Health Scrutiny Panel

17 July 2014

Time 2.00 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue Committee Room 3 - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Chair Cllr Claire Darke (Lab)
Vice-chair Cllr Zahid Shah (Con)

Labour	Conservative	Liberal Democrat
Cllr Milkinderpal Jaspal	Cllr Paul Singh	
Cllr Bert Turner		
Cllr Greg Brackenridge		
Cllr Jasbir Jaspal		
Cllr Peter O'Neill		
Cllr Daniel Warren		

Quorum for this meeting is two Councillors.

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**

2 **Declarations of Interest**

3 **Minutes of the previous meeting (10.6.14)** (Pages 1 - 8)
[For approval]

4 **Matters arising**
[To consider any matters arising from the minutes of the previous meeting]

DISCUSSION ITEMS

5 **Mental Health Strategy - Black Country Partnership NHS FT** (Pages 9 - 12)
[To note the recommendations of the review of the Adult Mental Health Strategy for Wolverhampton, which seek to make improvements to mental health services utilising existing resources. To note that the recommendations from the review do not constitute a substantial variation in service delivery and therefore statutory consultation is not required. To request the presentation of the new 0 to 25 care pathways and the commissioners' approach to funding these in the Autumn of 2014. These pathways present a very different way of providing services and therefore Scrutiny will want to consider the level of consultation. At a later date (Winter 2014 / Spring 2015), consider whether commissioners' plans to reduce pressure on mental health bed occupancy are robust as part of the Better Care Fund Mental Health Re-ablement Project]

John Campbell
Chief Operating Officer
Black Country Partnership NHS FT

6 **Hyper Acute Stroke Services - Sandwell & West Birmingham CCG** (Pages 13 - 98)
[To review the update of the Birmingham, Solihull and Black Country Stroke reconfiguration programme]

Kathryn Meredith

7 **Provision of elective services by The Royal Wolverhampton NHS Trust at Cannock Chase Hospital - commencement of the public consultation** (Pages 99 - 106)

[To support the proposals set out in the consultation document and to support the consultation and engagement plan.]

The presentation will be led by Dr Jonathan Odum, supported by Maxine Espley and Noreen Dowd

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Health Scrutiny Panel Meeting

Minutes – 27 March 2014

Attendance

Members of the Panel

Cllr Claire Darke (chair)
Cllr Ian Claymore
Cllr Paul Singh
Cllr Susan Constable
Cllr Ian Claymore

Other Councillors

Employees

Earl Piggott-Smith	Scrutiny Officer
Viv Griffin	Assistant Director Community

Other attendees

Charlotte Hall	Deputy Chief Nursing Officer (The Royal Wolverhampton Hospital NHS Trust)
David Loughton	Chief Executive (The Royal Wolverhampton Hospital NHS Trust)
Dee Harris	Wolverhampton Clinical Commissioning Group
Mark Lane	Wolverhampton Clinical Commissioning Group
Jo Kavanagh	West Midlands Ambulance Service
Nick Henry	General Manager, West Midlands Ambulance Service
Dr Johnathan Odum	Medical Director (The Royal Wolverhampton Hospital NHS Trust)
Justine Lewis	Care Quality Commission
Jonathan Potts	Care Quality Commission
Carol Bott	Healthwatch Chief Officer,Healthwatch Wolverhampton

Apologies

Apologies were received from the following Councillors

Cllr Milkinder Jaspal
Cllr Burt Turner

Part 1 – items open to the press and public

Item No.	*Title*	*Action*

2 **Declarations of Interest**

There were no declarations of interest received

3. **Minutes of the meeting 6.2.14**

Resolved

That the minutes of the meeting held on 6 February 2014 be approved as a correct record and signed by the Chair.

Minutes of the meeting 13.3.14

Resolved

That the Chair be delegated authority to approve amendments to the minutes. The following changes were approved by the Chair

Add the following to paragraph (2), page 8 “The Chief Executive is responsible to the Secretary of State and Parliament, and leads a 24 hour service governed by a local unitary board.”

Amend the wording on paragraph (3), page 8 to read “Jeremy Vanes commented on the challenges of working in a politicised environment, in a deprived catchment, with a workforce exceeding 7,000 headcount, delivering complex tertiary services.”

Amend the wording on paragraph (4), page 8 to read “Jeremy Vanes outlined the main responsibilities of the Trust Board and his appointment as Interim Chair following the departure of Richard Harris. Jeremy has been interim chair for nine of the previous 18 months, in two separate spells.”

Amend the wording on paragraph (1), page 9 to read “Jeremy Vanes stated that there had been four Chair’s appointed over an eight year period and there was no single reason linking their decisions to leave, but Richard Harris had served a short-term.”

Amend the wording on paragraph (3), page 3 to read “This included Patient Forums until 2008, after which, responsibility had passed to Local Authority’s to procure LINK and the Health watch. Jeremy Vanes explained the impact of introducing different structures for involving the public in health care provision since the abolition of Community Councils had mixed results in terms of success, but these were national changes that the Trust had always tried to make a success.”

Amend the wording on paragraph (4), page 9 to read “Jeremy Vanes commented on the potential future use of mobile phone technology to engage the public, and particularly young people - for example, the use of the phone to monitor blood pressure levels, which could easily be adapted to harvest feedback on services.”

Amend the wording on paragraph (6), page 9 to read “Jeremy Vanes commented that this situation has the potential to create tension, but considered that powerful management was needed to deal with the hospitals financial problems at the time of David Loughton’s appointment by the then Chair – Professor Mel Chevannnes in 2003/04. Jeremy Vanes while accepting that the article was embarrassing disputed the accuracy of parts of the report and also stated that some of the references relate to events that happened many years ago and were unrelated to the Trust.”

Amend the wording on paragraph (7), page 9 to read “Jeremy Vanes explained the role of the Strategic Health Authority prior to 2013 in appointing Chief Executives. Currently the Governors of a Foundation Trust or the Trust Development Authority now steer these appointments.”

Amend the wording on paragraph (2), page 10 to read “Jeremy Vanes commented on the increase in annual turnover from when David Loughton was first appointed. The turnover had increased to over £400 million for 2014, and is a change from the Trust making annual losses of £6 million per annum in 2007/08 to now achieving a regular surplus above £5 million per annum since 2010.”

Amend the wording on paragraph (4), page 10 to read “Cheryl Etches explained the processes and controls to assess quality impact which have been used by the Trust to deliver annual budget surpluses when funding proposals are submitted for consideration, for example Quality Impact Assessments on any changes that reduce expenditure.”

Amend the wording on paragraph (5), page 10 to read “Jeremy Vanes commented on the impact on the Trust due the issues at Mid Staffordshire Foundation Trust and the potential to deliver care as a result of using the resources at Cannock Hospital to create extra capacity at New Cross, which will reduce waiting times for elective procedures, and enable safe expansion of more emergency medical care.”

Amend the wording on paragraph (6), page 10 to read “Cheryl Etches commented that the area used previously for vascular surgery is now an acute medical ward used for winter pressures activity and it would be difficult to bring the vascular service back.”

Amend the wording on paragraph (7), page 10 to read

1. “Managing the medical research facility hub at the hospital on behalf of 14 health networks. The hospital has been given responsibility to coordinate funding of £27 million to support the research studies for five years.

1. Managing the takeover of Cannock Hospital and the development of services, which was the most suitable option to emerge from the enforced reconfiguration of the failing Mid-Staffordshire Foundation Trust.

2. Preparation for Foundation Trust application and recruiting extra nurses as part of the action plan following the Care Quality Commission Inspection in September 2013.”

Subject to the above amendments the Minutes were duly accepted as a fair and accurate record of the proceedings.

4. **Matters arising**

There were no matter arising from the minutes.

MEETING BUSINESS ITEMS

DECISION ITEMS

5. **West Midlands Ambulance Service – Quality Accounts 2013/14 [Nick Henry, General Manager, West Midlands Ambulance Service]**

Nick Henry outlined the performance of West Midlands Ambulance Service against nationally set standards in terms of response times. Nick Henry commented on the specific work being done to increase resources to improve ambulance response times for Category Red 2 (respond to 75% of calls within 8 minutes) and Green 2 (respond to 90% of calls within 30 minutes).

Nick Henry commented on the very positive working relationship with the staff in emergency department at the Trust to reduce delays in ambulance turnaround times. The working relationship was described as being the best across the West Midlands.

Nick Henry explained the criteria for Wolverhampton Clinical Commissioning Groups issuing fines for delayed patient handovers and the amount of fines issued for the period 1.4.13 – 31.1.14.

Nick Henry commented on work being done to reduce the number of high volume service users to refer people to the appropriate alternative service such as a GP to better manage their care. Nick Henry explained that extra paramedic staff being trained to respond to growing demands on the service following decision to increase funding.

Nick Henry explained that a copy of Quality Accounts was not available to be sent in advance of the meeting, but would be sent to the Panel following the meeting

Jo Kavanagh explained plans for the presentation of the Quality Accounts and that there will be an opportunity to answer any specific questions about the report.

The Panel queried the nature of the public complaints about the service and the work being done to improve the situation. Nick Henry explained that customer services training would deal with the complaint about behaviour. Nick Henry explained that the "other" category for complaints was a catch all group.

The panel queried the impact on performance following the introduction of the Make Ready scheme. Jo Kavanagh explained that the changes had allowed the service to respond more effectively and put more resources to meet peaks in demand. Jo Kavanagh explained the benefits of improved medicine

management, quicker turnaround times, and improved infection control for ambulances following the change.

Resolved:

The Panel welcomed the progress made to improve performance and agreed to receive a further update at a future meeting when the information is available.

The Panel to be sent a copy of the Quality Accounts report when received. — Earl Piggott-Smith

6. **Care Quality Commission - Proposed changes to the inspection and regulation of care services [Jonathan Potts/Justine Lewis, Care Quality Commission]**

Jonathan Potts gave a presentation about the role and responsibilities of the Care Quality Commission and the plans for developing new criteria for assessing the quality of care provided by health organisations. Jonathon Potts explained that the use of performance ratings will lead to improvements in quality of services.

Jonathan Potts explained that a series of 'listening events' are planned to get the views of the public about the new proposed assessment criteria.

Jonathan Potts explained that the new assessment criteria will apply to all services and the focus of the CQC is to 'shine a light' that supports improvements in the quality of care provided.

Jonathan Potts explained the consultation of the new assessment criteria will be completed in October 2014 and the aim is to have a robust system to check compliance against the care standards.

Resolved:

The Panel was supportive of the new proposed assessment criteria to inspect and regulate care services.

7. **Royal Wolverhampton Hospital NHS Trust - Care Quality Commission Chief Inspector of Hospitals inspection – outcome and action plan [Charlotte Hall/David Loughton, The Royal Wolverhampton NHS Trust]**

David Loughton introduced the report and commented that there were no surprises for the hospital following the inspection.

David Loughton commented on the findings of the inspection report which highlighted concerns about staffing levels.

David Loughton explained that the issue of staffing is common of hospitals nationally and there estimated shortfall of 230,000 in nursing staff.

David Loughton commented that it will take 18 months to 2 years to train a nurse and it is difficult to introduce a large number of staff to a unit at the same time – new staff do need to be introduced slowly in order to maintain patient care standards. David Loughton commented that there are 170 vacancies at the hospital which they are working hard to fill.

David Loughton was supportive of the new hospital inspection arrangements but had concerns about whether the teams will have all the necessary skills as there is shortage of the necessary expertise nationally.

Jonathan Potts commented on the similar challenge facing providers of adult care establishments who are also finding it difficult to recruit staff with the necessary skills and experience.

Resolved:

The Panel welcomed the progress made to implement the action plan approved by RWT Trust Board at the meeting on 27 January 2014.

8. **Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17 – Progress Report [Dr Jonathan Odum, Medical Director, The Royal Wolverhampton NHS Trust]**

Dr Jonathan Odum commented on different methods used to consult with the public about the proposed service changes.

Dr Jonathan Odum briefed the Panel on the main message from the public consultation on future for Urgent and Emergency Care Service in Wolverhampton. Dr Jonathan Odum explained that the report has not yet been finalised and the comments from the public were still being assessed.

Dr Jonathan Odum commented that 90 per cent of responses agreed with the proposals. Dr Jonathan Odum explained that there was specific feedback from the public about wanting to have more access to their GPs when they have an urgent problem.

The Panel commented on the commented on the consultation timetable. Charlotte Hall commented that there was support from staff about the planned changes.

David Loughton commented on public complaints about parking problems and concerns about the impact of more people being seen at the hospital when the Urgent Care Centre opens. David Loughton explained that hospital has good bus service, but the public are not willing to use it as an alternative to the care. David Loughton commented that the new car parking facility cost £5 million to build. The car park provides 550 extra hospital car parking spaces – the money spent on the car park could have been used to fund the cost of recruiting 166 extra nurses.

Resolved:

The Panel accepted the following recommendations:

- to approve the methodology used to undertake the consultation about plans for the new Urgent and Emergency Care Centre.

- to support the proposed strategy for Urgent and Emergency Care Centre.

9. **Health Scrutiny Panel Draft Work Programme 2014/15 [Earl Piggott-Smith]**

Earl Piggott-Smith briefed the Panel on a list of possible topics for inclusion in 2014/15 work programme.

Earl Piggott-Smith explained plans for annual health scrutiny event to inform the panel work programme. The event will involve representatives of all key organisations contributing to the discussion. Earl Piggott-Smith explained that details about the event will be sent to the Panel after discussions with Chair and Vice Chair.

Resolved:

The Panel accepted the recommendation to have annual health scrutiny planning event to consider topics for the 2014/15 panel work programme. — Earl Piggott-Smith

The meeting ended at 15:08

Agenda Item No: **5**

Health Scrutiny Panel

17th July 2014

Report title	Update on review of Wolverhampton's Mental Health Strategy
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Well Being
Wards affected	All
Accountable director	Sarah Norman, Community
Originating service	
Accountable employee(s)	Tessa Johnson Scrutiny Officer Tel 01902 554003 Email Tessa.johnson@wolverhampton.gov.uk
Report to be/has been considered by	Black Country Partnership NHS FT Trust Board March 2014 BCPFT Assembly of Governors Meeting April 2014 Wolverhampton CCG Commissioning Committee – April 2014

Recommendation(s) for action or decision:

The Panel is recommended to:

1. Note the recommendations of the review of the Adult Mental Health Strategy for Wolverhampton, which seek to make improvements to mental health services utilising existing resources
2. Note that the recommendations from the review do not constitute a substantial variation in service delivery and therefore statutory consultation is not required
3. Request the presentation of the new 0 to 25 care pathways and the commissioners' approach to funding these in the Autumn of 2014. These pathways present a very different way of providing services and therefore Scrutiny will want to consider the level of consultation.
4. At a later date (Winter 2014 / Spring 2015), consider whether commissioners' plans to reduce pressure on mental health bed occupancy are robust (as part of the Better Care Fund Mental Health Re-ablement Project).

1 Purpose of the Paper

This paper provides the health scrutiny panel with an overview of the review of the Adult Mental Health Strategy 2011 – 2015 which was developed by Wolverhampton City Council and Wolverhampton City PCT. Since taking over services in August 2011, the Black Country Partnership NHS Foundation Trust (BCPFT) was responsible for implementing significant elements of the Strategy. In the Autumn of 2013 it was agreed jointly by Wolverhampton City CCG and BCPFT to commission an independent review of implementation of the Strategy. This was carried out by Rubicon Consulting and the final report was produced in March 2014.

2 Mental Health Strategy Review

2.1 Scope

The purpose of the project was to review the implementation of the 2010 *Wolverhampton City PCT and City Council Adult Mental Health Commissioning Strategy* which covered the period 2011 - 2015.

The terms of reference for the review were to:

- Carry out a 'high level' review of the progress on the strategy;
- Undertake a critical analysis of work undertaken to date – testing whether care pathways are working and identifying gaps / bottlenecks and inefficiencies and whether the most efficient models have been adopted – evaluating for clinical effectiveness, value for money and delivery within timescales;
- Identify areas of improvement in service delivery and outcomes;
- Identify areas of little / no progress;
- Advise on potential solutions utilising national benchmarking comparisons or learning from nationally recognised good practice.

Services for people aged under 18, aged over 65 and/ or with learning disabilities were 'out of scope' (except in relation to transition to/ from adult services).

2.2 Approach

The review was carried out by triangulating information obtained through:

- Interviews with a large number of stakeholders including service users and carers, GPs, commissioners, the voluntary sector and BCPFT staff. In total almost 50 interviews were carried out.
- Assessment and analysis of background papers, and commissioner and trust data sets including benchmarking with national data where possible.

- A review of best practice and examples from elsewhere.

3 Headline Recommendations from the review

The review concluded that funding should not be cut from mental health services but that existing funding could be utilised in better ways to maximise benefits to patients, carers and their families.

Headline recommendations from the review include:

- That the Referral Assessment Service (RAS) should be retained as a 'Single' Point Of Contact (SPOC) into mental health services but that this should be strengthened with medical input. In addition co-locating a Social Worker in the RAS from the Intake Team could lead to a more integrated response to referrals;

- Re-establishment of the crisis resolution / home treatment team to support more effective hospital admission / discharge and respond to urgent referrals.

- Establish a liaison psychiatry service at New Cross Hospital which will support people attending A&E with diagnoses relating to mental health and provide a more responsive service.

- Wolverhampton is in the lowest quartile (along with Sandwell) of mental health beds per population size and there have been significant pressures on beds both locally and also nationally.

- As part of the review it was identified that up to 40% of those patients in adult beds at Penn would be able to be cared for in different environments such as step down and rehabilitation type services. Addressing this issue needs to be a key part of Commissioner plans in relation to the Re-ablement Pathway Project as part of the Better Care Fund. To reduce reliance on hospital beds Scrutiny's oversight of Commissioner plans to tackle this gap in service would be welcome.

