Service	**South London Acute Stroke Services**
Commissioner Lead	
Provider Lead	
Period	**2013/2014**

1. Purpose

1.1 Aims

To ensure that all patients have equitable access to world-class acute stroke care through the delivery of:

- Hyper Acute Stroke Unit (HASU) services[1]
- Stroke Unit (SU) services[2]
- Transient Ischaemic Attack (TIA) services (all sites)

To ensure that these stroke services are of a high quality, deliver value for money and meet the objectives of the National and London stroke strategies.

1.2 Evidence base

The need to improve the stroke services is supported by the following evidence:

- National Stroke Strategy Quality Markers– Department of Health 2007
- The Stroke Strategy for London 2008
- Stroke: diagnosis and initial management of acute stroke and transient ischaemic attack (TIA) – NICE 2008
- National Sentinel Clinical Stroke Audit – Royal College of Physicians 2008
- Health Needs Assessment in stroke – Public Health Action Support Team (PHAST) 2008
- Stroke Quality Standard – National Institute for Health and Clinical Excellence (NICE) 2010

Insert local population and public health needs data here. Information is available from the London Public Health Outcomes Framework

1.3 General overview

Stroke is the second highest cause of death and the most common cause of adult disability in the capital.

Delivery of the London acute stroke model will save thousands of lives over future years. It will also reduce disability and mortality and allow many who have a stroke to regain full independence.

Ongoing investment in the acute model is required to ensure the performance standards are maintained and the model remains fully implemented. The focus in 2013/14will be to ensure the tariff guidance is appropriately implemented to deliver the best outcomes for patients, providers and commissioners.

[1] South London HASU sites are St George's Hospital (SGH), King's College Hospital (KCH), Princess Royal University Hospital (PRUH)

[2] South London SU sites are SGH, KCH, , PRUH,St Thomas' Hospital (STH), Queen Elizabeth Hospital (QEH), University Hospital Lewisham (UHL), St Helier Hospital (SHH), Kingston Hospital (KH), Croydon University Hospital (CUH)

1.4 Objectives

- Deliver world-class hyper-acute stroke care and ensure that it is accessible to all (HASU sites only)
- Enable stroke patients to achieve mutually agreed, realistic rehabilitative goals and maximise their recovery
- Ensure carers and families are involved in the development of stroke services and their needs are considered
- Achieve the standards set out in the Stroke Strategy for London
- Identify stroke patients with atrial fibrillation and appropriately treat (i.e. anticoagulation)
- Identify and give advice on reducing risk factors (e.g. high blood pressure, cholesterol, smoking)

1.5 Expected outcomes

- Provision of a timely service
- Increase in number of patients receiving thrombolysis (HASU sites only)
- Reduced inpatient mortality
- Reduced morbidity using Modified Rankin Scale
- Improved patient experience
- Quality improvements and subsequent achievement of national and local metrics/indicators

2. Service scope

2.1 Service description

Three key services are required to provide acute stroke care:

- Hyper Acute Stroke Units (HASUs) to provide immediate treatment following a stroke and provide care for the first 72 hours;
- Stroke Units (SUs) for multi-therapy rehabilitation and ongoing medical supervision after the patient has been treated in the HASUs; and
- Transient ischaemic attack (TIA) assessment services to provide rapid diagnostic assessment within 24 hours for high risk patients and within seven days for low risk patients

2.2 Accessibility/acceptability

The HASU or SU service will be available and accessible for patients with a suspected TIA diagnosis, referred, presenting via LAS or self presenting at the Trust A&E.

The HASU service will be available and accessible for patients with a suspected stroke diagnosis, referred, presenting via LAS, self presenting at the Trust A&E or referred from local SU Trusts within the HASU catchment area.

The SU service will be available and accessible for patients with a confirmed stroke, who live with the SU catchment area, as defined by the stroke look up table.

The service must not discriminate on the grounds of race, disability, gender, sexual orientation, religion, belief or age *(N.B. Stroke services are only for those aged over 16yrs of age*).

Services should provide equal access for all and be responsive to diverse needs, free from stereotyping and discriminatory practice.

