Walsall Stroke Services

Business Case for Public Consultation

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1.0 STRATEGIC CONTEXT

Walsall Context

The aim to reconfigure stroke services for the benefit of Walsall patients has been considered by Walsall CCG in a number of initiatives since the publication of the clinical senate review in 2012, in essence this is not a new concept for Walsall or indeed Black Country as outlined in the following timeline;

- Clinical senate review – 2012
- Stroke services reconfiguration programme – Jan 2014
- 2014 – Walsall HealthCare Trust (WHCT) and The Royal Wolverhampton Hospital Trust (RWHT) discussed proposals to merge stroke services – no agreement reached
- 2015 – WHCT completed an options appraisal of stroke services
- 2016 - Developed Black Country Alliance (BCA) proposal for stroke services to remain at trust with additional activity from South Staffordshire – not viable
- Nov 16 CCG considered stroke provision at Walsall – Five options considered by GB – Agree to engagement exercise to explore options
- Jan 17 – Big conversation undertaken across Walsall
- Feb 17 – Ongoing informal discussions with RWHT and WHCT supported trust discussions for stroke proposal to be explored.
- April 17 – Evaluation of Big conversation – Identified support for ASU/HASU as an alternative provider
- June 17 – CCG/WHCT agree stroke services not sustainable at WHCT

National Policy

The National Stroke Strategy (2007) identified that service improvements for stroke would save lives, reduce disability and make services safer for patients. The strategy identifies major stages in a stroke patients 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. The publication proposed a hub and spoke approach, with the hyper-acute hubs being able to deliver 24 hour CT scans and rapid thrombolysis treatment to improve patient outcomes. This approach has been successfully implemented in London, where all patients displaying stroke symptoms are taken to hyper-acute units and which has demonstrated significant improvements to patient care; in fact, a recent study found that the

service in London has directly saved an additional 94 lives per year since its inception when compared to other variations of the hub and spoke model, such as in Manchester, where only patients displaying stroke symptoms for less than four hours are conveyed to a hyper-acute unit and which has had no effect on mortality rates in the four years of operation in the Manchester area. Both approaches however have led to earlier discharges of stroke patients from hospital.

Black Country Sustainability and Transformation Plan

The proposed stroke service reconfiguration meets the Black Country Sustainability and Transformation Plan vision as described in this extract from the executive summary of the plan;

'For the future, we must transform services to adapt to rising demands. We must make the most of modern healthcare through innovation and best practice in order to change the way we spend money and use our limited resources.

We must also focus on shifting demand away from our hospitals and to a more community-centred approach. When patients need hospital care, however, it should be of the highest quality, providing specialist interventions in the right place and at the right time with less variation in the care that patients receive.

It is clear to us that our current ways of operating are unsustainable. Under our plan, individual organisations and partnerships will continue to make the improvements and efficiencies that are directly within their own control but the overall scale of opportunity will be transformed by our working together as a single system with a common interest.

At the heart of our plan is a focus on standardising service delivery and outcomes, reducing variation through place-based models of care provided closer to home and through extended collaboration between hospitals and other organisations'

The proposals laid down within this business case are fully aligned with the vision of the STP.

Local Plans

Walsall CCG Governing Body, at its meeting of November 24th 2016, agreed the following overarching principles in relation to any future provision of stroke services:

Stroke services will conform to the specifications contained in the NHS Midlands and East Stroke Services Specification, take into account the National Clinical guideline for Stroke (5th Edition 2016) and meet the following WCCG principles:

a) We will only commission services which demonstrably meet accepted clinical safety and quality standards. This must be demonstrated both within the specific clinical services; and within the wider clinical environment e.g. If stenting is to be supported then the stenting standards will have to be demonstrated but the infrastructure will need to be available in case of an untoward incident.

b) We will only pay National Tariff prices for services

c) We will not buy if the overall pathway of care has more components, more complexity and is more expensive than if we went to an alternative provider.

Additionally the CCG requires that all patients, regardless of the length of time they had displayed stroke symptoms, would be conveyed to the hyper-acute unit in the first instance, in line with the London approach referred to previously in this paper.

Walsall Healthcare Trust have explored a proposal produced by the Black Country Alliance (BCA) to consider a merged stroke services arrangement across the BCA; this has been shared with the CCG but is no longer a viable option, with the BCA unable to generate clinical resource and support for the arrangement.

