qualitative study involving observations in 2 stroke services and interviews with patients, carers and staff, to explore sedentary behaviours and participants' capability, opportunity and motivation to address them. WS3 will develop an intervention using co-production principles; WS4 will explore the feasibility of its implementation using a case-study and action research approach. Finally, WS5 will evaluate clinical and cost-effectiveness using a multicentre cluster Randomised Controlled Trial in 34 stroke services with embedded process evaluation.
Results: The primary outcome will be health and disability (WHO Disability Assessment Schedule) at 12 months after recruitment (n = 1,156). Outcomes will be assessed at baseline, 6, 12 and 24 months and include sedentary behaviour, mood, quality of life, vascular events, CVD risk factors, death and health/social care service use.
Conclusion: The research will generate an internationally-leading dataset on patterns of sedentary behaviour after stroke, with linked health outcomes, and robustly evaluate a comprehensive intervention protocol suitable for a range of abilities. A successful intervention has potential to substantially impact functioning, health and well-being outcomes for stroke survivors at relatively low cost.

OG39

Clinical practice guidelines for stroke rehabilitation and long-term management: similarities and differences in recommendations for mood, aphasia and cognitive deficits

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Introduction: Intervention literature for long-term rehabilitation after stroke focuses on physical outcomes while the majority of stroke survivors also report emotional, cognitive and speech and language problems. As clinical guidelines for

long-term stroke rehabilitation set priorities for stroke management, they influence how these are addressed. The aim of this review is to compare psychological and pharmacological treatment recommendations for long-term management of these problems after stroke.

Methods: A systematic grey literature search for current national clinical guidelines using custom Google searches (until July 2016) across Western English-speaking countries was performed. Guideline quality was assessed with the validated AGREE II tool.

Results: Guidelines from 6 countries with comparable healthcare systems were identified: National Institute for Health and Care Excellence (NICE), Stroke Foundation of New Zealand (SFNZ), Scottish Intercollegiate Guidelines Network (SIGN), American Heart Association (AHA), National Stroke Foundation (NSF) and Canadian Stroke Best Practice Recommendations (CSBPR). NICE, SIGN, AHA and CSBPR focused specifically on long term rehabilitation. For aphasia all guidelines recommend referral to speech and language therapy, but they vary with regard to pharmacotherapy. Guidelines vary in recommended referrals and treatment for cognitive deficits. SFNZ, NICE and NSF recommend psychotherapy for post-stroke depression while pharmacotherapy is recommended by SIGN.

Conclusion: Insufficient evidence on effectiveness of interventions to address psychological outcomes after stroke contributes to inconsistencies and lack of specificity in recommendations. This may reduce both compliance with and impact of the guidelines. There should be a greater emphasis in stroke research on these aspects of long-term management.

OG40

A randomised controlled feasibility trial to investigate the effects of a functional standing frame programme versus usual physiotherapy in people with severe sub-acute stroke

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Introduction: The most common physical deficit caused by a stroke is muscle weakness which limits a person's mobility. Mobility encompasses activities necessary for daily functioning: getting in and out bed, on/off toilet, sitting, standing and walking. These activities are significantly affected in people with severe stroke who typically spend the majority of their time in bed or a chair and are immobile. Immobility is primarily caused by neurological damage but exacerbated by secondary changes in musculoskeletal and cardiorespiratory systems. These secondary changes can theoretically be prevented or minimised by early mobilisation, in this case standing up early post-stroke. Standing up early post-stroke has been identified as an important priority for people who have suffered a severe stroke. However, trials of prolonged passive standing have not demonstrated any functional improvements. Conversely, task-specific training such as repeated sit-to-stand has demonstrated positive functional benefits. This feasibility trial combines prolonged standing and task-specific strength training with the aim of determining whether this novel combination of physiotherapy interventions is feasible for people with severe stroke as well as the overall feasibility of delivering the trial. Our eventual aim is to determine if this combination is clinically and economically effective.

Methods: This is a pragmatic multi-centre feasibility randomised controlled trial with blinded outcome assessment. 50 people with a diagnosis of severe stroke, using National Institutes of Health Stroke Scale ≥ 16 or Modified Rankin Scale

≥ 4, will be randomly allocated to either the functional standing frame programme plus usual physiotherapy or to usual physiotherapy alone. All participants will be assessed at baseline and followed up at 3 weeks; then 3, 6 and 12 months post-randomisation. The outcomes of this feasibility trial include:

- Feasibility of delivering the intervention to people with severe stroke in a sub-acute inpatient rehabilitation setting including acceptability, tolerance and adherence.
- Ability and willingness of participants to provide consent and willingness of consultees to provide assent.
- Number and nature of adverse events.
- Impact and management of orthostatic hypotension.
- Acceptability of outcome measures, data completeness and ability to detect change.
- Generate realistic estimates of eligibility, recruitment, consent and follow-up rates.
- Process evaluation via assessment of treatment fidelity and qualitative evaluation of participant and treating physiotherapist experience.

Results: None. Recruitment is due to close September/October 2017.

Conclusion: The functional standing frame programme addresses a key concern for people who have suffered a severe stroke. However, several uncertainties exist which need to be understood prior to progressing to a full-scale trial, including acceptability and tolerance of the functional standing frame programme intervention and practicality of the trial procedures. This feasibility trial will provide important insights to resolve these uncertainties and enable a protocol to be finalised for use in the definitive trial.

OG41

"I ken if I've been sitting too long. I just get up and walk about and do something" What stroke survivors do when they are sitting and strategies used to break prolonged sitting

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Introduction: Sedentary behaviour (SB) is any waking behaviour where sitting or lying is the dominant posture and energy expenditure is low. Guidelines encourage reducing prolonged SB after stroke, but how to do this is unclear. A qualitative study was undertaken to elicit the views of stroke survivors on SB. We present the sitting activities stroke survivors reported and the strategies they used to break prolonged sitting.

Methods: Independently mobile Scottish stroke survivors were interviewed in their own homes at 3 months post stroke. Interviews were audio-recorded, transcribed verbatim and are being analysed using the Framework Method.

Results: 31 participants were interviewed (mean age = 66.8; SD = 14.6 years; 17 male). 14 interviews have been analysed (mean age = 64.0; SD = 17.4 years; 6 male). Participants described sitting activities across 3 domains: leisure-time, transport and occupation. Frequently reported sitting activities were watching television, socialising with friends/family, reading and resting. Strategies for breaking sitting were employed by many participants, mainly as part of their daily routine. Strategies clustered into themes relating to walking (round the room when reading papers; around the house; outside; parking car further away), preparing food from scratch to spend more time standing, visiting friends, spreading tasks throughout the day and standing when on the phone. Some participants were conscious of breaking sitting. Reasons for doing so related to relieving boredom or discomfort, rather than reducing sitting time.

Conclusion: Stroke survivors engage in a wide range of sitting activities. Understanding strategies employed by stroke survivors to break sitting is essential to allow development of successful interventions.

OG42

Primary care interventions for long-term outcomes after stroke: a scoping review of reviews and recent trials

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Introduction: An integrative account of the scope and focus of primary care interventions to address long-term outcomes after stroke is lacking. We aimed to provide an overview of generalist-delivered interventions to improve functional, physical and psycho-social outcomes in stroke survivors living in the community and their informal caregivers.
Methods: Established scoping review methodology (Arksey and O' Malley, 2005) was adopted. Inclusion criteria: (1) systematic reviews and meta-analyses of randomised controlled (RCTs) and/or controlled trials, supplemented with most recent (2011–2015) trials, (2) interventions delivered in primary care and/or community, (3) by generalist healthcare professionals. Exclusions: drug efficacy reviews/trials. 6 databases were searched: Medline, Embase, PsycINFO, CINAHL, COCHRANE Reviews and Clinicaltrials.gov. Data were extracted by 2 independent reviewers, collated and summarised.
Results: 21 systematic reviews (including 14 meta-analyses), and 10 RCTs were identified (35,188 total participants). Interventions were mapped on to International Classification of Functioning, Disability and Health based on primary outcomes. Often reviews focused on global functioning (activities of daily living, disability; 43%) and neuromuscular/ movement related function (mobility, balance, upper limb function; 29%). Only 2 reviews (9%) assessed specific mental functions in stroke survivors (depression, anxiety and aphasia). Continued focus on physical (54%) and global functioning (27%) was observed in most recent trials. 3 studies included informal caregiver primary outcomes.
Conclusion: Although stroke survivors report many unmet long-term psychological needs, primary care interventions focus on their physical health and global function. Since psychological outcomes are related to functional recovery after stroke, interventions aimed at improving survivors' long-term mental health are also needed.

