Stroke Services Reconfiguration Programme Brief

Birmingham, Solihull and Black Country

January 2014

Contents:

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 better patient outcomes.

2. Context

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 that is provided across the region. The West Midlands Strategic Health Authority was still concerned about the model / configuration for stroke services in the region. In January 2012 the NHS across the Midlands and East approved 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 Midlands and East Stroke Review for the Birmingham, Solihull and Black Country area concluded that there are six hospital trusts, which deliver nine Hyper Acute Stroke Units (HASU). Hyper Acute Stroke Units provide specialist stroke care in the first 72 hours after the stroke. 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 and considered a range of options from three to six HASU sites, all of which required local appraisal. Since this time a public consultation took place in Sandwell and West Birmingham to configure stroke services at Sandwell General Hospital, resulting in 8 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 the Solihull and Good Hope site to the Heartland location.

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. An important part of this pathway relates to the hyper acute stroke units. This review will look at whether six hyper acute sites is appropriate for the area and if they can deliver the necessary improvements to patient care. Analysis of travel times suggests that it may be feasible to move to between three and six sites, with patients able to be conveyed to hospital within the recommended 30 minutes. However Clinical Commissioning Groups (CCGs) are clear that other factors such as quality of care, workforce and patient experience also 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 are the most appropriate configuration for stroke services.

The evidence suggests that there is a minimum specification that all hyper acute stroke units should achieve if they are to provide optimal care to patients. This centres on the timeliness of response and requires 24/7 consultants on call, as well as access to rapid scanning and thrombolysis services. This specification recommends 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.

Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) is leading the Birmingham and Black Country Stroke Reconfiguration Programme. SWB CCG will have overall responsibility for the delivery of the programme and will host the Stroke CCG Programme Board to provide the strategic steer for the programme. The decision on the future placement of hyperacute and acute stroke centres will sit with the respective CCG Governing Bodies; the role of the programme board will be to advise and recommend the preferred model for hyper acute stroke units.

The focus of the review is to assess if there is a need to reconfigure hyper acute stroke units to deliver improved clinical outcomes for patients. 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 & CCG Landscape

The intended reconfiguration of 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 Midlands and East Service Specification divides the pathway into eight phases and specifies the standards to be achieved in each (Appendix 1). 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:

To understand the above services, a wider number of interdependences will require consideration, 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 vision for stroke services is to prioritise stroke as a focus condition for the adoption of a clinically-driven and clinically-owned model of 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 they suffered their stroke.

4.2 Outcomes

- Reduction in stroke mortality rates
- Reduction in average length of stay
- Reduction in stroke re-admissions
- Achievement of 90% stay on stroke ward
- Increase in the percentage of patients receiving thrombolysis
- 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 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 with 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 Project 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 Hyperacute 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 in both Birmingham and the Black Country and also acknowledges other neighbouring economies. In addition managing the interface between the acute phase and the rehabilitation phase, and the rehabilitation and long term care phases may also provide challenges.

5.2 Non Hyper-Acute Projects:

Working with lead CCG representatives and with the respective provider organisation the review seeks to understand current stroke service provision against the standards and criteria set out in the 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 respective provider.

5.3 Programme Deliverables:

The Programme will support the development of the following deliverables in order to successfully complete the programme:

- Providing submissions to the Area Team at given points on progress and also to confirm the intentions on future delivery.
- A decision making framework agreed across all CCGs to support a robust decision making process
- Mapping of current service delivery and gaps for all phases

- The construction of a Project Initiation Document /phased implementation plans for each section of the pathway including a risk management framework
- An Options Appraisal for future acute sector configuration
- Cost benefit analysis to support recommendation of optimum configuration
- A Communication and Engagement Plan with expected schedules identified for both internal and external engagement and communication of project progress to key stakeholders including Overview and Scrutiny Committees and the public
- A Resource Plan including an appraisal of current and likely future service costs, and a recommended locally agreed reimbursement system, that contains:-
    - Details of all current payments to trusts for stroke services (in scope)
    - Details of current service costs (incl fixed and staff costs)
    - Recommendations for a revised reimbursement system, based on an unbundled Payment by result tariff to support the financial sustainability of the proposed HASU options
- A completed Health Needs Assessment and Equality Impact Assessment
- Relevant consultation process undertaken within relevant legislative guidance and defined outcomes achieved
- Commissioning intentions for subsequent year(s)
- Agreement of KPIs and monitoring framework for each CCG
- Plan of action for all issues raised during the review
- Review closure and handover

6. **Procurement Strategy:**

Taking into account the legal advice, if a decision to reduce HASU centres is reached the Programme Board will recommend service reconfiguration to reduce HASU centres with a procurement process based on competition open to all providers. The timetable for this will be published once a decision has been made on the optimum number of HASU centres.

The clinical requirements of the hyper-acute stroke service are that:

- It must be provided in an acute setting which has intensive care facilities and specialist stroke clinicians; and
- That there are time limits for patients to be transferred to the provider by the Ambulance Trust.

If the CCGs decide that it is essential that these two conditions are met for these services, “all potential provider” will mean only NHS Acute Trusts which can be reached within the required time limits.

If the Programme Board reaches a decision endorsed by the seven CCGs, AT and OSC that six HASU centres are retained, this can be dealt with by way of variation of their existing specificationsas part of the usual annual contracting round. There is no need for any competitive process because it falls within the usual process for dealing with services which can only be provided by local Acute NHS Trusts. As there would not be decision to choose between those Trusts but continuing to work with all of them, there would be no change from current commissioning practice.

