London Cardiac and Stroke Networks

London Stroke Clinical Advisory Group minutes

Tuesday 7th June 2011

1. Clinical Advisory Group:

In attendance:

Tony Rudd (Chair)
Diane Ames
Bal Athwal
David Cohen
Geoff Cloud
Charlie Davie
Patrick Gompertz
Val Jones
Joe Korner
Dulka Manawadu
John Platt
Mirek Skrypak
Hilary Walker
Helen Williams

Caroline Kilby (Minutes)

Guests:

Gemma Snell

Apologies:

Sotiris Antoniou
Tess Baird
Gill Cluckie
Sue Fenwick-Elliott
Tom Greenwood
Nicola Harding
Emmie Malewezi
Rachel Sibson
Neil Thomson

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

Error in attendee list for the May meeting to be amended, remaining minutes of the previous meeting were agreed.

1.1. IEP (Actions carried forward from May meeting);
Action: Networks to confirm with stroke units whether they can routinely access images outside of normal working hours via IEP
Action: CK to forward and request response from all networks

1.2. HASU leads meeting;
Invitations had been circulated. This group agreed that Neil from LAS should be part of this meeting.
Action: CK to invite NT to meeting

1.3. LAS reporting;
The LAS are happy to report data (numbers, times etc.) to the pan-London Board, and had created a simplified report form. This was well received at the last Board meeting, except for slight confusion around times and inter-facility transfers that would be clearer in future reports.

1.4. Further LAS information
As NT was unable to attend this meeting a written update was provided ahead of the meeting, where comments have reflected items on the agenda for this meeting they have been inserted along with that item, all other comments are noted here;

1.4.1. Clinical governance issues – comment on incident where pre-alerts had not being accepted by A&E department
A meeting between the A&E and HASU leads took place and since then there had only been one incident like this reported; this had been handled locally. All HASUs probably need to periodically check that information on stroke pathways and LAS protocols is available, especially as middle-grade staff rotate.
Action: Clinical leads to ensure A&E junior docs within their networks are aware of LAS protocol

1.4.2. LAS were looking at provisional dates in mid October to run another HASU/LAS training day in collaboration with Imperial.

1.4.3. LAS were working with the e-learning team at St. Mary's to (a) provide accurate images and video clips and (b) to try to develop a package that could sit on the LAS e-learning platform and be used by their staff.

1.4.4. LAS held a members evening on stroke developments at the end of May. It was attended by about 50 people (staff, clinicians and patient representatives) and had very good feedback. They were also able to re-unite a patient with the emergency dispatcher and paramedics involved in his care.

1.4.5. LAS Head of Olympic Planning, Peter Thorpe might be available to attend the July CAG meeting alongside the SHA 2012 Programme Manager, Lola Banjoko.

3. Update from South East London

South London Healthcare NHS Trust had been accredited for 6 HASU beds, concerns remain regarding the medical staffing. This new service had seen very high levels of activity. Thrombolysis was being delivered on the Princess Royal University Hospital (PRUH) as per the London implementation plan. The HASU service appeared reasonably effective within the stated capacity but increases in activity was putting pressure on supporting services. Further liaison with LAS would continue to ensure activity at the PRUH was controlled to within a manageable level.

The transitional hyperacute services at St. Thomas' Hospital are due to cease in October when HASU services at PRUH increase to 14 beds.

It was hoped that DA would continue her transitional role at PRUH for a while longer so that the HASU there was fully supported.

4. London minimum data set (LMDS) - report

Gemma Snell, London Data Lead, gave a summary presentation of the preliminary report produced from the quarter 4 LMDS. A hard copy of the report was circulated.

Data quality issues aside and recognising that data had not been received from NE London or St Thomas Hospital, the report showed some encouraging information around the provision of stroke care across London. Further work would be done to begin to draw some conclusions from the information available.

GS asked that the members of this group took the report away and looked through it with their teams across the sectors in order to provide feedback on content and ideas for different ways of producing conclusions from the data.

