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 a public consultation taking place at Heart of England Foundation Trust, considering the options of moving HASU services from both Solihull and Good Hope hospitals to the Heartland site. If the consultation recommendations are approved 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. As part of this work, Clinical Commissioning Groups (CCGs) will consider a number of factors including travel time, quality of care, workforce and patient experience. 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 Centres 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 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 (Appendix 1 – Midlands & East Service Specification). 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.

3.4 Interdependencies:

The programme will take into consideration a number of interdependences, these include:

- Accident and Emergency Services
- Intensive and Critical care
- General Medicine
- Geriatric Medicine
- Radiology
- Neurology services
- Vascular surgery
- Voluntary sector
- Lifestyle interventions
- Geographical Boundaries

4. Programme Vision and Outcomes:

4.1 Vision

The programme's vision is to prioritise stroke care and to develop a clinically driven model for local stroke provision. The overall aim is to ensure a uniformly high treatment standard for stroke patients, irrespective of where in the Birmingham, Solihull and Black Country they suffer their stroke.

4.2 Outcomes

- Reduction in stroke mortality rates
- Reduction in average length of stay
- 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

4.3 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.

4.4 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. For further information please refer to Appendix 2 (Programme Brief), Appendix 3 (Programme Board Terms of Reference).

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 recommendation 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:

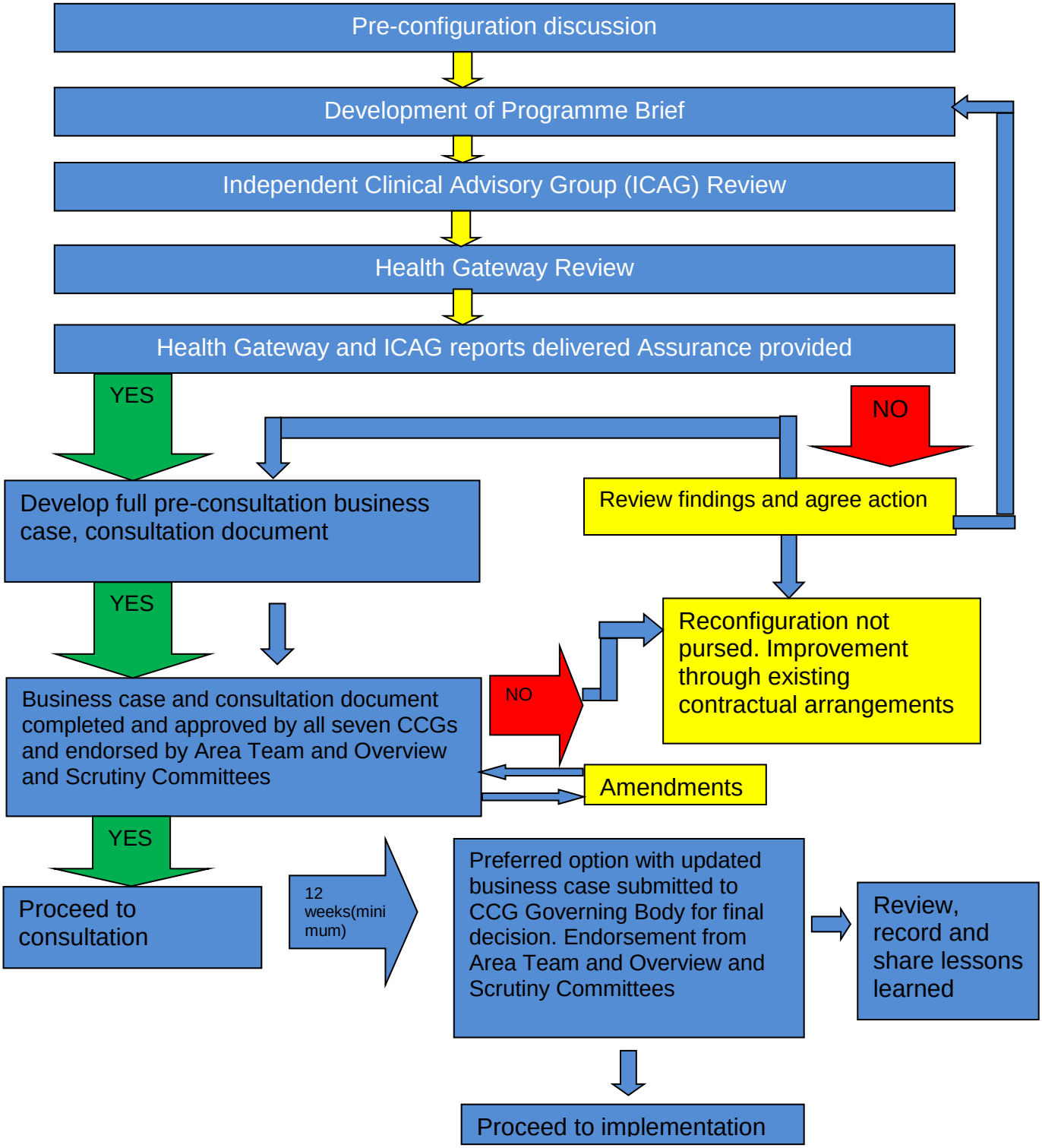
The Birmingham Solihull and Black Country Stroke CCGs will not support the Stroke programme to proceed to the next stage in the reconfiguration scheme without the successful completion of the following three stages of reconfiguration:

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, the public, their 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.