7. Stakeholder Engagement

To support the achievement of the programme it is necessary to clarify the components of the system and assign appropriate roles according to the tasks to be undertaken to oversee and provide assurance. The table below highlights the key stakeholder groups which we can identify as immediately critical to the project:

7.1 Key Stakeholders

Role	Body/Group
Lead	CCG Chairs and Accountable Officer Stroke Programme Board
Assure	CCGs Acute Stroke Providers Community Stroke providers WMAS Social Care providers CCG Governing Bodies
Deliver	All Stroke Providers
Oversee	Cardiovascular Network Area Team CCG Lead Commissioner Clinical Reference Groups
Check/Challenge	Directors of Commissioning Directors of Finance Directors of Public Health Provider Director of operations Clinical Reference Group
Support/Enable	Cardiovascular Network Leads Voluntary Sector
Consult/Engage	Health and Well-Being Boards Overview and Scrutiny HealthWatch The Public Providers

7.2 Stakeholder Engagement

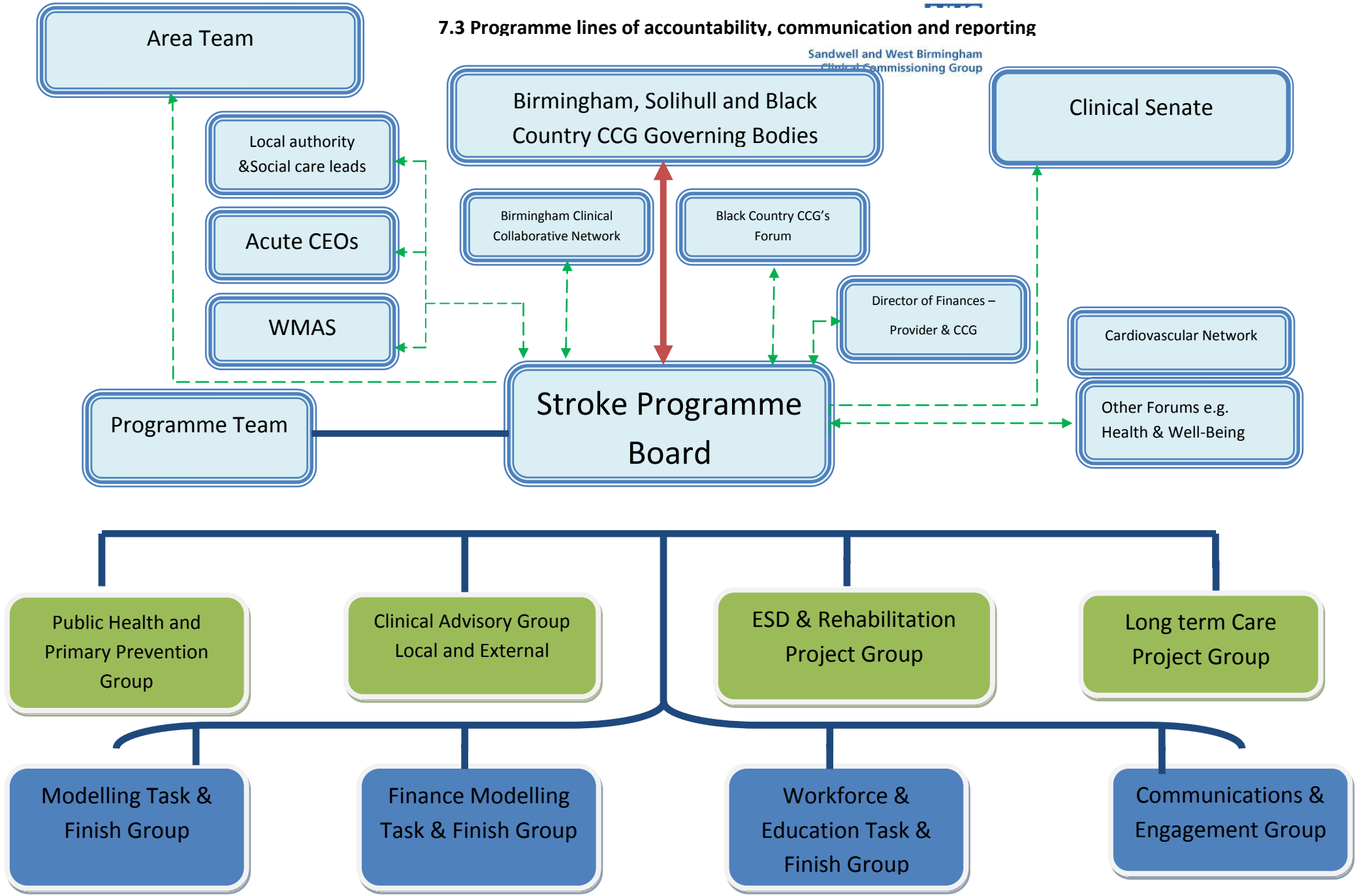
Key Stakeholders	Engagement	Role	Communications
CCGs	Stroke Programme Board CCG Governing Bodies CCG local stroke meetings	Actively shape the development of the local system proposal according to local commissioning intentions and health economics. As commissioners, take the lead in the preparation of and consultation on reconfiguration proposals. Accountable for the final decision on optimum HASU configuration	CCC Chairs Accountable Officers Directors of Commissioning Chief Financial Officer Clinical Leads CCG members
Providers	Provider Events 1:1 meetings Stroke Programme Sub-groups Ad-hoc communication	Work with commissioners to develop case for change, pre-consultation business case and consultation documentation and to take forward implementation. In collaboration with other providers as part of a local system, develop proposals and plans for how services will meet the standards set out in the regional best practice stroke service specification. Responsible for service change and improving quality of stroke services	CEOs Director of Operations Finance Directors Consultant Clinical lead Divisional Manager Stroke Coordinator Nursing and therapy leads
Cardiovascular Network	Stroke Programme Board Stroke Programme Sub-groups Ad-hoc communication	Provide oversight of the service from a West Midlands perspective and expert challenge the achievement of key milestones. The Network to provide advice to the system in support of the strategic development of stroke services in line with recommendations contained within the National Stroke Strategy, Royal College Physicians and National Institute for Health and Care Excellence guidance.	Clinical leads Management leads

