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

Date



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

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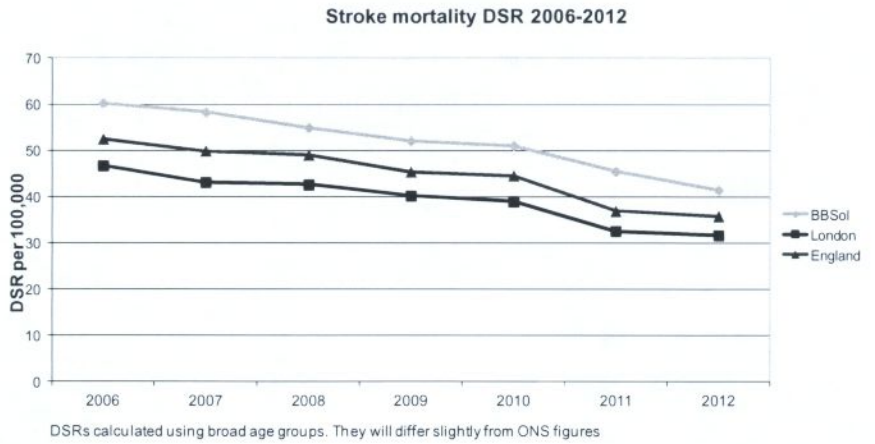
Stroke mortality



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

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Why are we reviewing services?

- Whole stroke pathway: from primary prevention to end of life
- Building on existing reconfiguration work (East and West Midlands) 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

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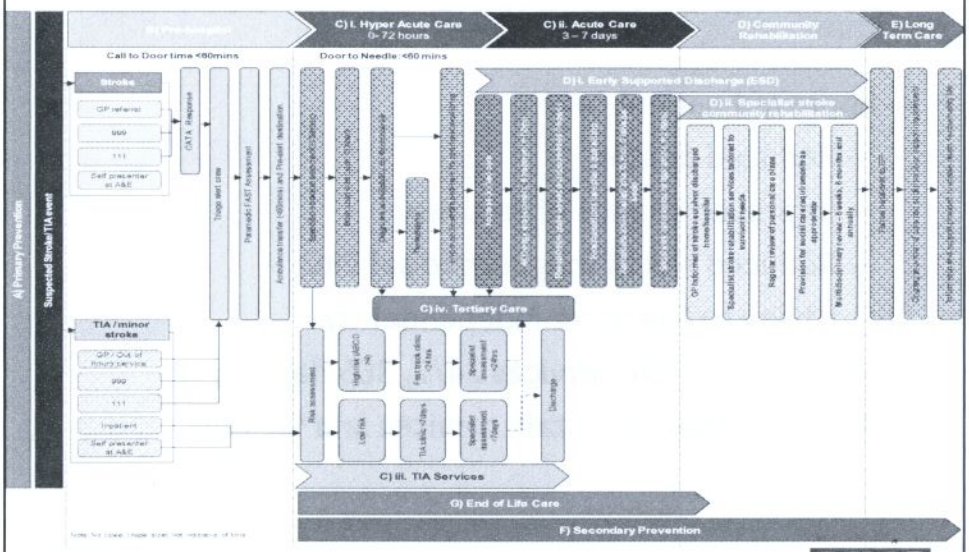
Stroke pathway



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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

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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

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What do stroke services look like at the moment?



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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

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Acute hospitals

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

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Do we need to change services to realise these benefits?



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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)
- With local consultations taking place we are already potentially moving towards this model
- This review will look at whether 6 sites is appropriate for the whole area

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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 (including patient experience)**
  - **Ease of deliverability**
  - **Improved strategic fit**
  - **Cost/efficiency**

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

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

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)
- Summer 2014- we should know if there is a need for change

