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

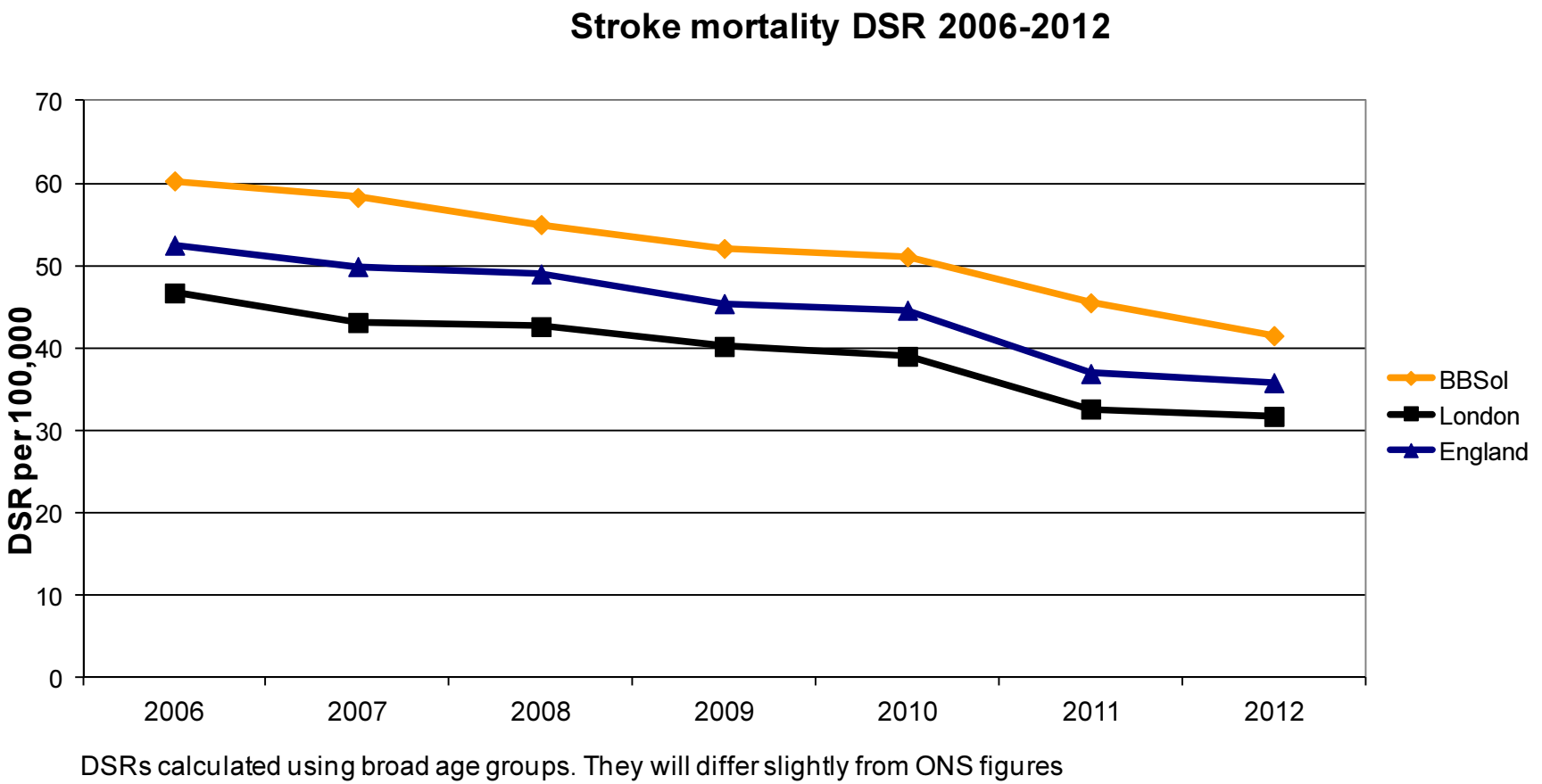
Will you change services?