Stroke Programme Board	Board meetings Ad-hoc communication	Provides overall direction and management of the project Takes major decisions for the project and make recommendations for approval for CCGs Accountable to the CCGs for the success of the programme Identifies and manages risks to project delivery and escalates issues to the Programme Board Co-ordinate and develop local system proposals on the future service provision in order to achieve the stroke service specification. Ensure cross boundary issues are explored and resolution sought with neighbouring areas/ stroke networks. Engage and seek support from local stakeholders in relation to these proposals via both pre-consultation and formal consultation. Make a clear recommendation to the CCGs and Area Team on the future system change to be implemented.	Refer to SPB TORs
Clinical Senate	West Midlands Clinical Senate meeting	This forum will provide advice on the clinical configuration for hyper and acute reconfiguration and the respective services specification for quality improvement and sustainability.	Clinical senate members
Independent Clinical Advisory Group	Sub-group developed using the framework of the EEAG TORs	This group will provide clinical input to the programme from a wide range of clinical areas involved in stroke and will approve the clinical aspects of the projects deliverables and act as a clinical advocate for the project. Provides clinical input to the programme from the wide range of clinical areas involved in stroke Approves the clinical aspects of the programmes deliverables Feeds in views and insights between the project and the programme board Acts as clinical advocates for the programme Provide endorsement to deliverables produced by the programme	Refer to TORs

		Each member of the Clinical Expert Panel is responsible for representing the opinions and needs of their specialist clinical area to ensure that the programme/projects achieve the best clinical outcome for patients.	
Local Clinical Advisory Group	Local Sub-group developed	Provide specialist clinical views Provide advice to inform the programme/ project outcomes, criteria and provider submission template. Provide clinical views and consultation forum on local clinical pathways where appropriate, for Primary Prevention, Hyper Acute Stroke Units, Early Supported Discharge, Rehabilitation and End of Life Care to ensure that services developed as part of the Stroke Programme are developed in accordance with best practice and clinical quality guidelines.	Refer to TORs
Area Team	Stroke Programme Board Ad-hoc meetings	Ensure that CCGs develop proposals for reconfiguration that are robust and fit for purpose (in line with the legal framework and current guidance)and that commissioners carry out consultations appropriately Will be consulted and informed of the clinical configuration for hyper and acute reconfiguration and the respective services specification for quality improvement and sustainability.	Area team members
Health and Well-Being Boards / Overview Scrutiny Committee	Communication and engagement plan to be developed	Scrutinise the planning, provision and operation of health services. Ensure that NHS organisations are held to account for their decisions on behalf of the people they serve. To provide insight and guidance in the development of new services. To ensure all groups are treated equally.	To be agreed
Patient and Public	Communication and engagement plan to be	To provide insight and guidance in the development of new services.	To be agreed

	developed		
Secretary of State (SofS)	To be agreed if required	Power to endorse or reject proposals referred by the OSC to ensure the effective provision of comprehensive health services in accordance with the NHS Act 2006.	If required
Independent Reconfiguration Panel (IRP)	To be agreed if required	Advises the SofS on proposals that have been contested locally	If required

7.3 Programme lines of accountability, communication and reporting



7.4 Programme Team membership

Role	Lead	Designation
Chair	Dr Nick Harding	Chair Sandwell and West Birmingham CCG
Deputy Chair	Dr Helen Hibbs	Wolverhampton CCG Accountable officer
Programme Sponsor	Andy Williams	Accountable Officer Sandwell and West Birmingham CCG
Finance Management lead	James Green	Chief Financial Officer Sandwell and West Birmingham CCG
Finance Clinical lead	Dr Helen Hibbs	Wolverhampton CCG Accountable Officer
Modelling Management lead	Matt Ward	West Midlands Ambulance Trust
Modelling Clinical lead	Dr Helen Hibbs	Wolverhampton CCG Accountable officer
Primary Prevention and Public Health lead	Jyoti Arti	Deputy Director of Public Health – Sandwell Local Authority
Primary Prevention and Public Health Clinical lead &	Dr Nick Harding	Chair Sandwell and West Birmingham CCG
Communications and Engagement Lead	Jayne Salter-Scott	Senior Commissioning Engagement lead Sandwell and West Birmingham
Communication Lead	Jenny Fullard	Communication and Engagement Lead Central Midlands CSU
Communications and Engagement Clinical Lead	Dr Nick Harding	Chair Sandwell and West Birmingham CCG
Independent Clinical Advisory Group	Dr Raj Mohan	Clinical lead Walsall CCG
Procurement Advisor	Alan Turrell	Head of Contracting and Procurement Walsall CCG
Procurement Leads	Mike Evans and Gary Hemer	Senior Procurement and Contracting Manager Central Midlands CSU
Analytical Support	Steve Wyatt	Central Midlands CSU
Cost Benefit Analysis	To be agreed	TBC
Programme Director	Nighat Hussain	Sandwell and West Birmingham CCG
Senior Programme Manager	Liz Green	Sandwell and West Birmingham CCG
Project Programme Officer	Stephanie Green	Sandwell and West Birmingham CCG

7.5 High Level Project Milestones and outputs:

	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. Assurance Process:

The reconfiguration assurance process describes the approach by which proposals for major stroke service change will be supported by the Birmingham Solihull and Black Country CCGs and how they will reviewed by the Birmingham, Solihull and Black Country Area Team and Overview and Scrutiny Committees to ensure they meet all the requirements.

