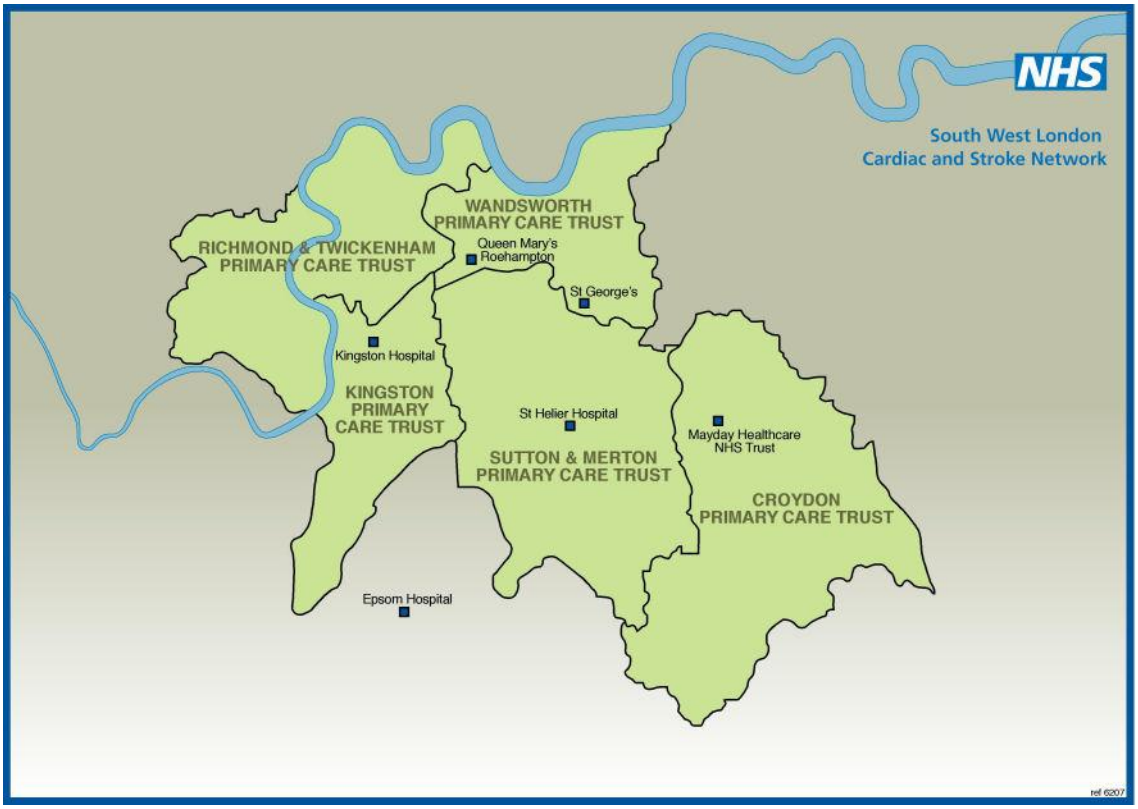
South London
Cardiac and Stroke Network

ACUTE BASELINE REPORT - STROKE SERVICES

SOUTH WEST LONDON



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1 Introduction

In May 2009, the South West London Cardiac and Stroke Network (SWLCSN) completed a baseline assessment of acute stroke services.

This review assessed the level and quality of service provision at the following Trusts as of December 2008: Kingston Hospital, Mayday Hospital, St George's Hospital & St Helier Hospital.

The purpose of this document is to provide the SWL Stroke Clinical Reference Group (CRG) with a baseline against which to monitor and measure performance as the new Healthcare for London model is implemented.

2 Background

In December 2007, the Department of Health published the National Stroke Strategy, emphasising the need to improve stroke service provision across England.

Healthcare for London's (HfL) Stroke Strategy in November 2008 supported this national directive, detailing the case for change, and means by which to ensure that a step-change in stroke care is delivered across the capital.