- Address service gaps that lead to people having to receive treatment out of area, which impacts on the quality of care they receive. For example, for female patients requiring psychiatric intensive care, they often have to travel significant distances to receive treatment out of area.

- In terms of transitions from children and young people's services (CAMHS) to adult services it is clear that few younger people make this transition. This is reflected nationally not just within Wolverhampton. The Trust is currently working on developing 0 to 25 age group pathways of care in collaboration with Commissioners. Subsequent to completion of these pathways Commissioners need to confirm the pathways they will continue to fund. The funding and implementation of these pathways may be subject to Scrutiny consideration when this is determined in the Autumn 2014.

4 Progress to Date

The Trust and the CCG have separately been working on developing five year plans which were submitted at the end June 2014 to Monitor (FT regulator) and the Local Area Team respectively. The implementation of recommendations from the Rubicon review have been incorporated in the plans for both organisations.

In terms of progress with implementation:

- Initial discussions have taken place in relation to seconding Social Workers from the Intake Team into the RAS;

- A business case is being developed to establish the Liaison Psychiatry service at New Cross under the Better Care Fund initiatives. The aim is to get this service up and running by November 2014, subject to business case approval and suitable accommodation of the Team being available which needs to be adjacent to A&E.

- Re-ablement Project Initiation Document (PID) has been developed by Commissioners (again as part of the Better Care Fund initiatives). This aims to establish a more cohesive set of services within Wolverhampton for re-ablement both to reduce the number of people requiring hospital treatment at Penn but also to support the transfer of low and medium secure patients in their recovery journeys back to the local area.

- The Trust (BCPFT) is developing a business case for a female Psychiatric Intensive Care Unit (PICU) for the whole of the Black Country which would be similar to the male PICU which the Trust developed at the Macarthur Centre in West Bromwich.

- The Trust has undertaken significant work on the development of clinically-led pathways for 0 to 25 years and will be discussing with Commissioners the process by which these new pathways will be commissioned.

Whilst this is positive progress the Trust and Commissioners recognise that progress can be hampered by a lack of project management and implementation capacity to drive change more rapidly. Both parties are looking at ways to enhance capacity to ensure progress is timely.

Authored & presented by: **John Campbell**
Chief Operating Officer
Black Country Partnership NHS Foundation Trust

Agenda Item no **6**

Update on Stroke Reconfiguration Programme
Birmingham, Solihull and Black Country

1. Purpose

To provide an overview of the Birmingham, Solihull and Black Country Stroke reconfiguration Programme. The programme aims to draw together work undertaken to date by the Midlands and East Stroke Review and seeks to understand if there is a need to reconfigure local stroke services to deliver improved patient outcomes.

2. Overview

Stroke is a major cause of death with 40,000 deaths in England; 12,000 in NHS Midlands & East region alone (2009). Over the past few years work has taken place at a national and regional level to improve stroke services. In 2010, the West Midlands Regional Quality Review Service led a review process in co-ordination with the West Midlands Cardiac and Stroke Networks. The purpose of the review was to assess compliance with the WMQRS (West Midlands Quality Review Service) quality standards for acute stroke and Transient Ischaemic Attacks (TIA) and to train future reviewers. The review team included a Stroke Consultant, Stroke Nurse, an Allied Health Professional and members of WMQRS and the Stroke Network. The process consisted of site visits and discussions with a multidisciplinary team. The outputs of the assessment process were used to inform the quality of care that was being delivered by each provider and to assess the capability of providers to deliver 24/7 thrombolysis and other stroke services.

The review process showed that there was significant variation in the quality of care provided across the region. The Midlands and East Strategic Health Authority was still concerned about the model / configuration for stroke services and in January 2012 launched a clinically led comprehensive review of stroke across the region, to identify options that would improve outcomes by improving mortality, reduce chances of long term disability and improve patient experience.

The regional review evidenced a best practice specification that all Hyper Acute Stroke Units (HASUs) should achieve if they are to provide optimum care to patients. HASUs are the specialist departments that deliver care in the first 72 hours post stroke. This best practice centred on the timeliness of response and required 24/7 consultants on call as well as access to rapid scanning and thrombolysis services. This specification recommended that HASUs see a minimum of 600 confirmed stroke patients per year to improve clinical quality, by enabling clinicians to treat enough patients to maintain their skills. National and regional evidence also

indicates that if patients have access to larger units they have a reduced risk of morbidity, reduced chance of long term disability and quicker access to thrombolysis services.

The regional review recognised that strong collaborative work and clear governance arrangements were required to take this work forward at a local level during 2013/14. The seven CCGs in Birmingham, Solihull and the Black Country have now joined together to launch this local review to take forward these regional recommendations.

At the time of the regional review there were six hospital trusts in the conurbation delivering nine Hyper Acute Stroke Units. Since this time a public consultation took place in Sandwell and West Birmingham to configure stroke services at Sandwell General Hospital, resulting in eight HASU sites across the area. There are further plans to move to six sites with Heart of England Foundation Trust, considering moving HASU services from both Solihull and Good Hope hospitals to the Heartland site. This would result in 6 HASU sites across the area.

There is evidence to suggest that changing the specification of the stroke care pathway in Birmingham, Solihull and the Black Country could lead to improved outcomes for patients. This review will consider improvements across the whole stroke patient journey, from prevention to hospital stroke care to rehabilitation services. However, a key part of this review relates to the Hyper Acute Stroke Units. This review seeks to identify if six hyper acute sites is appropriate for the area and if they can deliver the necessary improvements to patient care. Clinical Commissioning Groups are clear that factors including quality of care, workforce, patient experience and access need to be considered. This review will consider these factors to determine the recommended number of HASU sites for the area. No decision has been made, and the review may determine that six sites is the most appropriate configuration for local stroke services.

Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) is leading the Birmingham and Black Country Stroke Reconfiguration Programme on behalf of all seven CCGs. SWB CCG will have overall responsibility for the delivery of the programme and will host the Stroke CCG Programme Board to provide a strategic steer. The decision on the future placement of Hyper Acute and Acute Stroke Units will sit with the individual CCG Governing Bodies; the role of the Programme Board will be to advise and recommend the preferred model for Hyper Acute Stroke Units.

Our aim is for all stroke patients to receive high quality Specialist Consultant support 24/7. Working with clinicians, providers, patients and stakeholders we hope to agree a recommended model (number of HASUs) across the area. This work will need to consider clinical evidence, impact on neighbouring areas and current services.

3. Programme Scope

3.1 Provider and CCG Landscape

The review of stroke services is in relation to the following provider Trusts:

- Birmingham Community Healthcare NHS Trust
- Heart of England NHS Foundation Trust
- Royal Wolverhampton Hospitals NHS Trust
- Sandwell and West Birmingham NHS Trust
- The Dudley Group NHS Foundation Trust
- University Hospitals Birmingham NHS Trust
- Walsall Healthcare NHS Trust
- West Midlands Ambulance Trust

These are respectively commissioned by:

- Birmingham Cross City Clinical Commissioning Group
- Birmingham South Central Clinical Commissioning Group
- Dudley Clinical Commissioning Group
- Sandwell and West Birmingham Clinical Commissioning Group
- Solihull Clinical Commissioning Group
- Walsall Clinical Commissioning Group
- Wolverhampton Clinical Commissioning Group

The population for the programme will require a solution that takes in Birmingham, Solihull and the Black Country. Therefore the work will focus on the:

- Population registered with GPs within the boundaries of the seven CCGs of Birmingham and Black Country (BBC)
- People who live within the seven CCGs boundaries, but who are not registered with a GP
- People who access emergency health care services within Birmingham, Solihull and the Black Country area either on an ad hoc basis, or based upon the traditional referral flow (catchments of acute organisations)

3.2 Clinical scope

The regional Midlands and East best practice service specification divides the pathway into eight phases and specifies the standards to be achieved in each. These are:

- Primary prevention
- Pre-hospital
- Acute phase
    - Hyper-acute stroke unit (HASU) services
    - Acute stroke (ASU) services
    - Transient Ischaemic Attack (TIA) services
    - Tertiary care (i.e vascular and neurology care)
- In-hospital rehabilitation
- Community rehabilitation
- Long term care and support
- Secondary prevention
- End of Life

3.3 Outside Scope

Tertiary care (neuro-surgical referral) and strokes occurring in children are both outside the direct scope of the programme.

4. Programme Outcomes:

The vision for the stroke review is to prioritise stroke care and to develop a clinically driven model for stroke care. The overall aim is to ensure a uniformly high treatment standard for stroke patients, irrespective of where in the Birmingham, Solihull and Black Country area they suffered their stroke. In particular, the Birmingham, Solihull and Black Country stroke review aims to achieve:

- A Reduction in stroke mortality rates
- A Reduction in average length of stay
- A Reduction in stroke re-admissions
- Achievement of 90% of patients able to stay on a dedicated stroke ward
- Increase in the percentage of patients receiving thrombolysis treatment
- Achievement of diagnosis and treatment for high risk TIA within 24hrs
- Increase in the number of patients discharged to their normal place of residency

4.1 High Level Criteria:

In determining the optimum configuration of local stroke services, the CCG will prioritise the below criteria:

a) Quality of Services

Definition: Quality and continuity of care for stroke patients across the pathway. This also covers clinical critical mass which is the minimum throughput of patients to be maintained in order to ensure quality of service. It takes account of the number of patients required for an acute stroke service provider to be clinically effective, based on incidence and population.

Outcome: High standard of quality in the stroke system leading to improved patient outcomes. Regional evidence shows that improving outcomes for patients is dependent on a step-change in the quality and continuity of care across the stroke pathway.

b) Workforce including Innovation and Research & Development

Definition: Providers are able to attract and retain the best healthcare professionals, and invest in them via an accredited training and development programme, as well as rotating staff appropriately across the pathway. This includes delivering quality education and training for staff and continuous improvement through innovation and research.

Outcome: Optimum workforce to support stroke patients

c) Access

Definition: Maximum time taken for a stroke patient to be assessed at the point of arrival and treated within a HASU thereby helping improve quality and reduce health inequalities. Ambulance travel time is not the only consideration, as this criteria will also look at accessibility by public transport, impact on family and carers and patient experience.

Outcome: A stroke patient should be able to access a HASU that delivers access to high quality care. The access heading will also consider access to a HASU within a maximum of 30 minutes (by an ambulance with a blue light), this element will be picked up from West Midlands Ambulance Service returns. Patients and visitors will have access to local ASU and TIA services.

d) Ease of Delivery

Definition: Assess how the acute stroke service provider can improve substantially from current provision. Also covers implementation of infrastructure, capacity and feasibility of acute stroke service providers.

Outcome: Continued quality service to stroke patients.

e) Improved Strategic Fit

Definition: The ability of providers to work effectively with neighbouring providers. Networks will need to provide adequate coverage of the entire Birmingham, Solihull and Black Country population.

Outcome: Optimum service to stroke patients supporting collaborative capability across the Cardiovascular Network, providers, local authorities, voluntary sector and CCGs.

f) Cost and Affordability

Definition: The balance between impact on patient outcomes with the incremental cost of providing the new acute stroke services in a particular configuration. There are many competing priorities in Birmingham, Solihull and Black Country and the financial impact of the proposed changes for stroke must be evaluated against the impact on the overall healthcare system.

Outcome: Affordability of service within the current financial envelope ensuring high quality services can be safely provided.

4.2 Co-ordinating Commissioner Role

SWB CCG in conjunction with the Cardiovascular Network Team, will ensure that specifications for the service reflect the agreed guidelines and protocols developed through the Birmingham, Solihull and Black Country area. SWB CCG will ensure performance management arrangements for the programme are robust; clinical and financial risks are assessed and managed; and that robust and transparent arrangements are in place for the consideration of service developments against agreed priorities. It is important to recognise that the local performance management of services will continue to sit with each individual CCG.

SWB CCG will develop a shared central team to work on behalf of all the CCGs as the accountable bodies, working through the Programme Board, using the under spend identified in Cardiovascular Network resources (2012/13) to support and coordinate the programme for a time limited period (April 2013 up to March 2015).

5. Approach and Next Steps

It is recognised that each of the phases within the services specification will have a number of specific standards to be delivered and so will need to be treated as a specific project, with clear timescales and distinct actions and responsibilities. However it is intended these will all form part of an overall interlinked programme of work, with oversight by the Birmingham, Solihull and Black Country CCG Stroke Programme Board, which will ensure overall connectivity and that an integrated pathway of care is in place.

The programme will be designed into the following project specific strands as follows:

5.1 Hyper Acute Project:

This strand will support an options appraisal for future hyper acute and acute phase sector configuration. It is recognised that this will be complex and will therefore require the most capacity and focus. This phase includes:

- Pre-Hospital Phase
- Hyper-acute stroke services
- Acute stroke services
- TIA services

As above, it is also recognised that the programme will require a solution that takes into account Birmingham, Solihull and the Black Country and also acknowledges other neighbouring health economies.

In addition the review will need to consider the whole patient pathway and the interface between the acute phase and the rehabilitation phase, and the rehabilitation and long term care phases.

5.2 Non Hyper Acute Projects:

This review will consider the whole patient journey, not just Hyper Acute Stroke Units. Working with lead representatives in each CCG and with provider organisations the review seeks to understand current stroke service provision (within other stroke services) against the standards and criteria set out in the regional best practice service specification. The role of the programme team will be to support the gap analysis and recommendations to achieve best practice for the prevention, acute, rehabilitation, community and end of life phases of the pathway.

- Inpatient and Community Rehabilitation Project

- Long Term Care Project
- End of Life Project
- Prevention Framework Project

CCGs should ensure that they can support the evaluation and gap analysis of the above stroke pathway phases and to receive the recommendation from the individual projects. Respective funding for local service change will need to be agreed with each individual CCG and the respective provider.

6. Stages of Reconfiguration:

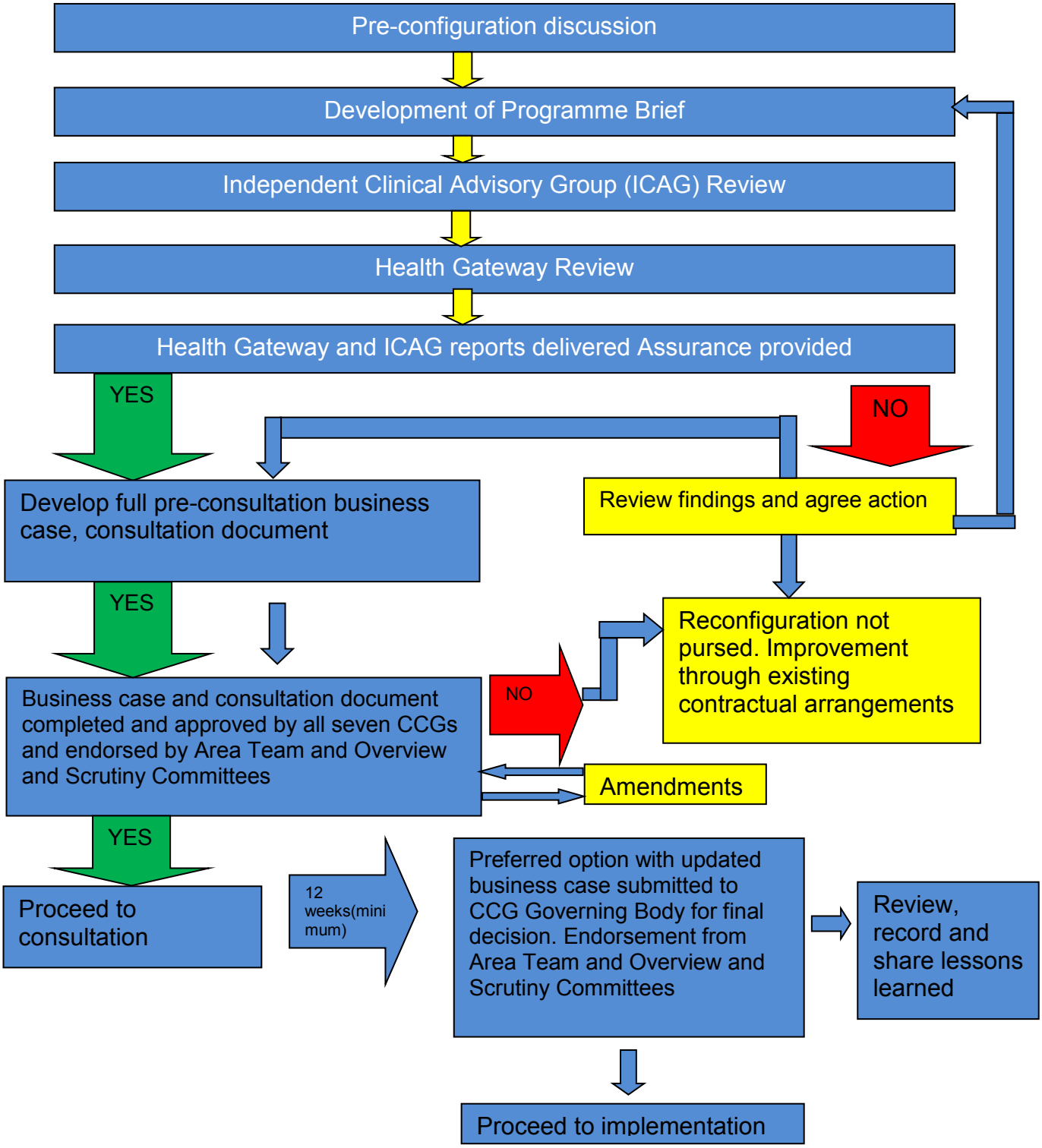
The Birmingham Solihull and Black Country Stroke CCGs will not support the Stroke programme to proceed to the next stage in the reconfiguration scheme without the successful completion of the following three stages of reconfiguration:

The pre-consultation process: including developing a robust clinical case for change and holding extensive dialogue with a wide range of stakeholders including OSCs, Health and Well-Being Boards and Councils, Healthwatch, public representatives, patients, carers, clinicians and NHS staff.

