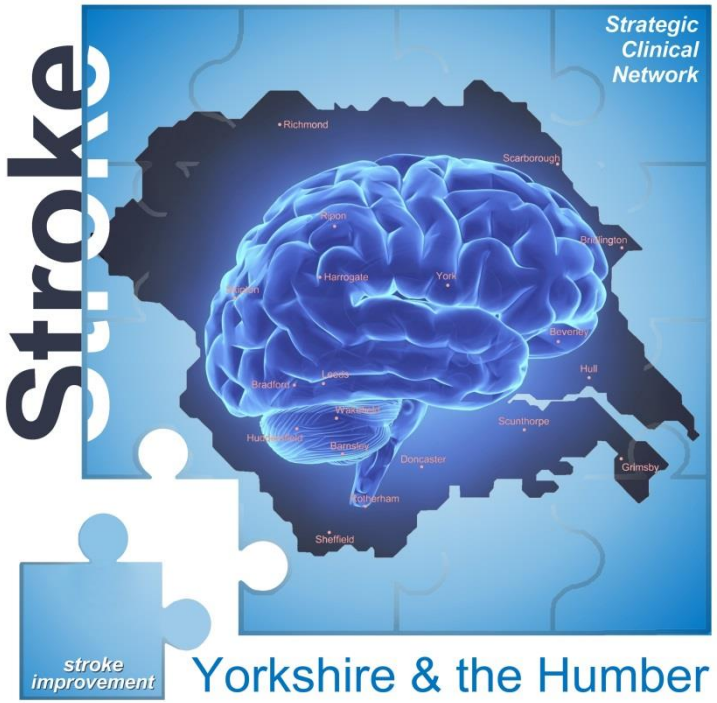

Yorkshire and the Humber Strategic Clinical Networks

Yorkshire & the Humber Stroke Clinical Expert Group (Webinar)

Date: Wednesday 7th October 2015
Time: 17:00

Agenda:

1. Intros & Apologies
2. Purpose of the meeting
3. National Update
    a. National Clinical Guidelines
    b. Medical Workforce
    c. Medical Care
4. Sub-regional Updates
    a. West Yorkshire
        i. Outcome of Provider Meeting 11.9.15
    b. Humber & North Yorkshire
        i. York/Scarborough External Review 6th Oct
        ii. Sub-regional meeting 13th Oct
    c. South Yorkshire
        i. Senate Review
        ii. Working Together Plans
5. Yorkshire & Humber Update
    a. Blueprint for Y&H
    b. Contingency Plans & Repatriation
    c. Governance Framework
    d. Workforce
    e. SQUINS
6. Intra Arterial Interventions
7. AOB
8. Future Meetings

1. Introductions & Apologies

Bradford Hospital Teaching Trust & Airedale Hospital	Dr Chris Patterson
Calderdale & Huddersfield Trust	Dr Pratap Rana ✓
Harrogate District	Dr Sean Brotheridge ✓
Leeds Teaching NHS Trust	Dr Sameer Limaye
Mid Yorkshire NHS Trust	Dr Michael Carpenter
Barnsley Hospital	Dr Ashraf Ahmed
Chesterfield Royal Hospital	Dr Mahmud Sajid
Doncaster Royal Infirmary	Dr Manohar Kini ✓
Rotherham NHS Foundation Trust	Dr Sunil Punnose ✓
Sheffield Teaching Hospitals	Amanda Jones Dr Kirsty Harkness (HASU) ✓
Hull Royal Infirmary	Dr Ahmed Abdul'hamid
NLAG	Dr Asem Ali
York District Hospital & Scarborough Hospital	Dr Paul Willcoxson
Yorkshire & Humber Strategic Clinical Network	Dr John Bamford ✓ Rebecca Campbell ✓

Apologies Received:

- Amanda Jones, STHT
- Dr Mahmud Sajid

2. Purpose of the meeting

- National & Local Updates
- Information Sharing – Aimed at Clinical Leads
- Agreement of Y&H Approaches – Not in initial meeting, but maybe subsequently.

- Any other comments….? No comments, but view was that this format was helpful.

3. National Update

- National Clinical Guidelines – 5th Edition under development and due for publication next year. Some changes anticipated, e.g. imaging guidance.
- Medical Workforce – Situation has not changed.
- Medical Care – RCP Project to replace the document "Consultant Working for Patients". Will be an updated version available as a web-based resource, by the middle of next year.