2.3 Whole system relationships

- LAS
- Other hospital HASUs
- Other hospital SUs
- Other stroke networks
- Neighbouring Trusts
- Inpatient rehabilitation units
- Community rehabilitation and early supported discharge (ESD) services
- GPs
- Adult social care services and enablement teams
- Sector Acute Commissioning Units
- Life after stroke services:
  - Family and carer support workers
  - Return to work services
  - Stroke support groups
  - Aphasia groups
  - Exercise groups
  - Day clubs
  - Self management

2.4 Interdependencies

- London Ambulance Service
- Emergency Departments
- Medical teams
- Stroke Units
- Radiology services
- Neurosurgical services
- Vascular services
- Community rehabilitation and ESD services
- Adult social care services and enablement teams

2.5 Relevant networks and screening programmes

Providers should be actively involved with the South London Cardiovascular and Stroke Network, including the submission of LMDS data (or SSNAP when this has been agreed by the CAG).

3. Service delivery

3.1 Service model

Acute stroke

All suspected acute stroke patients must be assessed and treated at a HASU site by a consultant led team with stroke specialist skills supported by the neuroradiological expertise to enable the rapid diagnosis of stroke and appropriate immediate action taken (e.g. thrombolysis where appropriate). There are relatively few indications for neurosurgery in patients who have had a stroke but appropriate intervention on specific cases such as intracerebral bleed, cerebellar haematoma, hydrocephalus and massive peri infarct oedema, may be life saving. Support from neurologists and neurosurgeons needs to be co-ordinated with the hyper-acute centre providing focused assessment and treatment in the early stage of the treatment pathway.

Patients with suspected stroke must also receive an immediate structured clinical

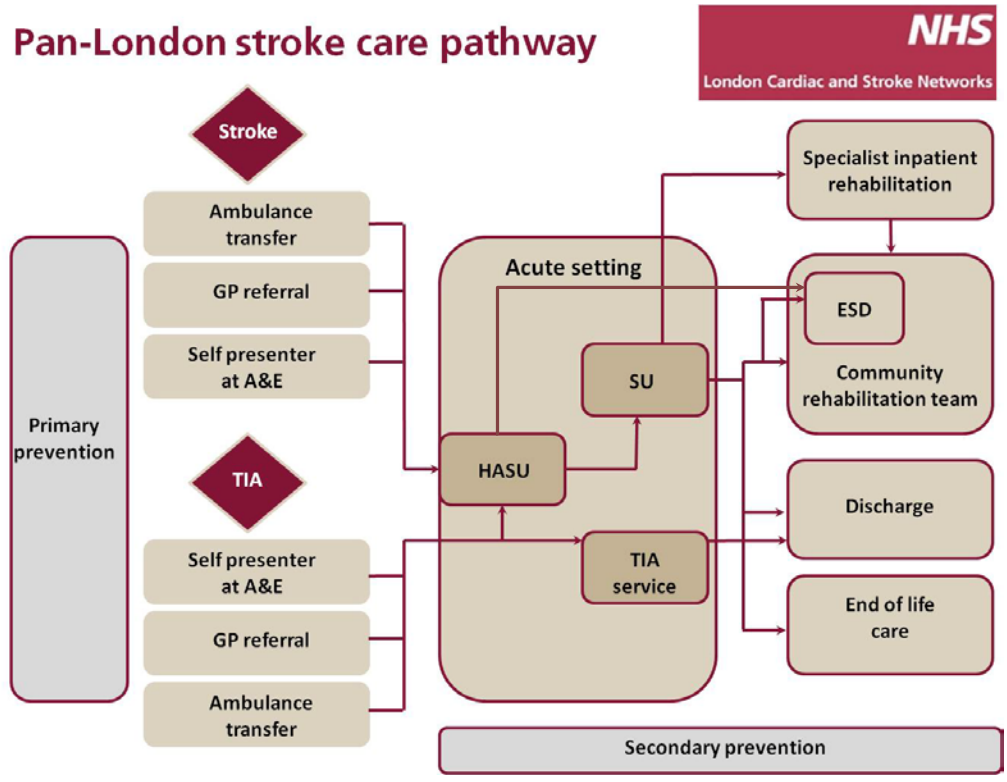
assessment to determine the likely diagnosis and whether urgent brain imaging is required. All patients with suspected stroke must be scanned as rapidly as possible with skilled radiological and clinical interpretation available. Specialist advice, including interventional neuroradiology/neurosurgery must be rapidly available, through collaboration within the network.