Royal Wolverhampton Trust has produced a document to support the decision making process of Walsall CCG pertaining to the future possibility of Walsall and Wolverhampton Stroke services combining in the form of a single ASU/HASU located at New Cross Hospital.

WCCG has met with both RWHT and WHCT and requested that discussions with both Trusts take place to consider a more viable option between both trusts for the delivery of stroke services for Walsall residents.

2.0 THE CASE FOR CHANGE

Rationale

Good quality stroke services, as defined by the National Stroke Strategy (2007), require 7 day, 24 hour access to thrombolysis treatment and a 7 day high risk TIA clinic. These services require a reasonable scale to ensure that there is sufficient consultant coverage to provide comprehensive, sustainable services. For this reason, stroke networks across the country have reviewed stroke provision and concentrated it on fewer, larger centres. It is likely that this trend will continue as it has a direct correlation with improved outcomes for patients.

Currently all patients in Walsall CCG area exhibiting symptoms of stroke are conveyed to and dealt with by Walsall Healthcare Trust (WHCT) at the Manor Hospital, and according to the Sentinel Stroke National Audit Programme (SSNAP) report for financial year 2015/16, WHCT treated 375 stroke patients. Whilst overall WHCT was rated as ‘good’ (and ‘improving’ over the last two years), the mainly low scoring domains (D or E average) were related to the stroke unit and thrombolysis provision.

The NHS Right Care Commissioning for Value Focus Pack for Cardiovascular Disease (April 2016) shows that Walsall is in worse in a number of areas of the pathway compared to CCG’s of similar size and demographics. In the main these outcomes pertain to lack of clinical resource and lack of capital resource, in particular with regards community beds.

At present Wolverhampton and Walsall see respectively approximately 600 and 400 confirmed stroke patients each year. To be a viable Hyper acute Stroke service it is recommended that there are a minimum of 600 confirmed stroke patients each year. For Walsall Healthcare Trust the income from activity of 400 confirmed stroke patients is insufficient to fund staffing levels to meet the HASU requirements and there is no potential to

increase stroke numbers in future, despite considerations of patient flow arising from other stroke reconfigured areas eg: Burton.

NHS England previously wrote to all providers of urgent care network specialist services requesting an audit of compliance against the seven day services standards for acute stroke, STEMI heart attack, major trauma, emergency vascular and paediatric intensive care services. The aim of this audit was to identify those individual services where attention and action was needed to ensure that all patients requiring services for stroke receive the best possible care on a 24/7 basis. The results of the audit have identified that WHCT are below the standard expected for time to first consultant review (60% not met) and Ongoing consultant-directed review (40% not met). Whilst the formal response from the trust to how it will manage to achieve these standards by November 2017 is awaited, it is expected to advise that it is not able to meet these standards, again due to reduced numbers and the inability to fund and support the clinical capacity required by that time, and the service is therefore unsustainable.

Sentinel Stroke National audit programme (SSNAP) figures have thrombolysis rates for Wolverhampton and Walsall at 14.5% and 10.5% respectively for 15/16. With Service unification we would expect to see the thrombolysis rate for Walsall patients improve as they would be thrombolysed at the RWHT rate. Furthermore after rationalisation of Hyper acute services in London, the stroke thrombolysis rates significantly improved with some centres achieving 20%. We would expect to see the same pattern and therefore expect the thrombolysation rate for the whole Wolverhampton/Walsall population to increase above current rates towards 20%.

Walsall and RWHT would have access to the same thrombectomy pathway, at present the local pathways are at Stoke and University Hospital Birmingham; this would require a defined and commissioned pathway.

With respect to Stroke consultant workforce in Wolverhampton there are 4 WTE consultants and at Walsall there are 2 WTE consultants. The British Association of Stroke physicians (BASP) recommend that a 24/7 Hyper-acute stroke service should consist of at least 6 WTE consultants. Combining two cohorts of consultants will improve the availability of senior decision making cover and more importantly achieve the compliance requirements for seven day services.

