London Cardiac and Stroke Networks

London HASU leads meeting

Friday, 22nd July 14:00 – 16:00
Room SB4 - 188 Tottenham Court Road

Attendees:

Tony Rudd *Chair*
London Stroke Clinical Director '

Rindy Kar
Consultant in Stroke Medicine – Charing Cross
Julia Slark
HASU Nurse Lead – Charing Cross

Dulka Manawadu
HASU Clinical Lead – King's
Maria Fitzpatrick
Consultant Nurse Stroke Management – King's

Neil Thomson
Assistant Medical Director – London Ambulance Service

David Cohen
HASU Clinical Lead – Northwick Park
Sue Fenwick-Elliot
Stroke Clinical Service Manager – Northwick Park

Ken Rhodes
Consultant Elderly Medicine – PRUH
Dee Slade
Stroke/TIA Clinical Nurse Specialist – PRUH

Patrick Gompertz
HASU Clinical Lead – The Royal London
Ann Rush
Matron – The Royal London

Barry Moynihan
Consultant in Stroke Medicine – St. George's
Alison Loosemore
Ward Manager – St. George's

Jonathan Birns
Consultant in Stroke Medicine – St. Thomas'

Khaled Darawil
HASU Clinical Lead – Queen's
Ann Russell
Stroke CNS – Queen's

Rob Simister
HASU Clinical Lead – UCLH
Simone Browning
HASU Ward Sister – UCLH

Diane Ames
Network Clinical Lead – NWL Stroke Network

Hilary Walker
Network Director – NCL&NWL Stroke Networks

Janelle Devereux
Assistant Director – SL Stroke Network

Caroline Kilby *Minutes*

Alec Fraser *Observation*

Apologies:

Charlie Davie
Network Clinical Lead – NCL Stroke Network

1. Meeting opened

The chair welcomed everyone to the meeting and led the introductions.

2. July 2010 – July 2011

TR delivered a presentation [circulated with minutes] to show the positive progress made since the HASUs went live in July 2010 and in comparison to the 2008 Sentinel Audit results.

TR advised that the completion of the economic evaluation being conducted by UCL Partners would give some further quality outcome information.

3. Transfers

A&E to HASU

There is a lack of consistency between HASUs in terms of the patients that are accepted for transfer from A&E departments on sites without a HASU.

Some A&Es in South London had been experiencing variation in which patients would be accepted for transfer to the HASUs. The South London Networks were auditing the reasons for why these patients were not transferred and would be feeding this information back to the HASUs through the governance meetings.

ACTION: All units/A&Es to include the stroke pathway within the trust induction for new doctors.

Repatriation

There were some examples demonstrating that repatriation was creating issues, either as a result of lack of capacity within the SUs or because patients did not want to return to their local unit. The South London networks have a specific group addressing repatriation issues.

4. Mimics

It is evident from the data submitted since July 2010 that the HASUs operate different 'front door policies', as some have a much higher proportion of mimics than others.

However, it would not be appropriate to put patients back into ambulances and transfer them to another A&E for bed management purposes; these patients should be managed within the HASU host hospital. A robust policy with the general medical team is required so that these issues do not need to be resolved on a patient-by-patient basis.

There was also a general consensus that neurological mimics were more appropriately managed by HASU teams rather than general medical teams. Therefore, a pathway that admits these patients to HASUs would be beneficial.

5. Thrombolysis rates

The group discussed the variances in the proportion of the stroke population receiving thrombolysis at each of the eight HASUs. Governance arrangements were discussed in order to provide assurance that reasons for these variations were being captured. All HASUs confirmed governance arrangements.

It was recognised that variation may be due to the experience at each unit of providing this treatment. Queen's is building its service and it is appropriate that the thrombolysis rate is below that of other HASUs at the present time.

There was internal variation at UCH at clinician level. When this was audited it showed different approaches to the management of patients with a minor stroke.

It was recommended that each HASU audits its own provision in order to provide consistency internally for further discussions at a London and national level.

6. Door to needle time standard; the move to 90% within 30 minutes

There was concern from each HASU that the percentage of patients delivered within 30 minutes was currently unmanageable and potentially not in the best interest of the patients. Only one unit in London was currently achieving a median of 30 mins or less door-to-needle time. Most (although not all) had longer door-to-needle times outside normal working hours.

It was suggested that the target time should remain 30 mins but the percentage needed to achieve the target be reduced.

Views varied as to the wisdom of changing the standard but everyone agreed that there should remain a target that encouraged improved efficiencies throughout day and night in delivery of care.

It was agreed that the views of this group would be fed back to the Clinical Advisory Group at their meeting in September where a final decision would be made on whether to make slight alterations to this standard.

It was also recognised that any changes to the assessment standards would have to be passed at the pan-London Cardiac and Stroke Network Board and noted as a change to the tariff.

7. Research

As part of the ongoing implementation of the London stroke model, the HASU leads discussed the opportunities for developing city-wide research, beyond complex industry trials.

Collaborative research would require easy patient recruitment.

It was agreed that the establishment of such research in this way required a separate session to which those working within the services could bring proposals.

ACTION: Set up research session

8. Education and training

The is an e-learning package being developed and there will shortly be SIM centre HASU training sessions run in four of the SIM centres in London.

The SIM centre training is Deanery funded so HASUs would only need to release staff to attend. There are two different levels of SIM course, one for band 5 nurses and junior doctors, and the other for band 6/7 nurses and senior doctors.

The majority of permanent staff working within the hyper acute stroke pathway should be encouraged to attend.

ACTION: Confirm and circulate dates for SIM centre training

Basic course information: http://www.slcsn.nhs.uk/events/events-stroke-sim-course-basic.html
Advanced course information: http://www.slcsn.nhs.uk/events/events-stroke-sim-course-advanced.html

The HASU nursing competencies had received UK Stroke Forum Training (UKSFT) accreditation and were available to use. There would be an education event to support this programme scheduled for 16th September.

The stroke course for GPs being developed with RILA would be available from October and LAS was organising another training day with Imperial.

9. Rotations across the pathway

The HASUs reported that whilst staff members rotate between the HASU and the collocated SU, some were also rotating into collocated inpatient rehabilitation units (see system in place at Queen's) but that there weren't any established rotations between the HASU and other SUs, apart from the consultant rota in place in NCL.

NCL were setting up a pilot to rate nursing staff from the other SUs in the sector into the HASU at UCH. The team at UCH agreed to present back the results of this pilot to this group at its next meeting.

10. What's next

It was planned that by the end of October all the HASU capacity at PRUH should be live and the HASU capacity at St Thomas' will have been transferred.

This group agreed to meet twice a year. The next meeting would be in January 2012.

The teams from the HASUs agreed to develop closer links with the paramedics transferring patients to their units so that they receive feedback and are able to found out the outcome for their patients. The HASUs would welcome LAS teams onto the ward and would set up local methods for doing this.

11. AOB

One HASU team reported that their trust was looking at reducing PTS costs and examined how this is paid within the London stroke model. It was confirmed that this cost had been included in the HASU tariff and was therefore the responsibility of the HASU trust to fund this transfer to the local SU.

The management of adolescents that suffer a stroke would form part of the next agenda for this group.

It was noted that having the nursing lead from each of the HASUs at this meeting had been very beneficial.

12. Close