The shape of things to come

Implementation and transition assurance
Stroke

Appendix 7b
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1 Introduction

This paper sets out the Healthcare for London stroke project board’s assurance that the implementation of the preferred configuration (eight hyper-acute stroke units and 21 stroke units and transient ischaemic attack (TIA) services, together with three stroke units with TIA services in north east London), as set out in the consultation The shape of things to come is deliverable. This paper also outlines arrangements which have been agreed to enable smooth transition.

2 Executive summary

The acute part of the proposed new stroke pathway is deliverable. However, support will need to be provided in the following areas:

a) specific support for a small number of providers;
b) support for recruitment;
c) support for development of community based rehabilitation and long term care services in many Primary Care Trusts.

These areas will need to be closely monitored.

Assurance is given that a robust process is in place which will enable implementation of the preferred option of HASUs, SUs and TIA services. The most significant risks to implementation are recruitment of sufficient workforce, transfer of patients following their SU stay and the development of HASU capacity in south east London. Mitigation plans are in place to address the workforce and transfer risks on a local and pan-London basis and actions are also being taken to mitigate against the risks regarding HASU capacity in the south east. Transition plans have been agreed and phased introduction of new services will commence from October 2009 with opening of new-style stroke units.

The amount of activity expected by providers has been carefully forecast to ensure appropriate capacity is in place across London and locally.

Each of the London cardiac and stroke networks has provided assurance that implementation of the proposals is possible for the providers in their sector and they are actively managing risks associated with implementation. Special attention has been paid to providers whose bids did not meet the bid overview requirements and that commissioners agreed would require intensive and sustained support. In north east London where a provider review is taking place, existing SUs will be confirmed at the time of the JCPCT decision, subject to possible amendment in the light of the results of the provider review.

The need to improve community based rehabilitation and long term care has been consistently raised and will be addressed by individual PCTs. The provision of sufficient workforce has also been raised by all the networks and this is being addressed on a local and pan-London level.

London Ambulance Service plans for transition and full implementation of the new acute service have been created and Healthcare for London is assured that they are deliverable.
Work has been carried out to develop pan-London protocols on a range of patient pathways to ensure consistency and equity of access across London.

Patients from outside London who have strokes in the capital have been taken into consideration when capacity planning. Meetings are taking place to engage with the health community outside London to ensure effective cross border working arrangements are in place.

The agreed introduction of HASU and SU services has been planned using a phased approach, based on agreed transition principles. This is particularly important for HASU providers which have not provided HASU-type services previously, and in order to support the step change in provision of services and recruitment of adequate staffing. New-style stroke unit capacity is planned to commence opening on 1 October 2009 and is planned to be in place before opening HASU capacity so that patients can be transferred to an appropriate SU.

Six of the eight HASUs are planning to begin to provide HASU-type services for their existing local catchment until 1 February 2010, when they will open an expanded service. On 6 April those six providers plan to open their full HASU capacity. All FAST positive patients will continue to be conveyed to Queen’s by emergency ambulance and it plans to open HASU capacity from April 2010. Princess Royal University Hospital (PRUH) plans to open limited HASU capacity from 1 February 2010, completing opening of capacity for all patients by summer 2011.

A London tariff has been developed to support the new model of care and incentivise providers to meet the quality standards. Providers will be expected to have reached all the standards by 18 months after ‘go-live’.

3 Scope

This paper sets out assurance that the sites which are in the preferred option for designation as HASUs, SUs and TIA services have robust plans in place for bringing those services into being on a phased basis. It also gives assurance that the plans that the London Ambulance Service has constructed will support phased roll out and final implementation.

This paper does not provide information that informs any decision between provider units. If the JCPCT opts for a decision in favour of the preferred option, this paper provides assurance that this option is deliverable and plans are in place to support its implementation. If the JCPCT opts for a decision other than the preferred option, this paper does not provide such an assurance, but does not suggest that alternatives would not be just as deliverable once similar implementation and transition plans had been developed.

Stroke prevention (other than that which is provided by TIA services), community based rehabilitation and long term care services are outside the scope of this paper, although comment is made regarding the provision of community based rehabilitation and long term care.