JK commented that the information available shows how much the services have improved since they were implemented just under a year before.

TR asked that members of this group use this opportunity to create some abstracts for the UK Stroke Forum that would be based on information from across the whole system.

DC suggested that this group also consider working with the LAS to submit an abstract on journey times.

Action: All to send feedback to Gemma Snell gemma.snell@nhs.net

Action: All to contact TR with suggestions for abstracts to be submitted to the UK stroke forum on behalf of the London stroke system

CK asked that this group continue to champion the collection of this data within the SINAP and additional fields system. Further support and training was available to all units from the data team; contact caroline.kilby@nhs.uk or gemma.snell@nhs.net for information.

5. Door to needle time

Based on the door to needle times reported across the city, and as some HASUs had already had their B assessments, it was agreed that the 45 minute measure would remain.

Action: CK to re-circulate the scoring system for this measure.

6. A&E to HASU transfers

Following the letter that had been sent from TR to all stroke services in the previous month, this group reported that there had been some concerns across London that the letter implied a change to the agreed service provision, when it stated that all potential stroke patients presenting up to seven days post onset of symptoms should be considered for transfer to a HASU.

TR asked this group whether there was a need to write again to trusts.

PG agreed that the seven day time frame had been discussed, but that the letter had potentially been misunderstood.

It was agreed that it should be noted that while these patients should be considered for transfer, that conversations between the referring hospital and the receiving HASU should take place and that as the letter had not set this out explicitly it had probably been taken to mean that there was no room for a clinical discussion. This group agreed that the intention was for the conversations to remain.

VJ commented that the letter had provided helpful guidance for A&E departments, particularly out of hours. There is concern from within the Stroke Units that if a stroke patient presents (between 24 hours and 7 days post stroke) at A&E out of hours then that patient may not see a stroke specialist for up to 48 hours.

BA added that there is also no accessibility to beds at Stroke Units from A&E as they are not set up to prioritise this transfer. A&E teams have asked for absolute clarity, and find that when they contact HASUs they receive a different answer about transferring a patient depending on who is on call at the HASU at the time.

JP confirmed that during hours the Stroke Unit teams are able to support A&E colleagues to make these decisions and confirm that patients who do not require transfer can be confidently managed by the Stroke Unit; it is out of hours where this is challenging.

DC confirmed that as a HASU they had no problems in accepting these patients from A&E colleagues.

DM commented that this may create challenges in terms on managing patients into and out of the HASUs and an increase in burden on their services.

DA agreed that the letter had provided helpful guidance for A&Es as the primary problem is with out of hours services, there was a need to apply these processes flexibly, particularly for patients inappropriate for transfer.

TR confirmed that referring clinicians at A&Es who feel that they need the expertise of a HASU then this should be provided.

The group agreed that transfers must happen up to 72 hours post onset of symptoms, clinician to clinician discussions are part of this. Beyond that patients should still be transferred if HASU expertise is required. No further communications were required but that clinical leads should work this through with the units in their sectors.

This group also agreed that where hospitals have A&E departments and no stroke unit all patients presenting with new onset stroke should be transferred to a HASU.

NT from LAS had also commented in writing before the meeting that; LAS were be broadly supportive of the agreement reached at the May meeting and clarified that: “Patients within the thrombolysis window will be moved as a critical transfer; those outside the window will be moved as an urgent/immediate (within 2 hours). Clearly moving these patients to a HASU has potential benefits for the individual patient, but may have an impact on capacity within the HASU, and may lead to longer journey times as patients are redirected from full sites.”

7. TIA Services

This discussion centred on whether there were any significant issues within these services and would this group monitor them in the future.

DC reported that despite the work completed by the North West London Network, habits in the community had not changed with regard to referral and awareness; therefore more could be done to raise awareness of TIAs with GPs and the public.

DA reported that services across NWL were responding sooner to referrals and two TIA services had been assessed by the network against the criteria in the tariff guide.