OG43

Using a dopamine agonist to treat hemispatial neglect during post-stroke neurorehabilitation: a case series

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Introduction: Hemispatial neglect (HSN) is the inability to respond to stimuli from one side of space and is common in the early period after stroke. It correlates with poor functional outcome more strongly than hemiplegia or initial severity. HSN incorporates deficits in spatial working memory and sustained attention, both supported by prefrontal dopamine receptors. Dopaminergic medication may improve neglect in chronic stroke patients, but the feasibility of this approach during intensive post-stroke neurorehabilitation is not known.
Methods: We treated 3 patients with left HSN following ischaemic right MCA stroke with the D1/D2 dopamine agonist Rotigotine (transdermal 4 mg/24 hours). All were undergoing intensive in-patient neurorehabilitation. Patients completed the star cancellation task over 4 consecutive weeks in an A1-B1-A2-B2 design (off-on-off-on Rotigotine, 1 week each) in order to assess their response.
Results: 1 patient experienced transient drowsiness but no other side-effects were reported. We observed an apparent effect of treatment on HSN in these patients, with a 79% improvement in left-sided targets identified which reversed when it was discontinued. There was a significant effect of session (ANOVA $p = 0.0013$) and improved performance on vs off treatment (t-test $p = 0.029$).
Conclusion: Dopaminergic medication warrants investigation as a treatment for HSN during early post-stroke neurorehabilitation, as this is when its impact is greatest and when greatest gains may be made in therapy. Our experience

shows this to be a feasible approach, but an RCT is needed to establish efficacy. Such a study should include an outcome measure that captures the effect of neglect on functional tasks.

OG44

Fluoxetine Or Control Under Supervision (FOCUS)

Williams C, for the FOCUS trial collaborators
Centre for Clinical Brain Sciences, University of Edinburgh, Edinburgh, UK

Introduction: Small trials suggest that selective serotonin reuptake inhibitors improve neurological and overall recovery after stroke. Our aims are to determine whether fluoxetine 20 mg daily for 6 months, started at 2–15 days after stroke onset in patients with persisting neurological deficits, reduces dependency at 6 months and whether any benefits persist to 12 months.
Methods: This UK-wide, multicentre, randomised placebo-controlled trial aimed to recruit more than 3,000 patients, sufficient to provide 90% power to identify an odds ratio of 1.30 on an ordinal analysis of the our primary outcome (modified Rankin score (mRs), equivalent to a 5.5% absolute increase in mRs. Eligible patients providing informed consent were randomised by a central web-based system. Patients' progress in-hospital and early adherence were collected by local follow-up at hospital discharge (for inpatients). Other secondary outcomes (adherence, survival, health related quality of life, mood, fatigue, Stroke Impact Scale), new clinical diagnosis of depression and resource use) are collected at 6 and 12 months via postal, or telephone questionnaires to patients and general practitioners. We have harmonised assessments with the Australian AFFINITY (Assessment of fluoxetine in stroke recovery) and Swedish EFFECTS (Efficacy of fluoxetine – a randomised controlled trial in stroke) trial which are still recruiting to facilitate an individual patient data meta-analysis.
Results: Recruitment closed 31st March with 3,127 patients and we are now in follow-up.
Conclusion: FOCUS will tell us whether fluoxetine, improves overall recovery in a broad range of stroke patients. The results will be presented at the UKSF 2018 in Telford.

OG45

Improving primary care after stroke – development of a multi-component service-level intervention to address long-term care needs of stoke survivors living in the community

Mullis R[1], Pindus DM[1], Kreit E[1], Makepeace C[2], Johnson V[2], Horne R[2], Aziz NA[3], Moore C[1], Lim L[1], Wellwood I[1], Carey M[2], Mant J[1]
[1]Department of Public Health and Primary Care, University of Cambridge, Cambridge, UK
[2]Leicester Diabetes Centre, Universit Hospitals of Leicester, Leicester, UK
[3]Department of Family Medicine, PPUKM, Kuala Lumpur, Malaysia

Introduction: No formal primary care based model of care exists to support stroke survivors living in the community. A large variation in the range, quality and access to health services offered to stroke survivors between and within local primary care trusts suggests that many of the stroke survivors' needs are not being met systematically. To address these longer term needs we aimed to develop a new model of primary care service to enable greater engagement with stroke care and community services, to link effectively to specialist services, and improve the lives of stroke survivors.
Methods: Multi-method approach involving reviews of literature; interviews with patients and carers; focus groups comprising specialist and generalist healthcare practitioners (including stroke consultants, GPs, nurses, AHPs), patients and carers; consultation with patient support groups, a consensus study, service mapping exercise; and a multi-disciplinary intervention development group.

Results: A multi-component service-level intervention to address long-term care needs of stoke survivors living in the community comprising:
1. Structured review of patient needs;
2. A self-management programme (MLAS) for stroke survivors and their carers involving individual and group sessions;
3. A direct point of contact for stroke survivors/carers at the GP surgery;
4. Improved communication between General Practice staff and specialist services;
5. Service mapping for stroke related needs;
6. Training for General Practice staff.

Conclusion: We have developed a new model of primary care service for stroke survivors and their carers, which will be evaluated for clinical- and cost-effectiveness in an ongoing RCT.

OG46
Peer support after stroke

Thetford C
University of Central Lancashire, Preston, UK

Introduction: A growing body of evidence indicates that peer support has a number of benefits in supporting people with long-term conditions (National Voices, Nesta 2015). However, there is limited research evidence surrounding peer support for stroke survivors and their carers (Dorning et al 2016). Peer support takes many forms. Provision varies in terms of what is delivered, when, to whom, the format, duration, frequency, by whom, in what context and the objectives of the support. This project will develop a typology of peer support to better understand existing models of peer support available to stroke survivors in the UK.

Methods: Peer support services will be identified using a range of sources. We will contact service providers to gather data on the characteristics of support provided (such as context, duration, format, activities). Data will be analysed to construct an empirically grounded typology.

Results: We will present a typology of peer support for stroke survivors and carers in the UK.

Conclusion: We will use the typology to inform the development of further research into peer support for stroke survivors and carers.

OG47
Methodologies to explore how variation in assessment and clinical management of dysphagia in acute stroke affects development of stroke-associated pneumonia (SAP)

Eltringham SA[1,2], Bray B[3], Smith C[4], Kilner K[2], Pownall S[1], Sage K[2]
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[2]Faculty of Health and Wellbeing, Sheffield Hallam University, Sheffield, UK
[3]Royal College of Physicians, London, UK
[4]Greater Manchester Comprehensive Stroke Centre, University of Manchester, Manchester, UK

Introduction: Dysphagia in acute stroke significantly increases risk of stroke-associated pneumonia (SAP). There are large variations in dysphagia assessment and management during the first 72 hours when patients are most susceptible. This study will investigate how these variations and organisational factors systemic to this patient group impact on development of SAP.

Methods: Phases 1 and 2 of this mixed methods study involve the development of a national survey, which will include a systematised review of the literature, a review of medical records, and interviews with patients and staff. Data will be triangulated to inform a survey about dysphagia screening and management in hospitals registered with Sentinel Stroke

National Audit Programme (SSNAP). Results from the survey will be cross-referenced with the SSNAP register and odds of developing SAP will be estimated.
Results: The systematised review will summarise current evidence on methods of assessment and organisational factors that affect the risk of SAP. The case note review will provide detailed understanding of dysphagia management during the first 72 hours from admission. 15 national interviews with staff and 5 patient interviews will provide insights into current practice not available from quantitative data. Statistical analysis of the survey responses with the SSNAP data will bring together this information to highlight the barriers and facilitators for reducing risk of SAP.
Conclusion: Potential learning outcomes include: increased awareness of potential risk factors of SAP, insights into the application of mixed methods to answer a clinical research question and large data registries to reveal variations in practice and patient outcomes.