There would also be a larger pool of stroke trained nurses to help drive forward the required standard of care. RWHT already has 7- day physiotherapy and occupational therapy which would be maintained, through this process 7- day Speech and language therapy access would also be achieved. The sharing of patient time and therapy spaces can only realistically be achieved in a single unit, preferably one physically laid out to mimic a patient's journey towards recovery. For this to be realistic a capital investment scheme for RWHT has been submitted. Whilst the movement to RWHT is not predicated on the achievement of the bid, it does offer all of the benefits that delivery through a single unit would support. The current arrangement at WHCT would require significant investment and work to enable a like for like unit on this site.

The key requirements to be delivered within the Stroke Services Service Specification:

- A 7 day/24 hour stroke physician led service – *Not possible in WHCT without increasing stroke numbers and increased consultant and specialist nurse capacity.*
- Direct admission to a HASU within 4 hours - *Not possible in WHCT without increasing stroke numbers and increased consultant and specialist nurse capacity.*
- Brain imaging (MRI/CT) within an hour with skilled clinical interpretation to be available 24/7 - *Not possible in WHCT without increasing stroke numbers and increased capacity.*
- 24/7 access to thrombolysis, - *Not possible in WHCT without increasing stroke numbers and increased consultant and specialist nurse capacity.*
- Enhanced staffing levels of stroke specific trained MDT - *Not possible in WHCT without increasing stroke numbers and increased consultant and specialist nurse capacity.*
- Door to needle time less than 60 minutes
- Combined Hyper acute & ASU
- Access to ESD and appropriate long term care support – *Will require review and additional investment to support capacity required.*
- Goal led inpatient rehabilitation for appropriate patients
- Access to TIA clinics, with consideration of a local TIA clinic in Walsall

Early supported discharge is a key element of the overall stroke pathway, including rehabilitation. The current ESD for Walsall results in stroke patients sustaining an increased length of stay in an acute hospital bed due to the non-availability and investment of specialist community provision.

WHCT is to provide Early Supportive Discharge (ESD) and community pathways for Walsall patients and it is proposed that WHCT to host TIA clinic with clinical provision by RWHT. Given the case for change discussed it may be reasonably concluded that stroke services for Walsall are not sustainable with the current arrangements.

3.0 OPTIONS WITH CCG EVALUATION

At the Walsall CCG Governing Body meeting on November 24th 2016 it was resolved *that 'The Governing Body also gave approval to explore all options, including engaging with RWHT on options with them'.* Subsequent CCG discussions with RWHT and WHCT, and discussions between both Trusts, have led to Option 5 becoming the emerging preferred option between all three organisations, and supported by Wolverhampton CCG. Other options considered and discounted by the CCG include:

1. **Maintain status quo** - continue to operate a HASU service, using existing WHCT infrastructure and staffing, with resolution of the gaps as finances allow.

   CCG comment: This option is no longer sustainable, the current service delivery model would continue to be only partially compliant with the HASU specifications, in particular with regards overall stroke activity being less than nationally recommended, consultant

capacity limited and no arrangements in place for community stroke rehabilitation beds and lacks system resilience with regards 24/7 cover.

2. **Financial investment by WHCT**, in a phased approach, to 'fill' the key gaps in the current HASU service delivery model to satisfy the HASU specification requirements and achieve the required performance.

   CCG Comment: This option would require additional funding and investment by WHCT to recruit additional staff to bring the service up to the acceptable HASU standard (as much as £650K) with the CCG possibly asked to provide funding for approximately 22 additional beds in community care. Given the current financially challenged position of both trusts this is not a current option. The comment in Option 1 regarding the CQC report is also applicable here.

   The option also only becomes viable if there is an increased attendance to 600 stroke patients per year. The report asserts that the additional attendances would come from the proposed withdrawal of stroke services by Queens Hospital Burton, and the opening of the Midland Metropolitan hospital in Birmingham, however, it has recently become apparent that stroke services in Burton are to continue due to Burton and Derby hospitals working more closely together, so the anticipated numbers attending Walsall Manor are unlikely to materialise, thereby making this option unviable.

3. **Fusion of capabilities** with Black Country partners under a 'Black Country Alliance' proposal that will be 'utilised' to 'share' staff to fill WHCT gaps to enable WHCT to satisfy with the HASU specification requirements and performance targets.

   CCG comment: the comments relating to option 2 above are applicable here, with the added complication that this option is out of step with the move towards an STP footprint for the Black Country, as the Black Country Alliance does not include Royal Wolverhampton Hospital Trust, a provider that some Walsall patients, particularly on the West of the borough naturally flow to.