PG reported that they had been practicing a model whereby the GP calls a specialist nurse at the TIA service that supports the GP to complete the ABCD2 score and completes the referral on the phone. This had received positive feedback, but that they move to an A&E/HASU model for TIA services across the sector.

BA commented that they had seen the same issues, referrals from A&E had improved due to the work completed by the Stroke Team and the new sector pathway that had been implemented in NCL but as the GP actions had not altered they had felt the need to assess all patients, not just high risk, within 24 hours. They also had concerns around the reporting of these services, the measure described that the time to assessment should be measured from onset of symptoms but that most services were measuring from time of referral or from fist presentation to a healthcare professional, distorting performance.

It was agreed that both time from onset to assessment and time of referral to assessment should be recorded as would give indications as to where in the pathway there is a problem.

CD noted that whilst they offer a seven day service they do not receive many referrals at the weekend, indicating that people are not seeking quick treatment for symptoms of TIA and waiting until they can have an appointment with their GP.

Action: TR to discuss how to promote awareness of TIAs to GPs with the Network Directors at their next meeting.

It was also noted that the new Stroke Course for GPs that was being developed by Rila with input from members of this group, was nearly completed and that this could be part of the strategy to work with primary care.

JK suggested that the group work with the Royal College of GPs and that communication from this group to GPs highlighting TIAs would also be beneficial.

Action: TR to contact Andrea Marlow to create a GP focused TIA bulletin.

8. Antiplatelet guidance

HeW updated the group on the status of this guidance. It had not been signed off as the recommendations for clopidogrel to be prescribed post TIA as well as post stroke had met with some resistance. This was down to clopidogrel not being licenced by NICE for TIA.

TR commented that TIA and stroke are the same disease and that as clopidogrel is preferred for post stroke treatment and is better tolerated it should also be prescribed following a TIA.

The group was in agreement.

PG suggested that letting primary care colleagues know that they are recommending its use would be helpful and that each sector should look at its existing structures for making these recommendations to ensure that this guidance becomes a part of the established processes.

Action: TR to draft letter for all TIA services across London to endorse.

Action: Clinical leads to ask their sector colleagues to email TR endorsing this guidance.

Action: HeW to remove the TIA guidance so that the Stroke Guidance can be signed off and distributed, TIA guidance to follow as a separate item.

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9. Any other business

9.1. Health economic evaluation
Bid won by UCLPartners. To be completed by end of October. The team at UCLP will require access to post model data and will be working with NCL/NWL networks to look at the information submitted as part of the LMDS.
LAS would be working with UCLPartners on this project.
Action: Networks to let services know that their data will be used for this purpose.

9.2. Stroke patients attending non-designated hospitals
Recent HES data showed that around 5% of the stroke population are being admitted to hospitals without designated stroke services.
DA commented that this may happen at the Hammersmith where there is a specific service for renal stroke patients so that they can access their renal care.
This group agreed that where provision like this had been made the network should try to work with those units to ensure that the stroke elements of care were being delivered inline with the London measures.
Action: Networks to review where patients are attending non-stroke designated hospitals to see if there is a way to ensure that the care for these patients is being monitored.

9.3. Concerns from Chelsea and Westminster
The clinical lead of the stroke unit at Chelsea and Westminster had raised some concerns with regard to; inappropriate transfers back from HASUs and to HASUs, incidences where HASUs had not repatriated patients at all and stroke unit representation on this group.
Feedback from the HASUs involved confirmed that these issues had been resolved at a local level.
With regard to the stroke unit representation on this group, it was agreed that the current five members from these services continued to provide meaningful and valuable contributions, as well as providing a balance to the HASU representation and therefore further stroke unit representation was not required.
TR confirmed that there would be an opportunity for all those involved in the London stroke services to provide feedback and question the model in the autumn of this year. This meeting would be a transparent and open process.

9.4. Circulation of minutes
This group agreed that the minutes from its meetings should continue to be available for all.
Action: CK to contact Andrea Marlow to plan dissemination of these minutes