All patients who have a confirmed diagnosis of stroke will be treated in the HASU and SU as appropriate where they will be cared for by a specialist stroke physician, supported by a multidisciplinary team (MDT) to include specialist nurses, occupational therapist, physiotherapist, speech and language therapist, dietician, social worker, psychology services, etc. in line with the standards set out in the London Stroke Strategy.

TIA

Approximately 10% - 20% of patients who have a TIA will go on to have a stroke within seven days. This high risk group should be identified using the Rothwell ABCD2 score; those at highest risk may justify immediate hospital admission. All 'at-risk' patients will be referred to an open access one-stop TIA service which accepts direct referral from primary care and ED. The aim is to offer a specialist assessment and treatment within 24 hours of referral, requiring access seven days a week, 365 days a year. High risk patients must receive specialist assessment and treatment within 24 hours of presentation to a healthcare professional. Lower risk patients with a TIA to be investigated within seven days of presentation to a healthcare professional.

3.2 Care pathways



Also refer to National Stroke Strategy Quality marker summary (DH Dec 2007, page 80) and London Stroke Strategy

4. Referral, access and acceptance criteria

4.1 Geographic coverage/boundaries

London Stroke Unit catchment areas defined as per the London stroke unit look up tool: www.LondonSULookup.nhs.uk

N.B. Catchment areas are not necessarily aligned with PCT boundaries and are determined by a patient's residential postcode as opposed to their GP's postcode.

Include local PCT coverage/boundaries here

4.2 Location(s) of service delivery

For local completion.

4.3 Days/hours of operation

Services for both HASU and SU will be available 24/7.

TIA services must assess and treat high risk patients within 24 hours of first contact with healthcare professional and all others within seven days.

4.4 Referral criteria and sources

Patients in the community with acute symptoms will self-refer or GP referral via the 999 system, presentation at A&E or other healthcare setting (including patients either attending A&E or suffering a new stroke as an inpatient at local SU Trusts within the HASU catchment area).

Health professionals have a range of tools including:

- FAST – Face, arm, speech test
- ROSIER – Recognition of stroke in emergency room
- ABCD2 – Risk stratification tool for TIA

and should use local referral documentation where appropriate

4.5 Referral route

Referral route may be self referral, GP referral via 999, presentation at the ED or by dialling 999 or through a health professional.

Referral to TIA services is through a health professional and may be made by telephone and FAX and using locally agreed TIA referral forms.

Specify local TIA clinic referral arrangements here.

4.6 Exclusion criteria

The stroke service as defined is for those over 16 years of age only.

4.7 Response time and detail and prioritisation

All suspected acute stroke patients should be assessed and treated at a HASU site by a consultant led team. If the HASU does not have a bed, it is incumbent on the HASU provider trust to have contingency plans to accommodate these stroke patients. There should be direct admission to the HASU to ensure a minimum of 95**%** of all appropriate stroke patients are admitted to the HASU directly from the ED.

Stroke Units should accept stroke patients for repatriation according to the London stroke unit

lookup tool within 24 hours of referral/confirmed discharge date and time from the HASU.

100% of appropriate stroke patients, identified as potentially eligible for thrombolysis treatment, are to be scanned within next available CT slot. This must support a door to needle time of 30 minutes for 50% of thrombolysed patients.[3] (HASU sites)

High risk TIA patients should be assessed and treated with 24 hours of first presentation to a healthcare professional and all others within seven days.

90% of appropriate TIA patients with symptomatic carotid stenosis to undergo a carotid endarterectomy (CEA) within 14 days of first presentation to healthcare professional.

5. Transfer of and discharge from care obligations

All medically fit patients should be repatriated from HASU to SU within 72 hours (earlier if appropriate). HASU should also consider discharge directly to community stroke or ESD teams.