The HfL Stroke Strategy outlines that the most effective treatment of stroke would occur in dedicated stroke centres, requiring specialist multi-disciplinary teams and rapid access to high-quality equipment 24 hours a day, seven days a week.

In order to deliver this new model of care, hospitals across London were asked to submit bids to HfL detailing which of the following services they wished to provide:

i. Hyper-acute stroke units (HASU): provide the immediate response to a stroke, where the patient is stabilised and receives primary intervention, and where length of stay is typically no longer than 72 hours.
ii. Stroke units (SU): provide multi-therapy rehabilitation and ongoing medical supervision following a patient's hyper-acute stabilisation, where length of stay varies and will last until the patient is well enough for discharge from an acute inpatient setting.
iii. Transient ischaemic attack (TIA) services: provide rapid diagnostic assessment and access to a specialist within 24 hours for high risk patients following a TIA, and within seven days for low risk.

HfL evaluated these bids, and following public consultation, a final decision regarding the designation of services will be made by the Joint Committee of PCTs (JCPCT) in July 2009.

3 Information sources and methodology

Each Trust across the sector has been benchmarked against the HfL performance standards and acute stroke services designation criteria. This covers the following services:

- Hyper-acute Care (HASU)
- Acute Care (SU)
- TIA services

Information for the baseline has been obtained from two sources:

- Bids submitted to HfL (November 2008) by each Trust as part of the designation process
- Evaluation & feedback comments from HfL re: each bid submission

Below is a brief explanation of the information which is detailed in the results section of this report.

Hfl grade: This indicates the timeframe by which criteria should be met:

HfL Grade	Implementation Date
A	To be implemented – October 2009
B	To be implemented – April 2010
C	To be implemented – October 2010
D	To be implemented – April 2011

Self assessed score: Each Trust was required to provide a self-assessed score, predicting their estimated time of completion. This equates to the following:

Score	Expected Implementation Date
5	Criterion is currently being implemented
4	Criterion will be implemented by 'go live' (October 2009)
3	Criterion will be implemented by 6 months from 'go live' (April 2010)
2	Criterion will be implemented by 12 months from 'go live' (October 2010)
1	Criterion will be implemented by 18 months from 'go live' (April 2011)
0	Criterion will not be implemented until after 18 months from 'go live'

Where a second figure is shown, this indicates that HfL assigned a different score to that which was submitted by the Trusts. If applicable, we have given precedence to the HfL scoring, and assigned a RAG rating according to their assessment, as opposed to that of the Trust.

RAG rating: The following colour key was then used to highlight areas and issues that need to be addressed by each Trust:

RAG	Trust Position
	Criterion already met
	Some work to be done, but criterion should be met at criterion implementation date
	Criterion will not be met at criterion implementation date