OG48

Development and refinement of a STroke friendly Oral health Promoting (STOP) toolkit to improve oral self-care practices after discharge from hospital stroke services

Smith CJ[1], O'Malley L[2], Powell R[3], Westoby W[4], Hulme S[5], Zadik J[6], Bowen A[7], Burton C[8], Djaelani R[9], Whitehead H[10], Lievesley M[9], Tyrrell PJ[5], Brocklehurst P[8]
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[4]Brain and Spinal Injury Centre, Salford, UK
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[6]Engagement in Research, Research and Development, Salford Royal NHS Foundation Trust, Salford, UK
[7]Division of Neuroscience and Experimental Psychology, University of Manchester, Manchester, UK
[8]School of Healthcare Sciences, Bangor University, Bangor, UK
[9]Faculty of Arts, Design and Social Sciences, Northumbria University, Northumbria, UK
[10]Community Dental Services, Salford Royal NHS Foundation Trust, Salford, UK

Introduction: Dental disease is highly prevalent in people with stroke. Stroke survivors regard oral hygiene as an important yet neglected area of stroke care, and may experience significant challenges with self-care due to complex disabilities. Despite this, there is little evidence defining the challenges faced by stroke survivors, how best to address these and how to improve self-care practices. Our aim is to develop an intervention for stroke survivors to improve oral health by supporting oral self-care behaviours.
Methods: The study comprises 2 discrete phases, incorporating qualitative methodology, Experience-Based Co-Design (EBCD, a participatory action research approach that puts users at the centre of the design process), and psychological theory (Behaviour Change Wheel and the COM-B [Capability, Opportunity, Motivation and Behaviour] model). Phase 1: Will use qualitative methodology to comprehensively understand the dental care experiences of stroke survivors, how they manage oral self-care practices and the context of the proposed intervention. We will also gain insights from relevant healthcare professionals. Phase 2: Will develop the STroke friendly Oral health Promoting (STOP) toolkit based on information gleaned from Phase 1, using EBCD principals and the Behaviour Change Wheel framework. The EBCD process will agree the toolkit's target behaviours, behaviour change techniques and the content and mode of delivery.
Results: Phase 1 will commence in September 2017 and we anticipate commencing Phase 2 in August 2018.
Conclusion: On completion of this study, our next step would be to evaluate the feasibility of testing the STOP toolkit in preparation for a Phase 3 randomised controlled trial.

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UK STROKE FORUM

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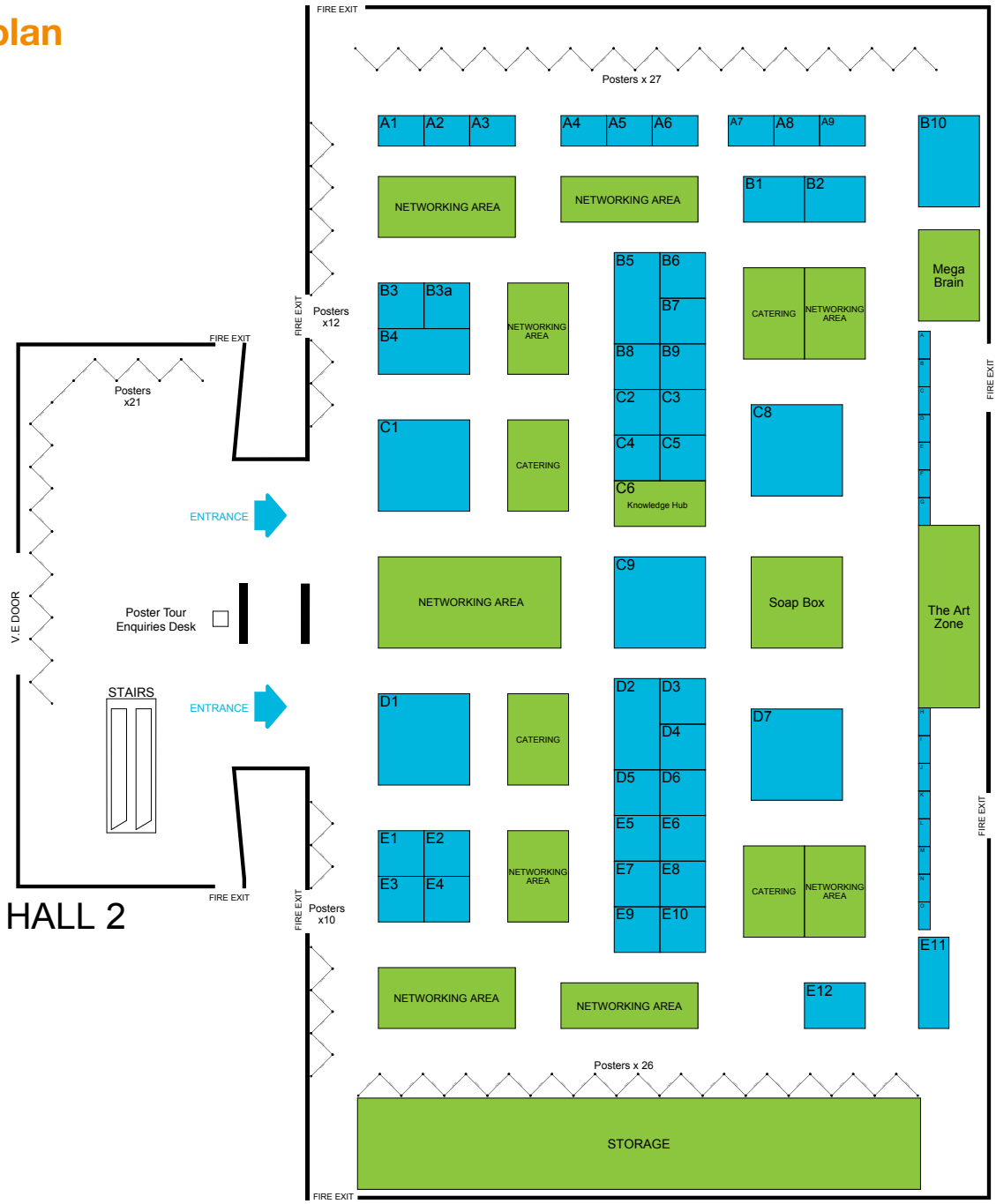
Exhibitors

	Stand No.
Academic Unit of Elderly Care and Rehabilitation, Bradford	B6
ACNR (Advances in Clinical Neuroscience & Rehabilitation) and The Primary Care Neurology Society	B3
Allergan	C8
Alzheimer's Society	A2
Amgen	E12
Bayer	D1
BMS/Pfizer Alliance	C1
Boehringer Ingelheim	A9
British Association of Stroke Physicians	C5
British Heart Foundation	D6
British Journal of Neuroscience Nursing	E3
Cyclone Mobility	B3a
Daiichi Sankyo	D7
DCC	E4
Dorset Orthopaedic	A4
Edinburgh Stroke Trials	A5
Firstkind Medical	C4
Fresenius Kabi	E6
GE Healthcare	B10
Halyard Health	B5
iRhythm Technologies	C3
Kora Healthcare	B9
Jobskin	A6
Knowledge Hub	C6
London South Bank University - Acupuncture and Stroke	A7
Medtronic	B4
MEYTEC GmbH Medizinsysteme	D4
Mindmaze	E2
Myoroface	C2
Nihon Kohden	B8
Novacor	D2
OMRON Healthcare UK	D5
Penumbra	D3
PJ Care	B7
Sage Products	E1
Silverlink	E9
SSNAP / Royal College of Physicians	B2
Stroke Association	C9
Stroke Research Centre, Institute of Neurology, UCL	A1
Stroke Research in Stoke	E7
Stryker	E5
Summit Medical and Scientific	E8
TICH-2 & RIGHT-2 Trials	E10
University of Glasgow	A3
Virtual Ware	B1
Wisepress Medical Bookshop	E11

Table Top Stands

	Stand No.
ACPIN	N
ARNI	M
British and Irish Orthoptic Society	D
Different Strokes	F
Education for Health	H
Lancashire Clinical Trials Unit / NIHR GCRG Improving Stroke Care	B
Later Life Training	K
NSNF - National Stroke Nursing Forum	C
NIMAST - Northern Ireland Multidisciplinary Association of Stroke Teams	L
Royal College of Occupational Therapists Specialist Section - Neurological Practice	G
Royal College of Speech and Language Therapists	O
SRR - The Society for Research in Rehabilitation	I
Stroke Association Voluntary Groups	J
Stroke-Specific Education Framework	A
Vision Research Unit	E

UKSF Exhibition Floorplan



Northern Ireland Stroke Conference Call for Abstracts

Call for Abstracts will open for the Northern Ireland Stroke Conference in January 2018

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All abstracts will be peer reviewed by a Multi-Disciplinary Team overseen by the UKSF / NIMAST Conference Committee to ensure consistency and objectivity.

