Whipps Cross University Hospital

NHS Trust

Councillor Christopher Buckmaster
Chairman
Pan London Joint Health Overview and Scrutiny Committee.

17/04/2009

Dear Councillor Buckmaster

Re: The Shape of things to come – developing new, high –quality major acute trauma and stroke services for London.

Thank you for inviting us to comment on the consultation document for Trauma and Stroke in particular around the proposed configuration and the arrangements for response from the London Ambulance Service.

Please find our response for the Pan London Joint Health Overview and Scrutiny Committee. Our response is focussed on the proposed configuration and impact on patients within North East London.

Having submitted a bid for the Stroke services including Hyperacute, Stroke and TIA the Trust would like to express its disappointment that, as well as meeting the Stroke and TIA designation criteria, we were not successful in being identified as one of the centres for delivery of a comprehensive Stroke service. This is also inspite of having one of the best clinical outcomes in terms of;

- a significantly lower than national average mortality rates of 22.7%
- a national expected average of 28.4%
- better than the majority of North East London Hospitals[1] (as demonstrated in appendix 1).

We would also like to draw your attention to the letter previously sent in response to the feedback from Healthcare for London (appendix 2).

In particular, the Trust needs to be reassured that the needs of our population are being taken into account in terms of the significantly higher incidence of stroke cases admitted to Whipps Cross, which shows that the Trust treated, between April 07 and January 09,

- in excess of 770 cases (17.5%) of all North East London patients
- against 530 cases at Barts and the London
- with the second highest activity as demonstrated in appendix 3[2].

The Trust is concerned that only sites that have a proven track record of high quality care to a critical mass of stroke patients should be selected.

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[1] **SOURCE:** Dr Fosters Intelligence tools
[2] **SOURCE:** Dr Fosters Intelligence tools

1. Trauma:

The Trust is supportive of the proposals made regarding the location of the Trauma centre at The London Hospital for North East London. The Trust would like assurance that Trauma centres and HFL work with local sites to establish agreed assessment criteria and protocols to determine and deliver quality of care to high level trauma patients. This is to ensure that the local needs of the patients, once treated at the Trauma centre, are being met and there is support for the spoke centres to provide the right level of specialist and rehabilitation care.

Whilst we understand the interface between neurosurgery and trauma the Trust would like to see more evidence to demonstrate that the model of co locating hyperacute and trauma services is a robust clinical model, which will be cost effective and not destabilise other emergency services.

2. Stroke:

- **Configuration;** The Trust has significant concerns regarding the suggested Stroke configuration and the proposed clinical model, especially as the Whipps Cross catchement population has a high incidence of stroke cases and extremely poor transport conduits, especially for family support post Stroke hospitalisation.

  The guiding principles are correct in having the best care in the best place. However, the final model of selection through geographical positioning, in some cases being the only selection criteria, does not provide evidence of best clinical outcomes being delivered for patients. The Trust would like to work further with you in addressing concerns regarding the Stroke configurations and the proposed clinical model and realistic expectations of the execution of service provision.

- **Timeliness and use of technology;** As outlined in the stroke strategy, clinical evidence suggests that best outcomes from thrombolysis are time critical. The Trust would like to see the advances of technology such as video telemetry units being used more prominently which would be a more innovative model of providing a networked approach to accessing remote on call expertise and review remotely with the provision of thrombolysis on local sites.

- **Pathway Development;** Similarly, the proposed model focuses on stroke as a stand alone disease without taking into consideration the treatment of multi-pathological patients and the care and continuity of care which they would receive from their nearest hospital. The Trust would encourage joint working with partner organisations in ensuring robust clinical pathways and communication networks are established.

  Non HASU sites which are designated Stroke Units would need to have robustly agreed protocols in place with the Hyperacute sites and we would like to see evidence of a joint partnership approach to clinical modelling across the whole patient journey.

- **Bed Availability**; We envisage, as a provider of Stroke and TIA services, that an increase in appropriate Stroke patients would not occur and meeting the demand under the available bed numbers would be feasible if a robust and mutually agreed pathway model is in place between the Hyperacute, LAS and Stroke Units.