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:

8.1 Consultation Phase

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.

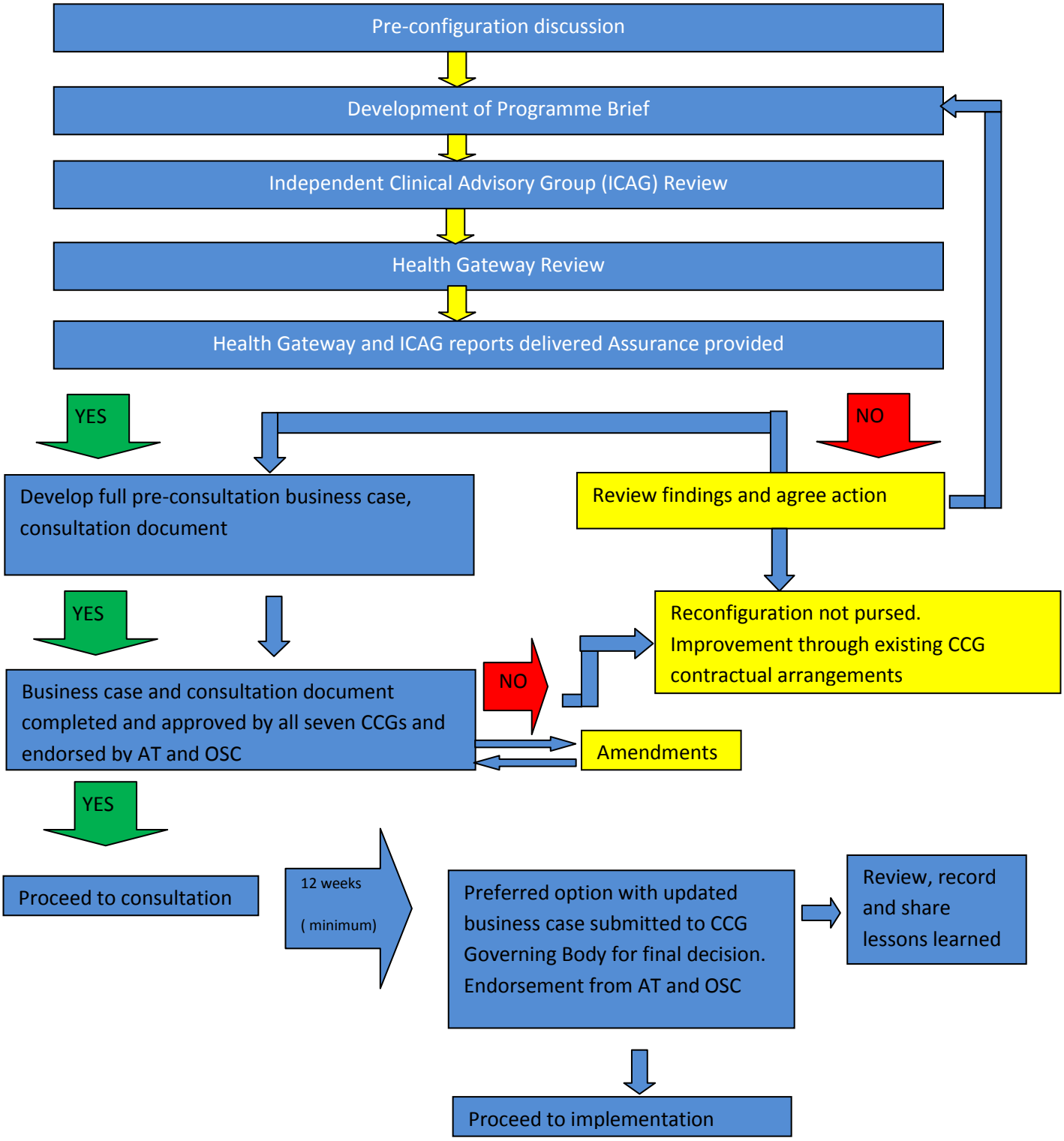
The consultation process: managing the consultation process, producing documentation and ensuring that statutory requirements to consult the public, healthcare professionals and other statutory bodies (including Overview and Scrutiny Committees) are met.

The post-consultation process: decision making process including sign-off with appropriate bodies and managing any subsequent reviews or challenges.

