Cross-Party Group on Stroke

Friday 3rd March, 12pm-1pm

Minute

Present

MSPs

Gillian MacKay MSP [GM]
Roz McCall MSP
Paul McLennan MSP

Non-MSP Group Members

Katie MacGregor [secretariat]
John Watson [JW]
Margaret Mitchell MBE
Dr Christine MacAlpine
Dr Amy Mulroue
Joanne Graham
Douglas Horn
Dr Chris Taylor
Dr Lesley Scobbie
Dr Tony Byrne
Andy Wilson
Professor Mark Barber [MB] [speaker]
Professor Maggie Lawrence
Dr Jesse Dawson
Colin MacFarlane
Dr Mary-Joan MacLeod
Dr Jacqui Morris
Dr Sarah Keir
Linda Campbell
Paul Gillen
Professor Gillian Mead
Professor Matthew Walters MBE
Dr Jackie Hamilton
Dr Matt Lambert
Colin McFarlane
Joyce Cattanach
Nicole Kane

Apologies

Dr Terry Quinn

Ian Lee
Professor Gillian Mead
Professor Andrew Elder
Professor Frederike Van Wyck
Alan Flynn

Agenda item 1 – Welcome and Apologies

Chair: Gillian MacKay MSP

GM welcomed members to the meeting of the Cross Party Group on Stroke and listed apologies. GM also welcomed new MSP member Roz McCall officially to the wider group.

RM introduced herself and shared her personal connection to stroke.

Agenda item 2 – Updates from last meeting and reflections from the last year

Gillian MacKay

GM talked through what the CPG has covered so far including all who the group has heard from over the various meetings. Main focus has been on psychological care post stroke and the research and lived experience perspective of all that.

GM spoke about the report that the Stroke Association subsequently published and the parliamentary activity around it including a Members' debate which took place on November 30th last year.

GM introduced Colin Oliver from the Stroke Association who gave a brief update on progress since this work in October.

CO reflected to the group about the impact of the debate last November. Encouraged members of the group to watch the debate back on the Scottish parliament website and hear from all those who contributed. Really encouraged by the response from the Cabinet Secretary for Health and Social Care.

Progress on the report ambitions and implementation of the model is being worked out by the civil servants at the moment. It is positive to see them engage on this issue. Psychological support is the poorest performing area of the RAG charts so it's encouraging to see them on this.

In terms of next steps, I know the civil servants have been speaking with the Scottish Stroke Psychology Forum and with the SG mental health and wellbeing team. There is a strategy document coming in the spring on mental health and wellbeing so there will be some collaboration there.

Will update more when we know more.

Agenda item 3 – Thrombectomy Update

John Watson

GM introduces John Watson, the Associate Director for Scotland for the Stroke Association.

JW gave overview of the activity. Stroke Association ran a campaign in summer last year, Saving Brains, at the time of launch Scotland didn't plan for much involvement as we were somewhat encouraged at the tone in Scotland around Thrombectomy. Did not pan out as expected. In the autumn, we heard that there was going to be severe cuts to the Thrombectomy budget. That was going to be accompanied by a recruitment freeze. This was really cutting the legs off the programme that was in its infancy. So much had gone into it. So much progress had been made. All that was at stake.

New budget not adequate at all and recruitment freeze makes an already difficult staffing situation worse.

Activity was very quick and efficient. Stroke Association met with Chest, Heart and Stroke Scotland. Together the charities wrote to Cabinet Secretary making the case for Thrombectomy. Make small investment but make big outcomes in the future.

15th December budget looming and no response from the Cabinet Secretary. At the same time, the charities were having conversations with clinicians, as there was real appetite to show public support for thrombectomy.

Stroke Association hosted an open letter on the website for clinicians working in stroke to add their name too. In just over a week, we secured 160 signatures from across Scotland.

Also worked with BIASP to show joint support and coordination.

Managed to then meet with the Cabinet Secretary for Health and Social care alongside key clinicians and CHSS and BIASP. In the meeting we were able to combine patient perspective, clinical perspective and campaigning perspective.

Sophie Bridger from Chest, Heart and Stroke updated from their perspective too.

SB echoed JW's points. Working with SA, working with clinical and patients was critical to show that there was real agreement from across the pathway about Thrombectomy. No disagreement about how effective a stroke treatment is. CHSS hosted a wider public petition on their website which achieved great support.

Next steps: How do we make sure that we continue to see the budget being allocated in the right way, people being recruitment for these key roles to make sure Thrombectomy happens, we've not seen a publicly stated timescale yet but hopefully will see that soon. Important to have the continued support of the MSPs too.

Action: GM: write to cab sec about how the money is being spent in the various hubs

Agenda item 4 – Reflections from the Scottish Stroke Care Audit with Professor Mark Barber

- Professor Mark Barber, Chair and clinical lead of the Scottish Stroke Care Audit

Professor Mark Barber talked us through the 20 years of the Scottish Stroke Care Audit and shared some reflections**.**

Areas that presentation will cover:

- History
- Methodology, Bundle and Standards/Targets
- Impact
- Future Directions

Presentation will not focus on data from the last two years as Covid affected many other parts of the system rather than specifics of stroke care.