3. Impact on the London Ambulance service:

- **Travel times;** The location of Hyperacutes in terms of the distance, coverage and proven expertise across London is an area that needs to be reconsidered in particular in North East London. As evident in the consultation document, there is a wide distance in North East of London between the proposed hyper-acutes whose successful clinical model depends on the ability of patients to be thrombolysed within three hours from the onset of stroke. This puts the onus on the LAS to transport our local patients to a hospital outside the catchement area within a short space of time. At the moment, the Trust does not have the confidence that this is, with the other pressures on emergency services, achievable.

- **Non Stroke patients;** There will also be a group of non-stroke patients being assessed by the FAST method by LAS as suspected strokes being transported to Hyperacute centres but with other complex needs and the Trust would like to see the clinical pathway being proposed to treat these patients and effectively ensure they are transferred to their local hospital.

- **Treat and Transfer;** The Trust would also like to highlight the potential in stretching the LAS service to the limit with journeys that need to be made in short timeframes to HASU's and then transfers for both the Stroke and non-Stroke patients to their local Stroke Unit. This needs to be balanced with the other pressures on the service including trauma patients, cardiac as well as increased pressure during the winter as demonstrated for the winter of 08/09 where the LAS were stretched to the limit to meet demand. Again, ensuring the LAS works closely with both Hyperacute and non-hyperacute providers to establish and monitor patient flows and manage trends throughout the year is critical to ensuring safe patient care.

4. Travel times for relatives and carers:

Travelling and convenience for patient's relatives and carers must be taken into consideration. Especially those who are older and those with small children using primarily public transport. The new model would mean that they would have to travel first to the Hyperactute and then subsequently to the local stroke unit, which may not be inconvenient.

We are committed to the provision of best stroke care for our patients and feel strongly that, given the opportunity, we can work with you and in partnership with the network to provide the right service that meets the local needs of our local population.

Yours Sincerely

Dr Lucy Moore
Chief Executive

Appendix1 - During April 07–Jan 09 period Whipps Cross had significantly less deaths than the national average for Mortality[3]

Provider	Spells	Superspells	% of all	Deaths	%	Expected	%	RR[4]	Low	High
All	**4383**	4255	100.0 %	1015	23.9 %	1042.2	24.5 %	97.4	91.5	103.6
Barking, Havering and Redbridge University Hospitals NHS Trust	1869	1840	43.2 %	465	25.3 %	456.1	24.8 %	102.0	92.9	111.7
Whipps Cross University Hospital NHS Trust	768	753	17.7 %	171	22.7 %	213.7	28.4 %	80.0	68.5	93.0
North Middlesex University Hospital NHS Trust	539	534	12.5 %	137	25.7 %	130.7	24.5 %	104.9	88.0	124.0
Barts and the London NHS Trust	503	472	11.1 %	107	22.7 %	95.7	20.3 %	111.9	91.7	135.2
Newham University Hospital NHS Trust	363	338	7.9 %	78	23.1 %	78.0	23.1 %	100.0	79.0	124.8
Homerton University Hospital NHS Foundation Trust	341	318	7.5 %	57	17.9 %	68.2	21.4 %	83.6	63.3	108

[3] Dr Fosters Intelligence Tools
[4] Relative risk

Appendix 2

Whipps Cross University Hospital NHS Trust

Whipps Cross University Hospital
Trust Corporate Offices
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Leytonstone
London E11 1NR
Direct Tel: 020 8535 6800
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By email

Wednesday 14th January 2009

Our ref: LM/ah/140109

Rachel Tyndall
Stroke Designation Team
C/o Healthcare for London
NHS London
Southside
105 Victoria Street
London
SW1E 6QT

Dear Rachel

Thank you for the letter and feedback regarding our submission for Stroke.

We have already indicated that we wish to meet with the stroke project team and I believe this is being arranged. As part of the process the Trust would like to understand/seek clarification on the following in respect of our bid to provide hyper-acute services:

First, we are concerned that in the overall bid assessment the evaluators highlighted the fact that Whipps Cross does not have any existing hyper-acute experience – we assume this relates to the delivery of thrombolysis as we already provide good quality acute stroke care. We were aware of the position in respect of thrombolysis and would like to understand why this is relevant - Queens Hospital have been designated for hyper-acute services – yet we do not believe currently provide this service. Indeed Whipps cross has a significant advantage. The consultant stroke lead at Whipps Cross provides hyper-acute leadership to the UCHL service – a service which has been designated and does have current experience. We also have a medical model agreed with emergency physicians to deliver this.