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The submission deadline is 17.00 on Friday 6 April 2018

NIMAST
Connecting Professionals in Stroke

UK STROKE FORUM

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Exhibitors

Academic Unit of Elderly Care and Rehabilitation, Bradford – Stand B6

Website: www.bradfordresearch.nhs.uk/research-teams/academic-unit-of-elderly-care-and-rehabilitation
Email: seline.ozer@bthft.nhs.uk

This year marks 30 years since the Academic Unit of Elderly Care & Rehabilitation (Bradford/University of Leeds) embarked on our first stroke (Stroke Association funded) research project. Since then the Unit has gone on to establish a record of addressing key, clinically relevant questions in stroke, including conducting two of the world's largest stroke rehabilitation trials. Our programme of multidisciplinary health services research has been facilitated by a supportive network of local and national colleague researchers, NHS staff, patients and their families. Our stand will exhibit examples of our past, present and future work and we welcome all to help us celebrate this milestone event!

ACNR (Advances in Clinical Neuroscience & Rehabilitation) and The Primary Care Neurology Society – Stand B3

Advances in Clinical Neuroscience and Rehabilitation (ACNR) is a UK-based, international, peer reviewed journal which aims to keep busy practicing specialists up-to-date with the latest advances in their fields. It is one of the best-read publications in the neurology field in the UK, popular and highly respected.
In conjunction with the Primary Care Neurology Society we also publish Neurodigest for primary and community care specialists.

Both journals are fully open access. Read online at www.acnr.co.uk and www.neurodigest.co.uk. Sign up for free email updates at the conference, online, or email the Publisher, Rachael Hansford, at Rachael@acnr.co.uk

Allergan – Stand C8

Website: www.allergan.co.uk

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For more information, visit Allergan's website at www.allergan.co.uk.

Alzheimer's Society – Stand A2

Website: www.alzheimers.org.uk **Email:** www.alzheimers.org.uk

Dementia devastates lives. By 2021, 1 million people will be living with the condition. But dementia won't win. Until the day we find a cure, Alzheimer's Society will be here for anyone affected by dementia – wherever they are, whatever they're going through. Everything we do is informed and inspired by them.

We are the UK's leading dementia charity. Every day, we work tirelessly to find new treatments and, ultimately, a cure for dementia. We provide expert information, training, and support services to all those who need our help. And we are creating a more dementia friendly society so people with the condition can live without fear and prejudice.

Let's take on dementia together. Volunteer. Donate. Campaign for change. Whatever you do, unite with us against dementia.

Amgen – Stand E12

Website: www.amgen.co.uk **Email:** gbinfoline@amgen.com

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Bayer – Stand D1

Website: www.bayer.com

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BMS/Pfizer Alliance – Stand C1

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Boehringer Ingelheim – Stand A9

Website: www.boehringer-ingelheim.co.uk **Email:** communications@bra.boehringer-ingelheim.com

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British Association of Stroke Physicians – Stand C5

Website: www.basp.ac.uk **Email:** basp@basp.ac.uk

The British Association of Stroke Physicians (BASP) is the principal UK-wide specialist medical society for consultants and trainees in Stroke Medicine, with over 700 members committed to improving and advancing the care of people with stroke across the UK. The current President is Professor Helen Rodgers, Professor of Stroke Care in Newcastle-upon-Tyne.

British Heart Foundation – Stand D6

Website: www.bhf.org.uk **Email:** pssevents@bhf.org.uk

We are the nation's heart charity and the largest independent funder of cardiovascular research. Coronary heart disease is the UK's single biggest killer but we are leading the fight against it. Our pioneering research has been key in developing our best practice programmes that have helped transform the care of people living with heart and circulatory conditions. www.bhf.org.uk

British Journal of Neuroscience Nursing – Stand E3

Website: www.magonlinelibrary.com/journal/bjnn **Email:** andrew.iafrati@markallengroup.com

The British Journal of Neuroscience Nursing is the only journal in the UK dedicated specifically to neuroscience nursing. The journal publishes articles on all aspects of clinical practice in neuroscience nursing and all content is peer-reviewed by leading authorities in the field to ensure the highest quality of evidence-based clinical reviews, original research and professional information.

Twice per year we also publish the BJNN's Stroke Supplement. This dedicated resource is published in association with the UK Stroke Association and the European Stroke Organisation and serves to inform and educate around the latest issues and guidance in specialist stroke care.

Cyclone Mobility – Stand B3a

Website: www.cyclonemobility.com

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Daiichi Sankyo – Stand D7

Website: www.daiichi-sankyo.co.uk

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Website: www.documentcapture.co.uk **Email:** info@documentcapture.co.uk

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We strive to understand and learn about their problem i.e. what it is that stops them from doing **better** what they are passionate about and apply our passion and expertise; making them aware of the powers of data and how this can enable them to perform better.

Dorset Orthopaedic – Stand A4

Website: www.dorset-ortho.com **Email:** kimw@dorset-ortho.com

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Edinburgh Stroke Trials – Stand A5

Website: www.ed.ac.uk **Email:** karen.innes@ed.ac.uk

Edinburgh Stroke Trials are academic randomised controlled trials initiated by investigators in Edinburgh, often in collaboration with others. They involve researchers and systems developed by the Stroke Research Group, Edinburgh Imaging, and the UKCRC-registered Edinburgh Clinical Trials Unit. Ongoing trials include the Fluoxetine Or Control Under Supervision (FOCUS), REstart or STop Antithrombotics Randomised Trial (RESTART), Prevent-SVD (or LACunar Intervention Trial 1, LACI-1), Start or STop Antithrombotics Randomised Trial (SoSTART), and the LACunar Intervention Trial 2 (LACI-2).

Firstkind Medical – Stand C4

Website: www.gekodevices.com

Firstkind has worked with The University Hospital of North Midlands NHS Trust to introduce geko™ into the stroke pathway when patients are unsuitable for drug prophylaxis and/or contraindicated or intolerant to IPC. Interim analysis highlights that the majority of high risk immobile acute stroke patients who could not tolerate IPC tolerated the geko™ device. These patients would have not been treated as effectively otherwise, with the potential that geko™ will reduce the risk of morbidity and mortality in stroke patients. Please visit stand C4 to find out more.

Fresenius Kabi – Stand E6

Website: www.dysphagia.org.uk **Email:** scientificaffairs@fresenius-kabi.com

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GE Healthcare – Stand B10

Website: www3.gehealthcare.co.uk

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Halyard Health – Stand B5

Website: www.halyardhealth.co.uk **Email:** customerservice.uk.ie@hyh.com

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iRhythm Technologies – Stand C3

Website: www.irhythmtech.com **Email:** supportuk@irhythmtech.com

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SATELLITE SYMPOSIUM

Control beyond the clinic: Managing NVAF patients with a high risk of stroke

Wednesday 29th November
08:00 - 08:50
Auditorium

Chair:

Dr David Hargroves
Consultant Physician and Clinical Lead for Stroke Medicine at East Kent Hospital University Foundation Trust

Speakers:

Dr Kneale Metcalf
Consultant Stroke Physician, Norfolk and Norwich University Hospital

Ian Evans
Consultant Nurse for Stroke, Somerset Partnership NHS Foundation Trust

SOAPBOX SCIENCE

An example of Joint Working between Chelsea & Westminster NHS Foundation Trust and Bayer Plc

The Hounslow community Atrial Fibrillation (AF) project

Wednesday 29th November
13:30 - 13:45
Exhibition Hall

Speaker:

Dr Sadia Khan
Consultant Cardiologist, Chelsea and Westminster Hospital NHS Foundation Trust