The consultation process: managing the consultation process, producing documentation and ensuring that statutory requirements to consult the public, healthcare professionals and other statutory bodies (including Overview and Scrutiny Committees) are met.

The post-consultation process: decision making process including sign-off with appropriate bodies and managing any subsequent reviews or challenges. Feedback review decisions and rationale to stakeholders.

Stages of Reconfiguration:

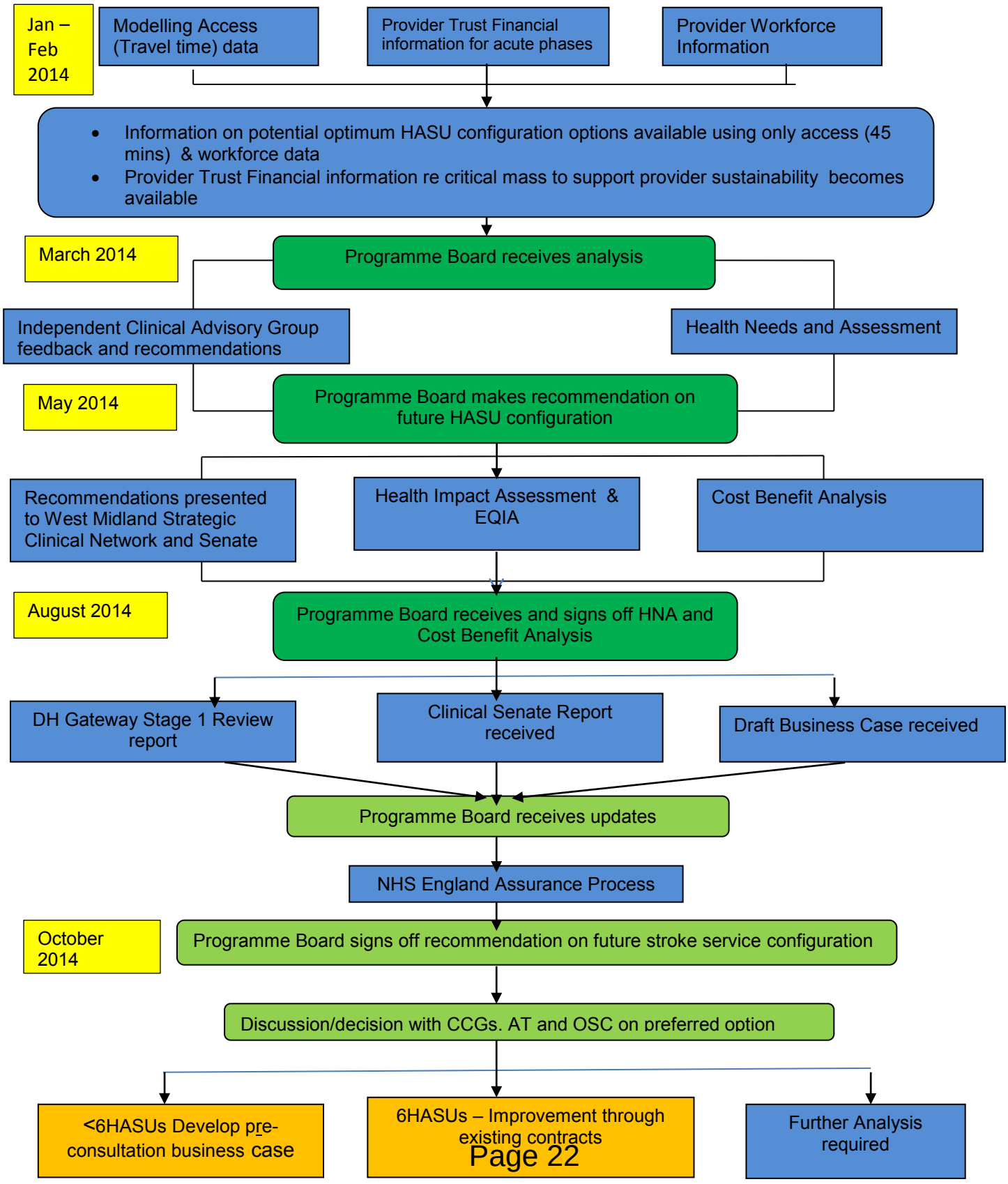


7. Decision Framework

It is anticipated that the Programme Board will reach a recommendation on the future hyper acute service configuration by July/August 2014. The following process will be followed to reach an agreement across key stakeholders:

1.1 Key Decision Points:

January 2014 to October 2014



7.2 High Level Project Milestones

	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14
Scoping	√												
Activity Modelling	√	√	√										
Financial Modelling	√	√	√										
Public Health data	√	√	√	√									
Provider Submissions			√	√									
Independent Expert Advisory Group					√								
Recommendation Programme Board						√							
Recommendations presented to Clinical Network and Senate, Health Impact Assessment and EQIA/ Cost Benefit Analysis completed							√	√					
DH Gateway Report Stage 1, Clinical Senate report received, Draft Business case received									√	√			
Programme Board receives updates									√	√			
NHS England Assurance Process									√	√			
Programme board signs off recommendation on future stroke and discussion/decision with CCGs, Area Team and OSC											√		
Potential Public Consultation if <6 HASUs or if 6 HASUs											√	√	

8. Update on Programme Review Progress:

8.1 Programme Sub Groups

A number of sub groups have been organised to deliver the stroke review, these include:

- Modelling task group (developing options)
- Finance sub group (considering the financial cost of the different options and developing a financial model that support s the patient journey)
- Communications and engagement sub group
- Public Health Sub Group (developing the Health Needs Assessment)
- Local Clinical Advisory Group (advising on Clinical Quality Standards and performance Metrics)
- Independent Clinical Advisory Group (assessing the options to ensure that proposed options meet the clinical quality requirements)

These groups will meet regularly, reporting to the Stroke Programme Board. Ultimately, the decisions will be made by each individual CCG's Governing Body. This Programme Board has been set up to help facilitate work over this large area; however any decisions will be made by each local CCG. This final decision will need to be endorsed by Overview and Scrutiny Committees and the NHS England Area Team leads.

8.3 Patient Advisory Group

A Patient Advisory Group with patient representatives from each of the CCG areas has been established; the first meeting took place on Wednesday 18 December. The Programme will work closely with this group throughout the review to ensure that patient views are at the heart of any commissioning decisions. The Programme will also be carrying out wider patient and stakeholder engagement over the coming months; however this group will meet regularly to help give assurance to the programme board.

8.4 Independent Clinical Advisory Group

An Independent Clinical Advisory Group (ICAG) has been established; chaired by Professor Tony Rudd National Clinical Director for Stroke NHS England. The Group will use the Midland and East service specification as an evidence based best practice specification for the whole stroke pathway, to guide the service in being clear about what needs to be provided to achieve a step change improvement in outcome. The ICAG will support the option appraisal process ensuring

that future HASU options can deliver high quality sustainable services. ICAG has a strong membership, with a combination of national expertise, and experience in the major review and implementation of improvement to stroke services.

9 Recommendations:

The Committee is asked to:

a) Note and endorse the programme scope & approach including governance arrangements, (please refer to programme brief)
b) Note that their primary points of contact are their local commissioners, supported by Sandwell & West Birmingham CCG
c) Note that if consultation is required this will be determined in September 2014; proposals will be subject to a period of formal consultation
d) Advise the programme board on the preferred route of communication

Report compiled by:

Nighat Hussain
Stroke Programme Director

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NHS Midlands and East

NHS Midlands and East

Stroke Services Specification

Version Control

Version No.	Date	Authors/ Editors	To be reviewed by	Status
v1.0	01 June 2012	Tim Lawrence, Laura Dendy	External Expert Advisory Group (EEAG)	1st Draft
v2.0	14 June 2012	Tim Lawrence, Laura Dendy	EEAG, Stroke Network Directors, Project Board	2nd Draft
v2.3	21 June 2012	Tim Lawrence, Laura Dendy	EEAG	3rd Draft
v2.6	22 June 2012	Tony Rudd, Tim Lawrence	Damian Jenkinson	4th Draft
v2.7	25 June 2012	Tim Lawrence, Laura Dendy	EEAG, Stroke Network Clinical Leads	5th Draft
v2.8	28 June 2012	Tim Lawrence	Damian Jenkinson	6th Draft
v3.0	29 June 2012	EEAG	N/A	Final

Version 3.0

1. Introduction and Purpose

1.1 Purpose

The following Service Specification document sets out the criteria,as recommended by the External Expert Advisory Group,that different parts of the stroke pathway needto meet to deliver high quality care to patients and achieve the step change improvement sought by the Midlands and East StrokeReview. These are the expected standards commissioners should adopt when commissioning stroke care services.

This service specification has been developed by the External Expert Advisory Group (EEAG)in consultation with stakeholders, including Stroke Networks, clinical staff working in stroke and other associated services, commissioners and patients and carers who have experienced NHS services. The document aims to build on clinical best practice and provide clarity on the system requirements for stroke services without prescribing the service model to be adopted locally.

1.2 Overview

The National Stroke Strategy (2007) provides the foundation for defining stroke services and outlines what is needed to create the most effective stroke services in England. The strategy identifies major stages in the stroke patient's pathway and stresses a need to reorganise the way in which stroke services are delivered, from prevention through to support for those who have experienced a stroke.

A whole pathway approach to the provision of stroke services is crucial to maximising the clinical outcomes for patients, the resultant quality of life and their experience of stroke services. The first 72 hours of care is vital to ensure the optimum clinical outcome for stroke survivors. This needs to be underpinned by an effective whole system pathway for assessment, discharge and repatriation to local stroke services, subsequent rehabilitation and longer term support.

Improving outcomes in stroke services is core to the NHS Midlands and East's ambitions to provide access to the highest quality services. Although there have been significant improvements in stroke services across the Midlands and East region over the last three years, there remains scope for further improvement; demonstrated by the gap between the regions' performance as measured against the national Integrated Performance Measures.

1.3 Midlands and East Vision for Stroke Services

Midlands and East want to achieve a step change improvement in the quality of stroke and TIA services and outcomes. The overarching vision for stroke services across the area is to ensure that all patients who experience a stroke have access to high quality acute care 24/7 and high quality life after stroke rehabilitation as part of a stroke pathway focused on providing patient and carer centric care, empowerment and facilitation of self-management leading to meaningful participation in daily life.

1.4 Objectives and Expected Outcomes

The objectives are to:

- Provide a fully integrated, end-to-end stroke service for NHS Midlands and East.
- Implement the recommendations of the National Stroke Strategy.

- Meet the service standards and specifications set by the Royal College of Physicians and NICE guidelines.
- Ensure that stroke services deliver:
  - Improved clinical outcomes e.g. reduced mortality
  - Improved quality of life outcomes e.g. reduced level of disability following a stroke
  - An excellent patient and carer experience e.g. experience across the whole pathway and including improved access
- Ensure equity of service provision, outcomes and experience across the region

In meeting the above objectives, the expected outcomes will be that any patient presenting with acute stroke symptoms will receive the most appropriate care for their condition. Placing patients on the correct pathway (TIA, hyperacute or acute) will maximise the likelihood of best possible outcomes and allow NHS Midlands and East to use resources effectively within the local area. The specific performance standards are listed in each section, but the general expected outcomes are:

- Improved outcomes of stroke patients, by reducing the levels of death and disability following a stroke
- Reduced length of stay of stroke patients in bed based services
- Improved patient experience and to enhance recovery following a stroke through long term support and follow up
- A service that is sustainable and provides good value for money through effective use of resources
- Access to the services and the quality of care provided is equitable across the region.
- Provide high quality specialist stroke professional development

1.5 Evidence Base

Stroke is the third biggest killer in England and the main cause of adult disability - Stroke killed more than 40,000 people in 2009 in England and over 12,000 in NHS Midlands and East. Around two thirds of people will survive their stroke, but half of stroke survivors are left with long term disability and dependent on others for everyday activities.

Stroke care costs the NHS and the economy about £8 billion a year – about £3 billion in direct costs to the NHS[1], £2.4 billion in informal care costs (costs of nursing home care and care borne by the patients' families) and £1.8 billion in income lost to mortality and morbidity and benefit payments.

This service specification is based upon a comprehensive and current evidence base and agreed best practice, including:

- *National Stroke Strategy* (2007) Department of Health.
- *National Clinical Guidelines for Stroke* (2012) Royal College of Physicians
- *Quality Standards Programme: Stroke* (2010) National Institute for Clinical Excellence.
- *Stroke Service Standards* (2010) British Association of Stroke Physicians
- *Quality and Outcomes Framework for 2012/13* (2011) NHS Employers.
- *The NHS Outcomes Framework 2012/13* (2011) Department of Health.
- *A Public Health Outcomes Framework for England 2013-2016* (2012) Department of Health.
- *The 2012/13 Adult Social Care Outcomes Framework* (2012) Department of Health
- *Supporting Life after stroke* (2011) Care Quality Commission

[1] NAO (2010) *Progressing in improving stroke care* report

2. Service Specification

The service specification is divided into phases of the care pathway for stroke patients:

This document is structured according to the stroke pathway phases below. In addition, expectations that apply across the whole pathway are described at the outset.

A. **Primary prevention**
B. **Pre-hospital**
C. **Acute phase**
    i. *Hyper Acute Stroke care*
    ii. *Acute Stroke care (including in-hospital rehabilitation services)*
    iii. *Transient Ischaemic Attack (TIA) services*
    iv. *Tertiary care services (e.g. neuro and vascular surgery referrals)*
D. **Community rehabilitation**
    i. *Early Supported Discharge (ESD)*
    ii. *Stroke specialist community rehabilitation*
E. **Long term care and support**
F. **Secondary prevention**
G. **End of life**

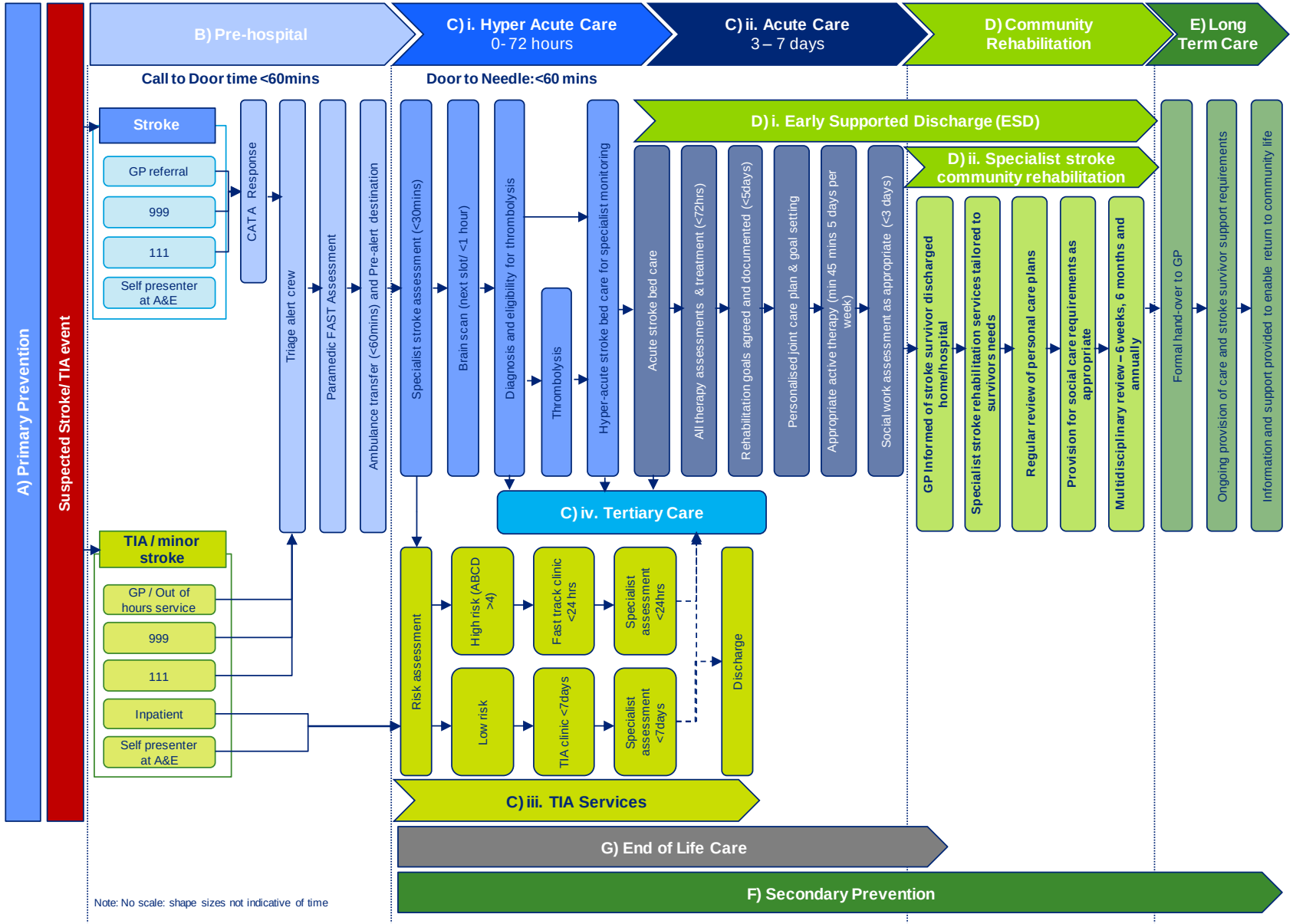
The specification divides the expected outcomes into three time windows – within 6 months, 6-12 months and 18 months or beyond. These are the expectation based on starting implementation following the Midlands and East SHA decision at the end of March 2013, therefore within 6 months would be by end of September 2013.