4. Sub-regional Updates
West Yorkshire

Healthy Futures report - Within West Yorkshire there are a number of services outwith the suggested minimum requirements and the quality of services as demonstrated by the SSNAP outcome indicators is variable with many below the national average suggesting a poorer quality of service. Workforce also highlighted as an ongoing challenge.

Meeting on 11th September:

The providers and commissioners were invited to consider whether to:

(1) Do Nothing

(2) Invest in all hyper acute services to improve outcomes to at least the national average or

(3) Develop further alliances and reduce the number of Hyper Acute services.

4. Sub-regional Updates - WY (2)
Next Steps / Actions (11.09.15)

Ref#	Next Steps	Owner	Due	Action
1	**Improving Outcomes:** A watching brief will be maintained on SSNAP quality outcomes to review whether the existing resilience plans are effective. A further meeting will be scheduled for 6 months to review.	SCN	April 16	Set up a follow on meeting in 6 months time (aligned to release of Oct-Dec 2015 SSNAP data) to review performance; progress on resilience plans and next steps
2	**Review of Resilience Plans:** CCG and Providers to conduct a review of local resilience plans.	CCGs	By Dec 16	CCG to ensure a review of action plans as part of annual peer review process
3	**Workforce: SCN to facilitate exploration of;** • Developing a regional stroke workforce • Nurse competencies/ HR standardisation / opportunities for escalation of skill development & training – e.g. placement • Sharing Best Practice models • Medical Workforce Planning and training opportunities • Mimics: Educational tools for primary care & A&E • Stroke Rehabilitation / ESD and developing links with social care • Intra-arterial Interventions (clot retrieval)	JC/AB/RC	By Dec 16	Jon Cooper, Alistair Bailey & SCN team
4	**Modelling Cross Boundary Implications;** SCN to support modelling and discussions with Mid Yorkshire, Calderdale and Barnsley	JJ	By Dec 16	Liaise with Working Together Programme and establish meetings.
5	**Programme Next Steps** Stroke will be moved under the umbrella of Urgent & Emergency Follow on meeting in 6 months to review progress - 18th March 2016, 1430-1630, Leeds venue (TBC).	PC/JJ	By Oct 16	Establish a meeting to align programmes All to note

4. Sub-regional Updates Humber and North Yorkshire

Commissioners focusing on improving quality.

Sub-regional meeting on Tuesday 13th October 1430-1630, Health Place, Brigg.

The purpose of this meeting is to:

- Review of the current quality and shape of services
- Understand the challenges facing Hyper-Acute Stroke Services
- Consider changes over the last 18 months
- Determine where we want to be in the future
- Agree the collective next steps.

Contact: Noreen.Slinger@nhs.net to book a place.

4. Sub-regional Updates – H&NY (2)

External Visit to York to review Scarborough Model 06.10.15 – Tony Rudd & Indira Natarajan (external reviewers)

Tony Rudd acknowledged that:

- change was required and that the choices were logical – either full divert to York or triage & transfer from Scarborough. The 'drip & ship' choice was understandable.
- the team has set out to obtain high quality data and has made the necessary changes to the protocol.
- the system has been shown to work, although there is also a lot of opportunity to fine tune and get it to work better.

Improvements could be made with regards to:

- **Scan times** - it was agreed that these could be improved and to look at the option of non-urgent patients from Scarborough to be transferred straight to scan in York.
- **Needle times** - The SSNAP thrombolysis tool should be used to look at needle times, and consideration should be given to small changes on both sites.
- **Workforce** - It was highlighted that running the service on 4 consultants across both sites is not sustainable. Also look at the nursing workforce, consider skill mix and more senior nurses.
- **YAS** - Tony was keen to ensure that flexibility of decision making was allowed within the ambulance service to avoid patients in the 'grey area' between York and Scarborough going to Scarborough when they could go direct to York. He also mentioned telemedicine within the ambulance as a future consideration.
- **Commissioning of ESD and funding for community teams** – further work to persuade CCGs required.
- **Pre-Alerts** – improvements could be made.
- **TIA clinics** – Consideration should be given to using telemedicine for virtual TIA clinics and/or to nurse-led TIA clinics in Scarborough. Nurse competencies could be expanded to include TIA clinics.

Recommendations:

- Carry on with the model.
- Continue data collection, ideally using SSNAP.
- Make improvements to the process.

4. Sub-regional Updates
South Yorkshire

Case for change established and supported by the Clinical Senate (August 2015) with a recommendation that a Y&H approach is established.