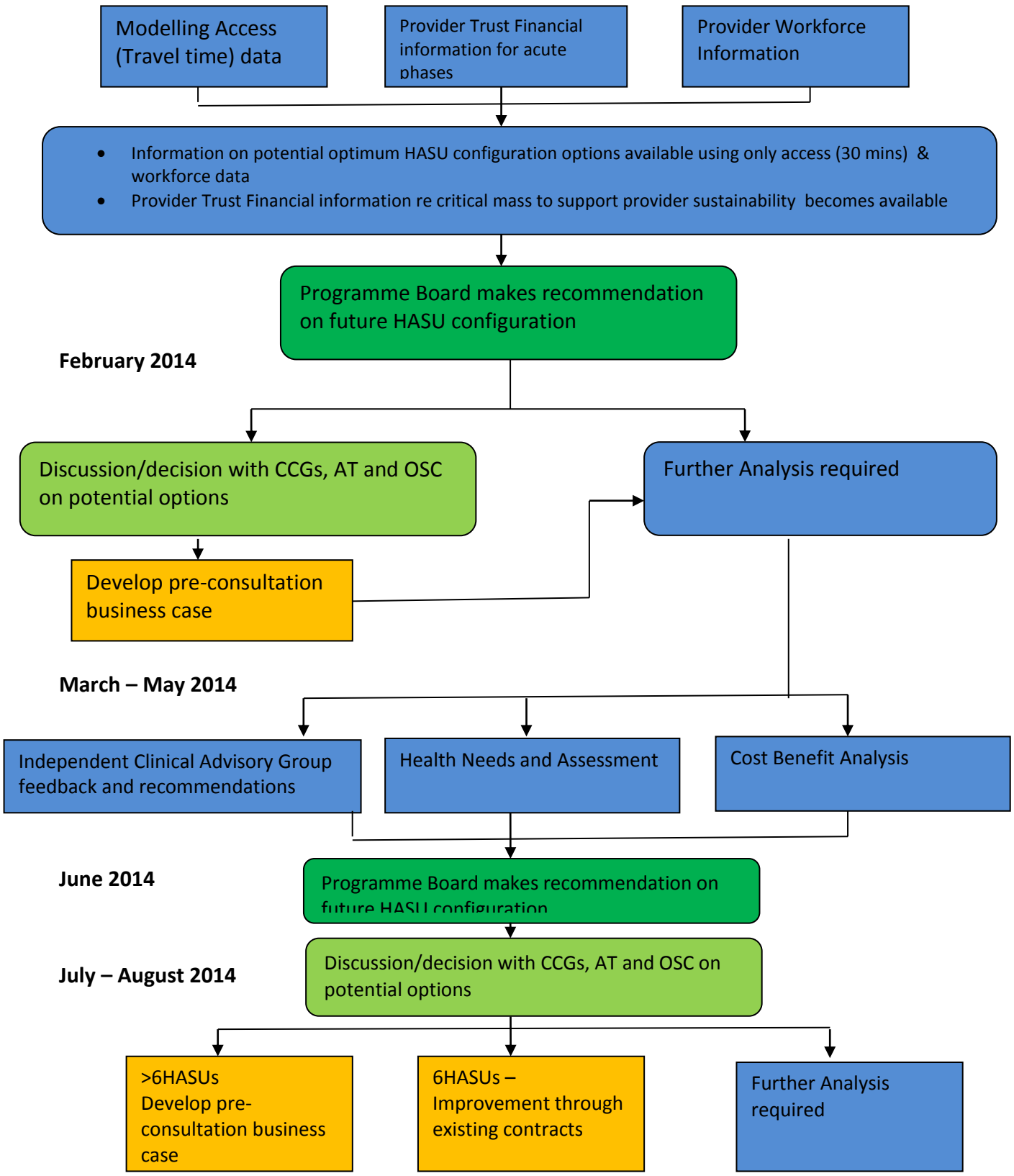
Stages of Reconfiguration:



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:

7.1 Key Decision points:



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	Jan 15	Feb 15	Mar 15
Scoping	√															
Activity Modelling	√	√	√													
Financial Modelling	√	√	√													
Public Health data	√	√	√	√												
Provider Submissions			√	√												
Independent Expert Advisory Group					√											
Cost Benefit Analysis					√	√										
Recommendation PB							√									
Decision 7 CCGs								√	√							
Public Consultation										√	√	√				

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. Future Updates

The Programme will issue monthly updates to all stakeholders. Confidential detailed reports for the key decision points will be sent to CCGs, Area Team and Overview and Scrutiny Committees. Organisations will be asked to sign both the Confidentially Agreement and complete the Conflict of Interest documentation; the confidential reports should under no circumstance be shared in the public arena as this would breach the procurement regulation of confidentiality for any future HASU service configuration. It is important to note that the responsibility for maintaining confidentially lies with the receiving organisation.

An update will come back to Health and Wellbeing Boards to inform on progress with the review and on the pre consultation business case if options are identified to change services.

10. Recommendation

The Health & Wellbeing Board 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