The implementation of the acute part of the London stroke strategy, which commences with the designation of HASUs, SUs and TIA services, will provide a step change in the quality of stroke services received by Londoners. Robust governance arrangements are in place to ensure continued delivery of high quality stroke services in the event of any future change to the provider landscape.
The consequences of the north east London provider review on the plans for designation of stroke units in that sector is detailed under section 4.4.

4 Assurance

4.1 Assurance of providers’ implementation plans

Each of the London cardiac and stroke networks have reviewed and assured all the provider plans they have received a short commentary from each network is detailed in the following sections. The networks will continue to monitor progress and support units as required to ensure implementation takes place as planned.

A number of sites which did not satisfy the independent clinical panel’s assessment of bids (scoring two or below out of five) were selected by commissioners for the preferred option. Commissioners agreed that additional support would need to be in place to drive the development of these services. The following sections detail these providers, the support which they have received in the planning process, and the support which they will continue to receive throughout transition and beyond as appropriate.

4.2 North west London

North west London service providers have shown they can plan to deliver a service to achieve the new London performance standards within the Healthcare for London suggested time periods. They have shown they are aware of the major risks to the project, including workforce provision, recruitment timeframes, requirements for ward remodelling, the effect of decommissioned sites and the requirement of standardised local/pan London protocols.

North West London Cardiac and Stroke Network has been assured by the providers that appropriate planning has occurred to detail the workforce and other resources required to reach the new London performance standards.

All providers’ plans have been externally reviewed by both the network project team and a clinical stroke specialist. Feedback has been issued and incorporated to increase the robustness of the plans.

Should Charing Cross hospital be designated as a hyper-acute stroke unit and St Mary’s hospital be designated as a major trauma centre, a plan would be developed to realise the benefits of future colocation on the St Mary’s site. This would be the responsibility of the relevant commissioners and Imperial Healthcare NHS Trust which runs both St Mary’s and Charing Cross hospitals. Clinical standards of these services would need to be at least the same, if not higher, than the current proposed configuration. All planning and associated decision-making processes would be informed by appropriate stakeholder engagement.

4.2.1 Providers not meeting the bid overview requirement

The network is able to provide assurance that the plans for the West Middlesex hospital TIA service are compliant with the Healthcare for London standards.
4.2.2 Stroke unit capacity

The JCPCT is recommended to approve stroke unit facilities serving north west London at Charing Cross hospital, Chelsea and Westminster hospital, Northwick Park hospital, St Mary’s hospital, Hillingdon hospital and West Middlesex hospital.

However, during the course of the consultation it has become apparent that stroke unit capacity is required above that originally planned. Whilst this could be provided by the above hospitals, a review will be carried out to assure commissioners that this is optimal and sustainable. It is possible that this review will recommend the commissioning of stroke unit capacity at an additional site beyond those listed above. Such a recommendation would need, necessarily, to be in line with the outcomes of the ongoing review of acute services. Appropriate engagement and consultation process will be observed as necessary.

4.3 North central London

North Central London Cardiac and Stroke Network is able to provide assurance that provider plans of proposed HASU, SU and TIA services are deliverable within the timeframes stated in the plans. Any risks to deliverability are stated within the detailed provider plan templates together with plans to mitigate against those risks. These cover workforce, skills and training, infrastructure, finance, patient/carer involvement and information and linkages (rotation, network and research).

4.4 North east London

Royal London and Queen’s hospitals were included as part of the Healthcare for London consultation. However, the remaining stroke units in north east London: Whipps Cross, Homerton and Newham were not part of the consultation due to the north east London review of acute services taking place.

The Cardiac and Stroke Network in North East London is recommending that there should be no change to the location of stroke units in the sector. Stroke units will therefore continue to be provided at Whipps Cross, Homerton and Newham, and these hospitals will be required to meet the standards set out by Healthcare for London. The bid from Newham hospital did not meet the bid overview requirement, however the sector recommend continuing to commission stroke services from Newham hospital to ensure that appropriate local access and sufficient capacity is available. This would not be possible without providing stroke care at Newham. The network has reviewed and assured plans for implementation at all of these hospitals. No further public consultation needs to take place because this does not represent a change from the current configuration of services.