4. **Outsource the HASU service to Royal Wolverhampton Hospital** (RWHT) with patients being repatriated back to the WHCT ASU to provide on-going acute bed based care. The community stroke services will be provided by WHCT.

   CCG comment: The implementation of this option would entail the apportioning of the national tariff for stroke between the hyper acute and acute phases of the pathway. The report indicates that the pathway apportionment generally operates on a 70/30 split, so this may bring into question the ability of WHCT to provide the acute part of the pathway on 30% of the tariff. Negotiations for similar arrangements in other areas of the region concluded that, even with a 60/40 split of tariff, it is financially unviable for the Provider of the acute part for the pathway. The business case for the same set of negotiations also placed the cost of a two site option at around 40% above the national tariffs for the whole pathway.

There becomes a further option for the governing body to consider that might satisfy the requirements of the relevant specifications, guidance and principles referred to in the introduction, which is;

5. **Walsall CCG actively considers commissioning Royal Wolverhampton Trust** (RWHT) to provide both Hyper-acute and acute parts of the Stroke pathway for all Walsall patients, thereafter Early Supportive Discharge and a Community Stroke Service provided by WHCT. (**Preferred Option)**

   CCG comment: This option seems to be the most viable in the current circumstances to provide a stroke service for Walsall patients that complies with our CCG overarching principles described earlier in this paper, satisfies the comments made by the WM clinical senate report (Oct 2015): 'The panel are of the view that co-location of HASU and ASU across all units does and will improve integration of acute stroke care and patient flow in the acute phase and, on that basis, will work towards that the proposed service standard of transfer from HASU to ASU at 3 days and discharge / repatriation at 7 days', and would be in line with the move towards an STP footprint for the Black Country.

   If RWHT were commissioned to provide a HASU/ASU service, it is envisaged the success of centralising HASU/ASU services by Heart of England FT could be replicated here. RWHT indicate that the annual flow would increase to around 1,100 patients per year, and they are confident they would be able to cope with these numbers.

Impact and benefits

Placing patients on the correct pathway (Hyper-Acute or Acute and ESD) will maximise the likelihood of best possible outcomes and allow for resources to be used effectively. The general expected outcomes are:

- Improved outcomes for stroke patients, by reducing the levels of death and disability following a stroke consultation
- Improved patient experience and enhanced recovery following a stroke,
- A single service that is sustainable and provides good value for money through effective use of resources,
- Equitable access to Stroke services and quality care across the region,
- Provide a fully integrated, end-to-end stroke service for NHS Midlands and East.
- Implement the recommendations of the National Stroke Strategy.
- In line with the requirements laid down from STP

These gains will partly arise from improved quality of outcomes for Walsall patients but also from economies of scale and the 'hub and spoke' model of specialist care that is proven to give better outcomes for patients.

Capital will be required to create a single stroke facility with flexible bed stock for HASU and ASU elements to be combined, TIA clinics, some degree of rehabilitation and pre-discharge and potentially direct access for Stroke patients brought in by ambulance.

Implications for wider urgent and emergency care system

Confirmation required with WMAS that suspected stroke patients would be conveyed to RWHT on each occasion – ongoing discussion with WMAS.

Potential additional investment to support this arrangement is under negotiation, but worse-case scenario identifies an additional investment of £250k,

Consideration also needs to be given to North Birmingham patient flow and Sandwell patient flow, with approx. 50 and 60 patients per annum currently treated by WHCT. There would be capacity at RWHT to treat these patients, if required, however, support for ESD would need to be established by the receiving trusts and is also a consideration of the proposed revised arrangements.

4.0 STAKEHOLDER AND PUBLIC CONSULTATION

Public and patient consultation

On 24 January 2017, NHS Walsall Clinical Commissioning Group (CCG) launched a seven week pre-public engagement exercise - The Big Conversation.

The purpose of the exercise was to engage with people in Walsall on their views and experiences of health care services and also share ideas for future healthcare delivery to ensure we have sustainable, quality services that are affordable and fit for the future.

One of the main areas of focus for public engagement was Stroke services - To consider how complex care could be delivered differently to reduce the demand for hospital services such as stroke.

Public events

Three public events were held in separate venues across Walsall. In total 173 people attended. The events were advertised via GP surgeries, email newsletters, posters, leaflets, the CCG website, through the local media, social media and through partner communication networks.