Second we note that in the evaluators general comments on bids they state that if a provider is able to deliver a reasonable stroke unit service, they were more likely to be able to provide a reasonable HASU. As above Queens hospital did not satisfy the criterion for a stroke unit. We would be grateful if you could explain the logic behind the different outcome for Whipps cross as compared with Queens Hospital.

Third we are concerned that the evaluators do not believe we understand the level of change required to deliver the new models of care and would like to discuss further where our proposal is lacking. The Trust is under no illusion of the significant change agenda both to improve quality and to implement strategic change.

Fourth we are concerned to see that the assessment had been made on the perception that we have made 'very little improvement' in quality of services. The 2004 to 2006 data demonstrate a step change improvement with further change in 2008.

The specific improvements we have made from previous years include;

Organisational Change- New services for TIA and community rehabilitation commenced in August and the Audit was submitted in May, but we would hope that the HFL submission would have reflected this.

CT Imaging This has improved from 2006, from a 5-24 hour turnaround to 0-4 hours turnaround in hours in 2008. In addition, Carotid Dopplers have improved from 2006 greater than 48hours to 25-48 hours. We did not have access to scanning with in 3 hours of admission in 2006 which we have now at the time the audit was completed.

Patient communication- This has been a focus and this has improved with provision of patients information on the ward. Further work is in hand.

Staffing – The staffing ratios have improved from 0.76 in 2006 to 1.07 in 2008. There has also been significant improvement across MDT including Junior Dr cover from 4.69 to 7.8. We made the appointment of a of stroke co-ordinator which was an improvement on 2006.

Clinical Research- Improvement made from 2006 in that clinical research has now been included in the job plan for Stroke Consultant. We are also intending to fund a stroke research nurse post and this will be closely linked with the newly establishes clinical research unit.

Leadership Training- The Trust has in place a Clinical Leadership Programme which key senior stroke team members have access to and will be asked to attend. In addition the joint UCLH/WX stroke consultant will be initiating further specific training programmes internally and identifying external programmes that staff will be attending.

Recruitment of Staff- it is recognised widely that recruitment to various nursing and therapist posts will be challenging across London for all trusts. However, in addition to our recruitment strategies we would also be seeking to work with other providers for the pooling of staff to work across sites in the hub and spoke model of stroke provision. We feel that these strategies will mitigate the risk of under recruitment to key posts.

Finally, we are very proud of the improvement we have seen in reducing mortality following stroke at Whipps Cross. We are also aware through our work with the network in North east London that this is not the case in all providers and in particular the mortality at Queens Hospital remains significantly higher than that at Whipps Cross Hospital. We would be grateful for an explanation as to why this is not a significant influence on the outcome of designation especially for hyper-cute stroke services. The overall aim of the Healthcare for London proposals are aimed at improving outcomes for patients. I am sure you will appreciate that we to be able to explain to our staff and stake-holders alike especially in the context of a process to formally consult on the Healthcare for London proposals.

We have already indicated via a previous email that we would welcome a meeting with you to progress this further as we feel that we have a strong case for achieving designation for all three services. We feel strongly that, given the opportunity we can work with you and in partnership with the network and other established hyperacute units to gain from shared experience to overcome any areas that require focus.

We look forward to hearing from you.

Yours sincerely

Lucy Moore
Chief Executive

CC: Heather O'Meara, Chief Executive, Redbridge PCT
Alwen Williams, Chief Executive, Tower Hamlets PCT

Appendix 3- Patient activity for Stroke between April 07–Jan 09 Whipps Cross compared to North East London Hospitals[5]

Provider	Inpatients	% of all	Episodes
ALL	4439	100%	8606
Barking, Havering and Redbridge University Hospitals NHS Trust	1870	42.1%	3526
Whipps Cross University Hospital NHS Trust	778	17.5%	1525
North Middlesex University Hospital NHS Trust	540	12.2%	1314
Barts and the London NHS Trust	503	11.3%	800
Newham University Hospital NHS Trust	390	8.8%	817
Homerton University Hospital NHS Foundation Trust	358	8.1%	624

[5] Dr Fosters Intelligence Tools