Stroke Services for London
Rachel Tyndall, SRO
Presentation to OSC – 4 February 2009
The case for change

- A stroke is the second biggest killer in the UK.
- It is also the single most important cause of physical disability in London and is the cause of around 2,200 deaths in the capital each year.
- Nearly one percent of London’s population has suffered a stroke.
- The impact on hospital services is huge with more than 11,000 admissions for stroke in London, each year.
- The number of stroke patients likely to regain independence, rather than die or become disabled, increases by up to 25 per cent if treated within a specialist centre. This could save up to 400 lives every year in London
‘Hyper-acute stroke units’ (HASU)
Eight units proposed
Immediate response to stroke
Stabilise
Primary clinical interventions
Thrombolysis if appropriate
Length of stay us. less than 72 hours

‘Stroke units’ (SU)
20+ units proposed
Inpatient care following a patient’s hyper-acute stabilisation
Multi therapy rehabilitation
On-going medical supervision
Varied length of stay (until patient well enough to be discharged from an inpatient setting)
JCPCT criteria for preferred option must all be met

JCPCT has three proposed criteria, all of which must be satisfied by any configuration of acute stroke services put forward for consultation.

- Sustainable and optimal quality of provider services
- Comprehensive coverage of London’s population
- Strategic Coherence

The preferred option is considered not only to meet these criteria, but to give the ‘best fit’ with the criteria.

Alternative choices considered did not always fully meet the criteria or were considered to meet them less well.
Ensuring sustainable & optimal quality:
robust plans will ensure all providers meet specification

- Every future provider of stroke services will be expected to meet new demanding service specification.
- Independent assessment of bids against this service specification has given a clear picture of providers’ preparedness for meeting the specification but does not, by itself constitute a principal determinant in determining appropriate configurations.
- Rather it provides a detailed diagnostic insight.
  - Some providers have a clear understanding of the challenges that they face and have developed robust credible plans for meeting those challenges.
  - Other providers either lack this understanding or have not developed appropriate plans.
- Where commissioners require the provision of a stroke service from a site where no provider was able to meet the bid overview requirement JCPCT must be assured that quality standards will be met.
  - Robust plans will ensure that these services meet the standards.
  - Bid assessments will inform development of local commissioning plans.
  - Formal external support will be needed.
- Differences in evaluator score may also be useful in informing choices between bidders where other criteria do not give a clear answer.
“Treatment with alteplase (a type of clot-busting drug) is nearly twice as efficacious when administered within the first 1.5 hours after the onset of stroke than it is 1.5 to 3 hours afterward.”

“From the moment the patient arrives at the door, every minute counts, and the only justifiable delays would be for performing brain imaging studies to exclude haemorrhage and for obtaining the results of a few simple laboratory tests.”
Comprehensive coverage requires commissioning of services where no provider met the requirement

- **No HASU configuration** that met the assessment requirements can give the 30 minute travel time access for London.

- **Services must be commissioned** in areas where no provider demonstrated they were able to fully meet the requirements, in order to meet population need.

- **At the request of CCG Chairs**, three additional locations for HASU services were included in options development:
  - **North East**
  - **Royal London**
  - **Queens, Romford**
  - **South East**
  - **Princess Royal, Bromley**

- **Consideration of options including these sites assumes full compliance with specification in an acceptable timescale.**
Eight HASUs will ensure comprehensive coverage

Less than eight HASUs: inadequate coverage

- Some configurations of 7 HASUs could meet the requirement that all Londoners should have access to a hyper-acute stroke unit (HASU) within 30 minutes by blue light ambulance.
- These configurations give less resilience under more conservative travel time assumptions and assurance of public and service confidence, involving for example blue light ambulance journeys across the Dartford River Crossing.
- They also fail to give appropriate capacity in each network/sector to match as closely as possible that network’s needs.

More than eight HASUs: diminishing returns

- Configurations of more than 8 HASUs are not necessary to meet these concerns, offer no other advantages to patients but inevitably result in reducing critical mass and concentration of expertise.
- They were therefore not considered appropriate for development.
To achieve strategic coherence, major acute hospitals are appropriate sites for MTCs and HASUs

- **‘Consulting the Capital’** proposed a limited number of major acute hospitals to provide round the clock world class specialist clinical care.
- HASUs and MTCs draw on some common facilities and services throughout a 24 hour day. Co-location could maximise the use of clinical expertise (eg. neurosciences) and investigative facilities (eg. CT).
- These advantages are highlighted by NCAT.
- HASUs in hospitals without MTCs will offer the same high quality clinical stroke care as HASUs co-located with MTCs.
- The identification of hospitals offering MTCs and HASUs is a strategic opportunity for commissioners to develop major acute hospitals across London.
- To achieve strategic coherence, major acute hospitals are the appropriate sites for the provision of MTCs and HASUs.
- Strategic coherence (and with this, co-location of hyper-acute stroke care with major trauma) should therefore inform choices between configurations.