The first event was held at Walsall Town hall and focused on setting the scene and updating the public on the CCGs financial situation and other local challenges. Attendees then broke away into smaller discussion groups looking at one of following areas; Walsall Together, Urgent Care, Stroke, Primary Care.

The second event was held at Rushall Community Centre and the main focus was on Walsall Together and primary care only.

The third event was held at Moxley People's Centre and the focus was on stroke and urgent care services.

Community Outreach – Big Conversation Camper Bus

A camper van was commissioned by the CCG to go out into various communities across Walsall. Staff from the CCG and Health watch representatives spoke to members of the public and handed out surveys. Ten venues were visited over a 7 day period, including a weekend.

Voluntary and community organisations were given the opportunity to have a visit from the Big Conversation Bus. Some of the venues that were visited include supermarkets, a place of worship, a leisure centre, libraries and markets.

Alongside the staff, a camera crew invited members of the public to give their feedback on camera. Over sixty three people participated in total.

Walsall CCG Patient and Stakeholder Advisory Group

The main role of the Walsall CCG Patient and Stakeholder Advisory Group is to ensure that the CCG undertake meaningful engagement with patients and public. The group were invited to help shape the engagement plan and kept informed of activity throughout. They were also asked to support the exercise and share the material and messages through their own communities and networks.

Focus groups

Health watch Walsall held 6 focus groups with 112 children in schools across Walsall. The children completed a questionnaire and had discussions about the different areas.

Patient Representative Groups (PRGs)/ Patient Participation Groups

GP practice PRGs were also enlisted to promote the engagement document in their practices. Practice Managers and PRG/ PPG Chairs promoted it within their surgeries and helped members of the public complete the questionnaire where necessary.

Copies of the engagement document were also distributed at the Patient Participation and Liaison Group meeting with is made up of Chairs and Vice-chairs of PPG/ PRGS across Walsall.

Posters/ leaflets / Publications

Promotional material was produced to raise awareness of the public events.

Communication about the engagement exercise and electronic copies of the engagement survey were sent to the CCGs stakeholders list which includes local GPs, MPs voluntary sector, CCG partners and providers.

Media coverage

Regular press releases were issued to the local media and the CCG secured two interviews with Made in Birmingham Television, an article in the Walsall Advertiser and a feature on local community radio station, Ambur Radio. Ambur Radio is the largest multicultural community station in the West Midlands, broadcasting in English, Hindi, Punjabi, Urdu, Bengali and Gujarati to over 200,000 live listeners and over 140,000 online each day.

Articles were also featured on websites and in newsletters from Health watch Walsall, Walsall Healthcare NHS Trust, Walsall Council and Dudley & Walsall Mental Health Partnership NHS Trust.

Social media

Throughout the campaign, the CCG regularly tweeted key messages, communication materials and photos from engagement events using the hashtag #Bigconversation. A total of 63 tweets were sent to over 5,500 followers, which had a potential total reach of 144,000. Messages have also been retweeted by staff, partners, local media and followers.

Website

Dedicated web pages were set up on the CCG's website: http://walsallccg.nhs.uk/be-involved/the-big-conversation

The feedback in relation to stroke to this engagement is as follows;

Stroke Services	
If a relative of yours required care for a stroke, what would be the most important things you would look for?	• Quick response • F.A.S.T • Compassionate people to care for the patient • Appropriate care for family and friends • Look for quality care • Recovery • Prefer to go to New Cross Hospital • Expertise of staff • Physio and Rehabilitation • Speed of being treated • Concerned about aftercare and the finances that go with it • Daily care • Whether there's a lack of support
What are the most important things for the CCG to consider when buying stroke	• Listen to what the public are saying • People want to know what's going on • There's not much in place for patients at home • Doctors being overstretched • Ensure that ambulances can accommodate all cases • Availability to those who need them

support services?	• Good care for patient and families • Easy access • Ensure patients don't feel like a statistic, be more personal • Ensure aftercare won't fully be provided • More local services • Ensure services are easily accessible for those with mobility issues • Hospital departments to meet patients in the community
Stroke Services	If a relative were to suffer from a stroke the most important main priority is fast, effective care with good quality outcomes.
	Good value for money was also an important factor for the CCG to consider alongside the above points. Effective local rehabilitation services with consistency of care was a key theme.
	It was felt the CCG need to consider more patient education on prevention of stroke and raise awareness of the national stroke campaign locally.
	Stroke care does not necessarily have to be in the Walsall area however travel time, road networks and good transport links all need to be considered.