The performance standards specified for each pathway stage are defined according to the data definitions of the stated data collection audit (e.g. ASI, SSNAP, QOF etc.)

The diagram overleaf summaries the pathway according to the patient movement across the phases since they are not necessarily linear and not all phases or services are applicable to all patients.

2. Service Specification

Summary stroke pathway diagram:



2. Expectations across the whole stroke pathway

Across the entire pathway stroke care must be underpinned by several universally applicable components – to improve the quality of care e.g. communications; to improve patient experience of stroke services; and to ensure the step change improvement being sought in stroke care can be achieved e.g. data collection. These elements that apply across the whole pathway are described in this section.

1. Patient Experience

- Patients and their carers are informed throughout the care pathway on a regular and timely basis of:
  - Their prognosis and situation
  - What is likely to happen to them next e.g. how soon they will be seen, frequency of contact, contact information for the new team, how goals will be carried over
  - Who is taking care of them and who is responsible for their care
  - What they need to be doing to facilitate their care and recovery e.g. advice and information about exercises or other activities that they can practice independently
- Patients and carers are able to access information provided to them i.e. provided in an appropriate format/ medium, and in relevant community languages other than English; and that is specific to the phase of recovery and their needs at that time.
- Patients and carers receive instruction and guidance regarding any prescriptions – verbally and supported by written information
- Families and carers are actively involved in day to day care, rehabilitation and decisions about the planning and delivery of their care
- Patients are directed to relevant voluntary service organisations
- The service has in place a process for incorporating patient/ carer feedback into quality improvement service developments

2. Engagement and Communications

- Awareness raising activities are proactive and ongoing e.g. FAST awareness across primary care, care homes and providers and the general public.
- Providers of stroke services are actively engaged with their local stroke network/s e.g. to ensure that each stroke unit is linked to a regional neurosciences centre for emergency review of local brain imaging
- Clinical teams proactively communicate between themselves and with anyone who takes over responsibility for a patients care, while the processes used to manage care involve all relevant people and support seamless transitions between services along the pathway
- Clinical team members communicate regularlywith patients and carers in appropriate ways for their condition and needs
- Formal links exist with patient and carer organisations e.g. local users' forum, Stroke Association Group, community stroke clubs.

3. Data Transfer and Information Sharing

- Accurate and explicit records of patients are recorded and shared using agreed protocols between all hospital, community and social care practitioners and individuals in a timely way

4. Data Collection and Monitoring

- All organisations should report historical Sentinel metrics where available and required
- All organisations should submit data for the DH stroke and TIA IPMRs
- All clinical services take responsibility for all aspects of data collection, keeping stroke register, and participating in national stroke audit(SSNAP) either directly of via upload of equivalent local data that enables comparison with regional and national peers)
- A sustainable system of coding for stroke patients is in place.
- Local guidance should be in place to support the collection of data between community and across service providers
- All organisations will need to develop a robust system for collection and validation of reliable and accurate stroke data with a lead responsible individual to approve and sign off the data. This may involve investment in data systems and personnel to avoid the burden of data collection responsibility on clinical staff.
- An assessment of patient and carer experience across the stroke pathway is required at regular intervals. This information should be used to inform the improvement of local services and results submitted to inform commissioners on the progress in improving patient experience.

5. Innovation and Research & Development

- To be part of a research network, have a dedicated stroke research lead and actively participate in research (e.g. On the role of interventional radiology in treatment of acute ischaemic stroke or whether the increased intensity of therapy result in improved outcomes)
- Work with Stroke Research Networks
- Be open to performing and participating in national and international trials

2. A) Primary Prevention

Lack of awareness of stroke and TIA – lifestyle causes, risk factors, prevention and symptoms – can be a significant challenge to the realisation of a successful outcome for someone whogoes on to experience a stroke or TIA. A proactive approach by all healthcare professionals to recognise patients at risk of stroke or TIA and subsequent mitigation against those risks will support the minimisation of stroke or TIAs.

	Immediate
Service Outcomes	Primary care and other health care professionals (e.g. opticians, ophthalmologists) are effective in: • Identifying patients at risk of stroke or TIA • Identifying atrial fibrillation and reducing the risk of stroke e.g. through anticoagulation • Promoting the "Know your Pulse" campaign and other national/ regional campaigns • Advising at risk patients of lifestyle choices and treatments to minimise risk of stroke and TIA • Advising and educating patients on how to identify symptoms of stroke and TIA to enable effective early intervention/ treatment • Ensuring patient attendance at vascular health check programme and regular long term condition reviews as appropriate
	Social care staff in domiciliary care, care homes and day centres, together with personal assistants purchased through Direct Payments are: • Effectively trained in the signs of stroke and TIA and aware of the consequences of delay • Able to recognise when a referral to emergency care is needed, and able to contact such services quickly • Able to reassure service users whilst the emergency services are en-route
	Members of the public are able to recognise and identify the main symptoms of stroke and TIA and know it needs to be treated as an emergency.[2] Local health economy, including voluntary organisations communicates basic information to patients on the symptoms, emergency treatment, risk factors, lifestyle factors and treatments.
Performance Standards	No metrics are proposed for monitoring. It is expected that local systems will performance manage primary prevention according to NICE guidelines on atrial fibrillation and anticoagulation. There are a large number of performance standards in the QOF and ASI that should be supported.

Delivering a step change in Primary Prevention is not the focus for the Midlands and East Stroke Review. However it is an important component of the stroke pathway and thus included at high-level for completeness to ensure it is recognised as part of a pathway wide approach to managing stroke.

[2] National Stroke Strategy Quality Markers – QM1: Awareness Raising

2. B) Pre-Hospital Phase

A fast response to stroke reduces the risk of mortality and disability – “Time is Brain”. The identification of potential stroke and TIA patients and their timely admission to an appropriate stroke centre is acritical stage of the care pathway. Promotion amongst healthcare professionals, the public and carers of stroke symptom awareness (e.g. FAST) that prompt emergency treatment can improve health outcomes through timely access to stroke care and specialist treatments such as thrombolysis, which must be administered within a few hours of the onset of symptoms.

	Immediate Requirements		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**Clinical assessment by ambulance staff:** Patients with suspected acute stroke (or sudden onset of neurological symptoms) are screened using a validated tool[3] to diagnose stroke or assess TIA risk[4]. • All patients with suspected acute stroke are immediately transferred by ambulance to a hospital with facilities to manage hyper acute stroke (to include FAST positive or where stroke is suspected by paramedics even if FAST negative). • Higher risk TIA (ABCD2 score >3, on anticoagulation or with crescendo TIA[5]) is treated as an emergency, being at greater and imminent risk of stroke, undergoes specialist assessment within 24 hours of presentation to healthcare professional.[6] • All suspected stroke patients are assessed and managed in accordance with best clinical practice and monitored for atrial fibrillation and other dysrrhythmias[7].		
	Ambulance transfer to hospital: Ambulance service transfer to the appropriate stroke centre within 60mins, ideally within 30 mins(from scene to hospital). Local areas may choose to set more challenging targets as their geography permits • All patients with suspected acute stroke are immediately transferred by ambulance to a stroke centre offeringhyper acute stroke services[8]		

[3] Note: Many valid tools exist and this specification does not specify which one should be used, though some suggestions are made
[4] NICE Quality Standards – Quality Statement 1; National Stroke Strategy Quality Markers – QM8: Assessment
[5] Crescendo TIA is defined as two or more TIAs in one week
[6] RCP2012 – 4.2.1C & D; low risk TIA should receive specialist assessment as soon as possible, but definitely within one week of onset of symptoms
[7] RCP2012 – 4.1.1.1F,G & H
[8] National Stroke Strategy Quality Markers – QM7: Urgent Response

2. B) Pre-Hospital Phase

	• Suspected stroke cases are assigned "Category A" 999 response (and meet Category A ambulance service standards – 2 man, 4 wheel response with the ability to transport patient). • The Ambulance Paramedic service links with the receiving hospital when they have a suspected stroke patient[9], providing a system of pre-alert to enable potential stroke patients (FAST positive) to be met on arrival. • Action plans are in place to improve ambulance response and on-scene times.			
Education & Training	All ambulance and triage staff follow best practice clinical guidelines in the recognition of and handling of stroke patients' e.g. FAST, ABCD2 • All Ambulance crews and paramedics are trained in stroke recognition using validated tools (e.g. FAST) • Stroke experience is included in paramedic training and staff able to prepare patient appropriately for admission to hyper acute stroke service according to agreed protocols. • Communication training provided to help manage patients with aphasia • Ongoing stroke specific training is included as part of Continuous Professional Development (CPD)		• Ambulance service has an established method of obtaining and implementing new guidance for stroke care	• Ambulance service participates in local Stroke Research Network trials and studies
Workforce	• There is sufficient and appropriate stroke skilled capacity in the ambulance service to provide the service to the required population to the defined performance standards. • There is an identified clinical lead for stroke within the ambulance service • Skill mix supports supervision of junior and trainee ambulance personnel			
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of suspected stroke patients transferred by ambulance where a validated tool (e.g. FAST) was used to determine stroke (SSNAP)	100%		
	2. Percentage of patients admitted to hyper acute services within 4 hoursof symptom onset (SSNAP)		60%	
	3. Percentage of FAST positive patients with a 'call to door' time <60 mins(SSNAP)	90%	95%	

[9] BASP Stroke Service Stanadards 1.1

2. C) i. Hyper acute stroke care

Hyper acute services provide expert specialist clinical assessment, rapid imaging and the ability to deliver intravenous thrombolysis 24/7, typically for no longer than 72 hours after admission. These services may be in a specialist Hyper Acute Stroke Unit (HASU) or as a dedicated area on a stroke unit. At least 600 stroke patient admissions per year are typically required to provide sufficient patient volumes to make a hyper acute stroke service clinically sustainable, to maintain expertise and to ensure good clinical outcomes.People with acute stroke will receive an early multidisciplinary assessment, including swallow screening and, for those that continue to need it, have prompt access to high-quality stroke care.

	Immediate		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**Clinical assessment:** All patients (including self/ GP referrals) with suspected stroke are admitted to a hospital with a hyper acute services and seen immediately by stroke team to receive immediate structured assessment by the appropriately trained staff in a consultant led teamto determine likely diagnosis and suitability for thrombolysis and ongoing care needs[10]: • Hyper acute service alerted prior to patient arrival (where appropriate) • Hyper acute service has sufficient capacity for all stroke admissions • Patients are seen and assessed by a member of the specialist stroke team without delay and within 30 minutes of arrival • Patients diagnosed with stroke receive early multidisciplinary assessment: ○ Eligibility for thrombolysis ○ Need for immediate brain imaging ○ Swallow screening (within 4 hours of admission[11]) with ongoing management plan for provision of adequate nutrition.Patients who fail swallow screen to be assessed by Speech and Language Therapist within 24 hours ○ Assessment for malnutrition and need for nasogastric tube or gastrostomy within 24 hours of admission[12] ○ Protocols for assessment and management ofother causes of stroke: intracerebral haemorrhage, subarachnoid haemorrhage, acute arterial dissection, cerebral venous thrombosis[13]		

[10]National Stroke Strategy Quality Markers –QM8: Assessment; NICE Quality Standards – Quality Statement 3
[11]NICE Quality Standards – Quality Standard 4
[12] RCP2012 – 4.17
[13] RCP2012– 4.7-4.9

2. C) i. Hyper acute stroke care

	○ Patients with ischaemic stroke or TIA found to be in atrial fibrillation should be anticoagulated (once intracranial bleeding excluded by imaging) at the discretion of the prescriber, but no later than 14 days from the onset[14] • Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital[15] • Ensure all patients with stroke are given an antiplatelet (e.g. aspirin 300mg) immediatelyafter scanningunless contraindicated[16] • Diagnosis discussed with patient and carer and plan of care clearly written in patient notes		
	Thrombolysis: Thrombolysis can be provided 24/7 to confirmed stroke patients with an appropriate protocol in place to screen patients against the medical criteria for thrombolysis: • Appropriate stroke patients, identified as potentially eligible for thrombolysis treatment, to be scanned within next available CT slot • Appropriate stroke patients to be scanned and receive thrombolysis, ideally within30minsand certainlywithin 60 minsof admission (door to needle time)[17]. • Thrombolysis should be conducted within the criteria specified within the RCP National clinical guidelines for stroke 2012		
	Monitoring: Protocols or pathways in place that ensure appropriate monitoring of stroke patients in the hyper acute phase of care: • All hyper acute patients should be monitored according to a protocol post stroke for 24 hours and then according to patients needs.[18] • Any thrombolysed patient should be closely monitored by stroke-trained staff according to a protocol for the first 24 - 72 hours post-thrombolysis in a monitored bed.		

[14] RCP2012 – 4.10.1C
[15] NICE Quality Standards – Quality Statement 5
[16] RCP 2012 – 4.6.1J-L
[17] BASP Stroke Service Standards 1.4
[18] Physiological monitoring and maintenance of hemostasis is recommended in RCP 2012 – 4.12

2. C) i. Hyper acute stroke care

	• All conscious patients admitted with suspected acute stroke are mobilised out of bed on the day of admission unless contraindicatedwith frequent opportunity to practice functional activities with a trained healthcare professional[19] • Mixed gender wards may be used for critical or highly specialised care in line with DH guidelines for mixed sex accommodation		
	Access to support services: Hyper acute services haveonsite access to the following support services and clinical interpretation: • Brain imaging (MRI and CT)– patients are scanned in the next scan slot within usual working hours, and within a maximum of 60 minutes of request out-of-hours with skilled radiological and clinical interpretation being available 24/7[20] • Carotid imaging (e.g. ultrasound, MRA, CTA), within 24 hours[21] Access (onsite or via clear pathway) is also available to tertiary care services with clear protocols to provide: • Neurosurgery • Vascular surgery		
	Repatriation/ Patient transfer: • If patient transfer is required from hyper acute to acute care services appropriate pathway protocols are in place and followed. • A system is in place to reduce delays in patient transfers.		
Education & Training	Hyper acuteservice staff have comprehensive knowledge of the stroke pathway: • Clinical staff assessing stroke admissions are trained in thrombolysis and interpretation of brain imaging • In-house multidisciplinary team stroke training programmes provided. • External stroke training available • Stroke physicians and non-medical specialist/ expert practitioners attend BASP thrombolysis training		

[19] BASP Stroke Service Standards – 3.7
[20] National Stroke Strategy Quality Markers –QM8: Assessment; NICE Quality Standards – Quality Standard 2;BASP Stroke Service Standards – 2.1
[21] RCP2012 – 4.4.1 C; BASP Stroke Service Standards – 2.2

2. C) i. Hyper acute stroke care

	• Communication training provided to help manage patients with aphasia. • All staff aware of the Mental Capacity Act and its implications • Specific education and training is developed and provided in accordance with the Stroke-Specific Education Framework		
Workforce	**Consultant Stroke Specialist led:** Access to consultant stroke specialist[22]decision making for all hyper acute stroke related issues, including thrombolysis 24/7: • In person or via telemedicine[23] • Sustainable on-call consultant with stroke training rota (no more than1:6) • At least daily consultant stroke specialist rounds, 7 days a week		
	Multidisciplinary Team: Hyper acute services have a sufficient multi-disciplinary team on rota to provide service outcomes with an identified consultant stroke specialist clinical lead: • 24/7 availability of appropriately trained staff for assessment of all patients, including thrombolysis eligibility assessment • Specialist stroke nursing is available for the care and monitoring of all hyper acute service patients • Meet at least once per week to exchange information about individual patients[24]		

[22] A stroke specialist is defined as a healthcare professional with the necessary knowledge and skills in managing people with stroke, usually evidenced by having a relevant further qualification and keeping up-to-date through CPD; it does not require the person to exclusively see people with stroke (RCP 2012 – 3.2)
[23]Telemedicine with telephone and video, with a local specialist stroke nurse (and IT support and regular audits for quality) can be used as an alternative to face-to-face with a stroke specialist (RCP 2012 – 3.4)
[24] RCP2012 – 3.2.1F

2. C) i. Hyper acute stroke care

	Staffing Numbers Hyper acute services provide minimum staffing ratios[25] of: • 6 BASP thrombolysis trained physicians on a rota 24/7 • 2.9 WTE nurses per bed to comply with 80:20 trained vs. untrained skill mix • 0.73 WTE Physiotherapist per 5 beds (respiratory &neuro) • 0.68 WTE Occupational Therapist per 5 beds • 0.68 WTE S&LT per 10 beds • Access to social worker			
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of all stroke patients admitted to hyper acute unit within 4 hours of arrival to hospital (SSNAP)	90%		
	2. Percentage of patients seen and assessed within 30mins of admission by a specialist in stroke (SSNAP)	90%	95%	
	3. Percentage of appropriate patients having thrombolysis within 60 mins of entry (door to needle time) (SSNAP)	85%	90%	95%
	4. Percentage of appropriate patients having thrombolysis within 45 mins of entry (door to needle time) (SSNAP)			90%
	5. Percentage of appropriate patients having thrombolysis within 30 mins of entry (door to needle time) (SSNAP)			50%
	6. Percentage of stroke patients, identified as ineligible for thrombolysis, scanned within 12 hours of admission (SSNAP)	95%		
	7. Percentage of all conscious stroke patients to receive a swallow screen within 4 hours of admission (SSNAP)	100%		
	8. Percentage of patients who fail swallow screen that are assessed by Speech and Language Therapist within 24 hours (SSNAP)	100%		

[25] RCP 2012 – 3.3

2. C) i. Hyper acute stroke care

	9. Proportion of patients with stroke assessed and managed by stroke nursing staff and at least one member of the MDT within 24 hours of admission to hospital (SSNAP)	80%		
	10. Percentage of all stroke admissions thrombolysed (SSNAP)	10%	15%	20%
	11. Percentage of patients who spend at least 90% of their time on a stroke unit (SSNAP)	80%		90%
	12. Carotid imaging performed within 24 hours for patients suitable for carotid endarterectomy	70%	80%	90%

2. C) ii. Acute stroke care

Acute stroke care immediately follows the hyper-acute phase, usually after first 72 hours after admission. Acute stroke care services provide continuing specialist day and night care, with daily multidisciplinary care, continued access to stroke trained consultant care, access to physiological monitoring and access to urgent imaging as required.In-hospital rehabilitation should begin immediately after a person has had a stroke. Rehabilitation services should continue for as long as required, to ensure the best recovery and the minimisation of any disabilities[26] though these are likely to extend beyond time in-hospital (see section D). Rehabilitation goals should be agreed between the multidisciplinary team and stroke patients and carers.