- 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

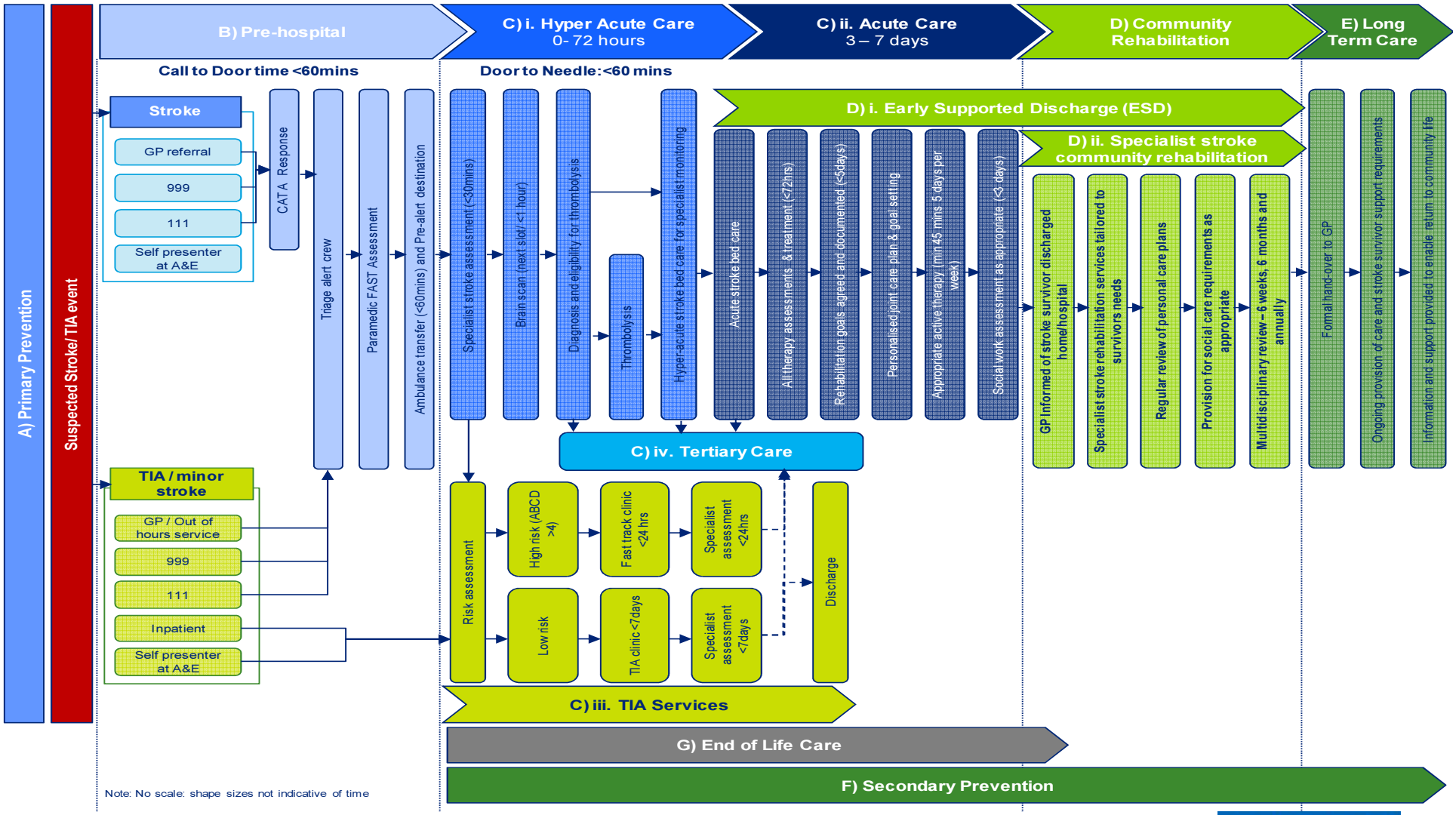
CCG	Provider
• Birmingham Cross City • Birmingham South Central • Dudley • Sandwell and West Birmingham • Solihull • Walsall • Wolverhampton	• Birmingham Community Healthcare NHS Trust • Heart of England NHS Foundation Trust • Royal Wolverhampton Hospitals NHS Trust • Sandwell and West Birmingham NHS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