4 Results

4.1 Hyper Acute Stroke Care

a. Quality of service – HASU

Criteria No.	Criteria	HfL Grading	SGH	Mayday
1.	An A&E service responsible for receiving suspected stroke patients, performing an initial assessment to determine if stroke has occurred, alerting HASU team of suspected stroke patient admission and transferring stroke patients to HASU	A	5	5
2.	A radiology service responsible for provision of the following: ▪ CT scanning for suspected stroke patients (24/7) ▪ CT reporting by radiology or stroke consultant (24/7) ▪ A contingency plan to ensure continuity of provision of CT scanning service in case of breakdown	A	5	4
3.	Established high-level thrombolysis treatment pathway	A	5	5 4
4.	24/7 availability of appropriately trained staff in eligibility assessment and administering thrombolysis treatment	A	5	4 3
5.	100 % of stroke patients, identified as potentially eligible for thrombolysis treatment, to be scanned within next available CT slot (this must support a door to needle time of 30 mins) (H1 performance standard)	A	5 4	5 4
6.	100 % of stroke patients eligible for thrombolysis (to be thrombolysed), to receive thrombolysis treatment within 30 mins of entry to A&E (door to needle time) (H2 performance standard)	B	5 4	4 3
7.	100 % of stroke patients eligible for thrombolysis to receive thrombolysis within 3 h or as soon as possible of symptom onset (H3 performance standard/Hfl Stroke Strategy)	A	5	5 4
8.	100 % of stroke patients, identified as ineligible for thrombolysis treatment, to be scanned within 24 h of admission to A&E (H4 performance standard)	A	5	4
9.	24/7 availability of appropriately trained staff in assessment of suspected stroke patients who are ineligible for thrombolysis treatment	A	5	4 3
10.	95 % of all stroke patients to be admitted to HASU directly from A+E (H5 performance standard)	A	5	4
11.	100 % appropriate stroke patients to receive a swallow test within 24 h of admission (H6 performance standard)	A	4	5
12.	100 % of appropriate stroke patients to be weighed during admission (H7performance standard)	B	5	4
13.	100 % of appropriate patients to receive physiotherapist assessment within 72 h of admission (H8 performance standard)	A	4	5
14.	100% of appropriate patients to receive continuous physiological monitoring (ECG, oximetry, blood pressure) by appropriately trained staff (H9 performance standard)	A	5	5 4
15.	Daily consultant level ward rounds (H 10 performance standard)	B	4	4 3
16.	Provision of 0.73 WTE physiotherapist/5 beds (respiratory & neuro) (BSRM & RCP (2003))	A	4	4
17.	Provision of 0.68 WTE Occupational Therapist/5 beds (BSRM & RCP (2003))	A	4	4 3
18.	Provision of 0.68 WTE SALT/10 beds	A	4	4 3
19.	Patient access to a social worker as an inpatient	C	5	5
20.	Arrangements for timely repatriation to appropriate local or co-located SU	A	5	4
21.	Sharing of information between HASU and SU	B	5	5
22.	Consultant led HASU team	A	5	5

23.	Provision of 24/7 consultant cover provided by at least 6 consultants on a rota able to make thrombolysis and hyper acute treatment decisions (H 11 performance standard)	A	5	4 3
24.	Provision of 24/7 nursing workforce to provide: 2.9 WTE nurses/bed (performance standard) 80: 20 trained to untrained skill mix (H12 performance standard)	A	2	4 3
25.	Recruitment plan for vacant positions and success in filling vacant positions	C	3	4
26.	Plan for rotation of posts across the professional groups along the patient pathway	D	4	5 4
27.	100 % appropriate patients and carers to receive contemporary patient information provided in a variety of formats (H13 performance standard)	B	4	5
28.	Evidence of management plan for access to neurosurgery, interventional neuroradiology and vascular surgery for appropriate patients	A	5	4
29.	Urgent access to investigations e.g. cardiac echo in selected patients, carotid imaging	B	5	5 4

b. Continuous improvement of service – HASU

Criteria No.	Criteria	HfL Grading	SGH	Mayday
30.	Process for obtaining and incorporating patient feedback into HASU services development	C	5	5
31.	Patient and carer involvement in development of stroke services	C	5	4
32.	Demonstration of a stroke management group to oversee service delivery and improvement e.g. review of performance standards, impact of new guidance and methods for improvement of service	B	5	4
33.	Evidence of timely implementation of service delivery improvements e.g. new guidance, performance standard compliance improvements	C	5	4
34.	Completion of leadership training by key members of the stroke team to support stroke service improvement	D	5 4	4 3
35.	Demonstration of participation in stroke related research, as a key part of HASU services	C	5	4
36.	Provision of structured training plan for new and rotational staff to ensure a competent understanding of the stroke pathway and compliance to Performance Standards	B	5	4 3
37.	Stroke physician attendance at British Association of Stroke Physicians (BASP) thrombolysis training	A	5	4
38.	Provision of, and attendance at, MDT stroke training programmes	A	5	5

c. Network working – HASU

Criteria No.	Criteria	HfL Grading	SGH	Mayday
39.	Active involvement in local stroke networks	B	5	5

4.1.1 Key sector findings:

- **30min "door to needle time":** This target is currently not being met for all patients eligible for thrombolysis.
- **Workforce:** Workforce across all professions (consultants, nursing, OT, physio & SaLT) does not meet the HfL criteria for staff:patient ratios. Whilst both Trusts have plans in place to address the shortfall, there is recognition that recruitment will be challenging across the sector, and appointments will extend beyond the 'go-live' date of October 2009. There are particular concerns re: recruiting nursing staff.
- **Training:** The level of staff skills, competencies and rotational opportunities have been identified as areas of concern across both Trusts.