	Immediate		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**Acute stroke care:** All stroke patients should have access to high quality stroke care and spend the majority of their time in hospital under specialist stroke care: • Patients have access to a stroke trained nurse at all times • Protocol in place for the promotion of bladder and bowel continence including a policy to avoid urinary catheters[27] and prevention of pressure sores • Daily consultant or specialist registrar ward rounds at least 5 days a week • Protocols are in place for receiving and discharging patients 7 days a week in a timely manner • All patients with stroke have access to a designated stroke rehabilitation services[28] whether in an acute stroke bed or on a specialist rehabilitation unit in hospital. • All patients to be mobilised out of bed on day of admission unless contra-indicated and offered frequent opportunity to practice functional activities with a trained healthcare professional[29]. Rehabilitation commences as soon as possible following admission into the acute stroke pathway. • Social work assessment as soon as possible and within a maximum of 3 days from referral, if appropriate		• Stroke trained MDT available 7 days a week

[26]National Stroke Strategy Quality Markers – QM10: High-quality specialist rehabilitation
[27]BASP Stroke Service Standards – 3.8
[28]BASP Stroke Service Standards – 4.1; NICE Quality Standards – Quality Standard 6
[29]BASP Stroke Service Standards – 3.7

2. C) ii. Acute stroke care

	Access to support services: Acute stroke services have access (not necessarily onsite) to the following support services and clinical interpretation: • Brain imaging (MRI and CT)[30] • Carotid imaging (including ultrasound, MRA, CTA) • Based on carotid imaging/stenosis, CEA should be undertaken as soon as possible and within 7 days[31] of symptoms Access is also available to tertiary care services (onsite or offsite with clear protocols) to provide: • Neuro surgery • Vascular surgery		
	Rehabilitation planning in hospital: Rehabilitation programmes are built around the individual needs with patient agreed goals: • Patients assessed by specialist rehab team within 72hours, with documented multidisciplinary goals agreed within 5 days[32]) • Personal care plan which is patient-centred, goal-led and implemented from admission. The expected date of discharge will be planned and worked towardsand plans shared with patient and carers • Multidisciplinary meetings at least once a week to plan patient care		
	Rehabilitation services available: Rehabilitation services that provide specialist stroke care 5 days a week: • Assessment by specialist therapists (Physiotherapist, occupational therapist, speech and language therapist) within 72 hours of admission[33] • Stroke survivors offered required active therapy at a level appropriate for obtaining rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it (target for 45 mins per discipline, 5	• Access to a service capable of appropriately managing mood, behaviour or cognitive disturbance following a stroke • A dysphagia	• Rehabilitation services that provide specialist stroke care 7 days a week

[30] Brain imaging should be performed immediately (ideally the next imaging sot and definitely within 1 hour) for people with acute stroke if several conditions apply, else as soon as possible and at most within 24 hours (RCP2012 – 4.5.1A&B)
[31] RCP2012 – 4.4.1C
[32] RCP2012 – 3.2.1
[33] NICE Quality Standards – Quality Standard 10

2. C) ii. Acute stroke care

	days a week)[34] • Identification of cognitive and perceptual problems within 7 days via a cognitive and psychological assessment using a validated screening tool for all patients by appropriate therapist • Screening of all patients to identify mood disturbance and cognitive impairment prior to discharge or within 6 weeks[35] • Specialised neuro-rehabilitation services e.g. spasticity, orthotics, continence, driving, vocational etc. prior to discharge[36] • Stroke survivors with continued loss of bladder control 2 weeks after diagnosis are reassessed and agree an ongoing treatment plan involving both patients and carers[37] • Comprehensive secondary prevention advice and treatment[38] is provided	management service is available including Percutaneous Endoscopic Gastrostomy (PEG)	
	Preparation for discharge: • Planning for care after discharge undertaken with stroke patients and their carer/s at as soon as possible to enable domiciliary care support and adaptations to be arranged in good time and in context of pre-admission status and family/ carer support available • Protocols are in place to ensure patients and families are fully informed and participate in the process of transfer of care • Discharge planning protocols ensures information handover with clear direction for community rehabilitation requirements, discharge destination (e.g. home, care home) with full participation of the ESD/ community rehabilitation team • Stroke survivors receive advice and support to enable a return to previous level of activities • A formal discharge summary report should be shared with the referrer, GP and stroke survivor (if requested) within 7 days of discharge		

[34]BASP Stroke Service Standards – 3.10, 3.11, 3.12, 4.4, 4.5, 4.6; NICE Quality Standards – Quality Standard 7; RCP 2012 – 3.14.1A
[35]RCP 2012 – 3.2.1 H
[36]BASP Stroke Service Standards – 4.10
[37]RCP 2012 3.2.1G; NICE Quality Standards – Quality Standard 8
[38]BASP Stroke Service Standards – 4.17

2. C) ii. Acute stroke care

Education & Training	All staff of the MDT are knowledgeable of the care standards and protocols of the stroke pathway: • In-house and external training provided, with staff released for training as required, including a stroke specific in-house induction training programme. • Staff skill mix supports supervision of junior and trainee personnel • All registered nursing staff in stroke units trained in urinary bowel continence • Specific education and training is developed and provided in accordance with the Stroke-Specific Education Framework or recognised competency framework. • Health and social care professionals should ensure that they are up to date with the current guidance from the DVLA • Staff are aware of the Mental Capacity Act and it implications • Communication training provided to help manage patients with aphasia.		• The practice development team incorporates stroke in education and training plans
Workforce	**Acute Stroke Services** Sufficient capacity to provide the service to the performance standards set: • Consultant specialist stroke physician available 5 days a week • Consultant to see all new patients on the next working day following admission and provide 5 day a week consultant review • Provide a means for a consultant review of a deteriorating patient out-of-hours • 24/7 provision of stroke trained nurses • Identified clinical leads (i.e. one A&E Clinical Stroke Lead and one Radiology Stroke Lead)		• 7 day provision of stroke trained multidisciplinary therapists • Regular stroke physician to input into the review and medical management of patients[39]

[39] BASP Stroke Service Standards – 4.3

2. C) ii. Acute stroke care

	Staffing numbers: Acute and rehabilitation services should have a multidisciplinary team comprising of[40]: ○ Nurses: 1.35 WTE per bed (65:35 trained to untrained skill mix) ○ Physiotherapists: 0.84 WTE per 5 beds ○ Occupational Therapists: 0.81 WTE per 5 beds ○ Speech & Language Therapists: 0.81 WTE per 10 beds ○ Psychologists ○ Dieticians ○ Social workers • Access is available to a range of additional professionals including those in: ○ Clinical Psychology ○ Oral health ○ Orthoptics ○ Orthotics ○ Pharmacy Note: where combined stroke units are used, it is expected that beds are designated as hyperacute and acute, then staffed according to the hyper acute service and acute service standards outlined.			
Other	**Equipment and Aids:** • All equipment and aids (e.g. wheelchairs, continence equipment etc) should be reviewed and ordered before discharge		• Open referral system in social services for assessments of home adaptations and equipment needs	
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of patients with agreed rehabilitation goals within 5 days of admission with appropriately formatted copy of goals given to them (SSNAP)	80%		
	2. Percentage of appropriate patients weighed (or alternative weight estimate if weighting not appropriate) within 72 hours of admission to acute stroke care (SSNAP)	100%		

[40] RCP 2012 – 3.3

2. C) ii. Acute stroke care

	3. Percentage of incontinent patients having continence management plan within 7 days of admission (SSNAP)	80%		
	4. Percentage of appropriate patients to receive an occupational therapy assessment within 72 hours of admission to acute stroke care (SSNAP)	95%		Within 24 hours – 95%
	5. Percentage of appropriate patients to receive physiotherapy assessment and treatment within 72 hours of admission to acute stroke care (SSNAP)	95%		Within 24 hours – 95%
	6. Percentage of appropriate patients to receive speech and language assessment and treatment within 72 hours of admission to acute stroke care (SSNAP)	95%		Within 24 hours – 95%
	7. Percentage of appropriate patients receiving 5 x45min face-to-face sessions per week each of occupational therapy as necessary[41] (SSNAP)	80%		
	8. Percentage of appropriate patients receiving 5 x45min face-to-face sessions per week each of speech and language therapy as necessary[41] (SSNAP)	80%		
	9. Percentage of appropriate patients receiving 5 x45min face-to-face sessions per week each of physiotherapy as necessary[41](SSNAP)	80%		
	10. Percentage of patients receiving cognitive/ perceptual screening within six weeks if required (SSNAP)	85%		
	11. Percentage of patients receiving a continence assessment before discharge (SSNAP)	100%		
	12. Percentage of appropriate patients and carers provided with joint care plan on discharge from hospital (ASI 7)	100%		

[41] NICE Quality Standards – Quality Standard 7

2. C) iii. TIA services

The risk of a stroke is high following a TIA – approximately 10 to 20 percent of patients who have a TIAwill go on to have a stroke within seven days. Specific TIA services provide rapid diagnostic assessment and access to specialist care for high risk patients thereby lowering the risk of a subsequent stroke.

	Immediate		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**TIA identification:** • TIA patients are risk stratified using the ABCD2 score • All TIA patients will be referred to a TIA service (accepting direct referral from primary care and A&E)		
	TIA Service: Specific TIA service is provided for those identified with TIA: • Access 7 days a week, 365 days a year. • The TIA service has both the facilities to diagnose and treat people with confirmed TIA, plus the facilities to identify and appropriately manage (which may include onward referral) people with conditions mimicking TIA • High risk patients[42] must receive specialist assessment and investigation within 24 hours of presenting to a healthcare professional and be started on an antiplatelet (e.g. aspirin) and a statin immediately[43] • TIA service has access to: ○ Blood tests ○ ECG ○ Brain scan (if vascular territory or pathology uncertain) – MRI DWI is preferred mode of imaging; urgently in high risk and within one week in low risk TIA ○ Completion of carotid imaging (where indicated) ○ Referral for carotid surgery[44] where indicated, which should be undertaken within 7 days of onset of TIA[45] ○ Provision of aspirin, clopidogrel orstatins as appropriate ○ Control of blood pressure		

[42] High risk TIA is defined as ABCD score of 4 or above or crescendo TIA (two or more TIAs in one week)
[43] RCP 2012 – 4.2.1C&D
[44] Carotid endarterectomy is the recommended procedure, with less routine indications for carotid angioplasty or stenting (RCP2012 – 4.4.1 L)
[45] RCP 2012 – 4.4.1 C

2. C) iii. TIA services

	○ Information and advice provided regarding stroke risk and secondary prevention • Lower risk TIA patients should receive specialist assessment as soon as possible, but definitely within one week of symptoms[46]			
Education & Training	• Specialist stroke practitioner assessing TIA patients have training, skills and competence in the diagnosis and management of TIA. This should be consistent with the UK Forum for Stroke Training[47] • Education and training for primary care staff in recognition and management of TIA patients • Specific education and training is developed and provided in accordance with the Stroke-Specific Education Framework or recognised competency framework.			
Workforce	• The service should be led by a specialist stroke consultant and provided by a specialist in vascular services with access to the consultant lead or specialist stroke nurse with appropriate specialist competency (where appropriate)			
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. TIA cases with a higher risk of stroke who are assessed and treated within 24 hours of presenting to a healthcare professional (ASI 5/ IPMR)	70%		
	2. Number of people who are referred as having a TIA who are at higher risk of stroke (IPMR)	70%		

[46] RCP 2012 – 4.2.1 E
[47] http://www.ukstrokeforum.org/

2. C) iv. Tertiary Care

Specialist neurosurgical and vascular procedures are sometimes necessary to prevent further damage following a stroke, or prevent stroke altogether. Effective and timely referrals are necessary to ensure that patients suffering a stroke receive the most appropriate care as quickly as possible to improve their long term outcome.

	Immediate Requirements		Long term Requirements (>18months)
	<6 months	6-12 months	

Service Outcomes	**Access to tertiary services:**
	Surgical services are provided as early as possible through early recognition of the need for surgical intervention:
	• All patients with a suspected non-disabling stroke or TIA have urgent access to comprehensive neurovascular services[48] . Neurovascular services include:
	  ○ Neurosurgical services
	  ○ Vascular surgical services
	• Access to tertiary services may be on site or off-site. For offsite services, clear protocols must be in place for a commissioned pathway of care.		

	Neuro surgical services There are relatively few indications for neurosurgical intervention in patients with stroke; however specific cases of stroke may require urgent management.For example: • Cases of middle cerebral infarction should be referred within 24 hours and treated (e.g. decompressivehemicraniotomy) within 48 hours[49]. • Treatment for aneurysm (endovascular embolisation or surgical clipping) should be available within 48 hours[50]		
	Vascular surgical services: • Carotid intervention (e.g. carotid endarterectomy) for recently symptomatic severe carotid stenosis should be regarded as an emergency procedure in patients who are neurologically stable, and be performed within 7 days of a TIA or minor stroke[51]		• High risk TIA[42] that require carotid endarterectomy are admitted for urgent investigation and surgery within 48 hours

[48] BASP Stroke Service Standards – 5.1; National Stroke Strategy Quality Markers –QM 9: Stroke Treatment
[49] RCP2012 – 4.6.1N
[50] RCP2012 – 4.8.1C
[51] National Stroke Strategy Quality Markers –QM 6: TIA and Minor Stroke Treatment; BASP Stroke Service Standards – 3.16; Also note: The use of carotid artery stenting (CAS) was reviewed by NICE/RCP; however, no evidence (no RCT) for early stenting was found on which to base a recommendation [RCP 2012 – 6.4.2; NICE CG68 1.2.1]

2. C) iv. Tertiary Care

Education and Training	• Staff trained to recognise when specialist referral is required			
Workforce	• Stroke physicians input to the multi-disciplinary management of appropriate cases			
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of patients receivingcarotid surgery within 7 days of symptom onset that triggered referral (UK Carotid Interventions Audit)	95%		

2. D) i.Early Supported Discharge (ESD)

Early supported discharge (ESD) enables appropriate stroke survivors to leave hospital 'early' through the provision of intense rehabilitation in the community at a similar level to the care provided in hospital. An ESD team of nurses, therapists, doctors and social care staff work collaboratively as a team and with patient and families, providing intensive rehabilitation at home for up to 6 weeks, thereby reducing the risk of re-admission into hospital for stroke related problems and increasing independence and quality of life with support the carer and family.

	Immediate Requirements		Long term Requirements (>18months)
	<6 months	6-12 months	
Service Outcomes	**ESD service:** ESD team should be stroke specific and sufficiently able to commence treatment within 24 hours of discharge: • Rapid response, same day ESD service provided 5 days a week at a stroke survivors place of residence to facilitate timely discharge from hospital setting for a period of up to 6 weeks. • Stroke survivors offered required active therapy, (target of 45 mins per discipline, 5 days a week) to an intensity equivalent to in hospital rehabilitation, but reflective of individual patient needs and goals • Single point of contact provided to patients, carer and families(into rehab) • Carers are appropriately educated and trained to recognise common causes of illness that result in avoidable admissions e.g. constipation, urinary tract infection (into rehab) • Collaboration with health and social services, the independent and third sectors to enable to stroke survivor to develop a greater quality of life and independence (in all or generic) • Access is provided to community rehabilitation services/ long term care provision following ESD if required.		• 7 days a week ESD service
Education & Training	• Specific education and training is developed and provided in accordance with the Stroke-Specific Education Framework		

2. D) i.Early Supported Discharge (ESD)

Workforce	• A stroke ESD multidisciplinary team composition should include as a minimum (WTE per 100 cases per year[52]):
	  ○ Occupational Therapy (1)
	  ○ Physiotherapy (1)
	  ○ Speech and Language Therapy (0.4)
	• The stroke ESD team has access to support from:
	  ○ Stroke physician (0.1)
	  ○ Nurse (0- 1.2)
	  ○ Social worker (0- 0.5)
	  ○ Rehabilitation assistants (0.25)
	  ○ Clinical Psychology
	  ○ Dieticians
	  ○ Orthotics
	  ○ Orthoptics
	• There are coordinated stroke skilled ESD teams working in partnership with local authorities and other health and third sector providers
	• ESD team meets weekly as a minimum to plan and manage patient care			

Other	**Equipment and Aids:** • All equipment and aids (e.g. wheelchairs, continence equipment) should be reviewed and ordered during ESD service		• Open referral system in social services for assessments of home adaptations and equipment needs	
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of stroke survivors supported by a stroke skilled Early Supported Discharge team (ASI 9)	40%		
	*2. Percentage appropriate stroke survivors whose treatment programme started within one working day of release from hospital**	80%	100%	

**Requires a separate data collection exercise. These metrics are believed to be important components of the care pathway, but at the moment there is not a existing data source to provide a standard means of collection and thus would require local collection.*

[52] East Midlands ESD Service Specification

2. D) ii.Stroke Specialist Community Rehabilitation

Stroke survivors' rehabilitation will continue after the initial time spent in acute in-hospital rehabilitation, out into the community. These servicesenable stroke survivors develop a greater quality of life and independence following stroke. Patients will access community rehabilitation servicesfollowing standard discharge from a stroke unit or following ESD. Community stroke rehabilitation services includes the transfer of care from hospital to home and time at home provided through collaboration with health and social services, the independent and third sectors.