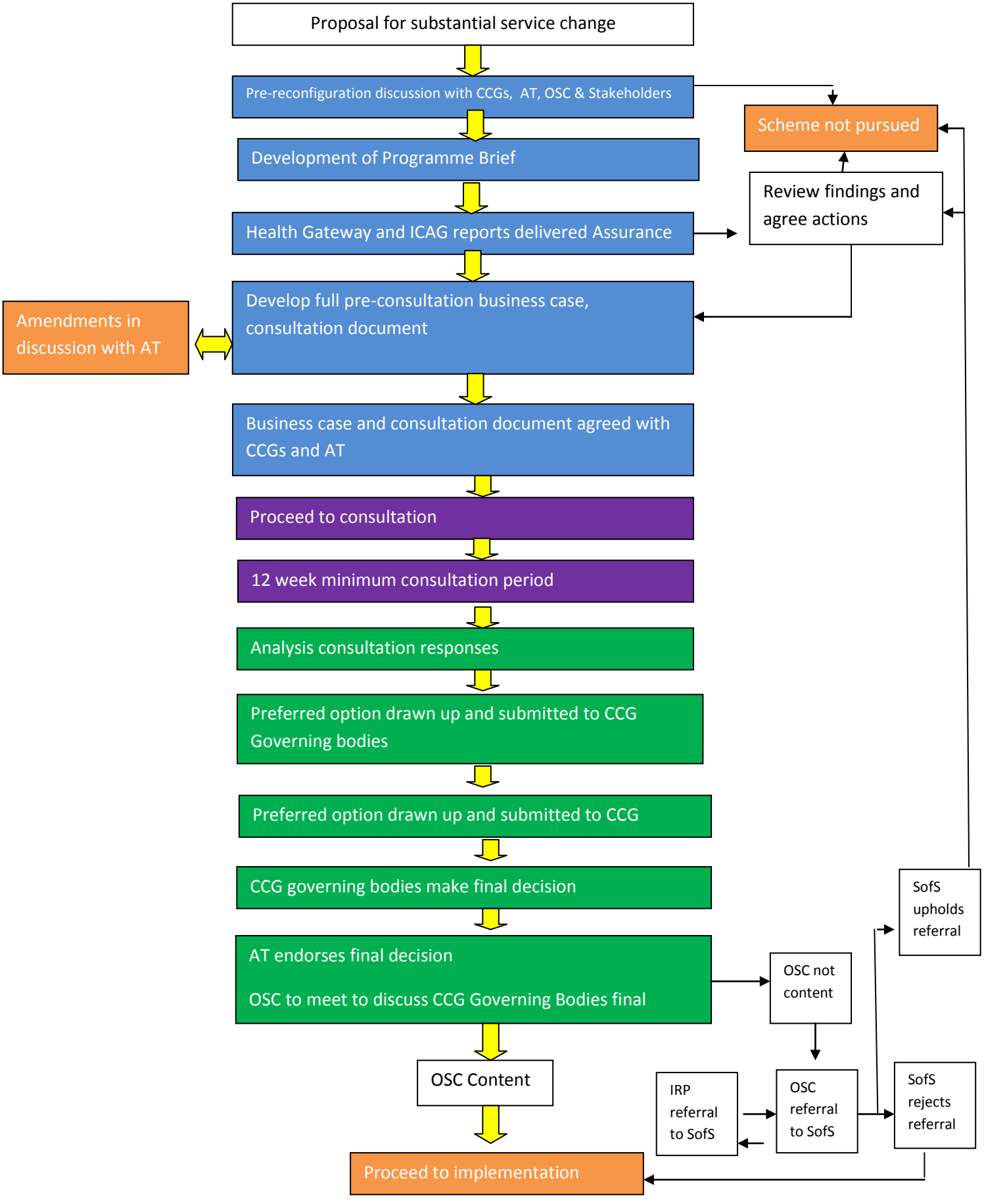
Designation Decision and Configuration Implementation -

Implementation of the configuration of stroke services and optimal care pathways will be informed by the outcome of consultation on the configurations for service delivery and occur from December 2014.

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:



8.2 Overview of the reconfiguration/consultation process:



8.3 Key Decision Points:

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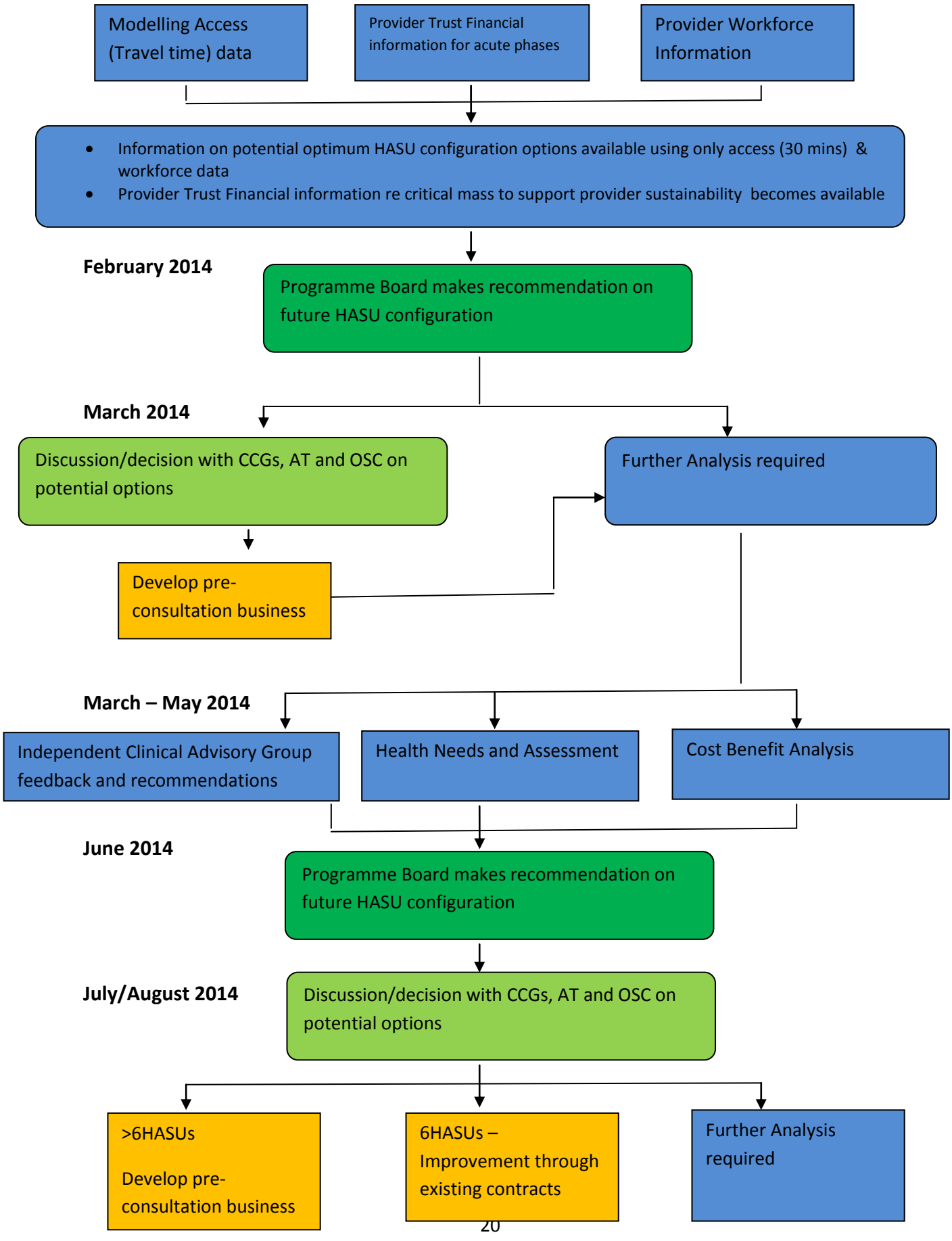