4.1.2 Key organisational findings:

Mayday

- **Imaging:** CT scanning is not yet available out of hours and over weekends.
- **Assessments:** Not all patients are being weighed during their time on the stroke unit.
- **Access to neurosurgery & interventional neuroradiology:** No regional protocols are yet in place.
- **Access to investigations:** It is unclear whether stroke patients are able to access carotid imaging and echo at weekends.

St George's

- **Assessments:** Not all patients are receiving swallow tests and physiotherapy assessments within the target timeframes.

4.2 Stroke Unit Care

a. Quality of service – SU

Criteria No.	Criteria	HfL Grading	SGH	Mayday	St Helier	Kingston
1.	Timely admission of patients from HASU	A	5 4	5	4	5
2.	95 % of all stroke patients to be admitted directly to SU on HASU transfer (S1performance standard)	A	5 4	5 3	4 3	5 5
3.	95 % of patients to spend all of their in-hospital time in SU (S2performance standard)	A	4 3	4 3	4 3	4 3
4.	100 % of appropriate patients to receive a physiotherapist assessment within 72 h of admission to SU (S3 performance standard)	A	4	5	4 2	
5.	95 % of appropriate patients to receive an OT assessment within 7 days of admission to SU (S4 performance standard)	A	5	5 4	5 4	5 4
6.	100 % appropriate patients to be weighed within 72 h of admission to SU (S5performance standard)	A	5	5 3	4 3	5 4
7.	100 % of appropriate patients to receive weekly nutritional screening	B	5 4	5 4	3	5 3
8.	Evidence of a protocol to initiate suitable secondary prevention measures in all appropriate patients	A	5	5	5	5 5
9.	A radiology service responsible for provision of the following: CT scanning and reporting MRI scanning Ultrasonic angiology	A	5	5	5	5
10.	100 % of appropriate patients to have mood assessed by time of discharge (S6 performance standard)	A	4	4 3	4 3	5 4
11.	Provision of 0.84 WTE physiotherapist/5 beds (BSRM & RCP (2003))	A	4	4	4 2	4 2
12.	Provision of 0.81 WTE Occupational Therapist/5 beds (BSRM & RCP (2003))	A	4	4	4 2	4 2
13.	Provision of 0.81 SALT/10 beds	A	4	4 3	4 2	4 2
14.	Patient access to a social worker (S7performance standard)	A	4 4	5 4	5	5
15.	Availability of supporting services e.g. orthotics, podiatry, orthoptics, dietetics	B	4	4	5	5 2
16.	Availability of rehabilitation facilities e.g. access to physio gym, OT kitchen, SALT equipment	A	5 3	5	5	5
17.	Demonstration of maintenance of all '5 characteristics of a good stroke unit': • Multi-disciplinary meetings at least weekly to plan care • Provision of information to patients about stroke • Continuing education programmes for staff • Consultant physician with responsibility for stroke • Formal links with patient and carer organisations	A	5 5	5	5	4 3
18.	Demonstration of agreed referral pathways from SU to community rehabilitation providers	A	5	5	5	4 2
19.	Arrangements for timely discharge of patient from SU with appropriate support	B	4 3	5 4	5 4	4 2
20.	Plan for management of average length of stay (LOS)	B	5 3	5 4	5	4 3