	Immediate Requirements		Long term Requirements (>18months)
	<6 months	6-12 months	
Service Outcomes	A range of services are in place and easily accessible to support the individual long-term needs of individuals, their carer/s and families[53], encouraging self-management where appropriate. Comprehensive social care is provided to all patients and their carers that need it • Single point of contact provided when patients leave hospital • All stroke survivors discharged from hospital who have residual stroke-related problems are followed up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management[54] • Any stroke survivors referred to a social worker will receive an assessment within 72 hours of receipt of the referral • Goals incorporated into a personalised care plan that allows the patient to take ownership of their rehabilitation and reviewed regularly (every 4-6 weeks) with the patient throughout the treatment period. • Active therapy at a level appropriate for obtaining rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it[55] (target for 45 mins per discipline, 5 days a week[56]) • The GP and other relevant community services are informed that a stroke survivor has been discharged home or to another hospital prior to discharge. • Age appropriate provision made for the social care requirements of stroke survivor prior to discharge, e.g. domestic tasks (such as shopping and	• Training in self-management, goal setting and problem solving skills is available[60]	

[53]National Stroke Strategy Quality Markers –QM13: Long term care and support; Adult Social Care Outcomes Framework
[54] RCP2012 – 3.8.1A
[55] BASP Standards – 3.10, 3.11, 3.12; 4.4, 4.5, 4.6; NICE Quality Standards – Quality Standard 7
[56]RCP 2012 – 3.14.1A
[60] Royal College of Physicians Stroke Guidelines; London commissioning guidelines

laundry)
- Adult social services provide advice on aids and adaptations to daily living
- Review of home environment, usually by a home visit by an occupational therapist, to adapt to patient needs where patient remains dependent in some activities[57]
- A carers assessment should be completed for each carer with links to carer support groups made and family support organisations and followed up
- Specialist stroke rehabilitation, support and any appropriate management plans will address the following issues either directly or by seamless onward referral where required[58]:
  - Mobility and movement (including exercise programmes, gait retraining, mobility aids and orthotics)
  - Upper limb rehabilitation
  - Management of spasticity and tone
  - Sensory impairment screening and sensory discrimination training
  - Falls prevention (including assessment of bone health, progressive balance training and aids)
  - Cognitive rehabilitation (including addressing impairment in attention, memory, spatial awareness,perception, praxis and executive function)
  - Communication(including aphasia support twice weekly during the first 20 weeks, techniques or aids for dysarthria and apraxia, information about local groups)
  - Everyday activities including provision of daily living aids and equipment (e.g. dressing, washing, meal preparation)
  - Emotional and psychosocial issues (e.g. depression, adjustment difficulties, changes in self-esteem or efficacy, emotionalism)
  - Swallowing (including swallowing rehab, maintenance of oral and dental hygiene, nasograstric tube feeding, gastrostomy)
  - Skin integrity (i.e. pressure care and positioning)
  - Nutrition (including specialist nutritional assessment, nutritional support)Visual disturbance
  - Continence (bladder and bowel)
  - Social interaction, relationships and sexualfunctioning (including

[57] RCP 2012 – 3.8.1 D
[58] RCP 2012 – 6.4 to 6.46

	psychosocial management or medications) ○ Pain (assessed regularly using validated score, referred to specialist where indicated) ○ Home assessment (including need for larger scale equipment or adaptation) ○ Return to work (including referral to specialist in employment or vocational rehabilitation) ○ Driving ○ Financial management and accessing benefits • Community leisure and exercise classes are available and promoted to stroke survivors, who are then supported to attend • Stroke survivors are aware of and offered options to promote wellbeing, including peer-led support groups, engagement in community activities and professional psychological therapies including IAPT and community mental health services • Telephone counselling support available for three months[59]		
Education & Training	• Specific education and training is developed and provided in accordance with the Stroke-Specific Education Framework • Staff are aware of the Mental Capacity Act and it implications • Carers receive training in care, for example, moving, handling and dressing; receive written information on management plan and point of contact for stroke information		
Workforce	• There are established stroke skilled, multidisciplinary community rehabilitation teams. Composition of the team should include as a minimum: ○ Physiotherapist ○ Occupational therapist ○ Speech and language therapist ○ Community nursing (as appropriate) ○ Social care ○ Rehabilitation assistants ○ Clinical psychology (as appropriate) • The community rehabilitation team has access to support from: ○ GP ○ Dieticians		

[59] RCP2012 – 3.8.1C

2. D) ii.Stroke Specialist Community Rehabilitation

	○ Orthotics ○ Orthoptics ○ Vocational rehabilitation • Initial assessment of the stroke patient is carried out by a qualified professional (some of the care may be delivered by rehabilitation assistants under the supervision of a qualified therapist)			
Other	**Equipment and Aids:** • All equipment and aids (e.g. wheelchairs, continence equipment etc) necessary to ensure a safe environment should be available at discharge and appropriate training provided to stroke survivors and carers.		• Open referral system in social services for assessments of home adaptations and equipment needs	
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of appropriate patients and carers with joint care plans on discharge from hospital (ASI 7/ SSNAP)	85%	95%	100%
	*2. Percentage of stroke survivors contacted by a member of community rehabilitation team within one working day and assessed within 72 hours**	80%	90%	100%
	3. Percentage appropriate stroke survivors whose treatment programme started within 7 days where agreed as part of care plan (SSNAP)	80%	100%	
	*4. Percentage of stroke patients that are reviewed six weeks after leaving hospital**	95%		

**Requires a separate data collection exercise. These metrics are believed to be important components of the care pathway, but at the moment there is not a existing data source to provide a standard means of collection and thus would require local collection.*

2. E) Long term care

Stroke survivors and their carers should be enabled to live a full life in the community[61] over the medium and long term (>3 months). Support is required from local services to ensure appropriate, tailored support is provided to assist re-integration into the community and maximise the quality of life experienced by stroke survivors, their carer/s and families.

	Immediate Requirements		Long term Requirements (>18months)
	<6 months	6-12 months	
Service Outcomes	**Provision of information and support for stroke survivors, carers and families:** • Ongoing physical, speech and language, continence and other required therapiesare provided where clinically appropriate to meet patient needs • Carers of stroke survivors with stroke are provided with a named point of contact for stroke information, written information about the stroke survivors diagnosis and personal care plan, and sufficient practical training to enable them to provide care[62] • Carers are provided with clear guidance on how to find help if problems develop	• All eligible users of social care services should have access to a personal budget	• Carers have the opportunity to access long-term emotional and practical support though peer support groups facilitated by charitable or voluntary groups
	Regular review and needs assessment: • The patient and family will be aware of their single named point of contact • All stroke survivors receive a review and onward referral to appropriate MDT members at six weeks, six months, 12 months and then annually that facilitates a clear pathway back to further specialist review, risk factor screening, advice, information, support and rehabilitation where required, is provided[63]. • Information from reviews should be shared across the entire team involved in delivering care to the stroke survivor, including with the stroke survivor themselves and their GP. • Stroke survivors and their carers are enabled to participate in paid, supported and voluntary employment[64]		

[61]National Stroke Strategy Quality Markers –QM15: Participation in community life
[62]NICE Quality Standards – Quality Standard 11
[63]National Stroke Strategy Quality Markers –QM3: Information, advice and support, QM 14: Assessment and review
[64]National Stroke Strategy Quality Markers –QM 16: Return to work

2. E) Long term care

Education & Training	• Staff seeing stroke survivors know where to go to obtain information on other local services, charities in the area and how the stroke survivor may access financial, emotional, social, and vocational support. • Staff are aware of the Mental Capacity Act and it implications • Health and social care professionals should ensure that they are up to date with the current guidance from the DVLA • Care home staff should be familiar with stroke care strategies and options (including physical, physchological and social), and the needs and aspirations of those in their care • Staff have the details of the local IAPT service so that those that need it can access the service • Carers involved with the care management process from the outset, and encouraged to participate in an educational programme (on stroke, care and management, prevention)		• Service should include staff with expertise and competence in assessing, treating and monitoring people with behavioural and cognitive disturbance	
Workforce	• Staff working in long term care should have access to support and guidance from stroke skilled staff			
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Proportion of stroke patients that are reviewed six months after leaving hospital (ASI 8/ SSNAP)	95%		
	2. Percentage of stroke survivors that received psychological support for mood, behaviour or cognitive disturbance within six months(ASI 6/ SSNAP)	40%	50%	60%
	3. Percentage of patients with Barthel score recorded at discharge (SSNAP)	100%		
	4. Percentage of patients with Modified Rankin score at discharge (SSNAP)	100%		

2. F) Secondary Prevention

Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke[65]. For those who have already had a stroke or TIA, prevention advice is even more important. This means assessing individuals for their risk factors and giving them information about possible strategies to modify their lifestyle that can reduce their risk. GPs need to actively manage these conditions in line with national guidelines.

	Immediate		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**Assessment:** After stroke, stroke survivors and their carers need to be offered a review from primary care services[66] of their health, social care and secondary prevention needs: • All stroke survivors with a stroke will have their risk factors assessed as soon as possible and certainly within one week[67]; documented and a personal care plan for secondary prevention as part of the stroke team's assessment which is passed onto primary care • Monitored regularly in primary care on a yearly basis at minimum	• Protocols in place for stroke survivors education for secondary prevention of stroke encouraging better compliance with end result of reduced recurrent stroke	
	Monitoring: This specification does not attempt to define all risk factors (see RCP National clinical guidelines 2012), though significant risk factors and assessment include the following: • Managing hypertension so systolic blood pressure is below 130 mmHg; treatment should be initiated prior to discharge or at two weeks[68] • Anticoagulation (e.g. Warfarin) for individuals with atrial fibrillationand where not contraindicated; prescribed before discharge or plans to anti-coagulate as out-patient which ever aligns with guidelines to administer 2 weeks following stroke onset • All patients with ischaemic stroke, not in atrial fibrillation, to have anti-platelets medication unless contraindicated • All patient who have had an ischaemic stroke or TIA should be offered a statin drug unless contraindicated[69] • Smoking cessation, alcohol, tailored exercise programmes and healthy		

[65] National Stroke Strategy Quality Markers –QM2: Managing risk
[66] National Stroke Strategy Quality Markers –QM 14: Assessment and review
[67] RCP2012 – 5.1.1A
[68] RCP2012 – 5.4.1D. Note: For non-admitted patients requiring blood pressure treatment, treatment should be stated at the first clinic visit
[69] RCP2012 – 5.6.1A

2. F) Secondary Prevention

	lifestyle advice for all stroke/TIA survivors.		
	Risk management: Risk factors, including hypertension, obesity, high cholesterol, atrial fibrillation and diabetes, are managed according to clinical guidelines, and appropriate action is taken to reduce overall vascular risk[70] • Participating GPs produce and maintain a register of patients who have had a stroke or TIA, forming a suite of indicators to provide quality of care[77] • Measures for secondary prevention introduced as soon as the diagnosis is confirmed, including discussion of individual risk factors • Information and advice strategies to ensure that clear, consistent, culturally sensitive messages are being given to those who have had a stroke, their families and those at high risk • Practices can produce a register of patients with stroke or TIA[71]		
	Information and advice: Those at risk of stroke and stroke survivors are assessed for and given information about risk factors and lifestyle management issues (exercise, smoking, diet, weight and alcohol), and are advised and supported in possible strategies to modify their lifestyle and risk factors[70] • Stroke survivors given named contact to help them plan and manage their long-term care[72] • Meet individual needs, tailoring for a variety of ages, ethnicities and lifestyles • Access to leaflets in variety of formats (i.e. different languages, large print, braille, dysphasia friendly)		
Education & Training	• All primary care professionals maintain and update their knowledge of national guidelines and implement them in practice, targeting high risk patient groups[70]		
Performance		**<6months**	**6-12 Months**	**>18 months**

[70] National Stroke Strategy Quality Markers – QM2: Managing Risk
[71] Quality and Outcomes Framework: Stroke 1
[72] Care Quality Commission: Supporting Life After Stroke

2. F) Secondary Prevention

Standards	1. Percentage of patients with stroke or TIA who smoke whose notes record smoking status within the previous 15 months[73] (QOF)	90%		
	2. Percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less[74] (QOF)	70%		
	3. Percentage of patients with a TIA or stroke who have a record of total cholesterol in the last 15 months[75] (QOF)	90%		
	4. Percentage of patients with TIA or stroke who last measured total cholesterol (measured in the previous 15 months) is 5 mmol/L or less[76] (QOF)	60%		
	5. Percentage of patients with stroke or TIA who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months[77] (QOF)	90%		
	6. Percentage of patients presenting with stroke with new or previously diagnosed atrial fibrillation who are anti-coagulated on discharge. (ASI 1)	60%	70%	80%

[73] QOF Smoking 3
[74] QOF Stroke 6
[75] QOF Stroke 7
[76] QOF Stroke 8
[77] QOF Smoking 4

G) End of Life care

Stroke is the UK's third biggest killer[78]. Patients with stroke may enter the End of Life pathway at many stages of the Stroke Pathway, in different care settings. Clear decisions will indicate when a patient's prognosis means that an end of life pathway is appropriate. It is important that this decision is made by the appropriate skilled and experienced individual, taking account of the needs and choices of the patient, carer and family.

	Immediate		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**End of life care:** • Decision to enter a patient into an end of life pathway should be taken by an appropriate and experienced individual, taking account of the needs and wishes of the patient, carer and family[79] • Patients and carer offered opportunity to be discharged home for end of life care • Palliative and End of Life care will be provided in line with clinical practice guidance and the local service specification for End of Life care. This may include referral to specialist palliative care services. • The Liverpool Care Pathway for the dying should be used to care for people in the last days or hours of life to deliver high quality care during this phase[79].	• Patients considered to be in the last 12 months of life are recommended for inclusion on the GP's GSF register	
Education & Training	• Preferred Priorities for Care (PPC) document shared with all health and social care staff involved in their care • Application of the 'Gold standards framework' to enable identification of appropriate patients and their care, and the Liverpool Care Pathway • Communication training provided to support practitioners in conversations about end of life care		
Workforce	• Patients receiving end of life care do so from a workforce with appropriate skills and experience in all care settings[79]		

Performance Standards	**<6months**	**6-12 Months**	**>18 months**
1. Percentage mortality of stroke patients at 1 month following a stroke (SSNAP)	N/A		

[78] Stroke Association Manifesto 2010-2015
[79] National Stroke Strategy Quality Markers – QM 11: End of Life care

G) End of Life care

	2. Percentage mortality of stroke patients at 6 months following a stroke (SSNAP)	N/A		
	3. Percentage mortality of stroke patients one year following a stroke (SSNAP)	N/A		
	No explicit performance measures are included for End of Life care services, though it is expected that the National Quality Markers for End of Life care are met, with data collected to support achievement.			

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Working in collaboration with Birmingham, Solihull and Black Country CCGs and providers

17th July 2014

Reviewing stroke services for a healthier future

NHS

Background

- Stroke is a major cause of death:
  - 40,000 deaths in England; 12,000 in NHS Midlands & East region alone (2009)

- 2008 National Stroke Strategy
- January 2012, Regional NHS Midlands & East review – following concerns about stroke performance
  - Variation in clinical outcomes across the region
  - Underperformance against national and international best practice
  - Regional best practice specification developed

Why are we reviewing services?

- Whole stroke pathway: from primary prevention to end of life
- Building on existing reconfiguration work (Midlands and East Review) and areas of good practice
- Draw lessons from other parts of the UK and within NHS Midlands and East
- Active engagement; if the review finds change is needed we will carry out a public consultation Summer/Autumn 2014

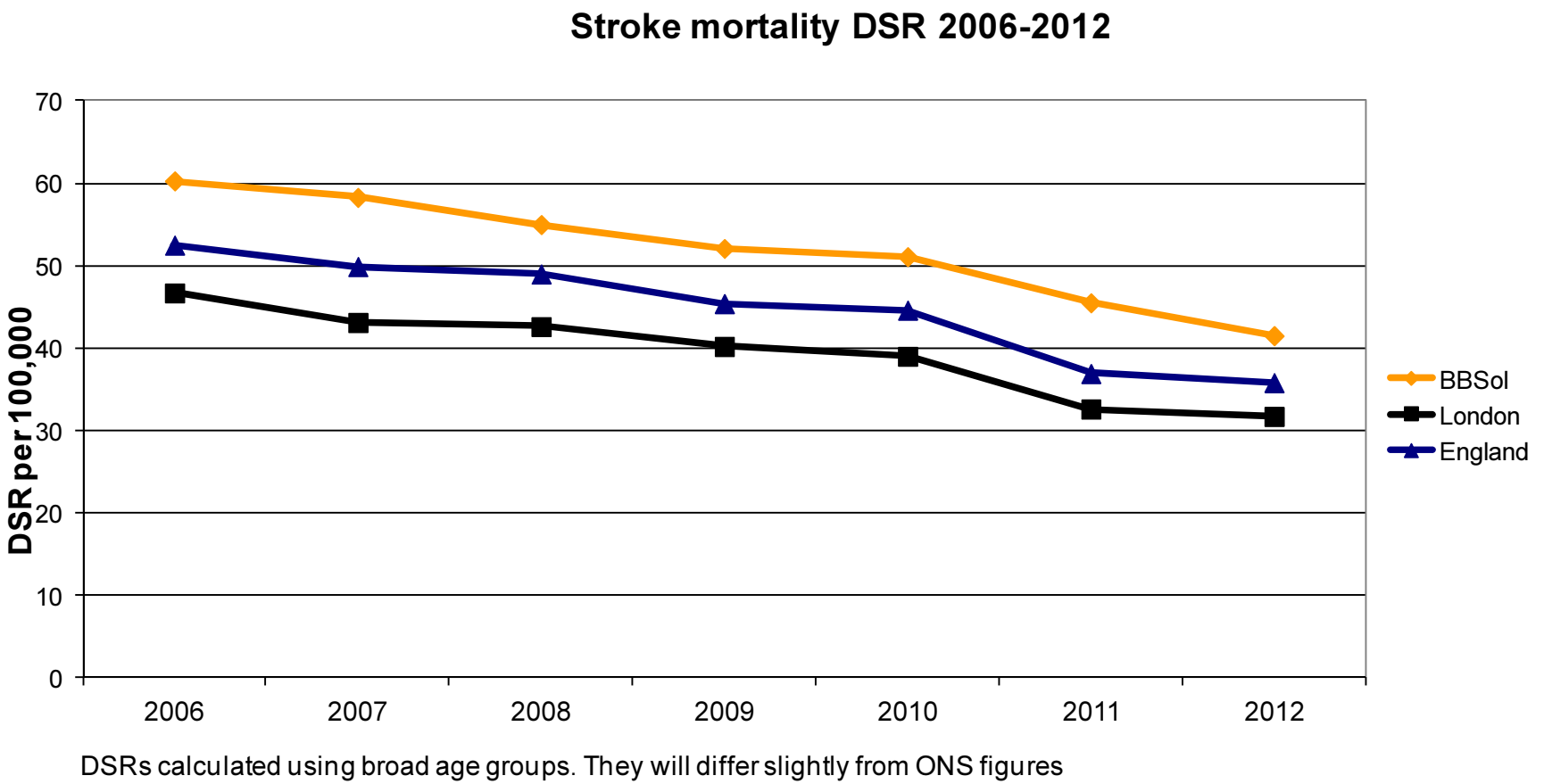
Will you change services?