9. Communication Plan:

If the preferred option is a reduction of the number of HASU centres for stroke services, then a formal patient and public consultation process would be undertaken. The following narrative highlights the different phases of stakeholder and patient & public engagement that the programme will follow.

9.1 Engagement Phase (pre-consultation)

9.1.1 Phase 1

Identify and agree key stakeholders

Objective for engagement (pre-consultation) phase to consult on:

- Share Principles of Decision Making
- Develop and agree framework to be applied to Option Appraisal process

9.1.2 Phase 2

To ensure that stakeholders are consulted on Option Appraisal process. To also ensure that Stakeholders fully engaged in pre-consultation process

a) Providers:
- Providers signed up to option appraisal process

b) CCGs
- CCGs engaged through Programme Board

c) Patient and Public:
- Patients, carers and their representatives are engaged through the establishment of a Patient Advisory Group
- Patient representatives participating in Programme Board and Option Appraisal Panel

9.1.3 Phase 3

Outcome of Option Appraisal process feedback to stakeholders and used to inform formal consultation documentation and plans.

9.1.4 Engagement Phase (formal consultation) Phase 4

Formal Consultation launched

9.2 Role of Patient Advisory Group

- Consult Principles of Decision Making
- Consult on Option Appraisal process (OAP)
- Representative on Programme Board
- Representative on OAP
- Participation in Impact Assessment (EQiA) Workshop

- Part of assurance process for the Programme Board around:
  - Equality Analysis Process
  - Consultation Plan and Consultation Documentation

10. Affordability

It is perfectly legitimate for CCG decisions to take into account affordability, given the limited resources available and the requirement to break even. There is also an express duty on CCGs to exercise their functions effectively, efficiently and economically (section 14Q, NHS Act 2006) and this should also be taken into account. The best approach is to be clear about this issue from the outset, so as to ensure transparency.

In addition, if the programme makes a recommendation to reduce HASU centres it is likely to be appropriate to consider including an affordability ceiling in the tender documents following the options appraisal. The programme will use the cost of the current service, the financial sub-group will support the analysis to demonstrate that the affordability ceiling is appropriate, supported by a clear audit trail that shows how this figure was calculated. NHS rules on agreeing prices for services where there is no mandatory tariff are also clear that prices should, among other things, are fair.

Finally, if a decision is made not to reconfigure the services because the options are unaffordable, the Programme Board will ensure that the reasons for the decision are fully documented so as to demonstrate that the decision is robust.

11. Option Appraisal Process:

11.1 Optimum HASU configuration

It is important to acknowledge that HASU configuration below three HASUs will not be considered for two reasons. The first critical mass from London and Manchester suggest that stroke activity volumes of 1300 and population coverage of one million provide optimum financial viability. The second is that the bed capacity requirements required for anything less than 3 HASUs would provide significant pressure on current services and require significant investment. Further validation will be supported by Trust clinical and financial submissions.

Financial Advice on volume of activity to support critical mass:

The financial sub-group will provide evidence from provider returns to support the optimum configuration to achieve financial critical mass to ensure provider financial stability. Overall financial landscape will be demonstrated using the current Pbr and local tariff to define the most cost-effective option.

Decision on optimum configuration:

The information above will be populated as demonstrated below to support the Optimum HASU configuration decision:

	Option 6	Option (s) 5	Option (s)4	Option (s)3
Meets 30minutes access travel time				
Meets Health Needs				
Cost affordability / Affordability				
Optimum configuration				

11.2 Option Appraisal Principles:

The Stroke Programme Board has agreed a period of consultation/market engagement with the six current providers to obtain information (non- financial & financial) to understand better the capability and capacity of providers to deliver current and future activity models. This information will be presented to the Independent Clinical Advisory Group Panel to review and recommend the most appropriate model that meets the clinical, financial and demographic solution for the Birmingham, Solihull & Black Country CCGs. The process will be carried out with a robust framework to ensure confidentiality is maintained and under no circumstances will any provider submission response be discussed with another provider or providers.

The current stage of the option appraisal process asks providers to put forward evidence of their capacity and capability to deliver current service and supporting information to provide increased level of stroke activity to support a high quality HASU in line with the Midlands and East Service Specification.

