Cross-Party Group on Stroke

Friday 24th June 2022, 12:30 – 14:00

Minute

Present

MSPs

Gillian MacKay MSP [GM]
Alexander Stewart MSP

Invited guests

Dr Luke Williams [LW]

Dr Louise Roach [LR]

Non-MSP Group Members

Douglas Horn
Margaret Mitchell MBE
Dr Christine MacAlpine
Eric Sinclair
Dr Amy Mulroue
Joanne Graham (Scottish Stroke Nurse Forum representative)
Dr Chris Taylor
Professor Frederike Van Wyck
Dr Fergus Doubal
Dr Terry Quinn (BIASP)
Dr Lisa Kidd
Alan Flynn
Ian Lee
Dr Leslie Scoobie
Dr Tony Byrne
Katherine Gillespie
Dr Mark Barbour
Dr Matt Lambert
Dr Rustam Salman
Sarah Keir
Katie MacGregor (secretariat, Stroke Association)
Colin Oliver
John Watson

Apologies

Professor Gillian Mead
Professor Jesse Dawson
Maggie Lawrence
Colin MacFarlane
Mark Smith
Mary Joan MacLeod
Dr Sue Pound (RCPE representative)
Catriona Renfrew
Paul Gillen
Clare McDonald
Dr Jackie Hamilton
Lizzie Edwards (RCGPG)
Dr Stephen Makin

Agenda item 1 – Welcome and Apologies

Chair: Gillian MacKay MSP

GM welcomed members to the second meeting of the Cross Party Group on Stroke and listed apologies.

Agenda item 2 – Update from last meeting

GM updated the group on the responses we received from the Cabinet Secretary for Health and Social Care and from the 14 Health Boards.

ACTION: CPG to write again to the Health Boards who haven't responded (NHS Lothian, Greater Glasgow and Clyde, Forth Valley, Highland and Dumfries and Galloway).

Agenda item 3 – Psychological Support for Stroke Survivors

GM provided context for the need for the group to draw attention to this area of unmet need and referenced the James Lind Alliance priority setting partnership and the Recoveries at Risk report that the Stroke Association published in 2020.

GM introduced the two speakers, Dr Luke Williams and Dr Louise Roach. Dr Williams is a Consultant Clinical Psychologist in NHS Ayrshire and Arran and is the Chair of the Scottish Stroke Psychology Forum and Dr Roach is a Clinical Psychologist in NHS Lanarkshire.

Speaker: Dr Luke Williams

LW notes that psychological needs have been identified in varying degrees in multiple national guidelines and documents throughout the last 15 years but yet for many patients and their families very little changed.

LW explains the impact of failing to address psychological needs are great and far reaching, not just for individuals and their families, but for staff and services too, as well as for society.

LW then goes on to explain why it is so hard to provide good psychological care. He identifies 4 main barriers through the lens of the National Model of Psychological Care in Stroke which was developed by the Scottish Stroke Psychology Forum. It provides a framework defining the services which should be available to those affected by stroke, provides a pathway to appropriate assessment and intervention of psychological needs, and the training requirements to meet this. The four barriers are:

1. Concept of psychological care
    - Wrong assumption that someone who has psychological needs need to be seen by a psychologist
    - There are actually any number of people that may be relevant or required to provide care to address psychological need
2. Implementation and Governance
    - The model recognises the role of psychologists in providing training, supervising and consulting with staff in their implementation of psychological informed practice
    - Therefore, we need to increase the number of psychologists with dedicated time for stroke services to allow them to lead the implementation of the National Model
3. Organisation and model of services
    - Rehabilitation services should adopt a holistic approach to rehabilitation , with a focus on how team function
4. Evaluation of psychological care provision
    - Important to acknowledge that we cannot meanginfully address the issue of psychological care if we are unable to measure it, unable to identify where change is needed and unable to show progress.
    - The holistic rehabilitation model incorporates this through having:
        - Ongoing monitoring of psychological need
        - Regular rehabilitation monitoring
        - Patient experience evaluation, and
        - Staff experience of the team and service working

LW closes by noting that The Scottish Government's Mental Health Strategy: 2017-2027, calls for parity of esteem between mental and physical health. There have been great advancements in the physical care of stroke patients, but we need now to improve psychological care.

Agenda item 3 – Example of Best Practice.

Speaker: Dr Louise Roach

LR starts by explaining that she is here to talk about what she and the wider NHS Lanarkshire team have been doing to try and implement the psychological care model that Luke described. LR notes that there are many different ways to implement the model. Will look different in each HB, depending on what services available.

LR gives a number of examples covering levels 1 and 2 of the model (the ones that don't need to be delivered directly by a psychologist.)

Examples from level 1 include:

- For all *new* staff working in stroke we offer a core competencies training to be done. That covers a whole variety of topics that are experienced in stroke care but psychology led session within that that covers cognitive, emotional and behavioural changes.
- Design of how specialist nurses contact patients so they work in the community and after discharge from hospital will have an initial contact with the patient and thereafter contact as required and then the 6 month review. Questions about Psychological distress and cognition has been embedded in that assessment process. So at the very least, at discharge from hospital, everyone should have at least been asked about these areas by a specialist nurse from the MCN team.
- Because psychologists are so embedded within the team, the specialist stroke nurses can easily consult with the if they need advice for a patient in an efficient way.

Examples from level 2:

- Well established self-managed course called 'positive stroke solutions' led by a specialist OT. Facilitates the course with specialist nurse and peer supporters.
- Course based on solution focused therapy approach. Redesigned in 2016, made sure the content was consistent with the evidence for psychological support.

