Cross Party Group on Stroke Minutes

Meeting: Cross Party Group on Stroke

Date: 19 September 2017

Venue: Committee Room 5, Ty Hywel, National Assembly

Chair
Dr Dai Lloyd AM (Plaid Cymru)

Assembly Members
Huw Irranca-Davis AM (Labour)
Mark Isherwood AM (Conservative)
Craig Lawton for Suzy Davies AM (Conservative)

Speakers
Dr Phil Jones, Consultant Physician, Stroke Lead for Wales
Dr Angus Ramsay, Senior Research Associate, UCL Dept of Applied Health Research
Dr Diptarup Mukhopadhyay, Consultant Stroke Physician, ABM UHB

Attendees
Dr Anne Freeman OBE, Hon Consultant ABHB, former Clinical Lead for Stroke, Wales
Philippa Ford MBE, Chartered Society of Physiotherapy, Public Affairs & Policy Manager for Wales
Nicola Davis-Job, Acute Care and Leadership Adviser, RCN
Dr Fiona Jenkins, Chair National Stroke Delivery Group, Executive Director of Therapies & Health Science, Cardiff and Vale UHB
Dr Richard Dewar, Consultant Stroke Physician/Lead, Cwm Taf University Health Board
Dr James Barry, Clinical Lead, All Wales Cardiac Network
Nicola Davis-Job, Acute Care & Leadership, Royal College of Nursing, Wales
Nick Cann, stroke survivor, LAS Award winner, Wales Advisory Committee Member & Ambassador/fundraiser for the Stroke Association
Stephen Davies, Stroke and Neuro Conditions Implementation Groups Coordinator
Irina Erchovaia, Research Assistant, Cardiff University, stroke survivor
Dr Jill Newman, Performance Director, Betsi Cadwaladr
Rachel Jenkins, Local Account Manager, Pfizer
Sue Beckman, Director, Delivery Unit
Chris Moore, Clinical Support Lead, WAST
Claire Butterworth, Clinical Specialist Physiotherapist in Stroke, Cardiff & Vale
Sheila Tagholm, Chair, North Wales Reference Group; Committee Member (Stroke Assoc)
Rob Thomas, Boehringer Ingleheim Ltd
Caroline Walters, Policy Officer, Royal College of Speech and Language Therapists
Olivia Wheatley, Speech and Language Therapist at Llandough Hospital, RCSLT
Robin Moulster, stroke survivor and Country Manager for BASW Cymru
Julie Mills, accompanied Mr Robin Moulster
Mr Jeff Harris MBE, a stroke survivor from Chepstow
Mrs Jeff Harris, wife of the above stroke survivor

In Attendance

Ross Evans, Acting Director, Stroke Association
Llinos Wyn Parry, Head of Services (Mid & North Wales), Stroke Association
Matt O'Grady, Policy & Campaigns Officer, Stroke Association
Jillian Haynes, Minute Secretary, Stroke Association

Apologies

Mike Hedges AM, Swansea East
Simon Thomas AM, Mid & West Wales
Neil McEvoy AM, South Wales Central

Annabel Jones, Wales Advisory Committee Member. Stroke Association
Rhodri Davies, Head of Influencing & Communications, Stroke Association
Rachel Lewis, Age Alliance Wales Manager
Christopher Williams, Age Cymru
Catherine Quarrel, Commissioning Manager, Powys Teaching Board
Ceri Williams, Policy & Public Affairs Lead, Social Care Wales
Joanne Oliver, Health Service Engagement Lead for Wales, British Heart Foundation
Rosaleen Doyle, Policy & Comms Officer, Royal College of Physicians
Trudie Lobhan, Founder & CEO, AF Society
Dr Jessica Quirke, Consultant Clinical Neuropsychologist, Llandough Hospital
Louise Lidbury, Primary Community & Independent Sector Adviser, RCN
Lynne Hughes, Stroke Coordinator, Betsi Cadwaladr
Tamsin Miles, Researcher, C&V UHB
Tina Donnelly, Director, RCN Wales
Vivienne Sugar, Chair of Bevan Foundation
Dr Azim Ahmed, Researcher, Diverse Cymru
Professor Chris Burton, Head of School of Healthcare Sciences, Bangor University
Debbie Davies, Primary Care Development Nurse, Public Health Wales
Jeannie Wyatt-Williams, National Exercise Referral Coordinator for Wales
Lorraine Morgan, Consultant on Ageing
Rachel Jenkins, Local Account Manager, Pfizer
Alun Morgan, Assistant Director of Therapies & Health Sciences
& Professional Lead for Quality, Safety & Patient Experience, C&V
Gary George, stroke survivor
Haydn Canter, Volunteer & Ambassador at Stroke Association
Stephen Ray, Healthcare Partnership Manager, Bayer plc
Sara Moran, Campaigns and Diabetes Voices Officer
Shan Owen, Llandudno Stroke Café Organiser, North Wales Reference Group Member