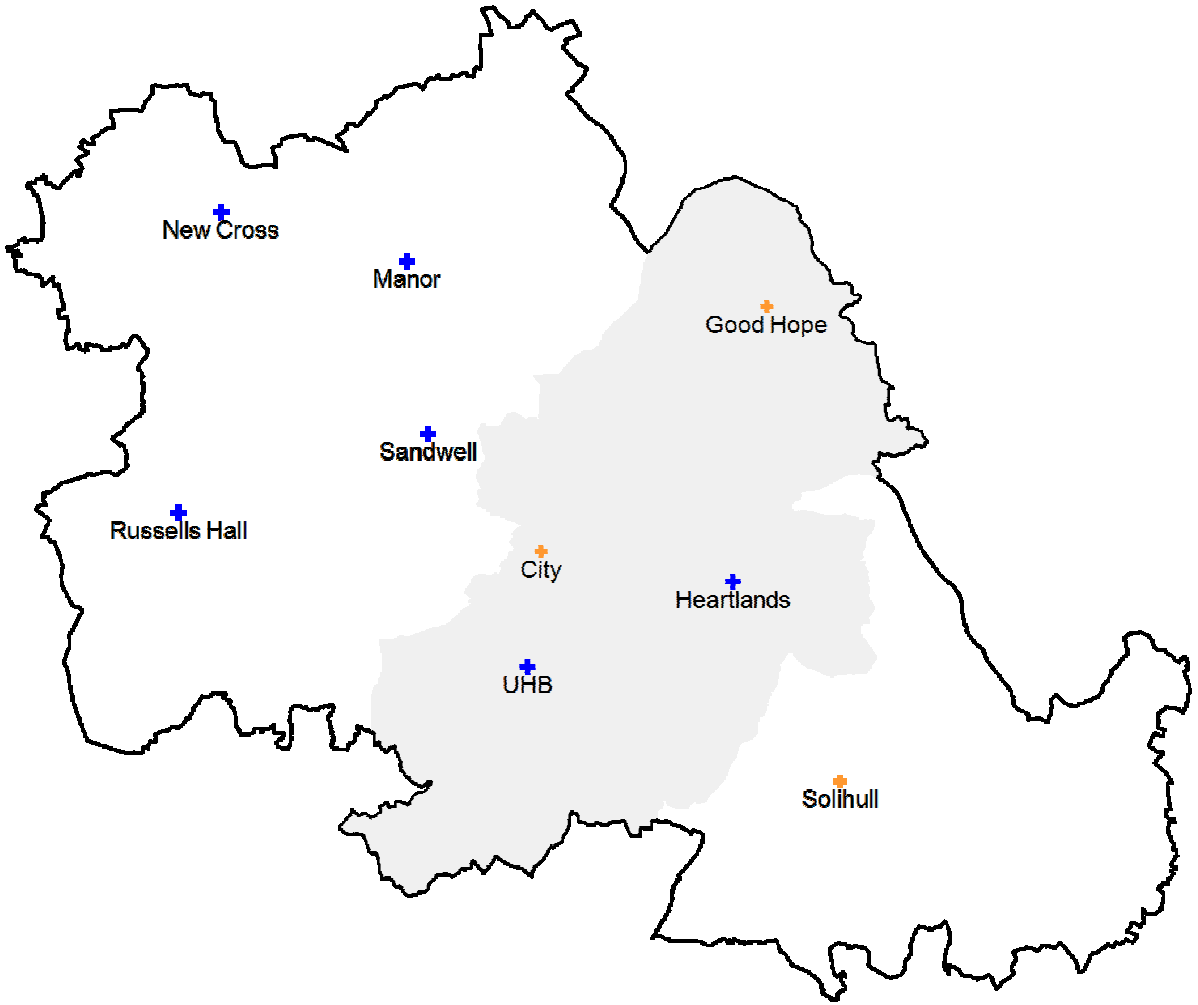
What do stroke services look like at the moment?