ACC Liverpool Wednesday 29th & Thursday 30th November 2017

SOAPBOX SCIENCE

Medicines optimisation through counselling

Thursday 30th November
10:25 - 10:40
Exhibition Hall

Speaker:
Sharron Gordon
Consultant Pharmacist in Anticoagulation, Hampshire

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Treatment of deep vein thrombosis (DVT) & pulmonary embolism (PE), & prevention of recurrent DVT & PE in adults (see W&P for haemodynamically unstable PE patients). **Posology & method of administration:** *2.5mg* – Oral *b.i.d.* dose; patients should also take a daily dose of 75 – 100 mg ASA or a daily dose of 75 – 100 mg ASA in addition to either a daily dose of 75 mg clopidogrel or a standard daily dose of ticlopidine. Start Xarelto as soon as possible after stabilisation, including revascularisation for ACS; at the earliest 24 hours after admission & at discontinuation of parenteral anticoagulation. If dose is missed take next dose, do not double the dose. *10mg* – Oral *o.d.* dose; initial dose taken 6 to 10 hours after surgery provided haemostasis established. *15mg/20mg* – Take with food *SPAF:* 20 mg orally *o.d. DVT & PE:* 15 mg *b.i.d.* for 3 weeks followed by 20 mg *o.d.* for continued treatment & prevention of recurrent DVT & PE. *All strengths* - Refer to SmPC for full information on duration of therapy & converting to/from Vitamin K antagonists (VKA) or parenteral anticoagulants. ***Special populations:*** Patients undergoing cardioversion: Xarelto can be initiated or continued in patients who may require cardioversion. Patients with non-valvular atrial fibrillation who undergo PCI (percutaneous coronary intervention) with stent placement: There is limited experience of a reduced dose of 15 mg Xarelto once daily (or 10 mg Xarelto once daily for patients with moderate renal impairment [creatinine clearance 30 – 49 ml/min]) in addition to a P2Y12 inhibitor for a maximum of 12 months in patients with non-valvular atrial fibrillation who require oral anticoagulation and undergo PCI with stent placement. ***Renal impairment:*** mild (creatinine clearance 50-80 ml/min) - no dose adjustment; *2.5mg /10mg* - moderate (creatinine clearance 30-49 ml/min) – no dose adjustment. Severe (creatinine clearance 15-29ml/min) - limited data indicate rivaroxaban concentrations are significantly increased, use with caution. *15mg/20mg* - moderate & severe renal impairment - limited data indicate plasma concentrations are significantly increased, use with caution – *SPAF:* reduce dose to 15mg *o.d., DVT & PE:* 15 mg *b.i.d.* for 3 weeks, thereafter 20mg *o.d.* Consider reduction from 20mg to 15mg *o.d.* if patient's bleeding risk outweighs risk for recurrent DVT & PE; *All strengths* - Creatinine clearance <15 ml/min - not recommended. ***Hepatic impairment:*** Do not use in patients with coagulopathy & clinically relevant bleeding risk including cirrhotic patients with Child Pugh B & C ***Paediatrics:*** Not recommended. **Contra-indications:** Hypersensitivity to active substance or any excipient; active clinically significant bleeding; lesion or condition considered to confer a significant risk for major bleeding (refer to SmPC); concomitant treatment with any other anticoagulants except under specific circumstances of switching anticoagulant therapy or when unfractionated heparin is given at doses necessary to maintain an open central venous or arterial catheter; hepatic disease associated with coagulopathy & clinically relevant bleeding risk including cirrhotic patients with Child Pugh B & C; pregnancy & breast feeding. *2.5mg* - concomitant treatment of ACS with antiplatelet therapy in patients with a prior stroke or transient ischaemic attack. **Warnings & precautions:** Clinical surveillance in line with anticoagulant practice is recommended throughout the treatment period. Discontinue if severe haemorrhage occurs. Increasing age may increase haemorrhagic risk. Xarelto should be discontinued at the first appearance of a severe skin rash, or any other sign of hypersensitivity in conjunction with mucosal lesions. *Not recommended:* in patients with an increased bleeding risk (refer to SmPC); in patients receiving concomitant systemic treatment with strong concurrent CYP3A4- and P-gp-inhibitors, i.e. azole-antimycotics or HIV protease inhibitors; *2.5mg* treatment in combination with antiplatelet agents other than ASA & clopidogrel/ticlopidine; *15mg/20mg* in patients with prosthetic heart valves; with PE who are haemodynamically unstable or may receive thrombolysis or pulmonary embolectomy. *Use with caution*: in patients with severe renal impairment or with renal impairment concomitantly receiving other medicinal products which increase rivaroxaban plasma concentrations; treated concomitantly with medicines affecting haemostasis; when neuraxial anaesthesia or spinal/epidural puncture is employed; in patients at risk of ulcerative gastrointestinal disease (prophylactic treatment may be considered); *2.5mg* in ACS patients > 75 years of age or with low body weight (<60kg). Patients on treatment with Xarelto & ASA or Xarelto & ASA plus clopidogrel/ticlopidine should only receive concomitant treatment with NSAIDs if the benefit outweighs the bleeding risk. *All strengths-* There is no need for monitoring of coagulation parameters during treatment with rivaroxaban in clinical routine, if clinically indicated rivaroxaban levels can be measured by calibrated quantitative anti-Factor Xa tests. Xarelto contains lactose. **Interactions:** Concomitant use with strong inhibitors of both CYP3A4 & P-gp not recommended as clinically relevant increased rivaroxaban plasma concentrations are observed. Avoid co-administration with dronedarone. Use with caution in patients concomitantly receiving NSAIDs, ASA or platelet aggregation inhibitors due to the increased bleeding risk. Concomitant use of strong CYP3A4 inducers should be avoided unless patient is closely observed for signs and symptoms of thrombosis. **Pregnancy & breast feeding:** Contra-indicated. **Effects on ability to drive and use machines:** syncope (uncommon) & dizziness (common) were reported. Patients experiencing these effects should not drive or use machines. **Undesirable effects:** *Common:* anaemia, dizziness, headache, eye haemorrhage, hypotension, haematoma, epistaxis, haemoptysis, gingival bleeding, GI tract haemorrhage, GI & abdominal pains, dyspepsia, nausea, constipation, diarrhoea, vomiting, pruritus, rash, ecchymosis, cutaneous & subcutaneous haemorrhage, pain in extremity, urogenital tract haemorrhage (menorrhagia *very common* in women <55 yrs treated for DVT, PE & prevention of recurrence), renal impairment, fever, peripheral oedema, decreased general strength & energy, increase in transaminases, post-procedural haemorrhage, contusion, wound secretion. *Serious: cf. CI/Warnings and Precautions – in addition:* thrombocythemia, thrombocytopenia, Stevens-Johnson syndrome/Toxic Epidermal Necrolysis, angioedema and allergic oedema, occult bleeding/haemorrhage from any tissue (e.g. cerebral & intracranial, haemarthrosis, muscle) which may lead to complications (incl. compartment syndrome, renal failure, fatal outcome), syncope, tachycardia, abnormal hepatic function, cholestasis and hepatitis (incl. hepatocellular injury), hyperbilirubinaemia, jaundice, vascular pseudoaneurysm following percutaneous vascular intervention. Prescribers should consult SmPC in relation to full side effect information. **Overdose:** No specific antidote is available. **Legal Category:** POM. **Package Quantities and Basic NHS Costs:** *2.5mg* - 56 tablets: £50.40. *10mg* - 10 tablets: £18.00, 30 tablets: £54.00 and 100 tablets: £180.00. *15mg* – 14 tablets: £25.20, 28 tablets: £50.40, 42 tablets: £75.60, 100 tablets: £180.00; *20mg* – 28 tablets: £50.40, 100 tablets £180.00; Treatment Initiation (42 tablets of 15mg, 7 tablets of 20mg): £88.20 **MA Number(s):** *2.5mg* - EU/1/08/472/025-035. *10mg* - EU/1/08/472/001-10, 022 *15mg/20mg* - EU/1/08/472/011-21, 023-024, 036-037, 040 **Further information available from:** Bayer plc, 400 South Oak Way, Reading, RG2 6AD, U.K. Telephone: 0118 206 3000. **Date of preparation:** August 2017.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Bayer plc. Tel.: 0118 206 3500, Fax.: 0118 206 3703, Email: pvuk@bayer.com

BAYER

Kora Healthcare – Stand B9

Website: www.korahealthcare.com

Jobskin – Stand A6

Website: www.jobskin.co.uk **Email:** michelle.wright@jobskin.co.uk

Jobskin® are a company that has built its reputation by producing outstanding quality medical pressure garments for over 30 years.

Leading the way in rehabilitation therapy, we are the largest UK manufacturer providing specialist custom made compression garments.

We offer the highest quality ready to wear and specialist made to measure products. Our range includes Premium, Classic and Alleviant for Pressure Therapy, SDO for our Dynamic Lycra Compression Garments, Surgical Corsets, Leg and Arm Gaiters, Orthowrap in our Orthopeadic support range and we offer ScarSil, Scar FX and Oleeva Silicone Gel Products for Scar Management.

Jobskin are dedicated to providing the ultimate in therapy management and our long standing reputation is maintained by our commitment to product research and development, allowing us to offer innovative products unmatched in the market today. Alongside our comprehensive specialist bespoke service, we also manufacture an extensive range of quality stock orthotic products.