The future configuration model assumes that irrespective of any HASU configuration change all current providers will retain the provision of Stroke Acute, Outpatient TIA, Inpatient and community rehabilitation, long term care services and end of life care. The joint provider and CCGs modelling sub-group will determine the length of stay for the acute and community phase and recommend the optimum hand-off points.

<u>Provider submissions are not required to address how the West Midlands Ambulance Service will support stroke services, or the triage protocol to be used.</u>

Should the decision be taken to reduce the number of HASU centres, there is an expectation that HASU stroke services to be operational in 2016. It is recognised that the proposed acute stroke service providers may not currently have the infrastructure in place to meet the requirements for increased level of activity from the outset. Therefore, as part of the provider submissions process, providers will be asked to provide evidence of requirements already met, and estimates for when the remaining requirements could be achieved.

High level plans for meeting those requirements not already met, within maximum specified timeframes will be required including, where applicable the proposed funding streams and other 'deliverability' factors.

11.2.1 Use of Provider Submissions in the Option appraisal process:

As part of the options appraisal, the programme is engaging with providers to obtain information which will help to inform the decision as to the future configuration of stroke services in the Birmingham, Solihull and the Black Country. The information gathered will be used to assess current service provision and to test the feasibility of the proposed future configurations.

Each provider submission will be reviewed to understand the capability and capacity of providers to deliver current and proposed activity models. This will inform an analysis as to the most appropriate model to meet the clinical, financial and demographic solution for the Birmingham, Solihull & Black Country CCGs.

Areas for Review of Provider Submission Evaluation
Quality of Services
Workforce including Innovation and Research& Development
Access
Ease of Delivery
Improved Strategic fit
Cost and affordability

The definition of the headings is described below:

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 level of quality for the stroke system improving patients' outcomes. Improving patients' outcomes 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: Heading covers workforce issues (attracting and retaining the best healthcare professionals, and investing in them via an accredited training and development programme, as well as rotating staff appropriately across the pathway and between similar care settings) and patient experience. This includes delivering quality education and training for staff and for the improvement to continue 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. Also considers accessibility by public transport to, HASU, ASU and TIA services.

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 WMAS returns. Patients and visitors will have access to local ASU and TIA services.

d) Ease of Delivery

Definition: The need for the acute stroke service provider to improve substantially from where it is now. 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, whereby a simple system will be easier to manage.

Outcome: Optimum service to stroke patients supporting collaborative capability across Network, Providers, Local Authority, 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.

11.2.2 The Review Process

Provider submissions will be reviewed as part of the option appraisal process. In reviewing the information received, provider submissions will be treated as confidential and will not be disclosed to other providers.

The provider submission review process will be co-ordinated by the Stroke Programme Board comprising members of the Independent Clinical Advisory Group and led by the National Stroke Clinical Lead.

The review of submissions will be undertaken by a review panel comprising clinicians and NHS senior management that are not associated with any Birmingham, Solihull and Black Country Acute Trusts.

It should be noted that the provider submissions will only be used to inform the options appraisal for future service configuration and not to assess and score individual providers against each other. Any assessment of the relative merits of individual providers will only take place as part of any procurement process which may flow from this options appraisal and would not take into account any information provided at this engagement stage.

11.2.3 Option Appraisal Process:

The option appraisal process will be carried out in line with the following methodology, which will support an evaluation method measuring quality and price. All six headings will have an equal score of out of a 100 and this will be distributed evenly within the subheadings of each area. The options with the highest score representing the most economically advantageous option.

Areas for Review of Provider Submission Evaluation	Score
Quality of Services	16.7
Workforce including Innovation and Research& Development	16.7
Access	16.7
Ease of Delivery	16.7
Improved Strategic fit	16.7
Cost and Affordability	16.7

Total	100

The questions that are to be answered by provider templates will be scored as follows:-

Score	Definition
5	Meets the standard exactly and demonstrates innovation.
4	Meets the standard exactly
3	Meets the standard in most aspects
2	Fails to meet the standard in most aspects
1	Fails to meet the standard
0	No response submitted

The scores will be summarised for each options as follows:

	Option 6	**Option (s)5**	**Option (s) 4**	**Option (s)3**
Quality of Services				
Workforce including Innovation and Research& Development				
Access				
Ease of Delivery				
Improved Strategic fit				
Cost and Affordability				
Total weighting for each option				

11.2.4 Timetable for change:

If a decision is made to reduce the number of HASU centres it is anticipated that the proposed new services will go-live from 2016, with a step-change in the quality of service being delivered from the outset and commitment to an implementation plan achieve the requirements detailed under the option appraisal headings (above) within the first 18 months.

The Programme Board will take into consideration potential timeframes for service change when considering the recommendation for future service configuration and reserve the right to change the go-live date based on the information submitted by providers.

A long list of possible configurations will then be reduced to a short list through analysis of how individual configurations compare against the factors outlined above. The short listing will be conducted by a panel of representatives from the Independent Clinical Advisory

Group, who will generate a recommendation to take forward to the Stroke Project Board. The Stroke Project Board will then approve the recommendation and issue it to the Birmingham, Solihull and Black Country CCGs to agree future stroke service provision.

In September 2014, it is anticipated that a shortlist of provider configurations will be brought to a public consultation. The decision on which configuration options will be included in the consultation will then be communicated to providers. The final decision on which configuration will be designated will be taken in December 2014 following the public consultation. Any decision to reduce the number of HASU centres will be followed by a competitive procurement tender process.