Source: Consulting the Capital

---

**WHAT A MAJOR ACUTE HOSPITAL SHOULD PROVIDE**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Hours open per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency surgery (including complex)</td>
<td>24</td>
</tr>
<tr>
<td>Complex planned surgery</td>
<td>12</td>
</tr>
<tr>
<td>A&amp;E taking most seriously ill</td>
<td>24</td>
</tr>
<tr>
<td>Inpatient children’s services including critical care</td>
<td>24</td>
</tr>
<tr>
<td>Doctor-led unit with associated midwife-led unit and level 2/3 neonatal intensive care unit (NICU)</td>
<td>24</td>
</tr>
<tr>
<td>Some outpatient services</td>
<td>12</td>
</tr>
<tr>
<td>Specialist tests</td>
<td>24</td>
</tr>
<tr>
<td>Some would be, or form part of, Academic Health Science Centres</td>
<td></td>
</tr>
</tbody>
</table>

- ‘Some of these hospitals (around 3) would take the most severely injured patients’
- ‘Some of these hospitals (around 7) would take stroke patients 24/7…’
Developing a preferred option (HASU) for consultation

- Key issues that emerge are:
  - Ensuring timely access in outer London
  - More capacity in central London than needed for comprehensive coverage and population need

- Although many theoretical configurations of 8 HASUs could be possible, in practice, a series of choices emerge. The preferred option arises from considering these in the light of the criteria:
  - Outer NW/NC – NWP or Barnet?
  - Inner NW – CXH or ChelWest?
  - North Central – Barnet or UCLH or RFH?
  - North East – To commission services at Queens, Romford and RLH;
  - Inner NE - RLH or St Thomas?
  - South East – St Thomas or KCH?; To commission services at PRUH
  - South West – St Georges or Mayday?

- Where there are existing high quality services close together providers should discuss working together
Hyper-acute stroke units – our proposal

- Northwick Park Hospital
- Charing Cross Hospital
- University College Hospital
- The Royal London Hospital
- King's College Hospital
- St George's Hospital
- The Princess Royal University Hospital

Hyper acute stroke unit

Healthcare for London

NHS
30-minute travel time from Hyper-acute stroke units
Stroke Units

- Stroke units will provide specialist treatment and rehabilitation for stroke patients.
- All patients will be transferred from a hyper-acute stroke unit to one of these dedicated stroke units. This may be in the same hospital or a unit closer to home.
- Dedicated, high-quality, specialist stroke units reduce death and levels of disability. Yet currently, only about 50% of stroke patients are treated on a dedicated stroke unit.
TIA Services

- Transient ischaemic attack (TIA) services will provide rapid assessment and access to a specialist within 24 hours (for high-risk patients) or within seven days (for low-risk patients) for patients having a mini-stroke.

- For patients who have a ‘mini stroke’, evidence shows that investigating their symptoms within 24 hours and providing specialist treatment can reduce the likelihood of them going on to have a full stroke by 80%. Over a third of hospitals in London are not meeting this target.
Stroke Units and TIA Services

• All units that met the assessment requirement should be designated.
• In addition, services should be commissioned at the following locations where the assessment requirement was not met: Queens, Royal London, PRUH, Queen Elizabeth (SU & TIA), St Helier (SU) & West Middlesex (TIA)
• These units were identified to have very significant development needs and would need more support to develop their services.
• We believe that services at these sites are required to provide local access

North East London
• Stroke services in NE London are part of a wider review of acute services in the area.
• The proposed locations of stroke units & TIA services in NE London (except for those located with hyper-acute stroke units) will not be clear until the review is complete.
• Stroke services at Whipps Cross, Homerton, Newham and King George Hospitals will continue to be provided whilst the review is undertaken.
• After the review’s completion in April, local NHS organisations will make specific proposals for stroke services of the highest quality which will be submitted to the Joint Committee of PCTs for consideration and, if appropriate, approval in July.
Stroke units

- Stroke unit
- Services do not change whilst review is undertaken
Summary

• We are proposing specialist stroke services with the highest standards of care be available to everyone in London.

• All stroke patients would be taken by ambulance to one of eight new hyper-acute stroke units where they will be assessed and treated within 30 minutes.

• Once stabilised, patients would be cared for in dedicated, local stroke units for continued specialist treatment and rehabilitation.

• More and better trained doctors, nurses and therapists will be needed to deliver new stroke services.

• A small number of hospitals that currently treat stroke patients may not continue providing these services.