- No decisions have been made
- **This review is looking at whether we need to change**
- We will only change the services if there is an overall benefit for patients
- If we do need to change there will be public consultation

CCG and provider landscape

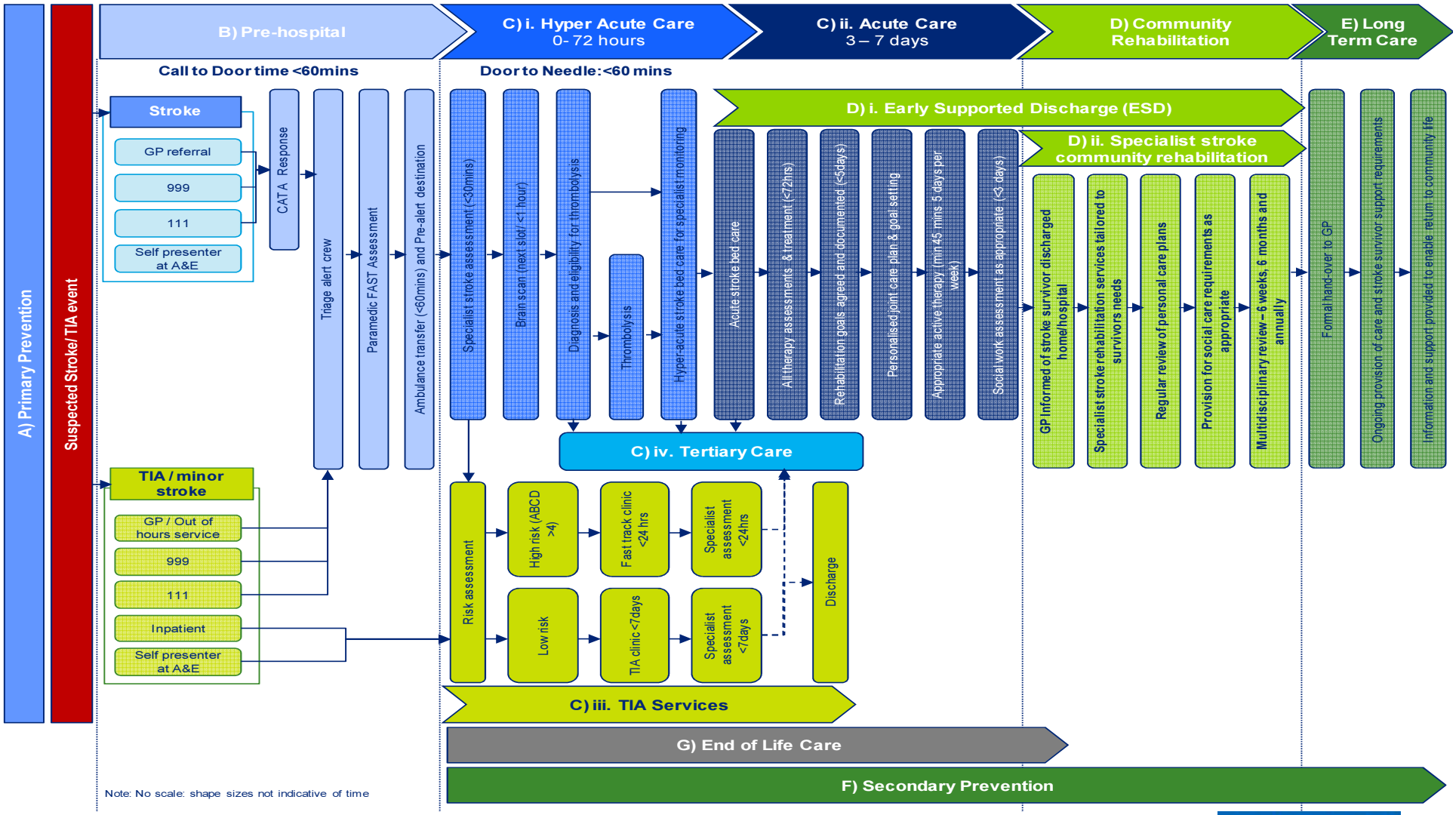
CCG	Provider
• Birmingham Cross City • Birmingham South Central • Dudley • Sandwell and West Birmingham • Solihull • Walsall • Wolverhampton	• Birmingham Community Healthcare NHS Trust • Heart of England NHS Foundation Trust • Royal Wolverhampton Hospitals NHS Trust • Sandwell and West Birmingham NHS Trust • The Dudley Group NHS Foundation Trust • University Hospitals Birmingham NHS Trust • Walsall Healthcare NHS Trust • West Midlands Ambulance Trust

Stroke mortality



DSRs calculated using broad age groups. They will differ slightly from ONS figures

Stroke pathway



Reviewing stroke services for a healthier future

What is a HASU?

- A hyper-acute stroke unit (HASU) is a specialist unit that gives all stroke patients access to the most up-to-date treatments and latest research breakthroughs during the first 72 hours after a stroke

- Swift action can reduce levels of disability and, in some cases, may even remove symptoms completely

Best practice recommends:

Specialist stroke units should see a minimum of 600 patients per year

- Specialist clinicians can maintain their skills
- Larger workforce, ensures improved clinical safety
- Faster response to suspected stroke patients including access to scan and thrombolysis
- Continual access to specialist care during first 72 hours

Local access

The following services will still be provided in local hospitals (after the first 72 hours):

- Acute Stroke Units (hospital care post HASU)
- Outpatient Transient Ischaemic Attacks (TIA)
- Inpatient and community rehabilitation
- Long term care services
- End of life care

Benefits of reviewing stroke services

- Improved patient care:
  - Reduced deaths
  - Improved chance of recovery
  - Reduced risk of long term disability
  - Ability to live more independently
- High quality, safe services 24/7, 365 days a year
- Access to specialist staff, services and facilities

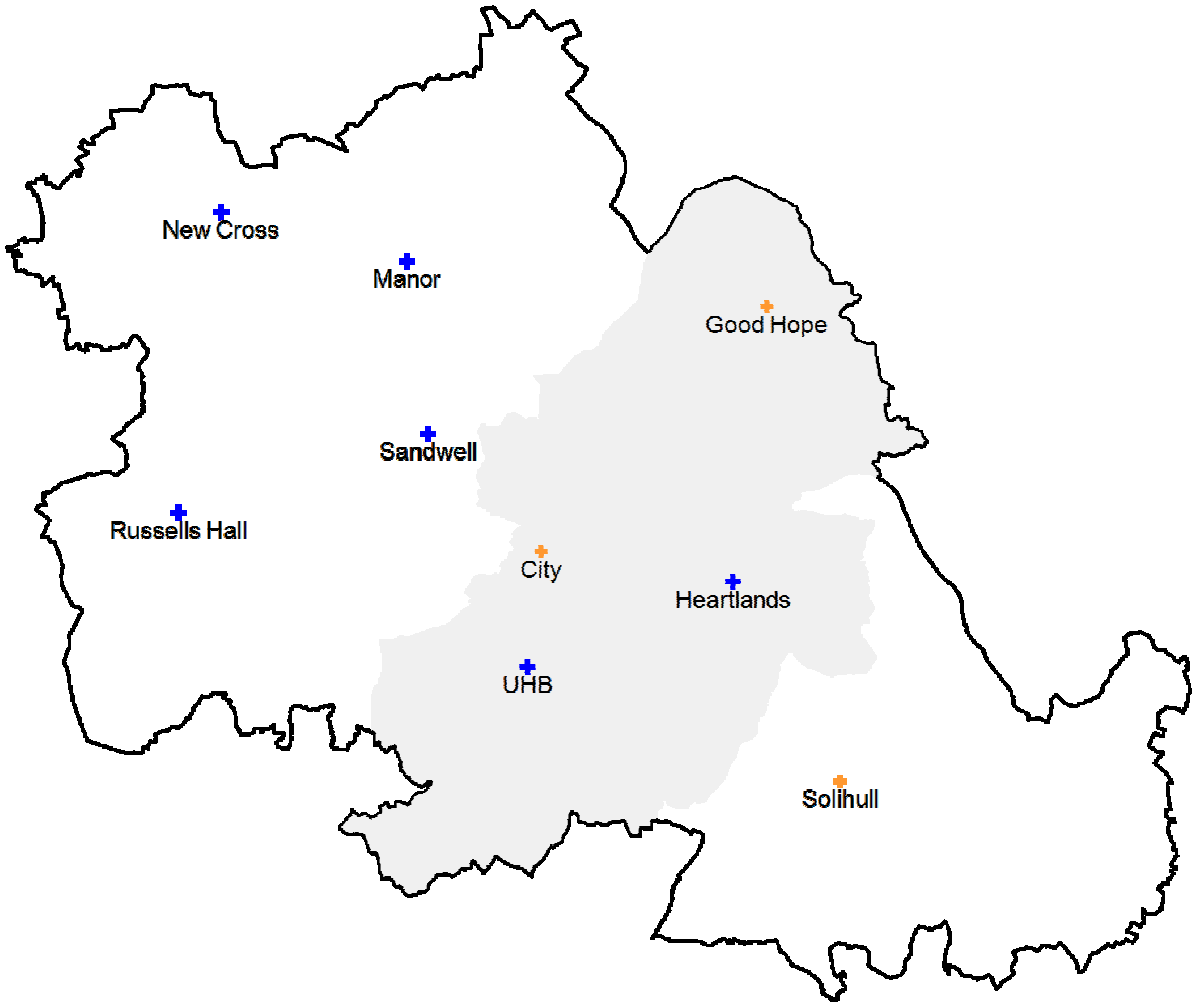
What do stroke services look like at the moment?

Reviewing stroke services for a healthier future

NHS

Current HASUs

- 9 major acute hospitals in the area
- Local consultations already taken/taking place to change:
  - City Hospital
  - Good Hope
  - Solihull Hospital
- If existing plans are approved there will be 6 HASU sites



Do we need to change services to realise these benefits?

Is there a need to change?

- Data shows our area can support a maximum of 6 HASUs (based on approximately 600 confirmed stroke patients a year)
- Access analysis has shown a range of possible configurations
  - Less than 3 HASUs compromise access
  - More than 6 HASUs does not significantly improve access
- Net benefit needs to be demonstrated if changing number of sites (quality, access, workforce etc.)
- The review will identify if there is a need to change

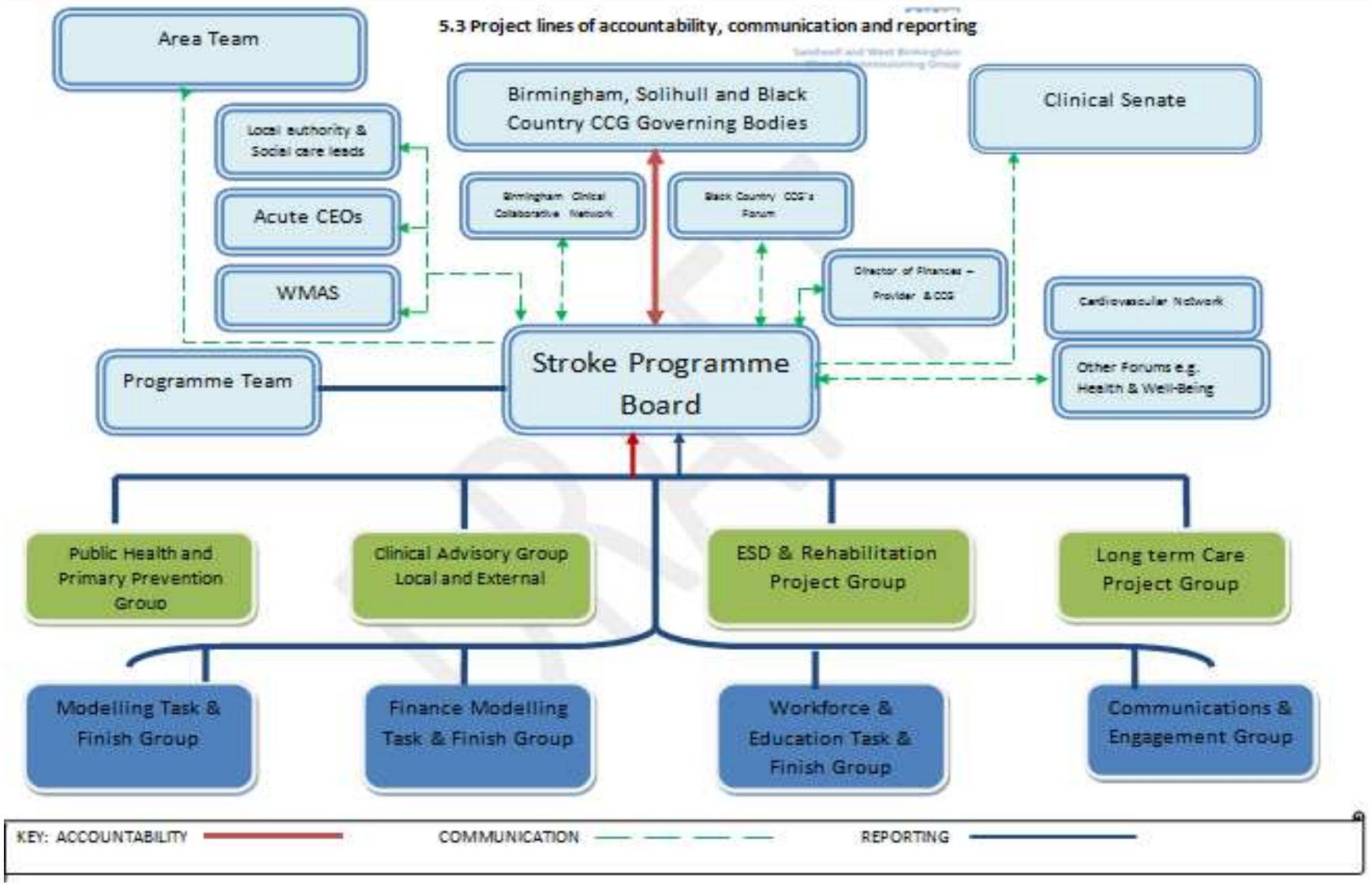
What matters most?

- Ambulance travel times is only one consideration
- To determine if we need to change services we will consider:
  - **Clinical quality of service**
  - **Workforce needs, including training, teaching and resource**
  - **Access**
  - **Patient experience**
  - **Ease of deliverability**
  - **Improved strategic fit**
  - **Cost/efficiency**

How will we decide?