Tel: +44 (0) 115 973 4300, Fax: +44 (0) 115973 3902, Email: orders@jobskin.co.uk
Address: Unit 13a Harrington Mill, Leopold St, Long Eaton, Nottingham NG10 4QG
www.jobskin.co.uk

Knowledge Hub – Stand C6

The knowledge hub is an area within the exhibition where delegates can meet speakers directly after sessions to ask questions and continue those important conversations. The hub shares outcomes and findings from the sessions, latest news, recruitment opportunities, blogs and much more!

Why not visit the hub in the refreshments and lunch breaks and meet with professionals from a variety of stroke-related disciplines to help grow your network.

London South Bank University – Acupuncture and Stroke – Stand A7

Website: www.lsbu.ac.uk **Email:** nicky.robinson@lsbu.ac.uk

As a university research group in Allied Health Sciences at London South Bank University our focus is on exploring the evidence base and opportunities for potential cost effective interventions for implementation within the NHS. These include evaluating traditional

Chinese medicine as part of routine care pathways and evaluating perceptions, attitudes and acceptability of these interventions among stakeholders. This is an important part of our attendance at the conference to explore stakeholders attitudes to acupuncture in stroke rehabiltation.

Medtronic – Stand B4

Website: medtronic.com **Email:** ann.blythman@medtronic.com

As a global leader in medical technology, services and solutions, Medtronic improves the lives and health of millions of people each year. We use our deep clinical, therapeutic, and economic expertise to address the complex challenges faced by healthcare systems today. That's why we're committed to partnering in new ways and developing powerful solutions that deliver better patient outcomes. Medtronic is committed to providing evidence based technology to treat Neurovascular disease providing solutions to hemorrhagic and Ischaemic Stroke patients. Medtronic is working in collaboration with health care professionals to increase patient access to Mechanical Thrombectomy. Learn more at Medtronic.com.

MEYTEC Medizinsysteme GmbH – Stand D4

Website: www.meytec.de **Email:** info@meytec.de

MEYTEC GmbH Medizinsysteme is a specialist tele-healthcare company, producing telemedical solutions under the VIMED® brand for clinical establishments around the world. MEYTEC has developed pioneering bespoke solutions, using the digital transmission of medical data and images. MEYTEC's state-of-the-art products offer secure, real-time, face-to-face contact between medical experts and patients via audio-video communication situated in remote locations. Pioneering projects such as TEMPiS (www.tempis.de) and STEMO (www.jove.com/video/50534/prehospital-thrombolysis-a-manual-from-berlin?status=a52540k), are testament to the evolution of MEYTEC's products, through the better understanding of, and in response to, the ever increasing impact of stroke on the world's population.

Mindmaze – Stand E2

Website: www.mindmaze.com **Email:** alexandra.baumann@mindmaze.ch

MindMaze aims to revolutionize the rehabilitation process by combining advanced brain monitoring technology with interactive 3D environments to develop the next generation of medical devices. MindMotion is our unique virtual reality based neuro technology platform targeting improved rehabilitation post stroke and other neurological disorders.

MindMotion PRO is a CE Marked hospital-based solution for early motor rehabilitation that enables you to increase the rehabilitation dose & intensity cost effectively. Simple set-up decouples therapist time from desired rehabilitation time.

MindMotion GO is a virtual reality based neuro-technology platform providing a new neuro-rehabilitation experience. It has been designed by experts to treat motor impairments related to stroke and other neurological disorders allowing patients to reach their full recovery potential.

Talk to us to find out more how MindMaze Technology enables exciting new applications for VR in healthcare.

Social Media accounts:
Follow us on Twitter@MindMazeSA
Facebook: @MindMazeSA

Myoroface – Stand C2

Website: www.iqoro.com **Email:** terry.morris@myoroface.com

IQoro® is shown in published studies to restore normal swallowing after stroke in most cases.

It is a new and innovative neuromuscular treatment method that requires just 30 seconds' exercise, three times per day. It works by training and strengthening the muscles, and by stimulating the brain to regenerate the pathways that control them. It is usually self-administered.

IQoro® is widely used by individuals and Health Care Professionals in Sweden, and now in the UK and elsewhere.

IQoro® helps people with problems in swallowing, with Hiatus hernia, facial paralysis, speech-, snoring- or sleep apnoea problems, and more.

The product and its training regime is supported by two decades' research that you will find at www.iqoro.com

Nihon Kohden – Stand B8

Website: www.nihonkohden.net **Email:** info@nihonkohden.co.uk

Nihon Kohden is Japan's largest medical device company renowned the world over for innovation, reliability and engineering quality.

Please come along to our stand to see Cereb Air our unique solution for providing continuous EEG within 5 minutes.

Novacor – Stand D2

Website: www.novacor.co.uk **Email:** enquiries@novacor.co.uk

R.Test Evolution 4 – The obvious choice for AF detection

The R.Test Evolution 4 – Automatic ECG Arrhythmia Detection System is a lightweight non-invasive ECG monitor especially effective for detecting the presence of AF and PAF over longer durations1. Weighing just (42g) and approximately the size of a small matchbox, the R.Test Evolution 4 has become the obvious choice for stroke professionals; providing an effective, swift and practical means to capture and identify or confidently exclude AF as a cause for stroke.

Visit stand no: D2 today for more information.

OMRON Healthcare UK – Stand D5

Website: www.omron-healthcare.co.uk **Email:** Leanne.plummer@eu.omron.com

OMRON Healthcare UK Ltd is committed to improving the quality of everyone's lives by providing clinically validated, innovative medical equipment for health monitoring, therapy and disease prevention. By looking beyond the technology, our real commitment lies in building healthy lives. We aim to provide a total healthcare management service, aimed at preventing and improving such increasingly common health problems as hypertension, respiratory conditions, diabetes and obesity.

Penumbra – Stand D3

Website: www.penumbrainc.com/ **Email:** info@penumbrainc.de

Penumbra, Inc., headquartered in Alameda, California, is a global healthcare company focused on interventional therapies. Penumbra designs, develops, manufactures and markets innovative devices and has a broad portfolio of products that addresses challenging medical conditions and significant clinical needs across two major markets, neuro and peripheral vascular. Penumbra sells its products to hospitals primarily through its direct sales organization in the United States, most of Europe, Canada and Australia, and through distributors in select international markets. The Penumbra logo is a trademark of Penumbra, Inc.

PJ Care – Stand B7

Website: www.pjcare.co.uk/ **Email:** enquiries@pjcare.co.uk

PJ Care is a leading provider of specialist neurological care and neuro rehabilitation for people with progressive or acquired neurological conditions. We specialise in the multidisciplinary care of adults and work with residents, families, charities and the NHS to provide the highest quality care for their residents.

Our residents' care is at the heart of everything we do. We strive to nurture dignity, independence and privacy through our purpose-built facilities, our highly trained multi-disciplinary teams, the care models we offer and the therapies and activities provided. We have three specialist neurological care units available in Milton Keynes and four Neurological Care Units and a Rehabilitation Service at our award winning Eagle Wood Centre in Peterborough.

Sage Products – Stand E1

Website: www.sageproducts.com **Email:** tpichel@sageproducts.com

For 45 years, Sage Products LLC has successfully developed and produced innovative prevention products that have significantly improved outcomes for patients and clinicians, while improving efficiency and profitability for healthcare facilities. In 2016, Sage was acquired by Stryker Corporation and is a business within the Stryker Medical Division. Sage is a leading developer of products used to prevent hospital-acquired conditions such as ventilator-associated conditions, skin injury due to incontinence, pressure injuries, surgical site infections and healthcare worker injury across the continuum of care. From the acute care setting to the skilled nursing and long-term care setting, as well as continued care at home, we create products that make caregiving easier and provide clinical outcomes.

Silverlink – Stand E9

Website: www.silverlinksoftware.com **Email:** info@capturestroke.com

CaptureStroke is Silverlink's marketing leading care performance system for stroke services. Offering Trusts full ownership of their data and real-time analytics to understand and measure performance throughout the care pathway, CaptureStroke forms part of Silverlink's best-of-breed solution portfolio. Silverlink has been a leading software supplier to the NHS for over 20 years and create solutions based on an in-depth knowledge of NHS processes and requirements. Designed in close collaboration with clinicians, CaptureStroke offers users intuitive workflow, facilitating paperless and mobile working, leading to better patient outcomes and proven return on investment, efficiency savings and improved SSNAP audit performance.

