Cross-Party Group on Stroke

Friday 21st April, 12:30 – 13:30

Minute

Present

Katie MacGregor [secretariat] [KM]
Nancy Dear
Colin Oliver [CO]
Fiona Dickens
Rustam Salman [RS]
Alan Flynn
Joanne Graham
Colin McFarlane
Lesley Scobbie
Matthew Lambert [ML]
Siobhan Connelly
Lisa Kidd
Amy Mulroue
Mark Barber [MB]
Douglas Horn [DH]
Bridget Davis
Angela MacLeod
John Watson
Andy Wilson
Maggie Lawrence
Charlie Chung
Jacqui Morris
Frederike van Wijck [FVW]

MSPs

Gillian Mackay MSP

Invited guests

Sam Brown [SB]

Agenda item 1 – Welcome and Apologies

KM welcomes everyone to the meeting as GM has not yet joined. KM introduces new members to the group.

KM outlined what was covered in the last meeting and the subsequent action points from that meeting. At this point the group is still waiting from a response from the Scottish Government on where the Thrombectomy budget was being spent across the three sites.

Focus of this meeting is on the recently published national clinical guideline for stroke [NCG]

First speaker is Sam Brown, Policy Officer at the Stroke Association.

Agenda item 2 – RCP National Clinical Guidelines for Stroke

Speaker: Sam Brown, Policy Officer, Stroke Association

SB outlines the history of the NCG, how it was last updated in 2016. Research changed significantly in those 7 years. This year it has taken a 5 nations approach for the first time (including both Scotland and Ireland) and have produced this document in collaboration with Royal College of Physicians, the Scottish Intercollegiate Guideline Network, and the national clinical program for Stroke Ireland.

The Stroke Association partly funded the guidelines update and has been intimately involved in the refresh, particularly ensuring that the patient perspective is represented. Stroke survivors are the people who primarily have the best understanding of what needs to change in the system so this insight was invaluable. Alongside that, the Stroke Association also funds a significant amount of research into stroke treatments and engages with many people from clinical teams across the whole of the UK and this insight also contributes massively to the evidence base.

The Stroke Association also helped to produce a plain language summary or patient friendly version of the guidance through a collaborative effort between professional bodies, the Stroke Association and stroke survivors as well who fed into the document at every level, making sure it's accessible and understandable and covers all the bases.

SB outlined how 300 of the recommendations within the guideline have been reviewed, updated or rewritten entirely from the 2016 guideline. SB goes to talk about the three potentially most important updates.

Firstly, the major rethink is to the treatment of thrombolysis for wake-up strokes. Time window has been extended to 9 hours. 9 hours since the patient was last seen well.

New eligibility criteria has been introduced for wake-up strokes and therefore new cohorts of patients are now eligible for thrombolysis. This also creates a larger number of patients who will require scans to confirm correct treatment pathway. So larger cohorts of patients must be offered the necessary scans and then given the intravenous thrombolysis.

Other big headline from the update is that more people will be eligible for thrombectomy. Patients who were previously excluded from thrombectomy due to the severity of their stroke

will now be eligible. Time window has also been extended, up to a maximum of 24 hours., depending on the results from a patient's scan and clinical assessment.

Benefits from thrombectomy include reduced chance of disability, improved quality of life, and reduced economic burden on the health and social care service. Previously we spoke about 10% of stroke patients being eligible for thrombectomy, this change in guidance for wake-up strokes means that it will be more likely to meet that 10% target. This will require sustained investment in thrombectomy service to ensure that more patients will benefit from this treatment.

SB goes on to explain the UK context, and outlines how even in the highest performing areas, we haven't reached that 10% target.

The second significant change in this guideline concerns the recommended rehabilitation dose and intensity. This has largely been driven by recent research into brain plasticity and stroke recovery which show that post stroke deficits are often not as permanent as previously thought. For motor recovery, daily therapy is now recommending 3 hours a day, and for language recovery it is 20-50 hours therapy recommended in the chronic phase. This is a huge expansion to the service and will require investment in people and services.

Thirdly, the guidance has seen improvements in the holistic aspects of stroke care. There are substantial improvements to sections such as return to work support, post stroke fatigue, psychological and emotional support as well as life after stroke support services.

People affected by stroke often have greater interest in these life after stroke support services, over more acute metrics like door to needle time and therefore it was vital that this part of the guideline received appropriate updates.

SB ends by summarising that the new guideline is really aspirational but it's going to be really challenging to deliver. As the stroke audits indicate, stroke care has been declining since the Covid pandemic. We've seen an increase in the door-to-needle time for vital stroke treatment, decline in the number of stroke patients who have been admitted to a stroke unit within one day amongst other key metrics.

It's vital that high impact stroke treatments, such as thrombectomy, high dose rehabilitation, receive significant investment to improve care and outcomes.

Agenda item 3 – What do the guidelines mean for Scotland?

Speaker: Dr Matt Lambert, Lead Stroke Consultant NHS Tayside

There was a big gap already with the guideline and what stroke care was being delivered in Scotland so this has really ramped things up. This document goes along nicely with the Progressive Stroke Care Pathway, published last year.

ML outlines the opportunities and challenges that these guidelines present.

Opportunities

- More and more evidence of what is an effective way to treat strokes which will help to influence policy and strategy
- Putting resource into the right places. Many of the interventions will help individuals as well as overall economics by preventing long-term spend in other areas
- Knock on benefits to other services – deliver good interventions for stroke services, will positively affect other services. Get our models of care right will benefit the health service in general.