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

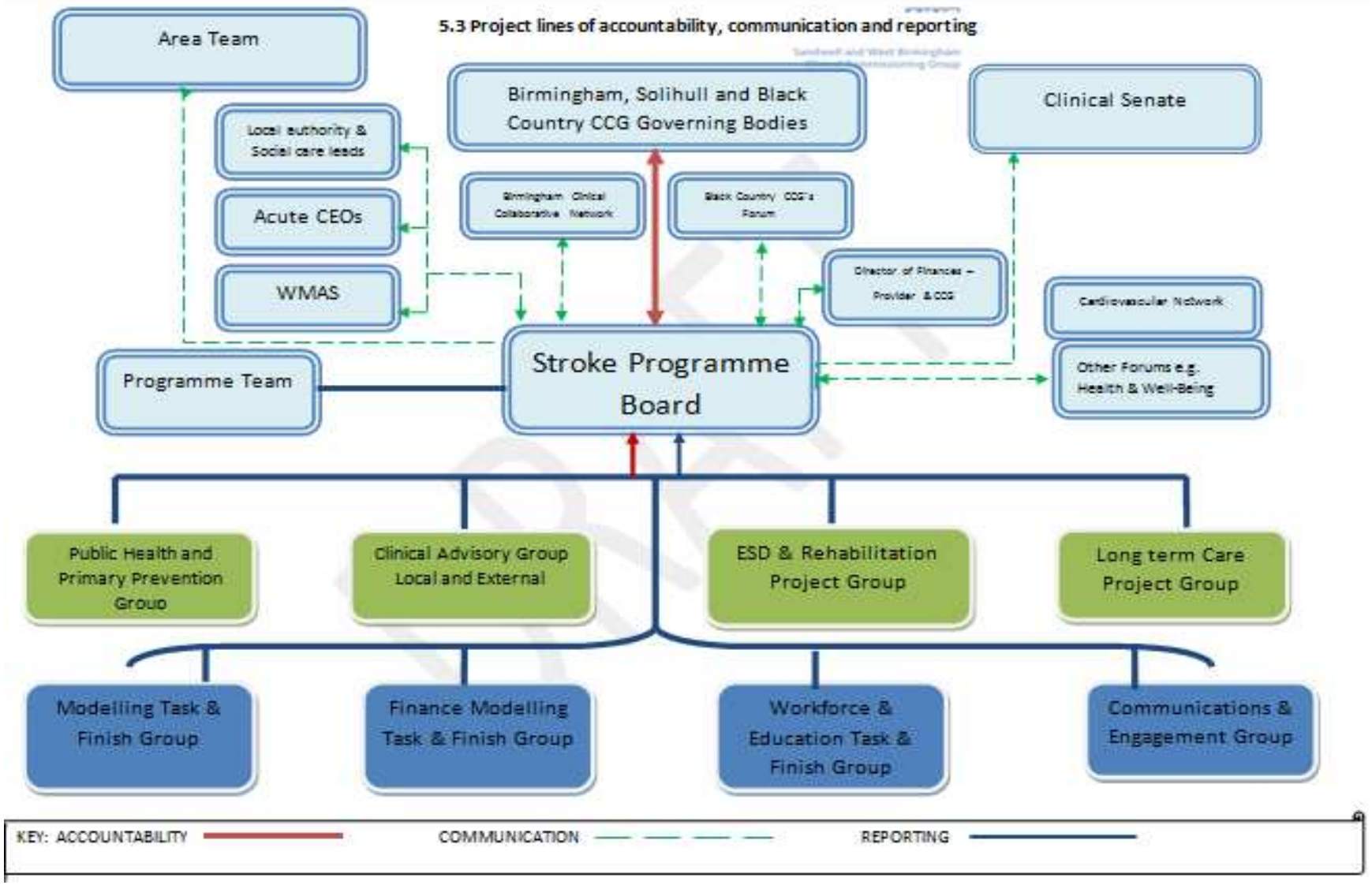
What matters most?