SSNAP / Royal College of Physicians – Stand B2

Website: www.strokeaudit.org **Email:** Mark.Kavanagh@rcplondon.ac.uk

The Sentinel Stroke National Audit Programme (SSNAP), based at the Royal College of Physicians, collects data on care provided in England, Wales and Northern Ireland. These data are reported back every four months and include key measures such as outcomes for intra-arterial interventions. SSNAP reports on 85,000 patient records annually, data for April 2016 –March 2017 is available to the public on the SSNAP website. This year's SSNAP annual report is focused on Quality Improvement, to pick up your own copy visit the SSNAP stand. Make sure to attend SSNAP presentations by Dr Ben Bray, Lizz Paley and Victoria McCurran.

Stroke Association – Stand C9

Website: www.stroke.org.uk

Stroke Association is the leading charity in the UK changing the world for people affected by stroke. We believe that strokes can and should be prevented and that everyone has the right to make the best recovery. We believe that together we can change the world for people affected by stroke. Stroke survivors look first to GPs, therapists and other health and social care providers for information about stroke. We provide information, advice and support for you to help stroke survivors makes the best recovery they can. To find out more about how we can help you visit stroke.org.uk/professionals.

Stroke Research Centre, Institute of Neurology, UCL – Stand A1

Website: www.ucl.ac.uk/ion/departments/repair/themes/stroke **Email:** e.allsop@ucl.ac.uk

The Second European Carotid Surgery Trial (ECST-2) is a multi-centre randomized trial designed to see if improvements in drug therapy have reduced the need for carotid surgery to prevent stroke caused by atherosclerotic carotid stenosis. Patients are randomized to receive optimised medical therapy alone or in combination with immediate revascularisation. It is organized by UCL Stroke Research Centre, an academic team in the Department of Brain Repair and Rehabilitation at UCL Institute of Neurology and led by Professor Martin M Brown. ECST-2 is currently actively enrolling new centres. MR Plaque Imaging is performed as a sub study in ECST-2.

Stroke Research in Stoke – Stand E7

Website: www.keele.ac.uk/maps2 **Email:** maps-2.uhns@nhs.net

The Stroke Research in Stoke group have been based at the University Hospitals of North Midlands NHS Trust and Keele University for nearly 20 years and in that time the team, led by Professor Christine Roffe has been involved in over 50 research studies including a number of home grown trials. The latest trial is MAPS-2 (The Metoclopramide and selective oral decontamination for Avoiding Pneumonia after stroke) is currently open to recruitment across the UK with a recruitment target of 1,160 patients. Pneumonia is a common complication of stroke, associated with high mortality and morbidity and this study will provide important data on this issue.

Stryker – Stand E5

Website: www.stryker.com **Email:** rowland.lock@stryker.com

Stryker NV is focused on advancing the practice of less invasive stroke therapies through its Complete Stroke Care solutions. Stryker is dedicated to providing innovative stroke products and services for ischemic and hemorrhagic stroke, and committed to providing clinical education and support to help physicians deliver better patient outcomes. Products include: stent retriever, detachable coils, stents, balloons, guidewires and microcatheters.

Summit Medical and Scientific – Stand E8

Website: www.summitmedsci.co.uk **Email:** info@summitmedsci.co.uk

Summit Medical and Scientific supplies innovative rehabilitation VR treadmill systems from Motek for the assessment and training of balance and gait. These systems support rehabilitation for brain and spinal injuries, neurological conditions including stroke, orthopaedic disorders, geriatrics, and movement disorders. Additional Body Weight Support is optional for users who are unable to stand or support themselves unaided. Products include the virtual and augmented reality C-Mill (which we are demonstrating on Stand E8), the Gait Real Time Interactive Lab (GRAIL) and the state of the art Computer Assisted Rehabilitation Environment (CAREN). We also supply Myon wireless EMG and AMTI force platforms.

TICH-2 & RIGHT-2 Trials – Stand E10

Website: www.nottingham.ac.uk/research/groups/stroke/index.aspx
Email: tardis@nottingham.ac.uk tich-2@nottingham.ac.uk right-2@nottingham.ac.uk

The University of Nottingham Stroke Trials Team co-ordinate the TICH-2 (Tranexamic Acid for IntraCerebral Haemorrhage) and RIGHT-2 (Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial) trials.

TICH-2 is recruiting in the UK and Internationally until 2018 with a recruitment target of 2000 patients. RIGHT-2 is a UK ambulance-based trial recruiting in the UK and will run until 2018 with a recruitment target of 850 patients. The primary outcome of both trials is shift in death or dependency (modified Rankin Scale) at day 90.

University of Glasgow – Stand A3

Website: www.gla.ac.uk **Email:** Alicia.Murray@glasgow.ac.uk

The University of Glasgow Stroke Research team run several large multicentre clinical trials in the UK.

ATTEST 2 is a prospective, parallel group RCT comparing IV rtPA with IV Tenecteplase in patients eligible for IV thrombolysis.

PRACTISE is a RCT investigating if the use of advanced imaging techniques (CTA and CTP) will lead to an increase in the proportion of patients with acute ischaemic stroke receiving thrombolysis.

TEMPO 2 is a prospective open label, blinded-endpoint RCT of thrombolysis with low dose Tenecteplase (TNK-tPA) versus standard of care in minor ischemic stroke with proven acute symptomatic occlusion.

XILO-FIST is a RCT of 464 participants with recent ischaemic stroke. It will assess whether allopurinol use reduces markers of SVD and BP.

Virtual Ware – Stand B1

Website: www.virtualrehab.info **Email:** info@virtualrehab.info

VirtualRehab is a CE marked adjunct therapy platform for neurorehabilitation that uses off-the-shelf motion capture technologies to deliver virtual rehabilitation to patients across the care pathway, including the hospital and home.

We have developed a series of therapeutic activities including assessments, exercises and exergames which help augment the dose and adherence of patients to meaningful therapy.

Therapists can use VirtualRehab to personalise ROM treatments for their patients for upper and lower extremities, as well as fine motor skills training of the hands, and then track performance remotely.

VirtualRehab has successfully been used for rehabilitation of stroke around the world.

Wisepress Medical Bookshop – Stand E11

Website: www.wisepress.com **Email:** info@wisepress.com

Wisepress.com, Europe's leading conference bookseller, has a complete range of books and journals relevant to the themes of the meeting. Books can be purchased at the stand or, if you would rather not carry them, posted to you – Wisepress will deliver worldwide. In addition to attending 200 conferences per year, Wisepress has a comprehensive medical and scientific bookshop online with great offers.

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VirtualRehab has successfully been used for rehabilitation of stroke around the world.

Table Top Stands

ACPIN – Stand N

Website: acpin.net **Email:** secretary@acpin.net

ACPIN is one of the largest Professional Networks recognised by the Chartered Society of Physiotherapy with around 3000 members. It is concerned with all aspects of physiotherapy related to the needs of neurologically impaired adults and their relatives and carers.

ACPIN is a dynamic and proactive group. Its function is to encourage the pursuit of excellence in the field of neurological physiotherapy practice. If you are interested in finding out more about ACPIN, please contact us on our stand or online.

ARNI – Stand M

Website: www.arni.uk.com **Email:** support@arni.uk.com

ARNI (Action for Rehabilitation from Neurological Injury) Institute is a national charity which supports the community teams by providing a community-integration path when therapy finishes due to time & resources. It matches stroke survivors who require further 'retraining' with independent therapists and highly qualified fitness instructors. ARNI instructors accredit via the specialist level Functional Rehabilitation and Exercise Training After Stroke Qualification (UKSF E&T Course No. 35) which is built around the latest evidence base (EBRSR). They assist with the performance of functional task-related practice & stroke specific resistance training. ARNI has over 150 insured and active instructors in the UK.

British and Irish Orthoptic Society – Stand D

Website: www.orthoptics.org.uk **Email:** howardc@liverpool.ac.uk

Visual problems following stroke cause significant impairment and can be a barrier to rehabilitation.

Orthoptists have clinical expertise in the diagnosis and management of eye movement abnormality, disorders affecting binocular vision, in visual neglect / perception and in visual field assessment. The orthoptist has an essential role to play in stroke rehabilitation and BIOS recommends that links between stroke and orthoptic departments should be established in all units. BIOS have produced a range of patient information leaflets, professional practice guidelines for orthoptists, as well as validated referral forms and care pathways (available at www.orthoptics.org.uk).

