Minutes of the Cross Party Group on Stroke: 3 December 2019

Third Evidence Session of the Inquiry into the implementation of the Welsh Government's Stroke Delivery Plan

1. Welcome, apologies and introductions

In attendance:

Cross Party Group Members

Dr Dai Lloyd AM

Giving Evidence

Dr Fiona Jenkins, Stroke Implementation Group
Dr Phil Jones, National Clinical Lead for Stroke
Gareth Lee, NHS Delivery Unit
Dr Tom Hughes, Welsh Association of Stroke Physicians

Other Attendees

Katie Chappelle, Stroke Association
Matt O'Grady, Stroke Association
Carol Bott, Stroke Association
Samadini Perera, NHS Delivery Unit
David Fitzpatrick, Stroke Survivor
Rachel Jenkins, ABPI Cymru
Liz Wilkinson, Cwm Taf Morgannwg University Health Board
Callum Hughes, Welsh NHS Confederation
Sarah Griffiths, Cwm Taf Morgannwg University Health Board/Royal Pharmaceutical Society
Sarah Williamson, Royal College of Physicians
Hywel Morgan, NHS Wales Health Collaborative

Via Video/Phone Link

Judith Rees, Betsi Cadwaladr University Health Board
Lynda Kenway, NHS Wales Health Collaborative
Joanne Oliver, British Heart Foundation
Niki Turner, Cardiff and Vale University Health Board

Apologies:

Alex Smith, Cardiff University
Emma Henwood, British Heart Foundation Cymru
Bethan Edwards, British Heart Foundation Cymru
Nick Cann, Stroke Survivor

Jill Newman, Betsi Cadwaladr University Health Board
Carmel Donovan, Bridgend Council

2. Approval of minutes

Approved by group.

3. Update on progress from actions agreed from last meeting; the way forward

No actions from previous meeting to take forward.

MO updated on other activity since last meeting, including launch of survey of stroke survivors.

4. Evidence session: Fast, effective acute care

Dr Fiona Jenkins and Dr Phil Jones

FJ said evidence would be joint presentation between herself and PJ.

FJ set out strategic position as Chair of SIG.FJ said role of SIG is to lead on implementation of the SDP. Highlighted that is delivered locally. Resourced by Minister. Supports Health Boards and their local delivery groups to deliver strong and joined up leadership and strategy. Each LHB has their own group to drive forward plan.

Existing plan runs up until end of 2020. Outlined what the SDP says around acute care.

PJ outlined definitions of hyperacute, acute and rehabilitation and the link between them and gave overview of stroke patient pathway.

PJ gave overview of SSNAP domains:

Scanning – Wales performing better than average, with median clock start to scanning time lower than in England. Four sites in UK top 20.

Admission times – Wales on par with the UK. Highlighted that getting to an acute stroke unit has impact on outcomes for patient. Wales reasonably well represented in top 20.

Thrombolysis – All units provide 24/7. Thrombolysis rate better than UK average. However number within one hour not as good as rest of UK. Door-to-needle time around ten minutes longer than UK average.

Specialist assessment – Outlined challenge in interpretation but on a par with rest of UK. Median time longer than UK. On swallow screenings Wales does reasonably well.

Thrombectomy – Not enough neuroradiologists at present, and about 25 in training across the whole of the UK. Also need equipment and suites. Service in Cardiff providing in house treatment as well as services in Bristol and the Walton with referral pathways. Belfast has highest rate per capita with ‘superb’ service. Service commissioned by WHSSC since April.

FJ said discussions had happened with those authoring new national clinical plan and stroke is likely to be included as a condition as seen as important and bespoke enough for own section. Two draft key elements to be contained within plan. TIA assessment and HASUs to be included. Said at present in Wales we’re not always quick enough as staff not always available 24 hours. HASU consolidation likely to mean one unit in north Wales, one in south west, one in south east and one in Cardiff. Additional thinking about model in rural Wales. Also thinking about Cwm Taf. Needs to not just be label but with additional staffing, but will provide best possible care.

Dr Tom Hughes

TH said giving evidence as President of WASP but also has insight as practicing physician.

Said in 2022 would be training for specialties for physicians including stroke. Said at present there is a crisis in stroke recruitment, with 48 posts available in the UK but only 16 filled for registrar to train in stroke, with no posts filled in Wales. Has impact on future of services. Need to be prioritised through link with HEIW.

TH said most important thing is neuroradiology, as currently limiting thrombectomy. Most neuroradiologists working on other elements, with thrombectomy only a small part of work. Need to recruit but also have close links between stroke and other neurological services.

Need to rationalise the current twelve units to a smaller number to concentrate expertise.

TH said there needed to be greater acknowledgement of current remit of stroke physicians. 40-50% of admissions at present are shown not to have stroke, and non-stroke is taking up resources. Data should be included in any analysis of those who have not had stroke.

Gareth Lee

GL gave an overview of the importance of thrombolysis, and outlined the review conducted by the Delivery Unit after being commissioned by Welsh Government.