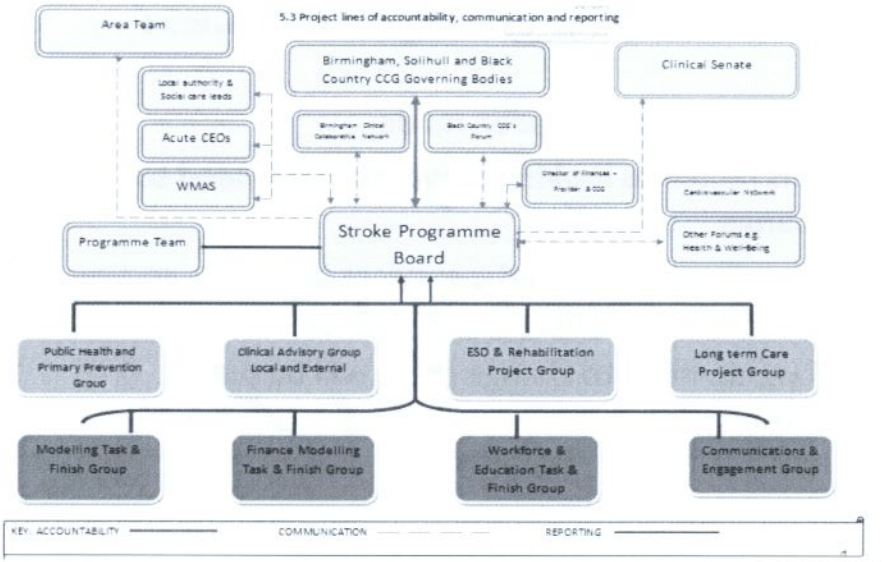
Will you change services?

- 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

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

Project lines of accountability, communication and reporting



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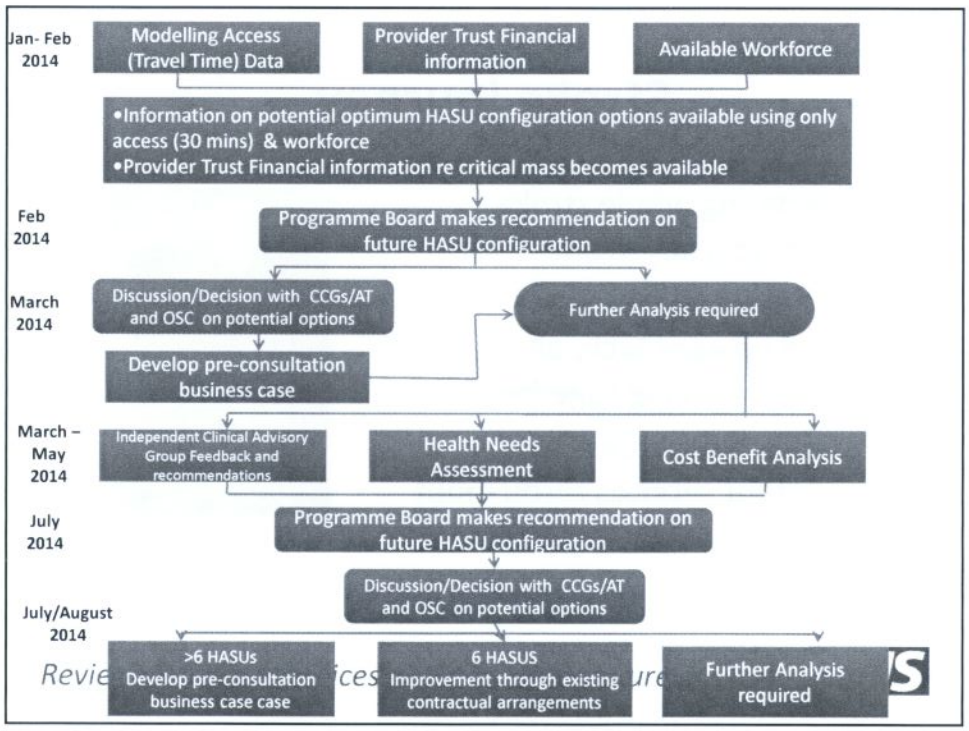

What happens next?

	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	Jan 15	Feb 15	Mar 15
Scoping	√															
Activity Modelling	√	√	√													
Financial Modelling	√	√	√													
Public Health data	√	√	√	√												
Provider Submissions			√	√												
IEAG					√											
CBA					√	√										
Recommendation PB							√									
Decision 7 CCGs								√	√							
Potential Public Consultation										√	√	√				

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Financial principles

- Aim to deliver service change within the current financial envelope:
  - Payment By Results
  - Best Practice Tariff (BPT)
  - Local tariffs
- Up to £4.5m BPT estimated cost pressure (based on 2012/13 data – to be validated)
- Identify new tariffs
- Identify options for optimal configuration in financial terms

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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

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
- 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

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

Questions?

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