21.	Sharing of information between SU and GP and rehabilitation provider (if applicable)	A	5	5	5	4
22.	Consultant led SU team 5 Consultant or equivalent led ward rounds per week Dedicated junior medical team trained in stroke management	A	5 3	5	5	4
23.	Provision of 24/7 nursing workforce to provide: 1.35 WTE nurses/bed (performance standard) 65:35 trained to untrained skill mix (S8 performance standard)	A	4	5 4	4 3	4 3
24.	Recruitment plan for vacant positions plan and success in filling vacant positions	B	4	4	3 2	3
25.	Plan for rotation of posts across the professional groups along the patient pathway	D	4 2	4 1	1	1
26.	100 % appropriate patients and carers to receive contemporary patient information and care plans provided in a variety of formats (S9 performance standard)	B	5 2	4 3	5 3	3
27.	Provision of a named contact within the care setting for each patient	B	5 4	4	5	5 3

b. Continuous improvement of service – SU

Criteria number	Criteria	HfL Grading	SGH	Mayday	St Helier	Kingston
28.	Process for obtaining and incorporating patient feedback into SU service development	C	5 5	4	5 4	5 3
29.	Patient and carer involvement in development of stroke services	C	5 3	4	4 3	4 3
30.	Demonstration of a stroke management group to oversee service delivery and improvement e.g. review of performance standards, impact of new guidance and methods for improvement of service	B	4 3	5	5 4	4 3
31.	Evidence of timely implementation of service delivery improvements e.g. new guidance, performance standard compliance improvements	C	5	5 4	5 4	5 3
32.	Completion of leadership training by key members of the stroke team to support stroke service improvement	D	4 1	4 1	2	5 3
33.	Demonstration of participation in stroke related research, as a key part of SU services	C	5	5 4	5 2	3 1
34.	Provision of structured training plan for new and rotational staff to ensure a competent understanding of the stroke pathway and compliance to Performance Standards	B	5 4	5	5 3	3
35.	Provision of, and attendance at, MDT stroke training programmes	A	5	4 3	5 4	4 3
36.	Evidence of the use of outcome measures e.g. RANKIN score or Barthel Index	B	5	5	5	3

c. Network working – SU

Criteria No.	Criteria	HfL Grading	SGH	Mayday	St Helier	Kingston
37.	Active involvement in local stroke networks	B	5	5	5	5

4.2.1 Key sector findings:

- **Repatriation:** Although the existing protocols are largely effective, there is acknowledgement that following the outcome of the designation process, these will need to be revised and tested.
- **Capacity**: No Trusts are currently meeting the target for 95% of patients to spend all of their in-hospital time on a SU. Internal bed pressures have been cited as particular concerns at Mayday & St Helier.
- **Workforce:** Workforce across all professions (nursing, OT, physio & SaLT) does not meet the HfL criteria for staff:patient ratios. Whilst all Trusts have plans in place to address the shortfall, there is recognition that recruitment will be challenging across the sector, and appointments will extend beyond the 'go-live' date of October 2009.
- **Assessments:** A number of Trusts are not meeting targets related to weighing, weekly nutritional screening and mood assessments. Issues re: staffing, skills & lack of monitoring processes have been cited as the primary factors.
- **Timely discharge:** Early Supported Discharge (ESD) services are not yet in place / underdeveloped across the sector.
- **Management of LOS:** Whilst all Trusts are monitoring LOS, this has not necessarily been incorporated into their existing management structures and/or monitored as a routine part of their governance arrangements.
- **Patient information:** It has been acknowledged that more work needs to be undertaken to ensure that patient information is as individualised as possible – detailing services specific to their locality, and available in a wide variety of languages and formats.
- **Patient involvement:** Whilst most Trusts have a dedicated patient & carer forum in place, there is concern re: the breadth of representation. In addition, there was little evidence provided to demonstrate that patient feedback/representation from these forums forms an integral part of existing management structures.
- **Named contact within care setting:** A number of organisations have protocols in place to address this issue. However, it is unclear whether this key worker arrangement is being actively implemented.
- **Training:** The level of staff skills, competencies and rotational opportunities have been identified as areas of concern across all Trusts.