King George’s hospital does not currently admit acute stroke patients and is not needed to provide access or capacity.

If following the review of acute services there is an emerging view that the role of certain hospitals should change substantially, then this will be consulted on locally, and plans for stroke care would be part of that consultation.

North East London Cardiac and Stroke Network is able to provide assurance that the HASU providers in the preferred option and SUs at Whipps Cross, Homerton and Newham have robust plans to provide services.
4.4.1 Providers not meeting the bid overview requirement

The network is confident in assuring that Queen’s hospital would be able to open HASU, SU and TIA services as it has demonstrated that it can produce robust plans, which have been externally reviewed by a number of senior stroke specialists. The Royal London hospital has been providing clinical support. A new clinical lead and stroke matron are in post and a consultant level applied health professional is being recruited. Additional project management support on site is being provided by the network to work on implementation.

Queen’s would be supported by North East London Stroke Network team to ensure operational performance is supported and closely monitored throughout the development and implementation of service. More intensive support would be made available if at any point this is deemed necessary. An executive-led process for feedback and management of risk would be implemented to ensure review and interventions are timely and appropriate.

The network can provide assurance that the Royal London has robust plans to provide HASU, SU and TIA services, which comply with the standards and model of care set out by Healthcare for London.

The team at Newham hospital is now working in partnership with the Royal London hospital to ensure that the required standards are achieved at Newham hospital.

4.5 South east London

South East London Cardiac and Stroke Network can provide assurance that the proposed new acute stroke model for London can be implemented across the sector. For HASU provision this is contingent on allowing the PRUH to be developed over a longer period than other HASUs with significant development support from King’s Health Partners throughout the process. Strong collaborative working will need to continue to ensure all units can provide the same level of high quality care.

4.5.1 Providers not meeting the bid overview requirement

The network is able to assure that Princess Royal University Hospital would be able to implement HASU, SU and TIA services. The project is being led by a senior manager within the trust and it is being sponsored by the Chief Executive. A potential package of support has been provisionally agreed with King’s Health Partners. The network is providing on site project management support. St Thomas’ hospital will be providing some transitional capacity in the south east sector until summer 2011 at the latest, when services will be fully up and running at PRUH.

During this period of transition, a small number of patients will experience a journey time of more than 30 minutes. For this reason, sufficient beds will be opened a PRUH to ensure that all patients can be conveyed within 30 minutes as soon as possible.

4.6 South west London

South West London Cardiac and Stroke Network can provide assurance that the proposed new acute stroke model for London can be implemented across the sector. The sector has a good track record in delivering stroke care, evidenced by the south west London pilot and the latest sentinel audit results. Strong collaborative working will need to continue to ensure all units can provide the same level of high quality care.
4.6.1 Providers not meeting the bid overview requirement

The network is able to give assurance that St Helier will be able to deliver high quality stroke unit services in the timeframe planned.

4.7 Key London-wide risks

4.7.1 Workforce

All networks have highlighted gaining sufficient workforce to meet the standards as a risk, because all potential providers will be recruiting at the same time for a significant number of staff. Although, as set out in the workforce assurance paper, it is possible to provide supply from the London pool, for many providers, notably Queen’s and Princess Royal, this poses a significant challenge. This is due to a step change in number of staff required, combined with the fact that these hospitals are in less popular locations according to historic recruitment trends, and that they do not currently have a reputation for providing high-quality stroke services. For this reason, a pan-London workforce group, chaired by the interim Stroke Clinical Director, with representatives from NHS London’s People and Organisational Development Directorate, London cardiac and stroke networks and Healthcare for London, has been set up to create a pan-London workforce plan. The plan will identify actions to supplement and support local recruitment activity and put them in place, working in conjunction with trusts, colleges, professional associations and the London Deanery.

The actions identified include:

1. Making stroke a more attractive option, which involves completion of work on stroke competencies, developing a career pathway and developing education and training;
2. Marketing working in stroke services: proposals include recruitment fairs and adverts and editorials in professional media;
3. Pan-London recruitment activity, including return to practice, national and international advertising and profession-specific recruitment in conjunction with the professional bodies as appropriate;
4. Filling the medical staff gap in the short and long term.

