Frequently asked questions (FAQs)

Changes to stroke services at Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital, Grimsby (DPOW)

The decision to centralise hyperacute stroke care at SGH has been made to ensure patients have 24/7 access to this service as previously it was only available Monday to Friday, from 8am to 8pm at SGH and DPOW.

Hyperacute stroke care is high dependency care provided to all stroke patients during the first 72 hours, not just those suitable for thrombolysis (a blood clot busting injection).

There is good evidence that centralising hyperacute services to fewer sites ensures that staff can maintain their skills in this area and improves outcomes for stroke patients. Other places across the country such as South Tees have already made this move and are seeing the improved outcomes for patients.

The centralisation of hyperacute stroke services is another step towards improving the health outcomes for the residents of Northern Lincolnshire.

Questions about transport

1. **Will the ambulance service take all suspected stroke patients who previously went to DPOW to SGH?**

No, suspected stroke patients will be taken to the nearest hyperacute stroke service, which could be Lincoln, Boston or SGH depending on where exactly the patient is located. Hyperacute stroke care is high dependency care provided to all stroke patients for up to the first 72 hours, not just those suitable for thrombolysis.

2. **Will the ambulance service cope with all the additional journeys they will have to make?**

EMAS (East Midlands Ambulance Service) have carefully considered how they will manage this and are confident they have sufficient resources in place to meet with predicted demand. This will be monitored closely.

3. **What happens if the ambulances don't cope? What are the contingency plans? What are the monitoring processes?**

Ongoing monitoring of ambulance capacity and capability will be undertaken which will encompass overall performance, call waiting times and response times. EMAS is in close contact with its commissioners to ensure a safe level is maintained and that ‘flex’ to ambulance provision can be achieved. Additional resources have been identified and can be deployed in line with variances in demand.

4. **How long will the journey to SGH take from North East Lincolnshire?**

A blue-light journey should take between 35-50 minutes depending on exactly where in North East Lincolnshire the patient is located. An ambulance travelling from DPOW to SGH should take no more than 35 minutes, including the time taken to transfer patients from the trolley.

5. **Have you considered the impact of bad weather, roadworks, accidents etc on travel time?**

All of these elements are part of EMAS daily business and considerations are made within their business continuity plans. Intelligence gathering on all of these elements takes place daily and EMAS is able to react and flex its resources based on any or all of these elements.

6. **Will transport be provided for elderly spouses who may have to travel from the outer boundaries of DPOW's catchment area eg Louth to visit first at Scunthorpe then to Grimsby and then back at Louth?**

Patients will be taken to the closest stroke unit so depending which side of Louth they live they may be taken to Lincoln, rather than Scunthorpe. For relatives of patients who have to spend their initial time in a hyperacute unit (for **most** patients this will typically be up to 72 hours) we would not provide transport following the initial admission journey but would aim to ensure we transfer patients back to DPOW or Louth as soon as clinically able to do so

7. **If someone from Grimsby had a stroke, what would happen to their husband/wife/next of kin. Would they be taken in the ambulance with them if they cannot drive? If so how would they get home? What would happen with regards to visiting their loved one during the hyperacute period before they are transferred back to DPOW?**

Wherever possible within the practicalities of transporting patients, EMAS endeavors to accommodate a next of kin, close relative or friend where this is in the patients best interest. While a patient is in hospital transport to and from the hospital by the relative is the responsibility of the relative.

8. **How many patients are likely to be sent to Lincoln hospital who would previously have attended DPOW? How long will it take to transport them?**

It is estimated that approximately 60 patients per year may be taken to Lincoln hospital and transfer time will depend on where the patient lives but will be in the range of 30-45 minutes.

9. **How many patients are likely to be sent to Hull hospital who would previously have attended DPOW? How long will it take to transport them?**

It is estimated that a very small number of additional patients will be transferred to Hull as this option is already open to the ambulance service for patients who live close to the Humber Bridge.

10. How will patients be transported back to DPOW after the hyperacute phase?

Patients will be transferred back by ambulance after the hyperacute phase.

11. If a stroke patient from the Grimsby area dies at Scunthorpe, whose responsibility is it to return them to North East Lincolnshire?

The patient would be taken to the on-site mortuary at SGH and would be collected by the funeral director of the family's choice.

Questions about treatment

12. Who decides whether it is a suspected stroke or not? Is it the ambulance crew?

Yes it would be the ambulance crew. There is a quick standard assessment tool they use to determine whether or not a stroke is suspected. If they assess and suspect stroke they will immediately ring ahead to SGH to alert them so that the stroke responders are ready when the patient comes in.