GL said there was a high level of variation between how long it takes someone to get to hospital, with delays in calling an ambulance being one of the main delays. The review found there was a link between socioeconomic status and delaying phoning

an ambulance. The algorithm used by WAST prioritised patients into either ‘Amber 1’ or ‘Amber 2’ based on whether they were within the thrombolysis window, but this created a risk of miscatogorised patients facing a delay. Ambulance response times varied heavily across Wales, often as a result of handover delays. Where good pre-notification existed between ambulance and stroke teams, thrombolysis door to needle times could be reduced. However there was variation in practice as to how this was conducted.

When a patient arrived at hospital, the review found processes varied depending on whether the patient arrived in or out of hours, with additional steps in the pathway causing delays.

The review found not all protocols used to assess patients for thrombolysis were the same across Wales, not always reflecting the most recent evidence or best practice. CT reporting also varied and could add additional time both in and out of hours.

Training on stroke thrombolysis also varied in quality and regularity, as well as audit and governance processes.

Questions from Cross Party Group to the panel:

KC asked FJ for further detail on how SIG holds LHBs to account, and what level of scrutiny SIG receives from the Minister. KC also asked how the national clinical plan should be implemented. FJ replied that performance management is done at health board levels, with meetings between Welsh Government quality department and health boards. Stroke bundles part of tier one targets. SIGs role is to use carrot not stick, with PJ working with health board leads. Element of competition between health boards, concern about Princess of Wales performance. Boundary change has made planning difficult and difference in care depending on when you arrive. PJ and FJ both have had discussions with Cwm Taf. When there is a problem they will directly intervene. Peer support and peer clinically led discussion to hold to account. Clinical as well as managerial lead from each LHB on SIG. Good network and know the people well. Short answer is peer support to hold each other to account. PJ and FJ meet with Minister once or twice a year. Delivery plan reporting system also holds to account. SIG tries not to do performance monitoring but uses clinically led approach to change hearts and minds. FJ said investment needed for HASU model, as LHBs will struggle to fund. Discussion needs to be had with Minister for national investment. Anxiety is that if each LHB left to do it then won’t get pace of change required. Welcome guidance from CPG.

DL said CPGs role was to collect evidence and pull it together.

DF said concern was around delivery as his experience was gaps in process, such as in accessing data. Still over-reliant on faxes. PJ said image transfer was a problem and was an information governance issue covering the whole of Wales. FJ

said there was a national imaging group which has just finalised terms of reference. Also change in national digital strategy to look at cloud based systems.

MO said the Stroke Association involved with HASU planning and that at present wouldn't refer to current plans as 'final', and picture not as rosy as described. Paper to SIG said funding an issue in two LHBs. Asked whether role of Delivery Plan was to turn intentions into a reality. Also asked why there was such variation in SSNAP performance between units. Mentioned that staffing was given as answer to this question during rehab meeting.

PJ said problem is large number of small units means small number of admissions, which means small statistical base can lead to one patient being more statistically relevant. One patient can be 10% of activity. Good learning points shared in SIG but has reservations over whether shared learning translated into practice locally.

SP said other countries have high variation in thrombolysis as well. Each hospital have different in and out of hours practices. Interpretation of guidelines also different and this contributes to variation. Huge variety in staff. Need for centralisation. MO asked whether variety of staffing was due to design or availability? SP said can be down to admission numbers.

TH mentioned discussion on data doesn't include those who are inappropriately thrombolysed. Very difficult to interpret data as a result. Also don't see outcomes of those who initially thought to have stroke but turn out not to. Doesn't think variation in Wales very different to variation in England. Some clinicians more cavalier in their approach, some more roundhead. Gave stats on haemorrhage after thrombolysis but reminded net benefit.

PJ said argument for HASU sound in urban areas but more tricky in rural areas.

SW said nursing staff levels important for monitoring.

CB asked what was being done to entice INRs to Wales? TH replied that 81 practicing at present in the UK. Attracted to centres with other services and expertise. St Georges find it difficult to sustain with six specialists. Need to concentrate on all parts of puzzle such as neurology to show critical mass of expertise. INRs will be offered larger rewards to go elsewhere.

PJ mentioned challenge of credentialing. Overlap with cardiologists. Original plan in Wales to develop Cardiff for credentialing.

FJ added that stroke intertwined with other parts of unscheduled care means stroke units take other patients as well. No unit in Wales staffed to deliver HASU services and no unit in Wales only treating stroke.

JR said staffing levels don't affect decision making but speed of care.

DF added need to integrate GPs for those who are experiencing less obvious stroke symptoms. DL agreed it is a clinical challenge.

SW mentioned discharge also vital, with role for pharmacists in this.

TH said that future of service predicated on training and currently no trainees in stroke in Wales. FJ asked whether HASU model would make Wales more attractive to trainees. TH said should attract more trainees.

Dates, time and venue of next meetings:

11 February, 12.30-13.30. Room TBC.

24 March, report launch.

Topic for next meeting: Draft report themes

Meeting ends