Different Strokes – Stand F

Website: www.differentstrokes.co.uk **Email:** info@differentstrokes.co.uk

Different Strokes is run by younger stroke survivors for younger stroke survivors to promote independent recovery and reclaim their lives. We recognise that the Different Strokes community of younger stroke survivors and family members are experts in stroke recovery and rehabilitation with first-hand knowledge of the issues and challenges facing families after stroke.

We provide information packs, resources for children of stroke survivors, a network of exercise and support groups, a facebook support group and an information line. We provide an important voice for younger stroke survivors to Government, service providers and funders, fighting for better standards and improved understanding.

Education for Health – Stand H

Website: www.educationforhealth.org **Email:** contact@educationforhealth.org

Education for Health is a leading UK-based educational charity, working to transform the lives of people living with long term health conditions. We aim to support nurses and other healthcare professionals in advancing their professional development to enhance the quality of patient care. We offer a comprehensive range of clinically-led education and training for healthcare professionals, including free-to-access online resources, workshops and accredited modules. Our academic team are clinicians and experts in their subject areas who continue to work in practice, bringing a real-life vibrancy to all that we do.

Twitter: @EdforHealth
Facebook: /EdforHealth/

Lancashire Clinical Trials Unit / NIHR GCRG Improving Stroke Care – Stand B

Lancashire Clinical Trials Unit (CTU) offers a high-quality service for the co-ordination and delivery of key services pertaining to feasibility and effectiveness trials of complex interventions and to other clinical studies. We specialise in complex interventions trials in stroke, midwifery, cancer, musculoskeletal health, public/population health and mental health. We offer all CTU services including trial design and development of collaborative applications to funders, Trial and site set-up, on-going trial management, IS design and management (including randomisation), data management (form design, data entry, data cleaning) and statistical analysis and reporting. Current portfolio includes CONVINCE UK, Strollers, NIHR Global Health Research Group on Improving Stroke Care at University of Central Lancashire, AGLoves and Adopts.

Later Life Training – Stand K

Website: www.laterlifetraining.co.uk **Email:** info@laterlifetraining.co.uk

Later Life Training deliver evidence based training courses across the UK and Europe to health and specialist exercise professionals and the social care sector. The outcomes of training aims to support improving the lives of stroke survivors and older people through longer term adherence to evidence based exercise interventions.

As of October 2016, LLT have qualified:
over 3000 Postural Stability Instructors
350 Exercise after Stroke Instructors
2491 Otago Exercise Programme Leaders (plus 636 in Europe since 2014)
Over 1000 Chair Based Exercise Leaders

NSNF - National Stroke Nursing Forum – Stand C

Website: www.uclan.ac.uk **Email:** NSNFEnquiries@uclan.ac.uk

The NSNF aims to represent and promote stroke nursing across the UK through:

- Act as a platform to express the collective views and experiences of members
- Facilitate access to education and training opportunities in stroke nursing
- Provide expert opinion on education and training in stroke nursing
- Promote research that advances the discipline of stroke nursing
- Provide a conduit for lobbying government on stroke and stroke nursing
- Provide expert advice regarding stroke health policy and service delivery

Northern Ireland Multidisciplinary Association of Stroke Teams – Stand L

Website: www.nimast.org.uk

NIMAST is the only multidisciplinary association for stroke in Northern Ireland and provides a forum for sharing best practice, disseminating service improvements and research findings. NIMAST also has significant influence on stroke service development, guidelines and stroke strategies, through direct co-operation with government, HSC and the Public Health Agency. NIMAST has strong links with stroke groups both in the UK and Ireland, including the Stroke Association and the UK Stroke Forum.

NIMAST can give you the opportunity to engage more fully with stroke service change and implementation, and help implement the things that you, as a front line stroke service provider, see as important.

Our annual conference is the only dedicated multidisciplinary conference in the UK or Ireland.

VISIT OUR NEW WEBSITE & JOIN NIMAST BY REGISTERING ONLINE www.nimast.org.uk

For a small annual subscription of £20, (reduced rate of £10 for students) you can gain full access to online discussion forums, links to other relevant sites, service improvement bulletins and conference presentations/ slides.

You will also benefit from reduced NIMAST/ UKSF conference rates.

- Please note that all current NIMAST members will soon be receiving further notification regarding updating their membership online.

Royal College of Occupational Therapists Specialist Section Neurological Practice – Stand G

Website: www.cot.co.uk/cotss-neurological-practice/cot-ss-neurological-practice
Email: enquiries@BrainTreeManagement.co.uk

The College of Occupational Therapists (COT) Specialist Section - Neurological Practice comprises of over 900 members throughout the UK and aims to improve knowledge, assessment and treatment of neurological conditions by encouraging awareness of up-to-date approaches, exchange of ideas, CPD and research. We provide expert knowledge and have members who provide advice in influencing policy development (internationally, nationally, regionally and locally) and patient care. We also assist in the development of national guidelines working in partnership with COT. Nationally we support frequent local training events as well as running a two day subsidized conference each year.

Royal College of Speech and Language Therapists – Stand O

Website: www.rcslt.org **Email:** info@rcslt.org

The Royal College of Speech and Language Therapists is the professional body for speech and language therapists and assistant practitioners. We promote excellence in practice and influence health, education and social care policies to achieve the best possible outcomes for people with communication and swallowing difficulties.

SRR – The Society for Research in Rehabilitation – Stand I

Website: www.srr.org.uk **Email:** patricia.dziunka@srr.org.uk

The Society of Research in Rehabilitation (SRR) is the major multidisciplinary rehabilitation research society in the UK. Its aim is to advance education and research into all aspects of the rehabilitation of people with disability and to disseminate the useful results of such research for the public benefit.

The Society aims to be inspiring and educational, whilst providing excellent opportunities for networking, for junior and established researchers.

The SRR runs two conferences a year, with topic specific research symposia, free scientific presentations and 'research in progress' posters.

Stroke Association Voluntary Groups – Stand J

Website: www.stroke.org.uk **Email:** info@stroke.org.uk

Stroke Association Voluntary Groups are peer support groups run by our volunteers, many of whom are stroke survivors and carers. The groups are based in local communities across the UK and provide opportunities for those affected by stroke to meet and learn from others who know what it's like to experience stroke. Many groups also provide activities such as exercise, art, gardening, singing, social activities and much more. The groups have been proven to reduce social isolation, improve emotional and physical wellbeing and play an important role in a stroke survivor's long term recovery.

Stroke-Specific Education Framework – Stand A

Website: www.stroke-education.org.uk **Email:** ssefenquiries@uclan.ac.uk

In response to the 2007 National Stroke Strategy, the Department of Health funded the establishment of the UK Forum for Stroke Training, which developed the Stroke-Specific Education Framework (SSEF).

The SSEF is a professional development tool which enables health-care professionals to assess their knowledge and skills against the framework, identify their training needs, and receive bespoke training suggestions; all on a secure website.

Training providers can register their courses, map them to the framework, and have them indexed on a searchable database, increasing accessibility to those looking for training.

Come and see us at Stand A to register for free!

VISION research unit – Stand E

Website: www.liverpool.ac.uk/psychology-health-and society/research/vision/about
Email: vision@liverpool.ac.uk

The VISION group evaluates visual impairment in acquired brain injury and neurological conditions, explores and develops outcome measures in orthoptics, and seeks to explore the complexity of co-existent visual and functional impairments.

UKSF 2018 Call for Abstracts

Call for Abstracts will open for the 13th UK Stroke Forum Conference in April 2018

Tuesday 4 - Thursday 6 December 2018 The International Centre, Telford

The UK Stroke Forum Conference is the largest multidisciplinary stroke event in the UK, attracting over 1400 delegates from across the stroke care pathway. It's an unmissable event for anyone working in the field of stroke care.

Showcase your research results or service delivery innovations to over 1400 stroke care professionals!

You can submit an abstract for the opportunity to present either a 10 minute oral presentation or poster presentation at the 2018 conference.

Abstracts are welcomed from all aspects of stroke care, service delivery and clinical practice.
All abstracts will be peer reviewed by a Multi-Disciplinary Team overseen by the UKSF Conference Scientific Programme Committee to ensure consistency and objectivity.

Prizes for the best research and clinical / practice posters will be awarded at the Conference.

The submission deadline is 17.00 on Wednesday 13 June 2018

UK STROKE FORUM

Hosted by

Stroke association

Join us next year for the
13th UK Stroke Forum Conference
The International Centre, Telford

4 - 6 December 2018

www.ukstrokeforum.org

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