4.2 .2 Key organisational findings:

St George's:

- **Availability of rehabilitation facilities:** The current physiotherapy & gym space has limited capacity. In addition, there is no allocated rehabilitation space for SaLT.

Kingston:

- **Research:** The Trust are not participating in any research studies at present and it is likely that this will remain a low priority.

4.3 TIA Services

a. Quality of service – TIA

Criteria No.	Criteria	HfL Grading	SGH	Mayday	St Helier	Kingston
1.	An A&E service able to carry out emergency assessment and initial management of TIA patients according to agreed protocols.	A	5	5	5	5
2.	Provision of TIA pathway (including initial assessment and use of ABCD2 risk stratification tool) to all local GPs and recommendations in place for referral of all high risk patients	A	5	5 4	5	5
3.	100% of appropriate TIA patients to be started immediately on aspirin (300mg/day)	A	5	4	4	5
4.	Established TIA pathway for treatment of high and low risk patients	A	5	5	5	5
5.	90% of high risk TIA patients to receive a specialist assessment and treatment within 24 h of onset of symptoms (T1 performance standard)	A	5	4 3	4 3	5 4
6.	90 % of appropriate (according to NICE guidelines) high risk TIA patients to receive brain imaging within 24 h of onset of symptoms (T2 performance standard)	A	5	4 3	4	4
7.	90% of low risk TIA patients to receive a specialist assessment and treatment within 7 days of onset of symptoms (T3 performance standard)	A	4	4	4	5
8.	90 % of appropriate (according to NICE guidelines) low risk TIA patients to receive brain imaging within 7 days of onset of symptoms (T4 performance standard)	A	4	4	4	5
9.	90% of appropriate TIA patients to have carotid imaging within 7 days of onset of symptoms	A	5	4	4	4
10.	90 % of appropriate TIA patients with symptomatic carotid stenosis to be assessed and referred for Carotid Endarterectomy (CEA) within 7 days of onset of symptoms	A	5	4	4	5
11.	90 % of appropriate TIA patients with symptomatic carotid stenosis to undergo CEA within 14 days of onset of symptoms (NICE guidelines)	A	5	4	4	5
12.	A radiology service responsible for provision of the following: MRI, MRA, CTA and/or carotid ultrasound service for suspected TIA patients Timely interpretation and reporting by competent clinician A contingency plan to ensure continuity of provision of brain and carotid imaging service in case of breakdown	A	5	5	4	5
13.	100 % of confirmed TIA patients to receive secondary prevention advice including medication management and lifestyle advice	A	4	4	4	5
14.	Availability of appropriately trained staff in TIA specialist assessment and early management	A	5	5 4	4 2	5
15.	Sharing of information between TIA service and GP	B	4	5	5	5
16.	Consultant led TIA service	A	5	5	5	5

b. Continuous improvement of service – TIA

Criteria No.	Criteria	HfL Grading	SGH	Mayday	St Helier	Kingston
17.	Process for obtaining and incorporating patient feedback into TIA service development	C	5	5	4	5
18.	Patient and career involvement in development of TIA services	C	5	4	4	4

19.	Demonstration of a TIA/stroke management group to oversee service delivery and improvement e.g. review of performance standards, impact of new guidance and methods for improvement of service	B	5	5	5	4
20.	Evidence of timely implementation of service delivery improvements e.g. new guidance, performance standard compliance improvements	C	5	5	4	5
21.	Process to monitor and manage delays to assessment and treatment of suspected TIA patients	B	5	4 4	5	5
22.	Evidence of a system to identify and manage inappropriate referrals to TIA services	C	5	4	5	2
23.	Provision of structured training plan for new and rotational staff to ensure a competent understanding of the stroke pathway and compliance to performance standards	B	5	5 3	5 3	3
24.	Evidence of A&E staff and GP education on the TIA pathway including TIA recognition and assessment	A	4	5	5	5

c. Network working – TIA

Criteria No.	Criteria	HfL Grading	SGH	Mayday	St Helier	Kingston
25.	Active involvement in local stroke networks	B	5	5	5	5