Purpose of the Cross Party Group on Stroke:

The CPG's priorities and required outcomes for the current year have been agreed as **post-acute care** (psychological and psychiatric support) and **prevention** (specifically, atrial fibrillation (AF)). There would also be a standing topic around **scrutiny of the implementation of the Stroke Delivery Plan** across health boards. It was the intention of this meeting to discuss the advantages and disadvantages of hyperacute stroke units (HASUs) as a concept, and the consequences of implementation as a model going forward. The Chair also agreed to discuss thrombectomy for stroke.

Introduction:

The Chair welcomed attendees and introductions were made.

Actions from the Minutes of the previous meeting were discussed and Dr Lloyd confirmed that he had not yet received replies from the Cabinet Secretary to his correspondence around 1) psychological and psychiatric stroke services and 2) atrial fibrillation. A number of questions had been submitted to the Cabinet Secretary and these can be found on the Assembly's website.

Hyperacute Stroke Units in Wales:

A paper had been written by the Stroke Association summarising the position in Wales and this had been previously received by attendees.

Presentation: Dr Angus Ramsay, Senior Research Associate, Applied Health Research Department, University College London

Dr Ramsay presented research on centralising stroke services in London and Greater Manchester (GM). The study examined the effectiveness, acceptability and process of implementation of different models on stroke care. Driving forces behind the study included the relationship between volume and outcome in some specialities, including stroke. The policy was reiterated in a piece of work called 'Five Year Forward View' written in 2014. The National Stroke Strategy of 2007 also set out a case for change, and stated that services were not organised to enable evidence-based clinical practices to be provided. As a result, London and Greater Manchester led the way in reconfiguring services to address these concerns.

Dr Ramsay summarised the situation both before and after the changes had been implemented. Initially, there were twelve stroke wards in Manchester and thirty in London. Following discharge, the stroke survivor would benefit from community rehabilitation services. After centralisation was introduced, a person with a suspected stroke would attend a 24 hour HASU and either follow on to a stroke unit or be signposted to community rehabilitation services.

Data was collected on more than a quarter of a million patients during 2008-12 and the results analysed. There was a difference in the methods of implementation within the two areas.

London operated a simple inclusive model in a 'big bang' approach with 93% of eligible patients treated in a HASU; standards were linked to financial incentives and the hands on approach meant that all services provided the necessary care in a timely

manner. A top down model was used in rolling out the approach which included political and clinical leadership. The financial incentives were linked to adherence to the new model. It was found that patient mortality decreased: 96 additional lives were saved compared to other areas. The duration of hospital stay also decreased.

GM operated a selective clinical-led model, where not all eligible patients were directed to a HASU: of the 73% eligible, only 39% of patients were treated in a HASU. This limited the development of the HASUs. The complex model was implemented in phases and standards, which created uncertainty. Adherence was not linked to financial incentives; additionally, the operation was less hands on, and leadership focused more on 'consensus building'. Patients were less likely to receive the care they needed and mortality rates showed no significant difference as a result. It was felt that findings were more relevant to large towns and cities. As a result, there has since been further centralisation in GM and a combination of a bottom-up/top-down approach to clinical leadership was considered most effective. It was advised that all stakeholders should be engaged from planning stages onwards, and a system-wide authority would counteract resistance.

Presentation: Dr Phil Jones, National Clinical Lead for Stroke Services in Wales

Dr Jones stated that the Stroke Implementation Group (SIG) had funded a report called 'A new Hyperacute Stroke Service for Wales' which was published in 2016 and which examined the options for the reconfiguration in Wales. The SIG had discussed the content of the report recently and it was agreed that the implementation of HASUs was a priority for Wales. A HASU was defined as a centre that provided a 24/7 care facility for the first 72 hours of care following stroke. He described the approach being undertaken by the NHS in Wales to the introduction of HASUs.