Stroke mimics who are not fit for discharge home should be repatriated to an appropriate care setting within 24 hours of a non-stroke diagnosis being made (e.g. to a MAU or other admitted bed in their local hospital).

The spell for the current SU tariff is based on an average length of stay of 21 days.
Acute provider SU will provide a six week follow up post discharge.

6. Self-care and patient and carer information

All patients have a right to knowledge and understanding of their condition at all stages of the stroke pathway and how to enhance their own health.

Patients, relatives and friends should have the choice to be involved with the patient care pathway as well as given the opportunity to be involved in broader decisions about service development and delivery and the future of stroke services.

Relevant information for patients and carers will be provided as required in a format accessible to the individual patients needs

7. Quality requirements

Performance indicator	*Indicator*	*Threshold*	*Method of measurement*	*Consequence of breach*
Quality				
Integrated Performance Measure on Stroke and TIA (Previously Vital Signs)	Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are treated within 24 hours	*Target is 60%*	Quarterly	Where planned trajectory or target is not met a remedial action plan will be requested. Where an agreed remedial action has not been implemented, follow process to issue Performance Notice and all

[3] HASU B standard is 90 % of patients having a 45 minutes door to needle time; C standard is for 50% within 30 minutes.

				subsequent performance controls as appropriate
Integrated Performance Measure on Stroke and TIA (Previously Vital Signs)	For SU at standard A1 % of patients who spend at least 90% of their time on a stroke unit	*Target is 80%* *Where stroke unit moves to standard A2 then target will change accordingly as per guidance.*	Quarterly	Refer to London Stroke Strategy acute commissioning and tariff guidance – prices applicable contingent on standards achieved
Quality Standards as specified in London Acute Commissioning and Tariff Guidance Appendix 6 and 7 as applicable Stroke-acute-commissioning-and-tariff-gui			London Minimum Dataset (LMDS). This will be replaced by the SSNAP dataset when agreed by the CAG	Failure to meet assessment standards and achieve London tariff uplift
London Stroke Strategy RI5 and NICE quality standard 7	Percentage of patients receiving Percentage of appropriate patients receiving 3 hours 45 minutes of each appropriate therapy (equiv of five x 45 minute face-to-face sessions per week each of OT, SLT & PT) as necessary.	100%	Quarterly This will be replaced by the SSNAP dataset when agreed by the CAG	
Accelerating Stroke Improvement 1 – Prevention of Strokes	Proportion of patients presenting with stroke with AF anti-coagulated on discharge.	60%	LMDS This will be replaced by the SSNAP dataset when agreed by the CAG	
Performance and productivity				
Not specified				

8. Activity				
8.1 *Activity performance indicators*	*Threshold*	*Method of measurement*	*Consequence of breach*	
Not specified				

8.2 Activity plan

As specified in contract activity plan proposals

8.3 Capacity review

As specified in contract

9. Prices and costs

9.1 Price

Price applicable is as per the Stroke Acute Commissioning and Tariff Guidance (London performance standards, Dec 2009) and are payable subject to the condition that the HASU and SU attain and maintain the quality standards including claw back arrangements as specified therein (See also Quality requirements, section 7 above).

Trusts are required to ensure the patient recording systems are sufficient to meet payment requirements as per the Stroke Acute Commissioning and Tariff Guidance.

All HASUs and SUs must use SINAP and the London Minimum Data Set to record activity. This will be replaced by the SSNAP tool when agreed by the London Stroke Clinical Advisory Group. This will be used to evidence whether Trusts meet the performance standards and related tariff.

Local CQUINS should be inserted here, where appropriate

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
See 9.1 above		See 9.1 above		Refer to finance plans
Total		**£**		**£**

**delete as appropriate*

9.2 Cost of service by commissioner

Not specified by commissioner – refer to activity plans where appropriate.

Total Cost of Service	Co-ordinating PCT Total	Associate PCT Total	Associate PCT Total	Associate PCT Total	Total Annual Expected Cost
£	**£**	**£**	**£**	**£**	**£**