11.2.5 Procurement Tender Process:

Key Milestones	Approx No. of Working Days
Issue Advert / Invitations	
PQQ Expressions of Interest Invited	
PQQ Expression of Interest Returned	10
PQQ Evaluation	10
PQQ Shortlist	
PQQ Standstill Period/debriefs	5
ITT/final proposal invited	
ITT/final proposal returned	20(max)
ITT Evaluations commence	25
Contract Award Recommendation	10
Contract Award Approved (eg Board)	5
ITT Standstill period	5
Contract Award	
Mobilisation (inc any TUPE issues)	85
Service Commencement Date	

Key

PQQ = Pre-qualification Questionnaire
ITT = Initiation To Tender
w/c = Week Commencing

N.B. all dates and no of days are approximate at this stage.

12. Cost-Benefit Analysis:

The cost-benefit analysis will support CCGs to make a decision on the optimum configuration of HASUs. Key objectives will be:

- Provide the cost-benefit of the option appraisal configuration to demonstrate the marginal cost-benefit of each configuration;
- Provide a return on investment for each of the configurations from six HASU sites to a minimum of three sites.

12.1 Development of an Economic Model

An economic model will be developed based on the outcomes of the options appraisal carried out by the programme board. It is anticipated that this will provide a number of scenarios which can be included in the economic modelling. The model will calculate the costs of the different options identified for HASU provision and will allow the benefits of HASU treatment to be modelled. The benefits of reconfiguration of HASU provision will be identified through the literature review but the key metrics are likely to include:

- Reduction in length of hospital stay;
- Improved mortality rates;
- Reduction in future event rates.

If data is available the model will seek to understand the potential effect of changes on aspects such as mortality and health-related quality of life, then these benefits will be calculated in terms of quality adjusted life years (QALYs). These benefits can then be monetised by applying a value per QALY, based on the range used by the National Institute for Health and Care Excellence (NICE), which uses a threshold value of between £20,000 and £30,000 per QALY.

In modelling the costs, the key metrics are likely to include:

- Staffing costs;
- Hospital bed occupancy;
- Costs of drugs and procedures, e.g. thrombolysis.

Activity data for patients will be gathered where possible from local systems. If local data is unavailable, data will be extracted from the Hospital Episode Statistics (HES) database, held by the Health and Social Care Information Centre. Data will be gathered from care providers where possible so that local variations in cost can be accounted for. Where data is unavailable, it will be extracted from publicly available national sources such as NHS Reference Costs, Payment by Results Tariffs, Unit costs of Health and Social Care, the Drug Tariff and the British National Formulary, as applicable.

An additional consideration for each of the options will be the cost of patient repatriation. For each of the options, the additional number of patient journeys that would need to be

made to repatriate patients from the HASU to their local hospital will be calculated. This will be done on the assumption that repatriation will be to a patient's local hospital rather than to their home address and unit costs of ambulance or patient transport journeys will be used to provide estimated costs.

12.2 Cost-benefit analysis of optimal HASU services configuration

Once the economic model is constructed, it will be used to estimate the costs and benefits for each of the options. The return on investment will be calculated for each option and presented in short, medium and longer-term scenarios. Demographic and epidemiological data from local and national sources will be used to project the costs and benefits forward into future years. Relevant discount rates and net present values will be used to make those estimates, adhering to the requirements of the Green Book.[1]

The model will present the user with additional components to test the 'uncertainty' of the parameter values used. For example, one-way and two-way sensitivity analysis will be conducted around the key parameter values such as costs and activity rates. This will be used to explore the sensitivity of the findings for each of the options.

13. High Level Risks & Challenges

As part of the process to date a number of key challenges & risks have been identified that will need to be worked through as part of the detailed discussions in order to support determination of the final preferred delivery model and also ensure that delivery is sustainable.

Key Risk and Challenges Include:

A. Case for changes:

The case for change needs to be revisited to understand the current quality of services and the gap to meet the best practice service specification; this may delay the option appraisal process due to the time it will take to carry out a comprehensive review.

B. Modelling Framework:

The programme no longer has access to the Deloittes' model and recruiting this may take a significant amount of time thus causing a delay in carrying out the option appraisal process.

C. Financial impact:

- It is recognised that the current 6 trusts have not achieved a 100% of the Stroke Best Practice tariff payment, initial analysis shows that this could lead to a cost pressure of 4.5 million to CCGs
- A reduction in sites could introduce an additional costs in ambulance conveyance and repatriation cost to local hospital sites for the acute care episode

[1] The Green Book: Appraisal and Evaluation in Central Government. HM Treasury, 2011.

- There is a risk that CCGs may not be able to collectively agree a mechanism where cost pressure are shared across the 7CCGs
- If the optimum configuration is to reduce HASU sites and this leads to an introduction of a cost pressure that CCGS are unable to support. CCGs will need to demonstrate a robust process if they decide collectively not to go ahead with the reconfiguration.

D. Service Outcomes & Performance Standards

- General concern has been raised regarding the achievability of a number of the standards, particularly without a step-increase in resources and also because of the reliance that this would place systems not within a provider's control.
- In particular it is felt that a burden of work would be likely to move to out of hours e.g. scanning, which again would require a step-increase in resources to fund this premium rate activity which is not recognised at present.
- A reduction in HASU sites may have an adverse impact on other clinical areas such as A&E, General Medicine, Geriatric Medicine, Neurology and Radiology

E. Workforce

The staffing levels required to achieve the expected performance standards are likely to require significant investment and recruitment of additional staff in each area.

Key Risks

A number of interdependencies exist which will impact on successful delivery of the programme. In particular failure to agree a revised resourcing mechanism will present a high level of risk to sustainability and affordability of any new models of care, and will also impact on the ability to agree the final configuration of the hyper-acute delivery. Delivery of the pathway is also heavily reliant on provider collaboration.