Challenges

- Getting financial and human resources in the right place
- A human resource is needed at the right time and right place, not just financial, there are multiple unfilled post within the health service. How do we get the people to deliver this service? Not going to get the staff members over night. Long term planning, appropriate training for existing and new staff is essential.
- Where stroke care sits in the list of priorities of things to deliver (both nationally and at health board or health and social care partnership level).
- Need integration between, health, social care and third sector to really work. Barriers will occur where integration doesn't work.
- Cost of delivering improvement may be seen as stroke costs whereas they are "system" costs – e.g. ambulance service, radiography services.

Specific

- In the hyperacute space there is a lot more we can do for patients now (e.g. thrombectomy) even when compared with 5 – 10 years ago. More and more people are falling into that category now who can be treated. This brings with it implications for public education and awareness, ambulance services (how they prioritise strokes), acute healthcare services, radiology etc on a 24.7 basis.
- Increased access to therapy – evidence around hours per day that people should receive. This bring with it huge issues with staffing and rostering implication and 7 day- service
- Minimum staffing levels to deliver a safe service – big implications for workforce. Helpful to have it done in black and white but brings challenge with how to recruit and retain staff (protected staffing – not value and respected in the same way).
- Increased use of technology (nerve stimulation, digital speech and language support). This will require both investment and staff training to be able to deliver it.
- Benefit of third sector and community services (e.g. leisure centres, gyms)

Key points

- This is complimentary to the progressive stroke pathway and puts a lot of the meat of the bones on it.
- It further emphasises the evidence that exists and the wider benefits of these treatments specifically around specific interventions and also how services are set up and delivered.
- Service delivery currently lags behind the evidence.
- Staffing levels and need to train more staff appropriately.
- Nee to move away from a Monday – Friday 9-5 service, this requires support from the wider structure from hospitals as well as increased resource.

- Re-evaluate where stroke care sits in the priority of things to deliver; need to think about the scale of stroke and the number of people affected every year.

Agenda item 4 – Q&A opportunity.

GM asks how the eligibility extension window for thrombectomy will affect both the staffing and wider stroke service?

ML: the expansion in hours is a huge driver in striving towards 24/7 service. Huge opportunity to benefit a larger number of patients. It will come with resource and workforce challenges if there are more eligible patients for this procedure; more time will be needed from the interventionalist, more demand on radiologists time, more time spent assessing people who previously would have been out of the time window.

RS: Re-emphasizes that this is an absolute landmark in the UK and Ireland because for those of you who don't know previously there wasn't a unified guideline for across the UK. During COVID – a 5 nation meeting was organized to try and get everybody working more closely together and it's great to see Scotland involvement via SIGN through this and there is no rolling back from this.

There is a wealth of evidence on the benefits of mechanical thrombectomy but we must also be mindful that it's the size of the benefit that matters and to whom.

Given that we're not going to have the required increase in the resource that are required to fund stroke care, we have some really difficult decisions to make about how we prioritise the finite amount of money we've got. Worth bearing in mind the interaction between guidelines, government, health boards to find the money to deliver these services.

MB: Makes comparisons with the NHS England and how they commission services in a different way. NHS Scotland doesn't talk about money and services in the same way. There is perhaps repercussions because of this as stroke, despite the wealth of evidence for investing in its, doesn't receive the correspond resource. Issue with lack of integration between NHS and social care.

GM: True that within politics there is an issue with evidence-based vs less strong evidence base for funding certain parts of the pathway.

SB: Highlights that there are issues with integration and autonomy for local areas in NHSE; some areas do gain efficiencies with each local area having autonomy over their budgets, but it can also lead to post code lotteries whereby local areas cut services without any consultation.

Stroke care is a kind of litmus test for the whole system so improvements in thrombectomy will have benefits for the whole system.

FVW: systems wide thinking, encouraged by Scandinavian countries where 'return to work' is one of the key purposes of rehabilitation so it is encouraging to see the return to work section within the guidelines was expanded thanks to involvement from stroke survivors and carers.

And it might seem to be a slightly reductionistic approach to think of really focusing on return to work, but that's such a central role in people's lives. And if we can encourage people to get back to some form of employment, or whether that's education, voluntary work, paid work sooner. And integrate them into the workforce then that has all sorts of returns for the entire system.

CO: Less well evidenced parts of healthcare receiving greater prioritisation and resources; what's the driver for making things happen for these interventions that are well less evidenced?

MB: Within the health service, we have quite a lot of things in the hospitals and community settings from when money was relatively abundant. So if you have to make a fundings decision between coronary reperfusion vs stroke, you would pick stroke based on getting more bang for your buck but at the moment we have a really well developed PCI centers across the country so therefore they maintain the funding.

The issue goes back to being whole system approach. Need to spend to save on these interventions and treatments to get people back into work, contributing to society and the economy. Delivering the recommended level of rehabilitation is going to be a challenge and it requires significant investment now.

DH: Spoke about his experience of stroke and how it is good that things are moving on just speaking about the physical impact of stroke.

ML: Raised point of how this work is aligned with realistic medicine.

GM: Write to the new cabinet secretary and invite to the next meeting. As well as raise with the new Cabinet Secretary in the next couple of weeks.

Actions from meeting

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A.O.B