- CCGs are developing options based on current and future demand
- We will use our criteria to assess these options
- Neighbouring areas will also need to be considered
- Options will need to ensure no detrimental impact on other services (e.g. A&E)
- We will be going through a rigorous assurance process with the Clinical Senate, NHS England and the Department of Health Gateway Review Team
- Autumn 2014- we should know if there is a need for change
- If we need to make significant changes there will be a public consultation

Project lines of accountability, communication and reporting



Communication and engagement

- Communication & Engagement Lead on programme board
- Communication & Engagement Sub Group in place
- Communication & Engagement high level plan in place
- Populating a comprehensive Communication and Engagement Stakeholder Plan
- Patient Advisory Group to offer assurance to the process
- Patient Advisory Group member on Programme Board
- Stroke Association lead on Programme Board
- Stroke Engagement Event aimed at patients and their carers – 30 January 2014

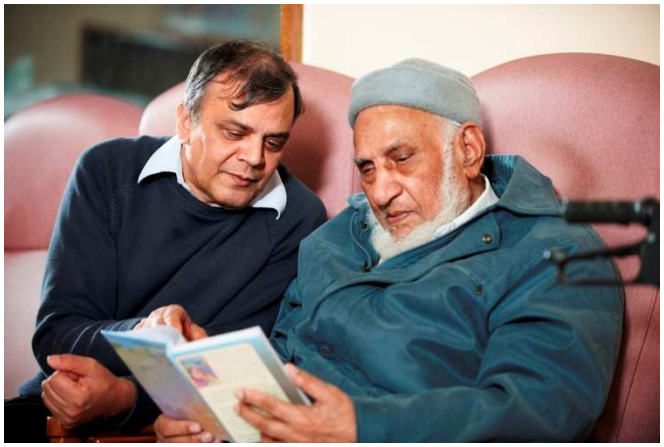
External advice

- Patient Advisory Group established
  - Stroke patient/ carer representatives from each CCG area
  - Representative on Programme Board
  - Patient perspective throughout review

- Independent Clinical Advisory Group established to give external scrutiny ensuring clinical safety

Patient experience

- Travel time for carers and relatives
- Public transport constraints
- Access to support services
- Continuity of care after transfer to a local hospital for post HASU care

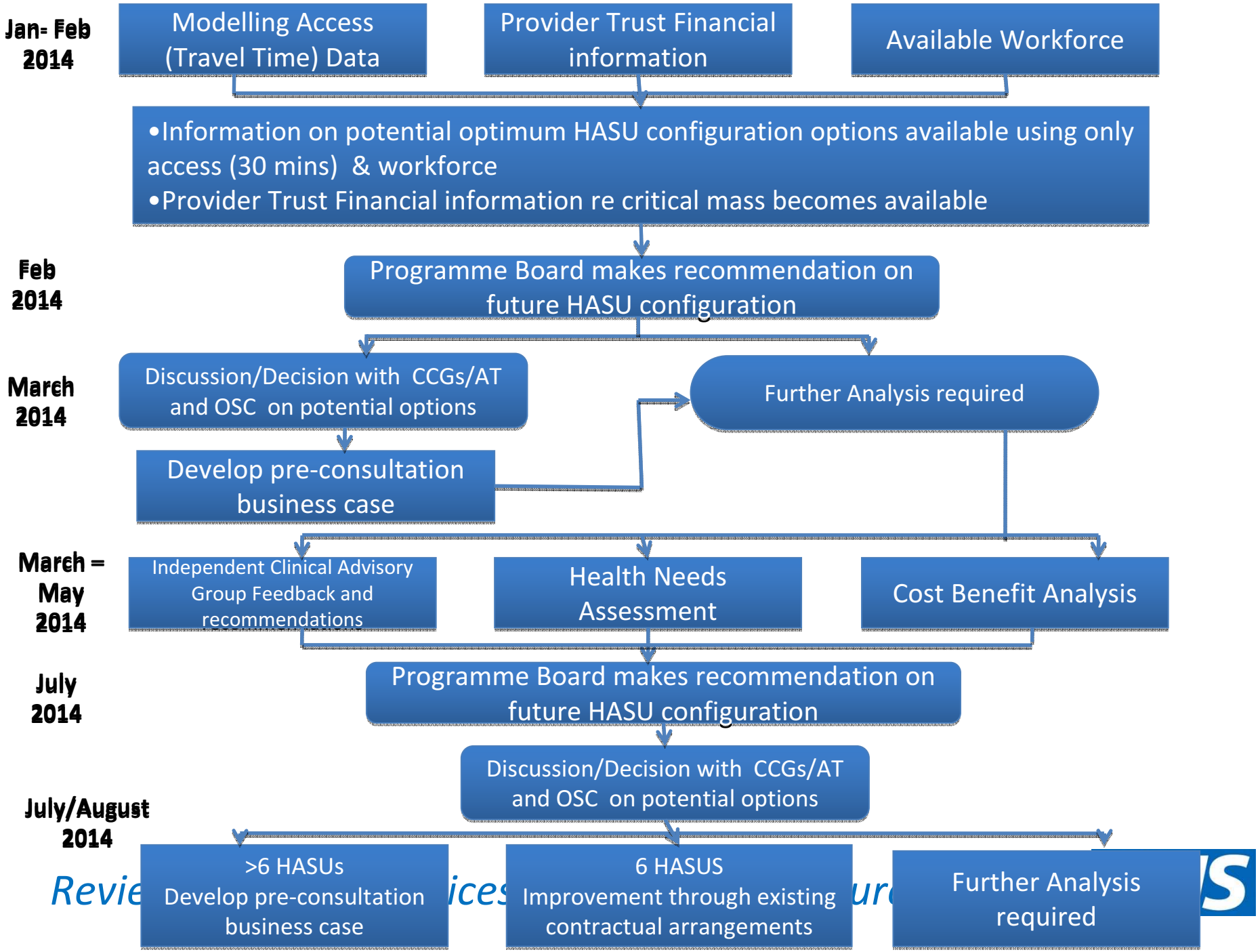


Stroke journey

- Considering whole stroke patient journey: from prevention to end of life
- Joined up approach, all services working together
- Patients have access to consistent services throughout journey

Key Milestones

Reviewing stroke services for a healthier future


Jan- Feb 2014
Modelling Access (Travel Time) Data
Provider Trust Financial information
Available Workforce
•Information on potential optimum HASU configuration options available using only access (30 mins) & workforce
•Provider Trust Financial information re critical mass becomes available
Feb 2014
Programme Board makes recommendation on future HASU configuration
March 2014
Discussion/Decision with CCGs/AT and OSC on potential options
Further Analysis required
Develop pre-consultation business case
March = May 2014
Independent Clinical Advisory Group Feedback and recommendations
Health Needs Assessment
Cost Benefit Analysis
July 2014
Programme Board makes recommendation on future HASU configuration
July/August 2014
Discussion/Decision with CCGs/AT and OSC on potential options
>6 HASUs
Develop pre-consultation business case
6 HASUS
Improvement through existing contractual arrangements
Further Analysis required

What happens next?

	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14
Scoping	√												
Activity Modelling	√	√	√										
Financial Modelling	√	√	√										
Public Health data	√	√	√	√									
Provider Submissions			√	√									
Independent Expert Advisory Group					√								
Recommendation Programme Board						√							
Recommendations presented to Clinical Network and Senate, Health Impact Assessment and EQIA/ Cost Benefit Analysis completed							√	√					
DH Gateway Report Stage 1, Clinical Senate report received, Draft Business case received													
Programme Board receives updates									√	√			
NHS England Assurance Process									√	√			
Programme board signs off recommendation on future stroke and discussion/decision with CCGs, Area Team and OSC											√		
Potential Public Consultation if <6 HASUs or if 6 HASUs											√	√	

Financial principles

- Aim to deliver service change within the current financial envelope:
  - Payment By Results
  - Best Practice Tariff
  - Local tariffs
- Up to £2.6M Best Practice Tariff estimated cost pressure (based on 2012/13 data – to be validated)
- Identify new tariffs
- Identify options for optimal configuration in financial terms

Procurement strategy

- Recommendation for 6 HASU sites – improvement through existing contracts
- Recommendation for less than 6 HASU sites – formal public consultation followed by competitive procurement process

Summary: what do we want to achieve?

- Improved chance of survival from stroke
- Patients are in hospital for less time
- Fewer patients need to be re-admitted to hospital
- Achievement of 90% stay on a dedicated stroke ward
- Increase in % of patients receiving thrombolysis
- Achievement of diagnosis and treatment for high risk TIA
- Increase in the number of patients discharged to their normal place of residency

Future communication

- Bi-Monthly updates to all stakeholders
- Confidential detailed reports for the key decision points will be sent to CCGs, Area Team
- Minutes of the Programme Board and respective sub groups

Recommendations

The Committee is asked to:

- Note and endorse the programme scope & approach including governance arrangements, (please refer to programme brief)
- Note that their primary points of contact are their local commissioners, supported by Sandwell & West Birmingham CCG
- Note that if consultation is required this will be determined by Autumn 2014; proposals will be subject to a period of formal consultation
- Advise the programme board on the preferred route of communication

Questions?

Nighat Hussain
Programme Director
nighathussain@nhs.net

Agenda Item No: **7**

Health Scrutiny Panel

17 July 2014

Report title	**Provision of elective services by The Royal Wolverhampton NHS Trust at Cannock Chase Hospital – commencement of the public consultation**
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Well Being
Wards affected	All
Accountable director	Sarah Norman, Community
Originating service	The Royal Wolverhampton NHS Trust and Wolverhampton Clinical Commissioning Group
Accountable employee(s)	Maxine Espley — Director of Planning & Contracting, RWT Noreen Dowd — Interim Director, WCCG Tel — 01902 695944 Email — Helen.davis4@nhs.net
Report to be/has been considered by	

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Support the proposals set out in the consultation document;
2. Support the consultation and engagement plan.

1.0 Purpose.

1.1 To provide the Health Scrutiny Panel with an overview of the consultation information, a copy of the proposed public consultation document and the background to the decision to change the location for the delivery of some clinical services. The consultation document and covering paper will be presented to the Health and Well Being Board for approval to follow the Health Scrutiny Panel meeting

1.2 The current constraints on capacity at New Cross Hospital driven by a number of factors including increasing demand on unscheduled (emergency and unplanned) care have resulted in the need to implement a clinical model that separates elective (planned surgery and medical treatment) and unscheduled/ complex care. The Trust is unable to make suitable changes on the New Cross site therefore delivering this model on the New Cross site is not an option.

1.3 This report outlines the process for public consultation in relation to the provision of elective services at Cannock Chase Hospital under a revised model of clinical care described in 1.2 above.

2.0 Background and Context

2.1 Following the announcement by the Secretary of State for Health regarding the dissolution of Mid Staffordshire Foundation Trust (MSFT) The Royal Wolverhampton NHS Trust (RWT) will acquire some services from MSFT in addition to Cannock Chase Hospital. This transfer will be a legally binding Transaction which will result in a new Statutory Instrument for RWT.

2.2 This acquisition critically important for clinical pathways and driving up patient experience. There is a growing national evidence base that supports the separation of routine elective and unscheduled activity onto separate sites. Around the country Trusts who operate in this way either independently or through arrangements with other providers deliver an enhanced patient experience with greater certainty, the potential for better clinical outcomes and improved efficiency both of the patient pathway and the use of resources.

2.3 Ensuring our clinical models support staff, particularly clinical staff in delivering high quality services and getting the range of experience through the level of activity they undertake to remain highly skilled means that the Trust is able to recruit and retain the best staff. This has a direct impact on the range and quality of care we can deliver to our patients and helps to secure a comprehensive range of services locally.

2.4 It is also is strategically important for RWT and the patients it treats. Economic evidence shows that for long term service viability acute trusts need to serve a catchment population for secondary care services of around 500,000 and to have an operating budget of around £500 million – this acquisition takes RWT to those thresholds.

3.0 Delivering services for patients

3.1 The Trust's priority is to deliver safe and effective services for our patients and to increase the certainty for delivery of routine elective surgery. Over the last couple of years we have faced increasing pressure on all our services due to the rise in unscheduled care including admissions from A&E and other emergency portals. This has resulted in an increase in cancellations of patients about to undergo elective surgery. As part of its bid for the services from MSFT RWT proposed a clinical model which will enable the Trust to more effectively schedule elective care and prevent cancellations resulting from unscheduled admissions. The Trust presented its clinical model to the National Clinical Advisory Group (comprising the chairs of all the Royal Colleges and Associations). The proposals which are outlined below where approved by this Group as being clinically safe.

The Trust has presented to the Health Scrutiny Panel and other forum on a number of occasions regarding the pressures on its services. Most recently the Panel has heard about the City wide Urgent & Unscheduled Care Strategy. WCCG has discussed the Trust's plans and agree that the proposed model will address the current pressures on elective care and give patients a better experience.

3.2 *S*ervice Provision at Cannock Chase Hospital

The Trust has delivered a range of services at Cannock Chase Hospital under Service Level Agreements with MSFT.

Current service provision includes:

- Day Case Ophthalmic Surgery for the population of South Staffordshire and Wolverhampton
- Outpatient Haemodialysis Service in an 18 stationed satellite Haemodialysis facility, linked to the Renal Service at New Cross Hospital, Wolverhampton, for the population of South Staffordshire and Wolverhampton

Previous service provision included a range of orthopaedic inpatient and daycase surgery now proposed in the new model

In establishing our plans for Cannock Chase Hospital it is proposed that new services will be provided from this location to patients, including Wolverhampton residents, including:

Day Case Surgery:

- General Surgery
- Orthopaedics
- Gynaecology
- Breast Surgery
- Dermatology/plastic surgery
- Urology

Day Case Medicine:

- Endoscopy (consistent with current service provision on this site)
- Rheumatology (consistent with current service provision on this site)
- Dermatology

Elective Inpatient General Surgery:

This will be limited to patients who meet international clinical criteria for measuring overall fitness and will include the following services:

- 23 hour stay surgery
- Breast Surgery
- General surgery
- Urology
- Gynaecology
- Orthopaedics

4.0 The Clinical Model at Cannock Chase Hospital

4.1 Surgical Services

Pre and Post-Operative Management

All patients will have a pre-operative anaesthetic assessment of risk of surgery/anaesthesia prior to listing for surgery at Cannock, and all will have a named consultant for their surgery and in-patient stay.

Surgery will be performed by the consultant led team (including their trainees/junior doctors). This team will undertake the immediate post-operative assessment prior to handing over care to the on-site out of hours team which will include:

- surgical cover will be provided by an SHO equivalent, who will cover general and orthopaedic surgery patients
- separate middle grade surgery cover for orthopaedic and general surgical patients
- anaesthetic cover will be provided by a middle grade doctor (ST3+ equivalent) with consultant anaesthetist support off site but with availability to attend, if required.

There will be on-call consultants for general/urology surgery and orthopaedic surgery off site, but with the availability to attend Cannock Hospital for patient assessment and management if required.

In the case of a patient deteriorating and requiring urgent/emergency care, then the patient will be stabilised (and, if necessary under exceptional circumstances intubated and ventilated) and transferred as an emergency to New Cross Hospital, Wolverhampton. Time for transfer from Cannock to Wolverhampton using blue light paramedic ambulance is 15 minutes.

Pre-operative and post-operative ward rounds will be undertaken by the surgical and anaesthetic team, on a daily basis. In addition there will be ortho-geriatric availability to advise on the medical management of the preoperative and post-operative care of relevant orthopaedic and surgical patients when requested/required (see below)

4.2 Medical Services

A 28 bedded Rehabilitation Unit (Care of elderly) will be located on the Cannock site which will be supported by a consultant COE physician and a middle grade doctor, in hours.

Out of hours cover will be provided by a middle grade doctor off site with on-call Consultant support and attendance, when required. Patients deteriorating and requiring emergency treatment would be seen by the on-site anaesthetist, stabilised and transferred back to New Cross Hospital.

This service will provide routine care of the elderly medical support and input into pre- and post-operative surgical patients.

Endoscopy, Dermatology and Rheumatology Services will be provided on the Cannock site. These will mainly be outpatient and day case services.

4.3 The Patient Pathway

All patients will follow a pathway that supports care close to home as far as is safe and efficient. Service provision will be as follows:

Outpatients: new, follow up and pre assessment will be offered at both sites for patient convenience
Day case surgery: some services will be offered at both sites for patient convenience
In patient: all routine elective surgery will be undertaken at Cannock except for those patients assessed as high risk
Trauma: all trauma will be undertaken at New Cross
Physiotherapy: will be offered at both sites for patient convenience

4.4 What this means for Patients

As outlined in the section above the majority of pre and postoperative services will be delivered on both sites which means that in many instances patients will be able to

choose which site they go to. For a number of patients undergoing day case and inpatient care travel to Cannock Chase Hospital will be the same distance or possibly closer than travel to New Cross. For some patients the distance will be longer but we believe the benefits of greater certainty and choice within their clinical pathway will offset this to a great extent. The actual number of patients will fluctuate dependent on types of referral and patient suitability however we anticipate in the region of 10,000 inpatient and daycases (c.21.5%) and 23,000 outpatients (new/follow up/procedures) (c.4.3%) a year will be treated at Cannock for all specialties (this number includes non Wolverhampton residents currently treated at New Cross. The detail by specialty will be provided in the consultation document.

4.5 Communication Plan

The Trust has developed a detailed communication and engagement plan which is shown in full in the consultation document. The plan includes:

- information on both the Trust and WCCG websites including an online comments form
- a public meeting in each locality
- hard copy and electronic consultation document available (available in other formats and languages as required)
- information posted in key areas across the Trust including the Patient Information Centre, in GP practices across the city and signposting through links on other agencies websites
- information provided to patient groups electronically and hard copy as required and through social media
- meetings with forum such as Healthwatch,

5.0 Financial implications

5.1 RWT will continue to deliver services within the financial envelope available through the commissioning of activity by Clinical Commissioning Groups, Local Authorities for Public Health and NHS England for specialist/tertiary services. WCCG will ensure through contract monitoring processes that RWT delivers services in accordance with local and national requirements

6.0 Legal implications

6.1 The Trust has taken guidance from its legal advisors as part of the overall transaction for MSFT.

7.0 Equalities implications

7.1 RWT and WCCG are fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity, so that we can remove or minimise disadvantages between people who share a protected characteristic and those who do not The clinical model the Trust will implement mirrors that in place in a number of places across the country and will ensure that services are appropriate and do not discriminate on

the basis of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex and sexual orientation. The TSA commissioned an extremely comprehensive independent Health Equalities Impact Assessment report as part of its work. Whilst this assessment was for the Staffordshire population many of the findings and recommendations will apply to the population of Wolverhampton in the context of the move of services to Cannock. RWT took account of these recommendations when planning its clinical model. Both RWT and WCCG will further review the recommendations in the context of people in Wolverhampton as part of this consultation. The rights and pledges contained in the NHS Constitution will be upheld at all stages of the patient journey

8.0 Environmental implications

8.1 The Trust's plans take account of the redevelopment programmes for New Cross and Cannock Chase Hospital

9.0 Human resources implications

9.1 Workforce planning will be part of the individual service changes

10.0 Schedule of background papers

Trust Special Administrator's Final Report and recommendations

TSA Health Equality Impact Assessment

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