4.7.2 Community based rehabilitation and long term care

All of the stroke networks have highlighted issues with community based rehabilitation and long term care for patients, citing risks from inadequate capacity within onward services including community teams that would facilitate timely discharge.

The recommended introduction of HASUs and SUs, as laid out in the acute stroke strategy, is expected to positively change the outcome of people who have had a stroke. It is expected that there will be an increased number of people having mild disability or limited therapy needs and that there will be fewer people who die following a stroke. The impact of this decrease in mortality will mean that the number and profile of patients requiring rehabilitation and community stroke services may be expected to stay broadly similar. No study has prospectively looked at the issue of how hyper-acute care modifies therapy input; however, it is clear that thrombolysis increases the number of patients with a good outcome and it is very likely that hyper-acute care per se has a similar effect.
It is the responsibility of individual PCTs to ensure that sufficient community based rehabilitation and long term care services are provided. The networks have assessed the current provision.

The sentinel audit shows an improving trend with three units having access to early supported discharge in 2006 and this increasing to nine units in 2008, and 13 units having a specialist community rehabilitation team in 2006 and this number rising to 23 in 2008.

The publication of the National Stroke Strategy motivates the development of the community based rehabilitation and long term care services and progress can be seen across London. For example, Tower Hamlets PCT’s specialist posts work across care settings and Health and Social Care to provide an integrated approach to community service delivery; Camden PCT's carer and family community support worker operates an in-reach service; and Greenwich PCT has commissioned Carers UK to provide support to primary care to increase referral and assessment for carers.

Healthcare for London is drawing on the model of care outlined in the National Stroke Strategy and on good practice from across London's PCTs to inform the commissioning guidance being produced in the autumn of 2009 (see stroke whole pathway paper for further details).

4.8 London Ambulance Service

4.8.1 Plans

All relevant staff are already trained in recognition of stroke (FAST) as it is delivered as part of paramedic training. Changes to the call prioritisation to ensure that all FAST positive patients whose onset of symptoms have occurred within two hours are treated as category A have taken place.

Eighty per cent of patients who are assessed by ambulance crews as being FAST positive have had a stroke. ROSIER, which is an alternative method of stroke recognition, is currently being trialled by ambulance crews in north east London and may be rolled out across London in place of FAST.

The London Ambulance Service are planning for delivery of increased job cycle times as a result of increased journey times whilst continuing to deliver targets for the rest of the population. It has modelled the impact of this and secured initial funding for extra staff and vehicles. It will be working with commissioners to confirm funding.

Although high-level plans have been agreed on a pan-London basis, detailed plans for transitional implementation and full implementation will be agreed locally late in 2009.

Plans for communication with staff will be agreed with the stroke networks, understanding that the key to a successful transition and full rollout for the London Ambulance Service is good communication with crews. In addition, a plan for development of internal communications to ensure that all internal stakeholders are aware of the changes in stroke care has been locally agreed.

The London Ambulance Service has been closely involved in transition planning to ensure that changing patient flows can be managed and that individual units are not destabilised by decisions taken by ambulance crews on the ground.

1 Only some patients who are FAST positive but who have not suffered a stroke are admitted because clinicians at the hospital are able to diagnose their condition before admission.
4.8.2 Delivery of response times

The catchments for HASUs as determined by modelling undertaken by Healthcare for London have been reconciled with London Ambulance Service blue light journey times to ensure that all patients are within 30 minutes of the HASU they will be conveyed to. However, this may not be their nearest HASU.

4.9 Pathways

A working group was established to develop pan-London guidance for local protocols on a range of patient pathways, to ensure consistency and equity of access across London. The North East London Cardiac and Stroke Network coordinated this piece of work, which is chaired by the South West London Cardiac and Stroke Network lead clinician, Dr Geoffrey Cloud.

This guidance governs local development of protocols for the patient pathways outlined below:

1. Protocol for transfer from HASU to SU;
2. Protocols for SU to community transfers;
3. Protocol for transfer of mimics when diagnosis not stroke;
4. Protocol for managing strokes occurring in in-patients (including pre-operative stroke);
5. Protocol for managing possible stroke patients presenting at a non-HASU A&E;
6. Protocol for TIA referral pathways;
7. Protocol for 24/7 neuroradiology access;
8. Protocol for neurosurgery referrals;

Work is being undertaken to put these and any local protocols which are developed in place by ‘go-live’.