Dr Jones confirmed the above findings, quoting from trials completed in 2013 which stated that patients who received organised multidisciplinary care in a HASU are more likely to survive, be independent and be living at home a year after their stroke. It was observed that absolute mortality at 90 days was decreased by 1.1% in the London model (ie HASU care for all stroke patients) as opposed to the GM model (where patients were directed to HASU within four hours of stroke). This equated to 168 fewer deaths in the 21 month period examined.

SSNAP data showed that the ten services, or 'domains' recognised within the HASU each performed significantly better as a HASU than as a separate facility. Overall performance across Wales was discussed.

Dr Jones continued that the Royal College of Physicians audits the structure and staffing of stroke services every two years, the last audit being in 2012. Three of twelve sites in Wales provided consultant ward rounds every day. A number of challenges were recognised and discussed, most notably the logistical issues of creating three HASUs in Wales, based on the fact that most metropolitan models assume a million potential patients in their local catchment area, and access within around thirty minutes.

Solutions suggested could involve aligning HASUs with major vascular centres, and therefore Rhyl, Swansea and Cardiff could be examined. It was agreed that there would be an overwhelming concentration of patients in Cardiff given the local population, and so to alleviate this it was suggested that another centre would be

required in the SE Wales area. Access to HASUs generally would be an issue to overcome, and cross-border patient migration may need to be considered. It was predicted that research, emerging therapies and recruitment of multi-disciplinary stroke staff would be improved as a result of HASU implementation.

Discussion, Suggestions and Conclusions:

Dr Fiona Jenkins, Chair of the Stroke Delivery Group, stated that the implementation of HASUs had been on the agenda for many years and suggested that now may be the right time for decision.

Dr Richard Dewar queried the investment that had been made in London, and asked how the staffing levels had improved as a result. The outcomes achieved did not arise solely due to the reorganisation, but also he advised, due to the funds allocated and this was a significant factor for consideration. Dr Jones replied that GM had performed better than London in recent times but that there were more improvements to be made.

Ms Pippa Ford queried whether costings had been recorded and a gap analysis performed. Dr Jones replied that the Chief Executive had been asked to relay relevant information to the SIG but he had not responded. He acknowledged that there was a significant amount of work to consider with such a reorganisation.

Dr Diptarup Mukhopadhyay observed that recruitment would be an ongoing issue as more front line staff would be required all over Wales.

Ross Evans concluded that there were questions to be asked regarding identification of the preferred HASU model and best location.

Action: Dr Lloyd confirmed that he would correspond with the Cabinet Secretary regarding the HASU concept, the preferred model and appropriate locations.

Mr Robin Moulster enquired whether future analysis of staffing levels would include therapists. He recounted his experience following two strokes and stated that there seemed to be a distinct lack of physiotherapy services in Wales. Following discharge he suffered a bilateral pulmonary embolism and was advised by the hospital that he had not been active enough. Dr Jones confirmed that the new re-organisation would include therapists. He advised that the National Audit would quantify the number of therapists working in Wales. He acknowledged that Wales did not employ the full complement.

Dr Jill Newman stated that travel time was a concern with regard to a favourable outcome and a HASU's benefits needed to be balanced against this logistical challenge. It was agreed that some people would gain and some would lose, but that there was no obvious solution. Ms Irina Ercovaia related her experience following stroke; it took only twenty minutes for her to reach hospital but then 48 hours before she was given an injection, so travel time was not the cause of the delay in her case.

Mr Jeff Harris MBE suggested that all elements were portable and so survival depended largely on the individual. The challenge lay with the type of model to adopt, how to implement it and how to interpret the feedback to ensure success. Improvement cannot be sustained, he continued, and therapy was crucial following

discharge. Matt O'Grady stated that access to therapy and other appropriate staff would need careful consideration during the planning stages.

Dr Diptarup Mukhopadhyay agreed that following HASU care, a patient would need rehabilitation.

Ms Nicola Davis-Job noted that specialist staff would require ongoing specialist training.

Mark Isherwood AM agreed to discuss the issues with the Wales Neurological Alliance.