Engagement with OSC

Walsall Health Overview and Scrutiny Committee

The public engagement plan for the Big Conversation was shared with members of Walsall Health Overview and Scrutiny Committee for comments and feedback on the 10th January 2017.

All councillors were also invited to the public events and given the opportunity to complete the questionnaire via the local authority communication channels.

Plan for public consultation

We will be working closely with colleagues at Healthwatch Walsall to engage with local people.

We are proposing our consultation exercise will take place over six weeks starting from 14th August to 22nd September. To ensure we can be as inclusive as possible, we plan to carry out a range of consultation activity which will include a mix of public events, focus groups, social media, production of easy to read and jargon-free material and questionnaires to gather views. A comprehensive plan for public consultation will be prepared with the involvement of the CCGs Patient Advisory Group, which is made up of a range of patient representatives, representatives from a local faith group and the third sector. The types of consultation activity we will carry out are listed below.

As part of our plan we will also make sure that following the consultation exercise, a communications campaign takes place to inform the public and patients of the outcome.

Consultation Activity:-

1. A suite of consultation material will also be prepared with the input of our Patient Advisory Group:
    - A plain English, jargon-free consultation booklet will be available online and as a hardcopy. Versions in different languages will be available on request.
    - An easy-read version will also be produced and distributed to public buildings such as GP surgeries, leisure centres, libraries and community centres.
    - Leaflets will be distributed via the CCGs networks including the third sector
    - A hardcopy and online questionnaire will be produced to capture feedback. This will be tested with our patient representatives before publication.

2. Face-to-face events with a chance to ask questions and hands-on support to complete the questionnaire:
    - A series of drop-in sessions at locations across Walsall where people can find out more about the proposals and give feedback
    - With the support of our Patient Participation Groups (PPGs), we will be canvassing patients to give their views at GP surgeries.
    - Focus groups will take place in schools, third sector groups targeted at people with long- term conditions, carers, mums, homeless people etc.
    - An offer to all local groups of a speaker from the CCG to come out to one of their meetings, explain the proposals, and seek feedback.

3. Web-based consultation activity to reach a wider audience will take place:
    - A social media campaign signposting to the consultation material
    - A dedicated web portal will be set up to access all consultation material and the questionnaire
    - A short video outlining potential changes and how people can get involved will be produced

4. Promoting the involvement opportunities will be a key part of our plan to encourage people to participate:
    - Communication in the local media outlets
    - Flyers and postcards, publishing newsletters, posters and banners

The comments made by participants in the ‘Big Conversation’ public engagement earlier in 2017 have been taken into account and help form the basis of the proposed public consultation on the future of stroke care services.

As mentioned previously the Overview Scrutiny Committee (OSC) was involved in the engagement exercise in 2017. Subject to Governing Body approval of this business case the CCG plans to meet with the Overview and Scrutiny Committee in July 2017 to present the plan for further consultation which is proposed to take place during August and September 2017.

5.0 DELIVERABILITY

Hyper-acute Stroke Unit and Acute Stroke Unit

At RWHT common improvement themes include:

a. Strengthening the delivery of CIP
b. Ensuring the delivery of safe high quality services
c. Ensuring the delivery of national targets for Urgent and Emergency Care, cancer and referral to treatment time

These improvement priorities do not present risks to the delivery of the project. Centralisation of Stroke services and the resultant increase in staff members and availability of the Stroke Team on one site will improve the likelihood of the Trust meeting the national target for Urgent and Emergency Care.

The scheme is intended to support providers to deliver safe, effective clinical care of patients with a potential and actual diagnosis of Stroke.

A capital investment bid has been made by RWHT to enable the centralisation of ASU/HASU arrangements within the trust, the option is not predicated on the capital investment though.

Early Supported Discharge and Community Pathway

There is a requirement to review community capacity for Walsall, there is currently no community based facility to support ESD and no community bed stock, current arrangements are delivered through excess bed days being incurred at the trust due to the lack of any community provision. Initial planning assumption has identified the requirement for approx. 12 (To be Determined) community beds and a defined supported discharge pathway.

