London Cardiac and Stroke Networks

London Stroke Clinical Advisory Group minutes

Tuesday, 1st May 2012

1. Clinical Advisory Group:

In attendance:

Tony Rudd (TR)
Bal Athwal (BA)
Gill Cluckie (GiC)
Geoff Cloud (GeC)
David Cohen (DC)
Charlie Davie (CD)
Sue Fenwick-Elliott (SFE)
Patrick Gompertz (PG)
John Platt (JP)
Merik Skrypak (MS)
Hilary Walker (HiW)
Caroline Kilby (Minutes)

Guests:
Alec Fraser

Apologies:

Diane Ames
Val Jones
Joe Korner
Neil Thomson
Rachel Sibson

2. Minutes and Matters arising not covered elsewhere in the agenda

2.1. Changes to the previous minutes;
GeC to lead on the revision of the London transfer protocol
Endovascular trial name to PISTE

2.2. **Stroke mimic repatriation**
following TR's email of 27th April 2012 there had been some feedback from stroke unit services. It had been requested that this notice be formally sent to the Director of Operations at all SU trusts as it was difficult for the clinical teams to implement this protocol.

Action: TR and network directors to write as requested.

2.3. **London HASU capacity protocol**
a revised draft of this protocol was circulated prior to this meeting and had received feedback.

LAS feedback;
Request to HASUs to include their anticipated capacity four hours from the time of call in their reports to EBS so that this can be distributed along with the actual capacity.

UCH HASU feedback was discussed;
The protocol reads as if there were two pathways, one for those who present within 4.5 hours of their stroke and those who present later. This group confirmed that this was not the planned intention and therefore would need to ensure the documentation reflected the single pathway.

Action: TR to work through with Rob Simister where corrections can be made so the protocol does not seem to include two pathways.

There was concern that this protocol would lead to high numbers of patients being diverted past their closest HASU and therefore they would miss the opportunity to receive Thrombolysis due to the longer journey times.

Action: LAS to monitor volume of diverts, however would be difficult to show if this is as a result of this protocol

Action: Receiving HASUs to note if a patient has been diverted to them and that this has resulted in that patient being outside the time window for Thrombolysis.

Recommend that for those patients who present to an A&E without a HASU more than 24 hours after symptom onset that if their local HASU reports that they have no beds available to call LAS for a non-critical transfer and let EBS decide which HASU is the most appropriate for that patient.

Discussions on how to manage demand when there was no capacity was had, this group agreed that rather than restrict the entry pathway and deny patients access to HASU care the solution to limited capacity would more likely come from stroke units.

Action: Network clinical leads to request that stroke units prepare plans on how they could support HASU capacity in these circumstances and formalise protocols within their own trusts. Report back at June meeting.

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3. Successful patient experience model

Presentation from St. George's delivered by Geoff Cloud, on behalf of Barry Moynihan. Presentation circulated with these minutes.

This group requested that the team at St. George's share the questions that they used and their methodology.

It was agreed that each unit should provide biannual reports on how they are integrating patient experience into the management of their services. Suggested the reports should be submitted in September 2012, with the second in March 2013.

Action: Clinical leads and network directors to communicate this to the services in their sectors

The Stroke Association had recently released a report based on a national survey that said stroke survivors were 'denied recovery'.

They had produced a smaller summary on the London services highlighting that stroke survivors were positive about their experiences of the London acute stroke services but felt that a gap between Health and Social Care services remained.

Action: TR to circulate the report recently published by the Stroke Association

Action: Add Health and Social Care to the June agenda

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4. Acute standards of performance

Following a review of the SSNAP data fields it appeared as though it would be possible to continue monitoring all the London standards of performance (aside from those which are infrastructure based) for the acute services apart from; the HASU weight standard, the SU weight standard and the SU nutritional screen standard, but SSNAP does capture information about nutritionally screening and intervention by a dietician.

This group agreed that the SU standards could be replaced by a standard that looked at the dietician's intervention rather than the frequency of screening and that both the HASU and SU weight standards could be removed.

Action: TR to draft a replacement standard of performance for nutrition.

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5. Stroke rehabilitation services update

TR fed back to this group that there had been some progress made with regard to establishing a clearer referral pathway for stroke patients to neuro consortium units.

Action: Circulate the new form designed to support this pathway with these minutes

TR had also begun visiting the inpatient rehabilitation units across North London, there would be a summary report following the completion of these visits during the summer.

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6. Rehabilitation standards of performance

Item deferred until August when the report (see item 5 above) would be available

7. AF and TIA services

This group agreed that there was a lot of focus on the AF services from other bodies at the present time and that whilst they would remain interested in their development this group would not be directly driving change in this area.

There were reports that some TIA services had been reviewed against the standards within the commissioning and tariff guidance but this approach had not been consistently replicated.

The perception was that these services were working well.

Action: Clinical leads to review TIA services in their areas and confirm that they are functional and delivering equal, good quality care and to report back.

8. Any other business

HASUs are finding that they are unable to repatriate patients who have required ITU level care and may still have high level needs to some stroke units and that stroke units vary in their ability to manage these patients.

The Clinical Advisory Group recognised that it is very challenging for a stroke unit team to maintain the competencies to manage these patients when they probably would only see a small number of patients requiring this level of care but the group also recognised that these patients may require a longer hospital spell and that the HASUs were only designed to manage patients for the first 3 days of their pathway,

Action: Clinical leads and network directors were requested to map the stroke units in their sectors looking at what which units are able to manage the patients and to work with the HASUs in their sectors to understand the number of people who require this level of care.

Future meetings;

Tuesday 12th June, 15:00 – 17:00

July meeting CANCELLED.

Tuesday 7th August, 15:00 – 17:00