4.3.1 Key sector findings:

Imaging: 7 day provision of CT scanning & MRI imaging is not yet available at a number of Trusts.
Secondary prevention: Not all patients are being given appropriate information on medication management and lifestyle advice.
Patient involvement: Whilst most Trusts have a dedicated patient & carer forum in place, there is concern re: the breadth of representation. In addition, there was little evidence provided to demonstrate that patient feedback/representation from these forums forms an integral part of existing management structures.
Training: Structured training plans for new and rotational staff are not yet in place across a number of Trusts.

5 Recommendations

5.1 HASU:

1. Out of hours thrombolysis services need to be improved to ensure that the 30 minute "door to needle time" is met for all suitable patients.
2. Creative recruitment strategies are to be developed by each Trust to ensure that the staff required to deliver this new model of care are in post ahead of 'go-live'.
3. Training needs and gaps are to be identified and addressed across the sector.
4. Mayday Hospital are to ensure that 24/7 access to CT scanning is available within the Trust.
5. Mayday Hospital are to ensure that all patients are being weighed during their time on the stroke unit.
6. Access to neurosurgery, interventional neuroradiology and investigations such as carotid imaging and echo need to be improved at Mayday Hospital.
7. St George's Hospital are to ensure that all patients receive swallow tests and physiotherapy assessments within 24 hours and 72 hours of admission respectively.

5.2 SU:

1. Repatriation protocols are to be revised, agreed and tested across the sector.
2. All organisations need to ensure that 95% of stroke patients spend all of their in-hospital time on a stroke unit.
3. Creative recruitment strategies are to be developed by each Trust to ensure that the staff required to deliver this new model of care are in post ahead of 'go-live'.
4. Each organisation is to ensure that weighing, weekly nutritional screening and mood assessments are carried out within the required timeframe. Protocols need to be implemented effectively, with robust monitoring mechanisms in place.
5. Early Supported Discharge services are to be introduced in each PCT area, enabling the timely discharge of patients from stroke units.
6. Each Trust is to ensure that the patient information they provide is as individualised as possible and available in a wide variety of languages and formats.
7. Patient and carer involvement needs to be strengthened by all Trusts. The breadth of representation is to be expanded, and feedback is to form an integral part of service development.
8. Trusts are to implement key worker arrangements, so as to ensure that each patient can be provided with a named contact within the care setting.
9. Training needs and gaps are to be identified and addressed across the sector.
10. Additional rehabilitation facilities are to be made available at St George's Hospital. This is to include allocated space for SaLT.
11. Kingston Hospital are to continue liaising with the Stroke Research Network regarding opportunities to participate in research studies.

5.3 TIA services:

1. All organisations are to ensure that 100% of confirmed TIA patients receive appropriate secondary prevention advice.
2. Patient and carer involvement is to be strengthened by all Trusts. The breadth of representation is to be expanded, and feedback is to form an integral part of service development.
3. Training needs and gaps are to be identified and addressed across the sector.
4. 7 day provision of CT scanning needs to be implemented at Mayday and St Helier Hospitals.

6 Next Steps

In terms of addressing the issues which have been highlighted in this report, the South West London Cardiac & Stroke Network will be using 2 mechanisms to ensure that improvements in acute stroke services are being made across the sector. They are as follows:

6.1 Implementation Plans

In preparation for the delivery of this new model of care, each Trust will be asked to produce a detailed implementation plan, outlining how and when they intend to develop their stroke services to meet the HfL criteria.

The Network will be monitoring progress against these plans on a monthly basis, through regular communication with staff at the Trusts, and attendance at Trust-wide Stroke Steering Group meetings.

6.2 Acute Workstream Group

The Network has put in place an Acute Workstream with representation from key clinical and managerial staff from each Trust across South West London.

It is anticipated that this Group will meet every 6-8 weeks to share good practice and work collectively to address sector-wide issues such as workforce, training and repatriation.