Focus on transformation which will reduce the existing number of HASU sites with cross boundary implications potentially on both W Yorkshire and H & N Yorkshire

4. Sub-regional Updates – SY (2)

Yorkshire & the Humber Clinical Senate (August 2015) – Summary Recommendations:

- The Case for Change, however, focuses on the Hyper Acute Stroke part of the pathway and the Senate advises commissioners that the anticipated benefits of service change will not be achieved unless all aspects of the pathway are brought under the remit of the review.

- The Senate recommends that the Case for Change could be strengthened with greater use of the SSNAP (Stroke Sentinel National Audit Programme) data, further reference to the financial implications of change and greater clarity on the Early Supported Discharge (ESD) models and Repatriation Policy.

- A centralised model of HASU care is the only option the Senate can support to improve patient care in line with national guidance.

- The Senate strongly recommends that commissioners reach agreement on how to bring together the recommendations from the stroke reviews occurring concurrently across Yorkshire and the Humber as the boundary issues need to be addressed to provide a coherent service.

- Discussions are in the early stages and the Senate recommends the need for a clear commitment from Trusts and Clinical Commissioning Groups (CCGs) to a set of principles to be achieved with regard to improving quality and patients outcomes, and therefore a commitment not to retract support as the details of the service develop, even if the local roles may change in order to deliver the service. These principles need to be agreed across the entirety of the stroke pathway.

- The Senate supports the need for a comprehensive communications programme with service users in the next stage of the work programme.

Available here: http://www.yhscn.nhs.uk/cardiovascular/Stroke/stroke-documents-and-links.php

5. Regional Update - Blueprint for Y&H

Meeting held with 3 CCG Chief Officer CVD Leads on 25th September:

Agreed that a Y&H approach would be welcomed with regards to:

- Establishing principles i.e no service will be below the minimum 600 or above maximum 1,500 activity threshold (consideration of growth required) and will have a commissioned ESD service
- Communications – framing and coordinating
- Finance - establishing understanding and principles regarding tariff splits
- Modelling the current activity levels and flows, workforce, ambulance travel times and estate of providers to enable a future 'blueprint' of HASU sites on a Y&H regional footprint.

Next Steps:

- A paper outlining the process to establishing the Y&H blueprint will be taken to the Y&H CCG CO Forum on 27 November. Work will continue in the interim to develop a first draft 'blueprint'
- Y&H regional blueprint first draft by February 2016.
- Preferred option agreed by May 2016 to allow public consultation (aligned to working Together timescales)

5. Regional Update - Contingency Plans & Repatriation

The resilience reviews in Y&H highlighted the need for standardised contingency arrangements to be in place for all providers of Acute Stroke Care across the region. This will ensure that there are robust measures in place to safeguard the ongoing provision of high quality acute care for patients who have suffered, or potentially suffered, a stroke.

- Provides the ability to respond to a contingency situation through anticipation;
- Provides a structured escalation process, both internally and with external partners;
- Coordinates a response in a way that minimises the impact of the contingency situation on the functioning of the organisation and other organisations, through effective arrangements for the command, control and coordination of services within the trust;
- Provides clarity on roles and responsibilities and describes the appropriate lines of communication to ensure that all relevant individuals are kept informed;
- Ensures that planning is undertaken in conjunction with all local and regional NHS partners and that appropriate arrangements are in place to provide and receive mutual aid locally and regionally;
- Ensures that suitable and sufficient training arrangements are in place to ensure the competence of staff in performing emergency planning and major incident roles;
- Ensures that suitable governance arrangements are in place to provide resilient stroke services across the Trust;
- Ensures that systems and facilities are in place to safeguard the health, safety and welfare of all staff in a situation where there is a risk to the continuity of the provision of stroke care.

5. Regional Update
- Contingency Plans & Repatriation (2)

Underpinning Principles of the Repatriation Protocol:

- Patients who require repatriation are identified by a stroke consultant and the decision communicated to the patient, carers and receiving unit as soon as possible;
- Once the decision has been made it must be supported by the appropriate documentation and communicated to the staff who will organise the safe transfer for the patient, in accordance with the relevant transfer guidelines;
- Transfer of a patient to another trust, closer to their home, to continue specialist care or re-enablement following specialist hyper-acute care should occur within 48 hours of the decision to transfer;
- Prompt escalation of issues by both the referrers and receiving trusts is to be made in line with the protocol, 7 days per week, 365 days a year;
- When escalation is due to there being no available bed for the transfer, the checklist of activities should be completed and verified confirm the internal escalation process has been exhausted;
- If the two respective directors agree a plan which is outside of the 2 calendar day standard, then the safe transfer must be organised (ambulance transfer booked, etc.) **shortly** after the agreement is made. It is then the responsibility of the Clinical Service Unit to ensure that the plan is carried out and to escalate to the senior manager responsible, if for any reason the plan cannot be carried out.