4.10 Patients from outside London

Patients from outside London currently account for approximately 10% of stroke activity at London hospitals. Patients will be both visitors to London, including commuters, and people who live close to the county boundary and for whom a London hospital is their nearest hospital.

Capacity planning for the new London stroke system has assumed that London will continue to provide stroke care for the same number of patients from outside London as has been the case in recent years. While it could be argued that more patients may be brought to London if HASU care is seen as superior, it could also be argued that as HASUs would now be more distant for some non-Londoners who live near the county boundaries than other units providing stroke care within their own county this may reduce cross-boundary flows. Both positions would however be speculative and in the face of this uncertainty neither has been factored in to the modelling.

HASU capacity has been planned to ensure sufficient capacity to provide hyper-acute care to all non-Londoners admitted with a stroke. SU capacity has also been planned to give sufficient capacity for non-Londoners assuming transfer to their local hospital or home at the same time after stroke as has been seen historically.

As part of implementation planning, meetings are being undertaken with neighbouring Strategic Health Authorities and stroke networks to ensure effective
cross border working arrangements are in place, especially in understanding the impact on ambulance providers; promoting dialogue and joint working where models of care are different; ensuring effective repatriation processes for non-Londoners returning to a stroke unit outside London following an admission to a HASU and the new London stroke tariff.

4.11 Capacity planning

Healthcare for London has forecast that London needs 132 HASU beds and 598 SU beds. Beds have been allocated by agreement between Healthcare for London, the stroke networks and providers to ensure sufficient capacity to meet population need.

Please see section 5.2.2 of finance and commissioning assurance paper for further details on the factors considered when calculating the number of beds which need to be provided.

As set out in the consultation, patients will be transferred to an SU close to their home, which may be the SU attached to the HASU they were originally admitted to. The legal definition of choice does not apply to the acute part of the new stroke pathway, although patients may express their preference for which SU they would like to be transferred to, for example one close to relatives, rather than their own home, which will be taken into consideration.

4.12 Transition

The introduction of new stroke services has been planned using a phased approach, based on agreed transition principles. This is particularly important for HASUs which have not provided HASU-type services previously in order to support the step change in provision of services and recruitment of adequate staffing.

4.12.1 Stroke units

Full stroke unit capacity will be in place before expanding HASU bed numbers in order that patients can be transferred to an appropriate local stroke unit. Stroke unit opening is planned to commence in October 2009 and full new stoke unit capacity is planned to be available from the end of January 2010. During this time beds will continue to be provided in units to be decommissioned in order to maintain the number of beds required across London until they are no longer needed or until 6 April 2010 at the latest.

4.12.2 Hyper-acute stroke units

Opening of hyper-acute beds is planned to take place in phases. Development of services at Queens, Romford and Princess Royal University Hospital (PRUH), Bromley will take longer. It is proposed that in addition to the HASUs in the preferred option, additional transitional capacity for south east London is provided by St Thomas’.

Until 1 February 2010: All patients will continue to go to their existing acute stroke provider. Northwick Park HASU will develop a thrombolysis service for their existing local catchment. Charing Cross, University College Hospital, The Royal London, Kings and St George’s will continue to provide thrombolysis and hyper-acute care as now.
From 1 February: The rollout of HASU bed capacity will commence with all HASUs (except Queens and PRUH) opening enough capacity for all patients potentially eligible for thrombolysis in their new catchment. All patients who are not eligible for thrombolysis will continue to go to their usual acute stroke care provider.

From 6 April: All HASUs (except Queens and PRUH) will open full HASU capacity for all patients in their new catchment. Queens will begin to provide thrombolysis as appropriate from April 2010 and gradually increase its HASU capacity until full capacity is reached in October 2010.

From October 2010: PRUH will begin to provide thrombolysis as appropriate and gradually increase its HASU capacity until full capacity is reached by summer 2011 at the latest, at which time transitional capacity at St Thomas’ will no longer be required.