13. Will patients receive any treatment during the journey?

Yes. The immediate care of patients who have suffered a stroke is a fundamental skill of a paramedic. Managing the patient's presenting condition will take place from arrival of the ambulance crew and throughout the patient's journey to the stroke unit.

14. What will happen when patients arrive at SGH?

The ambulance team will have contacted the hospital on route so the stroke team will be ready and waiting to treat the patient as soon as the ambulance arrives. The patient will receive the appropriate treatment from the stroke team which will involve scanning the patient and having the diagnostic report returned to the consultant, usually within 60 minutes of arrival. This information is used to decide whether the patient should receive thrombolysis treatment (a blood clot busting injection). All patients diagnosed with a stroke (whether they have received thrombolysis treatment or not) will be moved from the emergency centre to the hyperacute stroke unit as soon as possible for specialist care. This unit provides the type of care that you would normally find in a high dependency unit.

15. The advice is to 'act FAST' and within the 'golden hour' – won't the additional travel time compromise people's chances of a good recovery?

Patients will be scanned and thrombolysed if appropriate as soon possible with the aim to have a scan and report done within 45 minutes of their arrival. Thrombolysis is most effective if delivered within about four and a half hours of the onset of the stroke – patients will be transported well within this timeframe. Moving hyperacute services onto one site means these services will be able to be delivered around the clock every day of the week instead of 8am to 8pm, Monday to Friday. Stroke patients who are not appropriate for thrombolysis treatment will also be nursed on the hyperacute stroke unit where there are the facilities for closer monitoring and more intensive input to patients during the critical initial period after a stroke has happened. All the national guidelines for stroke services and the evidence behind these guidelines recommend services are provided in this way as the outcome for the patient is better.

16. Will Scunthorpe staff have access to North East Lincolnshire patients' hospital records?

Yes they will.

17. When will patients be able to leave SGH and return to DPOW or another hospital?

As soon as it is clinically safe to do so. This will vary from patient to patient and for **most** patients will be up to 72 hours after admission to hospital; in a small number of cases a patient may have to stay on the hyperacute stroke unit for more than 72 hours.

Questions about resources

18. How many more staff have been recruited due to the changes?

NLAG has recruited nine more registered nurses and one more healthcare assistant at SGH and some staff will be working across both SGH and DPOW.

19. Will some DPOW staff move over to SGH?

All staff are being given the opportunity to rotate through the hyperacute unit at SGH and some staff have changed their working patterns so that they are doing some sessions at DPOW and some at SGH.

20. How likely is it that the changes will result in a skills drain from DPOW with staff preferring to work in Scunthorpe?

This is not indicated so far; none of the DPOW nurses applied for any of the advertised jobs on the Scunthorpe stroke unit. The DPOW stroke unit has undergone some significant changes in recent months and the team there is very keen to provide a high quality service.

21. How many beds will there be in the SGH unit? How many hyperacute beds did there used to be across both sites?

There will be 21 beds in total at SGH; six of these will be for hyperacute stroke patients and the other 15 beds are for stroke patients who are no longer in need of hyperacute care but do still need to be in hospital. Previously there were four hyperacute beds across the two sites (two beds on each site).

22. How many consultants and nurses will there be at the SGH unit?

There will be two dedicated stroke consultants at SGH with the 24/7 thrombolysis provided by six consultants. There will be 29 registered nurses and 11 healthcare assistants.

23. Will the SGH unit be able to cope with demand?

We are confident that the unit will cope with the demand. We are increasing the number of hyperacute beds to six and have used the opportunity to revise policies and procedures and communication of them to ensure that patients are seen as quickly as possible and transferred back to the appropriate bed as soon as clinically safe to do so.

24. Is access to an MRI scanner at Scunthorpe guaranteed on a 24/7 basis?

Yes.

25. How will staff cope with the extra demand for scans on the SGH site?

Appropriate imaging for stroke patients is achieved using a CT head scan – these scans are available 24/7 at both SGH and DPOW. We will carefully monitor the new demand at the SGH site and understand if access to one CT is adequate to provide this service. Should a contingency plan be required, there is a second CT scanner available on the SGH site that could be used to support access to timely diagnostics.

26. If the patient is diagnosed with heamorrhagic transformation, following repatriation, will the patient be readmitted to SGH for hyper acute care, even though they wouldn't be appropriate for thrombolysation?

As haemorrhagic transformation post tPA happens mostly in the first 24 hours, the patient will spend that time at SGH as a second event needs to be treated in a hyperacute unit.

27. What service exactly will still be provided at DPOW?

An acute care and rehabilitation stroke service will continue to be provided at DPOW (the full range of stroke care that is given after the hyperacute). There are 17 beds on the stroke unit at DPOW, which is open 24/7.