The development of the integrated intermediate care model provides a sound base for the principles of early supportive discharge to be made. It is expected this pathway will provide the basis on which the ESD pathway can be implemented.

The likelihood of community stroke bedstock being delivered through a dedicated stroke community building is limited, although some potential areas will be explored. The likely arrangement will be a supportive MDT arrangement delivered through an independent sector care home in Walsall. Costings for such arrangement are to be worked through, but will be expected to be offset by the reduction in LOS and potential closure of the dedicated stroke ward.

It is worth noting, Walsall does have a proven track record of high quality care being delivered through the care home sector and works well with the sector to ensure standards are consistently high and deliver the requirement of such services.

Procurement and contracting

CCG to contract directly with RWHT for the provision of the Hyper acute and acute parts of the stroke pathway, and to contract directly with WHCT for the stroke Early Supported Discharge and Community Rehabilitation services.

Finance & Activity (Capacity and Demand)

Initial investigations into the activity consequences of the transfer of the service from WHCT to RWHT have identified a number of areas of the pathway which require clarification.

Further work will be undertaken to identify activity levels relating to all aspects of the WHCT stroke service (HASU, ASU and ESD). This will inform negotiations between RWHT and WHCT regarding the unbundling of the national Payment by Results stroke spell tariff into pathway element payments.

This work will also identify related non-stroke activity (mimics) to ensure that appropriate capacity and patient pathways are identified.

Indicative implementation timeline

- Stroke business case to CCG Commissioning Committee June 17,
- Governing Body consideration of public consultation business case 4th July 2017
- Stroke paper recommending non sustainability of stroke services to WHCT board 6th July 17
- Presentation of business case proposal to Clinical Senate July 19th
- Presentation of business case proposal to Overview and Scrutiny Panel July 20th
- Consultation of proposal to commence August 17
- Agreement on proposal by CCG – 26th September 17
- Revised service mobilised and in place April 18

Risk and Mitigation

Commissioning risks and mitigations are set out as follows:

Risk	Mitigation
ESD Pathway not established	Principles of new integrated Walsall I.C model supports ESD
Community provision not in place	Independent sector capacity available Potential to secure dedicated site in Walsall quickly
Capital bid not approved for RWT	To consider alternative estate arrangements
Sustainability of clinical staff at WHCT during transitional period	WHCT have worked hard to ensure divisional clinically led decision and involvement
Consultation exercise fails to support proposal	Providers will review the sustainability of stroke services over the short to medium term
Travel time to RWT exceeds therapeutic requirement	Public Health supporting analysis

There are potentially additional risks identified for WHCT and RWHT, these will be managed locally by each trust in the first instance. Once agreed a project board utilising PRINCE2 methodology will be established, a full risk and mitigation log will then be held by the project team during any transition.

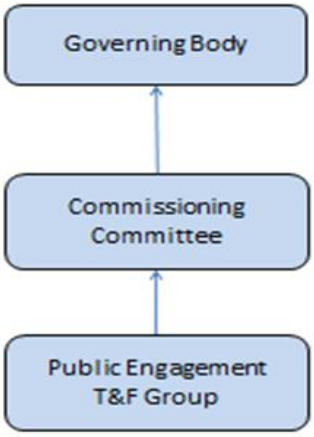
The potential risk to workforce, both in ensuring appropriate recruitment and any potential impact on existing workforce, in particular potentially destabilising medical capacity at WHCT and the potential knock on effect for junior doctor placements is considered to be both a local trust issue and one requiring a network view and solution. It is likely through the forthcoming period, that there will be significant impacts on the workforce of the Black Country and as the STP arrangement progresses and vertical integration develops this will require a wider system and overall network view to ensure ongoing stability and sustainable services through transformation.

6.0 GOVERNANCE

Decision-making

In Walsall CCG the development of commissioning strategy and plans is the responsibility of the Commissioning Committee, with the final decision on the proposals being made by the Governing Body. Both CC and GB have stipulated a requirement to ensure appropriate and relevant consultation prior to any decision being agreed, this includes dialogue with all relevant stakeholders and OSC.