4.12.3 TIA services

Until new TIA services are established, existing pathways of care will be maintained. The TIA service ‘go-live’ date is synchronised with SU opening as some high risk TIA patients will need to be admitted to an SU.

Once implementation is complete, all Londoners will be within a 30 minute ambulance journey from a HASU. Longer journey times may be experienced while HASUs are increasing the number of beds they are providing. While there are internal measures that designated providers must take to ensure that they build in systems of work and operational flexibility to deal with normal variation in demand for services, Healthcare for London is working with the London Ambulance Service and others to ensure that variation in demand is addressed across the capital.

There is the possibility of using the existing emergency bed service system to manage this, or to develop a cross-network bed management function based on the system currently used nationwide for ITU beds. Such a solution would ensure that HASU capacity across London was available in real time to allow the flow of stroke patients to be managed.

4.12.4 Tariff

Providers will be able to claim the uplifted tariff once they open the new service. This will not be before 1 October 2009 for SUs and not before 1 February 2010 for HASUs. See section 5.3.2 of the finance and commissioning assurance paper for a description of the phasing of PCT costs.

4.13 Transition of units to ‘gold standard’

Before bidding to provide services commenced, it was recognised that the proposed acute stroke service providers may not currently have the entire infrastructure in place to meet all of the criteria by ‘go live’\(^2\). Therefore providers will have a period of up to 18 months after the ‘go live’ date to complete their implementation plans to deliver all criteria, thus achieving a gold standard HASU service. In accordance with this staged implementation approach, each criterion was graded according to when it is to be met, as follows:

\(^2\) These criteria can be found at [http://www.healthcareforlondon.nhs.uk/stroke-project-documentation/](http://www.healthcareforlondon.nhs.uk/stroke-project-documentation/)
Transition of units to ‘gold standard’
A Criteria must be implemented by ‘go live’
B Criteria must be implemented by six months from ‘go live’
C Criteria must be implemented by 12 months from ‘go live’
D Criteria must be implemented by 18 months from ‘go live’

These criteria include performance standards which providers are expected to deliver by April 2011.

During the planning process, it has become apparent that providers have to invest a great deal in order to meet the A criteria and so it has been agreed that the A criteria should be split and the uplifted tariff should be split in order to encourage and reward providers on their journey to reaching all of the A criteria, whilst funding provider costs fairly.

If providers do not continue to meet the criteria, or are not able to meet B, C, and D standards at the appropriate time, some of the uplift they received will be withheld until they are able to demonstrate that they meet the criteria.

Performance monitoring and management is being developed in conjunction with the networks and sector acute commissioning units.

Full tariff is payable for TIA as soon as the service is able to meet Healthcare for London criteria.

4.14 Contingency planning

The Healthcare for London stroke project board, which recently recast its membership to focus on implementation, will continue to meet on a monthly basis. It will receive monthly highlight, exception, risk and issue reports from each network.
The stroke project board will undertake a formal review of readiness to proceed before each key step on the critical path.

Emergency planning for HASUs, SUs and TIA services in case of serious incident will take place in line with national and local best practice guidelines.

5 Conclusion

Each of the five London cardiac and stroke networks have assured that HASUs, SUs and TIA services can be implemented by all the sites in the preferred option. Assurance has also been given for the recommended sites of stroke unit and TIA services in north east London. The London Ambulance Service has set out plans to support implementation.

Some caveats to this assurance exist, chiefly workforce and community based rehabilitation for patients following their SU stay.

There are significant workforce requirements across London, which workforce specialists at NHS London have assured will be possible to meet. However, there are some concerns that although it is a new pathway and, as such, should be attractive, there will be difficulty for some providers in recruiting staff to the timescales set out in plans. As a result, Healthcare for London has initiated a London-wide workforce plan.

Due to the variability of provision of community based rehabilitation and long term care services, the networks have highlighted that there is a risk that there will be no services for units to discharge to in the community. It is the responsibility of individual PCTs to ensure that these services are provided. Work is ongoing both on a network level and a pan-London level with PCTs regarding provision of these services.

Transition plans have been agreed and phased introduction of HASUs and SUs are planned to commence from October 2009.