- 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

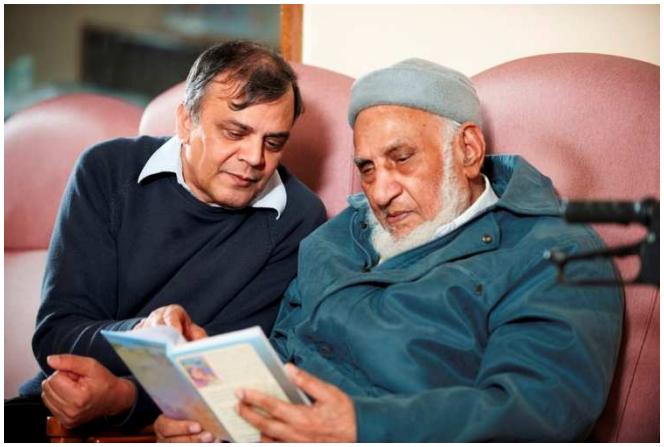
External advice

- 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

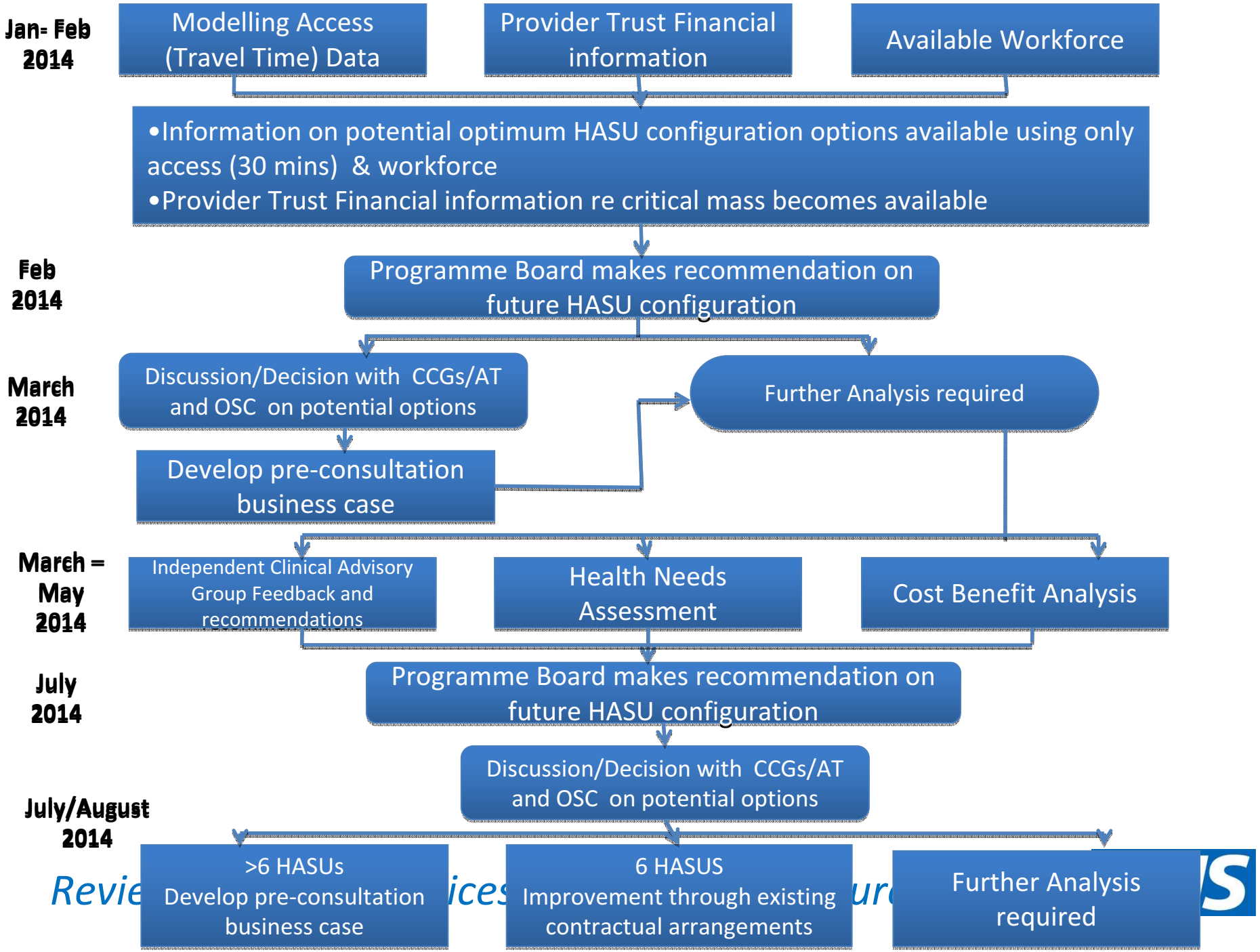


Stroke journey

- 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
Discussion/Decision with CCGs/AT and OSC on potential options
July/August 2014
>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