But, MB does reflect that the the audit was useful to show the impact of Covid and use as an opportunity to talk about stroke care.

Stroke care has been audited, to some extent, since the 1990s. Over 2002 the Coronary Heart Disease and Stroke strategy for Scotland was published and it mandated the Scottish Stroke Care Audit (SSCA).

MB acknowledges that audit provides numbers, not necessary improvements, but numbers can be useful.

A steering group was created, which meets 2-3 times a year and have agreed many definitions including what a stroke is, what a hospital admission is and what a CT scan is etc.

The SSCA team have produced a national report since 2004/05.

MB stresses the need to act on the data collected; particularly at a local level. The current Stroke Improvement Team focus strongly on this alongside quality improvement. The SSCA sends monthly report to all health boards and the stroke improvement team also visit them twice a year to discuss and challenge the numbers with the aim of improving outcomes. MB notes how really useful information sharing

comes out of the process. Good work in one health board can encourage quality improvement across other boards.

MB outlines what all is included in the stroke bundle (i.e the standards that the SSCA includes). There are 3 things that have evidence base that show they improve patient outcomes; swallow screen, stroke unit, brain imaging. Target is 80% for the bundle and it is important to understand that it might not always be appropriate to meet the standard.

Current challenges are not necessary within stroke care itself but rather at the front end of the hospital; not getting assessed quickly enough at the front door for example.

MB then explained the recent developments with data linkage with the Scottish Ambulance Service which now allows for improvements to outcomes, for example they can reduce the door-to-needle (DTN) time as they can more accurately measure the time spent on scene with someone before transferring to hospital.

What's next for the audit?

Huge focus on rebuilding post Covid 19. Many of these are whole, system-wide NHS problems, not specific to stroke and can't be fixed by one team. But, there is a lot of pressure to fix it from the outside. As a stroke team, focus on things they can control.

Thrombectomy will become an important part of the audit from this year. It's important to audit this new service and ensure that the people who can get it, do get it, and that outcomes are acceptable and people are getting it within the right timeframe.

Following on from the Progressive Stroke Pathway being published last year (2022), there are things that the SSCA are expected to do, including working through the newly updated RAG charts.

Some challenges exist currently because of the electronic system that is being used; it can take two or three years to change something. Next year the team are hoping to change the system to one which will allow them to change things from the inside.

Finally, there is also a hope to use the audit data to improve access to research projects with patients and, a longer-term goal, of utilising learnings from England with the PREMs project to better understand patient experience.

Agenda item 3 – Q&A

GM Are there plans to start to collect rehab data that would be useful for when we interrogate how some of the services are doing?

MB: Yes. Looked at this for about 10 years now. One questions that always arises is that just because it is done south of the border, does that mean that it should be

done here as well. Often the answer is yes, e.g with PREMs and PROMs. The challenge with rehab is that it is not just a numbers thing. It is quite difficult to collect info about inpatient / outpatient journey. More rehabilitation in general is a good thing. Some patients are suitable to have lots and lots of rehab, some are not medically fit enough so might not be suitable.

The challenge of a numbers game is that rehabilitation in terms of minutes by itself is not very important; it is the quality of that rehabilitation.

A lot of AHP therapist time is spend recording paper notes, rather than actually delivering therapy. We try to limit that as much as we can. We don't have a simple electronic system that would record this information. Data about intensity and time about rehab has to be collected on paper.

We've looked at all these factors and just collecting a number of minutes isn't the right thing to do.

A big part of the PSP is rehabilitation and long-term support. None of these things can be measured as a number. RAG charts is a big part of what the Scottish Stroke Improvement Team do. There are 32 section and 24 of these sections are on rehabilitation and long-term support post stroke. Although self-marked they must demonstrate to how they have come to their score.

Going forward, the only solution to provide the intensity of rehabilitation is to have many more AHP. Technologies will also have a big role to play here; robots, games, etc. It may be that these systems are measurable and therefore can be included in the audit.

Christine MacAlpine

CM made a couple of points. Firstly that, any person who has had a stroke needs to encounter an AHP / psychologist who knows and is specific to stroke. Second point concerns six month reviews and how they are asked, who gets offered one and what they include in them.

Lesley Scobbie

Makes clear that it is critical that we start collecting numbers on community rehab. Although certain things aren't countable, some service level data would be possible to quantify (i.e. how long it takes for someone to start receiving community rehab services; do they receive 6 month review etc.)

LS also points out that improvements should be data drive quality improvement. Needs to be a mix of process and data driven assessment and quality improvement services. Need to make it easy for therapists to collect this data. We are behind other countries including England, Australia etc.

GM

What aspects can we quantify and what aspects do we need to make of a qualitative approach with.

MB

Although it is not numbers, the RAG chart element of audit will provide areas for improvements and show inequity across the country. Do have an amazing quality improvement tool within the RAG chart.

A.O.B

GM brings meeting to a close, confirms action to write to the Cabinet Secretary for Health.

Next meeting is 21st April.