Consultation Governance Framework



- **Public Consultation T&F Group** - in addition to relevant CCG staff, group includes representation from the patient voice panel, patient advisory group, , Healthwatch and Patient Representation Groups. Input from Equality & Diversity. T&F Group will identify and manage risk and escalate when outside scope of influence. Scrutiny of proposal from Consultation Institute, NHSE and Walsall Overview & Scrutiny Committee
- **Commissioning Committee** – main function are to approve the public consultation business case; receive assurance from T&F group that consultation plan is implemented on time, and that risks are recorded and managed; to receive escalated risks for mitigation.
- **Governing Body** - Ensure compliance with the statutory duty to involve the public in commissioning decisions, Equality Act. Director of Commissioning is Lead Sponsor and Chief Nurse is the Clinical Consultation Lead

Once the reconfigured stroke service has been agreed the CCG will receive assurance on performance issues via the contract mechanism and will ensure the service is safe and effective through programmed Clinical Quality Review meetings. There will be an agreed set of Key Performance Indicators to measure the service against which will support the effective monitoring of services, these will form the basis of a revised and robust service specification.

In addition the stroke service at RWHT has a robust governance structure that meets the requirements set out in the Trust's Clinical Governance Strategy. The Trust delivers its clinical and operational services through a Divisional and Directorate structure. Within the directorate-level structure there are three core meetings which look at performance, measurement and improvement of the stroke service. Existing arrangements between

WHCT and CCG will be reviewed to ensure fit for purpose and reflective of any revised arrangements.

Equality Duty

The impact on those people with protected characteristics has been taken in to account in developing the options for public consultation, and has been informed by the Equality Impact Assessment for the Birmingham, Solihull and Black Country Stroke Review published in June 2014.

Whilst the focus of the public consultation will be mainly of the service users and their immediate family or carers as any changes to stroke care must consider the ease of access relatives/friends/carers have to stroke patients. The impact of this proposal on users of this service is relatively small, given that they will invariably be conveyed to hospital under blue light conditions. There is likely to be an impact, in terms of increased travelling time, for relatives visiting the hospital, however the impact will be dependent upon where they reside in Walsall and the duration of the patient stay in hospital. It is important that the protected characteristics groups are covered in the public consultation. This will be included in the consultation plan and the updated equality analysis assessment.

The provision of Stroke Services will meet national standards for access to all groups that are required of all NHS funded services.

Four Tests of Service Reconfiguration

Four tests of service reconfiguration are set out in the Government mandate to NHS England. These are: strong public and patient consultation; consistency with current and prospective need for patient choice; clear, clinical evidence base; support for proposals from commissioners. The government's four tests of service reconfiguration are:

Strong public and patient consultation.

See Section 4: There has been ongoing public and informal consultation on the future of stroke services. The public engagement exercise in January to March 2017 had public and patient involvement in the form of Healthwatch, Patient Representation Groups and the Patient Advisory Group. Planning for the formal consultation to take place from July 2017 has the same level of public and patient involvement. Political and stakeholder consultation is a key feature of this arrangement.

Consistency with current and prospective need for patient choice.

See Section 1: National policy for stroke service care is to deliver the key requirements contained within the Stroke Services Service Specification (NHS Midlands & East) to patients suspected of suffering a stroke. Currently WHCT are currently only partially compliant with the specifications for hyper acute stroke services. The case for change has identified that WHCT is no longer a sustainable organisation to deliver stroke services for local people and to a certain extent choice of provision is therefore limited. That said a public consultation exercise is planned to consider the impact for patients should the option be supported. The initial engagement exercise has identified that patients priorities centre

around high quality services, 24 7 day a week and the destination of these services is less significant as long as they remain local i.e.: Black Country.

Clear, clinical evidence base.

National guidance as cited in section 1 sets out the clinical case for the implementation of a hyper acute and acute stroke service in line with the NHS Midlands & East Stroke specification. Centralisation of hyper-acute stroke care has the potential to improve health outcomes, including mortality, by increasing thrombolysis rates, and possibly through the concentration of expertise and treatment of higher volumes of patients. The specification to be delivered through RWHT will be fully reflective of the NHSE Midlands and East Stroke Services Specification and therefore wholly evidenced based.

Support for proposals from commissioners.

The CCG is leading this formal consultation on changes to stroke care services and is fully supportive of the option being considered. In addition the proposal is in line with the requirements laid down within the STP arrangement for Black Country and therefore in support of a wider commissioning system view.