5. Regional Update - Contingency Plans & Repatriation (3)

Draft document developed and **will be circulated for wider comment and agreement**. Prior to this the following questions were posed to the planning group regarding the repatriation policy (responses received from Amanda Jones & Collette Cunningham):

New Stroke Admissions: Patients enter the TIA pathway and are triaged according to their ABCD2 score into high-risk and low-risk categories. High-risk patients should be assessed at their local TIA clinic within 24 hours – Should high risk be worked up before transfer?

- I feel patients should have their initial work up prior to transfer but should not be kept in a particular service whilst waiting for a carotid duplex for example; e.g. if a patient was being transferred to Chesterfield from Sheffield, we would probably do the duplex also prior to transfer should they need carotid intervention, but smaller DGHs may struggle to get the investigation in a timely way.
- not always possible

Discharge Home: Arrange the follow-up under receiving Stroke Consultant Physician - Is this what happens on the ground?

- I think it is reasonable to arrange follow up by the hospital the patient is being transferred from for follow up (this happens in Sheffield)
- Yes I believe so

Escalation Policy - Level 1: In the unlikely event that the receiving dedicated stroke unit does not accept the patient for a medical reason, the HASU consultant will discuss the case with the receiving stroke team consultant at the receiving dedicated stroke unit immediately or **within 2 hours** of notification of transfer. If the receiving dedicated stroke unit does not accept the patient for a non-medical reason, the HASU ward manager should contact the receiving dedicated stroke unit ward manager immediately or **within 2 hours** of notification. – Should this be both the consultant and ward manager or just one, and if so which one?

- The initial discussion should be medic to medic and then the ward manager should organise transfer
- consultant is for clinical reason for refusal, ward manager is for non-clinical reason for refusal.

5. Regional Update - Governance Framework

Proposed Governance Framework for the provision of hyperacute care including thrombolysis care by clinicians who are not core members of the stroke MDT (agreed in South Yorkshire in 2011)

Competency Framework

When clinical staff who are not core members of the stroke MDT are delivering hyperacute care to people with acute stroke they should be able to demonstrate the following competences:

1. They should possess a current NIHSS assessment certificate.
2. They should have participated in thrombolysis training/ master classes with updates at times to be agreed during their annual appraisal. They should have knowledge and understanding of local protocols and procedures for hyperacute stroke and thrombolysis.
3. They should be able to demonstrate competency in CT reading or be supported by a second professional radiology opinion either on site or via a remote facility.
4. They should participate in regular multidisciplinary thrombolysis outcome review meetings.

Organisational responsibilities

Organisations relying on non-core staff should ensure:

1. All non-core stroke MDT staff are compliant with the above.
2. There is a clear audit trail of decisions made by non-core members of the stroke MDT including *whether or not* to offer thrombolysis care.
3. That all patients who will benefit from hyperacute care, whether or not they receive thrombolysis care, are admitted to a hyperacute care unit that meets the seven acute criteria as set out in the National Strategy for Stroke. In particular there should be a named clinician responsible for the ongoing care of people admitted to HASU and ward rounds seven days per week, undertaken by a specialist stroke practitioner, to ensure that complications are detected and patients are moved on to rehabilitation at an appropriate time.
4. The presence of a 24/7 Stroke Nurse Specialist Team.

This advice is not intended to be guidance for remote consultation using Telemedicine

5. Regional Update - Governance Framework

Circulated for comment: For those not in South Yorkshire, please could you let us know if you have equivalent guidelines in place and if not, would your organisation be prepared to adopt the attached framework which would give commissioners the reassurance that they need that the service is being delivered by appropriately qualified staff.

Comments received:

Paul Willcoxson, York

Personally I think that these recommendations are entirely sensible and would have no objection to using these as a staffing/quality template for our region.

Pratap Rana, Calderdale & Huddersfield

The scenario of 600 admissions/year reflects real situation in Calderdale and Huddersfield NHS Trust.

I am in full agreement with agreed standards re the no. of DCC's.

Only one thing I would like to clarify –

- there is no mention of MDT on Rehab ward.
- Are Ward round and MDT on Rehab ward are expected to be done during one DCC session?

Can you please update us re the BASP Stroke Cons Workforce requirements which were to be refreshed in September 2015 and Prof Graham Venable referred to in his email.