LR then outlines some barriers that they have encountered through this implementation.

- Limited resource national and local level
- Need psychological staff to train and give ongoing support to other staff
- Online / pc based resources work for something but only in subset of patients – not appropriate for majority of people

Ways to overcome these:

- Psychology embedded in MCN team allows for psychological care to be part of holistic and interdisciplinary approach, facilitates consultation and training with team
    - MCN works well because of interdisciplinary approach – psychological care is everyones problem
    - Benefit from managerial support to make time for training and pilots and evaluation
    - Holistic approach

Agenda item 4 – Q&A opportunity.

Question 1

GM: Is it a recruitment or a workforce issue that has resulted in varying levels of psychological support across different Health Boards. How easy is that to resolve? Is it Health Board level or National Government?

Answer

LW: Yes it is an issue; there are many competing demands from different conditions that are requesting psychological acre. In Greater Glasgow and Clyde, psychology staff are well supported but that is because it came from stroke funding and therefore didn't need to compete against other conditions to get the funding.

Funding tends to come when there is a recognised awareness of the need for it.

LR: One way to overcome is to offer placement to offer training to psychologists. Training placements are usually 6 – 12 months so it is a significant undertaking, trainees hold their own caseload with support from a clinical psychologist. It is part of our role to bring people on and help trainees understand how attractive this can be; but the flip side is that it is a lot of work for already very stretched services.

Other option to consider is to ring-fence funding for stroke psychology to ensure suitable flor of experienced staff coming through.

Question 2

Plea to understand the huge emotional journey that a stroke survivor is going through. Vital that the number of FTE psychologists with dedicated time to stroke services is increased and ensure that at level 1 and 2 is personalised to each stroke survivor as every survivor is different.

Answer:

LR: Agrees that level 1 and 2 must be personalised and unique to that person. There are general principles that are included in the training and they are also encouraged to seek support of a Clinical Psychologist if they are uncertain. This is an incredibly complex area and important that those working in it walk the line of right balance.

LW: We need to make sure psychological support is embedded within services so we can constantly support and monitor the implementation and reality of how people address psychological care.

Question 3

Why is there no / limited funding for stroke psychology posts – is it because you can't get funding for anything or are there particular barriers / issues / ways of working specific to stroke

Answer

LW: Challenge nationally for funding. One issues is that stroke has not sat at the table of stroke decisions makers, it is very challenging to influence for things when you are not included at the table.

Second issue is that stroke sits within many different places in each Health Board which further dilutes the power of stroke representation. Those in the seat of power often do not value or understand psychology support.

LR: Notes that for a long time stroke is mostly considered as a predominately physical health condition with invisible symptoms. People who make the decisions about funding lack the expertise of recognise the psychological struggles of stroke / invisible symptoms that are just as important as the physical outcomes.

Important to promote awareness of the hidden effects of stroke. We can do things to help with that.

The variety of how stroke services are organised, can create issues with sometimes stroke services meaning that psychological needs are addressed by mental health services and mental health

Question 5

Really support this framework. We are more likely to make this work if we reduce the need for psychologists. Thinks that level 1 is really, really important and we can do things there that don't need huge qualifications to achieve. There are more people out there who can deliver level 1 services and can therefore reduce the need to escalate up the levels and require more highly trained staff.

Answer

LW: Firmly agrees that with early intervention it will lead to the reduction in need for psychological services. Often fail to look at the bigger picture, and instead solely focus on those with MH conditions (depression/anxiety) but if we widened up the picture then we could be preventative in the subsequent progression to depression/anxiety etc.

In order to get level 1 and 2 right, we need the right number of psychologists to be there to provide the training and ongoing support required for levels 1 and 2 to be effective in the long term.

LR: There is lots of work to be done at all levels of the model. SPSS recognises that there is so much more we want to do at all levels of the model. There is a lot that we know what we want to deliver at all levels.

Question 6

How do we go about delivering this on the ground? Important that we build it into how we structure the wider stroke team and give the wider team the skills to deliver it. Challenge around nursing time and resource, majority of nurses spend their time running around delivering fundamental are who in reality do not have the time to be more involved in psychology aspect of patient care.

Answer

LW: Highlights good examples from oncology that we can learn from. They have been able to show that by providing psychological informed care, they actually saved time, their consultations are much more effective, shorter and much more fruitful to the benefit of

everybody. So we end up saving time as we don't end up with big problems as they are dealt and identified earlier on through listening to the patient.

LR: We need professionals and the lived experience community to come together to be arguing about how services should look and be putting in bids jointly for more resource. It's not seen as something being opposed from the outside, or an unwilling team or a problem for someone else to deal with. Team needs to be well equipped for it.

Question 7

How many FTE Neuro/Clinical Psychologists should be part of the team per stroke survivor? Could the MCN be responsible for achieving this?

Answer:

Amy Mulroe: It is a piece of work I've been doing as part do the SSPF, we have an idea of what the guidelines say about how many psychologists we should have for each aspect of the patient journey but I think they are outdates as well, because when we say about moving towards things such as early supported discharge teams, they need far more resources than a community provision that is recommended at the moment. That is an ongoing piece of work we are doing and we are going to be refreshing the work we have been doing for the stroke improvement plan comes out.

Actions from meeting

Action 1: Re:write to the boards and meet with those who have been named. Link in with the MCN to do this.

Action 2: Raise this topic with the Cabinet Secretary for Health and Social Care in August

Action 3: Develop wider campaign into this topic

A.O.B

Next meeting will be on 16th September with the topic TBC but the secretariat will be in touch shortly with more information.