Thrombectomy:

Dr Anne Freeman OBE introduced the item, stating that thrombectomy for stroke was now regarded as one of the greatest advances in medicine in the last decade and was a procedure that could prevent severe disability. She proffered that Wales has no commissioned facility and would benefit greatly from the introduction of the procedure. Dr Freeman related that evidence has shown that around 10% of patients with an ischaemic stroke could be eligible for thrombectomy, amounting to around 500 patients per year, one third of whom would make a good recovery according to statistical evidence. This procedure would cost around £12,000 per patient and would be a significant saving when compared to a lifetime of supportive care either in the community or in a care home.

The Welsh Health Specialised Services Committee (WHSSC) recommended the implementation of an interim plan of patient relay to appropriate hospitals following stroke in Wales.

Dr Diptarup Mukhopadhyay presented RCP guidelines and findings. He confirmed that there was no agreed referral pathway for professionals to follow when dealing with a potential case of mechanical thrombectomy in stroke patients in Wales.'

He suggested that patients with acute ischaemic stroke should be considered for thrombolysis and clot extraction if they have a large vessel occlusion; the arterial puncture can begin within five hours of onset. Similarly, patients with acute ischaemic stroke *and a contra-indication to intravenous thrombolysis, but not to thrombectomy*, should be considered for clot extraction if they have a large vessel occlusion; the arterial puncture can again begin within five hours of onset.

Dr Mukhopadhyay related a case of a 29 year old female who experienced a very severe stroke subsequent to giving birth which had required intensive care management. As there is no clot retrieval service in Wales, the patient was intubated and the ITU Consultant suggested that he would prepare the family for organ donation, as the likely scenario suggested non-survival. However, he simultaneously contacted the stroke on-call unit at the North Bristol Trust and an emergency vehicle was arranged to relay the patient to Bristol. A clot was retrieved and the patient made an excellent recovery.

In conclusion, Dr Mukhopadhyay suggested that health boards in Wales should have an interim arrangement and an agreed pathway for referrals to Bristol/England in cases of mechanical thrombectomy need, until a service could be implemented in

Wales/Cardiff. There were four neuro-radiologists working in the Bristol Trust. He expressed concern around explaining to families that there was no funding for thrombectomy in Wales, meaning that his patients could not have the treatment that people living in England would receive.

Dr Fiona Jenkins stated that in 2015, 48 neuro-radiologists were trained in England but only one in Wales and that recruitment was difficult. England decided to commission the service but there was insufficient capacity in Wales (WHSSC was approached for funding in January 2017).

The SIG had decided that the primary concern would be to support WHSSC and strengthen it, and in this way give benefit to a whole population, rather than benefit to individuals which thrombectomy would offer. The SIG was in the process of asking the health boards to fund HASUs, via WHSSC funding. The paper would be returned to SIG by the end of the month. It was proposed that an interim position would be decided upon, to which all health boards would agree. Dr Jenkins would be speaking to the seven health boards over the coming weeks to determine progress with the commissioning plans.

Dr Jenkins suggested that the costs of implementing thrombectomy procedures in Wales was prohibitive, but Dr Freeman compared this to the costs of subsequent patient litigation suggesting that in the long term, implementation of a thrombectomy service would be the most cost effective solution, given the evidenced based need for such a service.

Dr Phil Jones summarised that thrombectomy was invaluable and eighty cases were admitted to St George's Hospital in London over the period under analysis. He enquired as to the health boards' current position. Matt O'Grady stated that there was no reliable data in Wales and no statistics collated by the Welsh Government. Dr Jones replied that the Annual Report was a source of relevant information but Matt O'Grady questioned whether these figures were classified by the patient's home address rather than the location in which the procedure was performed.

Jill Newman commented that there was a good relationship between the health board in north Wales and the Walton Hospital in Liverpool, however they also had their own staffing challenges.

Action: Dr Lloyd agreed to raise the issues in a letter to the Cabinet Secretary which would outline the discussions and consequences of not implementing thrombectomy procedures in Cardiff.

Dr Lloyd reported that he was supported by at least one other Assembly Member, namely Huw Irranca-Davis AM.

<u>Any other business:</u>

No other business was discussed.

Date, time and venue of next meeting:

The next Cross Party Group on Stroke was scheduled for 28 November at 18:30, in Committee Room 5, Ty Hywel. The meeting would review progress of Group's work since the first meeting in March 2017.

Dr Lloyd directed that the National Assembly's website shows dates, times and venues of future meetings as well as Minutes of all previous meetings.

Minutes approved by Dr Dai Lloyd AM as a true reflection of the content of the meeting held on 19 September 2017:

Signed: ……..…… Date: …….