Prof Graham Venables also referred to the Governance framework in South Yorkshire re the non-core Physicians providing stroke care.

In our stroke services, I confirm that we have got 4 stroke physicians providing stroke care full time i.e. 9.0 DCC PA's /consultant, adding to 36 in a week.

We don't have any non-core physician providing stroke care in our services.

5. Regional Update - Workforce

The Current State Assessment undertaken in West Yorkshire identified workforce as a key area for further work. It was agreed that this work should be led by the Strategic Clinical Network and cover Yorkshire & the Humber. Nurse Workforce Forum formed following regional meeting on 24 April. Meetings held in June and August. Next meeting 08.10.15. Representation sought from all sites.

- Development of:
  - Band 6 Competencies & Handbook
  - Band 5 Competencies & Handbook
- Consideration of development of competencies for Community- Based Stroke Nurses
- Baseline of competency training
- Involvement of Health Education Y&H

5. Regional Update - SQUINS

The intention is for Trusts to provide a refreshed Annual Report, and an update on the Action Plans submitted in 2014. In addition, workforce levels will be requested.

SSNAP data will continue to be reviewed.

The purpose of the process is, as far as possible, to provide CCGs with assurance that the stroke services commissioned continue to be of high quality or, where necessary, highlight areas that require attention and improvement. In such cases, the SCN can support commissioners to organise a Peer Review visit, with external assessors if required.

Action	Date
Providers to submit updated Action Plan, Annual Report & Workforce Data	30th November 2015
SCN Review of Submissions	1st December 2015 – 11th January 2016
Feedback by SCN to CCGs	By 15th January 2016
Feedback by CCGs to Trusts	By 12th February 2016

6. Intra Arterial Interventions

Standards for providing safe acute ischaemic stroke thrombectomy services (September 2015).

The national clinical lead (Tony Rudd) would like to work with a region to understand the practical implications regarding establishing this service and Y&H are keen to support this.

Meeting held with Specialised Commissioning on 25th September. The following were agreed:

- Work with Specialised Commissioning in order to be prepared for the Service Specification.
- A letter / position statement to be sent to providers.
- Request permission to work with NCD to be taken to Specialised Commissioning Oversight Group

The Standards for providing safe acute ischaemic stroke thrombectomy services (September 2015) are available on the BASP Website:
http://www.basp.ac.uk/Portals/2/Final%20Thrombectomy%20StandardsSeptember%202015-2%20(1).pdf

Kirsty Harkness reported that feasibility discussions are underway in Sheffield. Kirsty also informed the group that this is an agenda item at the British Society for Neuroradiology Conference in Sheffield on 9th & 10th October.

7. Any Other Business & Actions

ANY OTHER BUSINESS:

- Early Supported Discharge & Community Rehab: SCN work to re-commence, led by Ginny Fieldsend (ginny.fieldsend@nhs.net).
  - Meeting planned for Thursday 17th December PM (more details to follow)

- Any other business? No other matters were raised.

ACTIONS:

- Contingency Planning & Repatriation Documents to be circulated for review.
- Governance Framework – Comments required please.
- SQUINS Plans to be noted.
- Forthcoming Meeting dates to be noted (Next Slide).
- Feedback on format of this meeting to be requested.

8. Future Meetings

Future dates & format of Y&H Stroke CEG? It was agreed that this is a useful format and should be continued. The next meeting will be on **Wednesday 13th January** at 5pm.

Dates for your Diary:

Date: Wednesday 18th November 2015
Venue: Oak House, Rotherham
South Yorkshire Stroke Clinical Network Meeting – 1500-1700

Date: Thursday 17th December 2015
Venue: Wakefield (TBC)
Early Supported Discharge Meeting – 1330-1530

Date: Thursday 14th January 2016
Venue: Leeds / Teleconference
Stroke Nurses Workforce Group –1000-1200

Date: Friday 18th March 2016
Venue: Leeds (TBC)
West Yorkshire Providers Meeting – 1430-1630

9. Contacts

Dr John Bamford: drjohnbamford@gmail.com
Yorkshire & the Humber SCN Clinical Lead for Stroke:

Rebecca Campbell: rebecca.campbell6@nhs.net / 0113 253448 / 07825 256356
Quality Improvement Manager (Stroke & Renal), Yorkshire & the Humber SCN

Ginny Fieldsend: ginny.fieldsend@nhs.net
Quality Improvement Lead (Cardiac & Stroke), Yorkshire & the Humber SCN

Website:
www.yhscn.nhs.uk/cardiovascular/Stroke

Twitter:
@YHSCN_CVD