28. Will the CT scanner and MRI scanner at DPOW still be used to diagnose stroke patients?

No – patients suspected of having a stroke will be transferred to the hyperacute site at SGH.

29. Has there been a reduction in the number of stroke beds at DPOW?

There has been an overall increase in the number of beds across the two sites. The two hyperacute stroke beds at DPOW have moved to the SGH site and an additional two hyperacute beds are being added, taking the total from four to six. There will be 21 beds in total at SGH.
An acute care and rehabilitation stroke service will continue to be provided at DPOW (the full range of stroke care that is given after the hyperacute). There are 17 beds on the stroke unit at DPOW, which is open 24/7.

Questions about the decision

30. Why was the decision made to consolidate 24/7 hyperacute services on one site and why SGH?

- The request from the Northern Lincolnshire Mortality Action Group and the Keogh review to address concerns with the DPOW stroke service.
- The static mortality position in DPOW and the improving mortality position in SGH.
- The recognition that the population size of Northern Lincolnshire would never be sufficient to sustain two hyperacute units.
- The difficulties DPOW were facing in recruiting and retaining nurses on the stroke unit (work was ongoing with the stroke unit team to address issues relating to leadership and culture).
- The bed number at DPOW had been temporarily reduced due to the lack of nursing staff.
- The availability of trained resources for thrombolysis both now and in the future.
- The availability of a back-up CT machine at SGH.

31. Did you assess the risks of having just one hyperacute service?

The following risks were recognised:

- Increased travel times for some patients – this was deemed a lesser risk than the inequity in access between days of the week and that even if resources or ability to recruit staff were not barriers it was deemed better for patients to be able to have access to thrombolysis at all times even if this meant travelling further.
- Ability to recruit and retain staff for the hyper acute service – while it was recognised that recruitment of staff is an issue at both sites, there are more challenges in recruitment and retention at DPOW
- Changes to the hyper acute element of the service may not alone result in an improved mortality position – continued work on recruitment, training &

development, leadership and work with community and primary care colleagues is needed in both NL & NEL.
- Loss of activity from the Trust – it was recognised that patients will be taken to the nearest hyper acute site which would not equate to a complete transfer of activity from DPOW being taken to SGH.

32. Why weren't the public consulted on this decision?

There's no requirement for the Trust to consult on temporary decisions made in the interests of patient safety, and ultimately the Keogh review expected swift action. It is regrettable that the Trust did not have time to better involve local stakeholders and members of the public or provide more information about what was happening at that point in time. However, people will be able to get involved in the longer-term plans for stroke services in the area.

33. Why can't DPOW have a 24/7 hyper acute service as well as SGH?

The size of the population in Northern Lincolnshire (320,000) means there are not enough patients who will need thrombolysis going through the service to maintain the skills of the staff nor the resources available to sustain two hyperacute units. This is the same as the national picture where reviews of stroke services have already been undertaken and changes made to centralise hyper acute units to maximise outcomes for a greater number of patients. Residents across the patch will benefit from having a 24/7 stroke unit closer to their homes than before.

34. Why was DPOW not considered as the site for the consolidated 24/7 hyper acute service?

The mortality position and general performance at the SGH stroke unit was significantly stronger than at DPOW, and the there are two CT machines at SGH.

35. When will the changes be implemented?

The changes are being implemented from Monday November 4, 2013.

36. Are the changes really temporary or will they become permanent?

This was a decision taken by the Trust on grounds of patient safety, following the Keogh review which asked for action to be taken quickly, and the Trust is only able to make such decisions on a temporary basis.

37. What will happen in the long term to stroke services in Northern Lincolnshire?

There are two pieces of work taking place that will decide the long-term future of stroke services in our area. One is the Healthy Lives, Healthy Futures review being led by North Lincolnshire and North East Lincolnshire commissioners, the other is a regional review of stroke services across Yorkshire and the Humber. We expect that, following public consultation on both of these reviews, a decision will be made

regarding how many hyperacute 24/7 stroke units there will be in the wider region, and where exactly these will be located. Until now there have been five in our region: Hull, York, Scarborough, Scunthorpe and Grimsby.
Visit the Healthy Lives, Healthy Futures website for more information on the local healthcare review www.healthyliveshealthyfutures.nhs.uk

Other questions

38. How many patients were diagnosed with stroke at DPOW last year?

There were 369 diagnosed strokes at DPOW in 2012.

39. Do these changes affect Goole patients in any way?

Patients in the East Riding may benefit from having an alternative 24/7 hyperacute stroke service at SGH which in some cases may be quicker to reach than the one provided at Hull.

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