Herefordshire Council

NHS Herefordshire

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NHS Midlands and East Stroke Services Review

July 2012 For Information and Comment

Stroke Review: achieving a step change improvement in stroke care.

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1 Purpose of the paper

1.1 The purpose of this paper is:

- to summarise the arrangements for reviewing stroke services across NHS Midlands and East (NHS M&E) in 2012/13;
- to draw attention to the opportunity over the summer in shaping options for how the service can deliver a step change improvement in stroke care
- to seek comment on the high level criteria against which recommendations will be made about delivery of a step change improvement in stroke care..

2 Background

2.1 Stroke is acknowledged as a major cause of mortality and morbidity, accounting for in excess of 40,000 deaths a year in England of which over 12,000 are in Midlands and East.

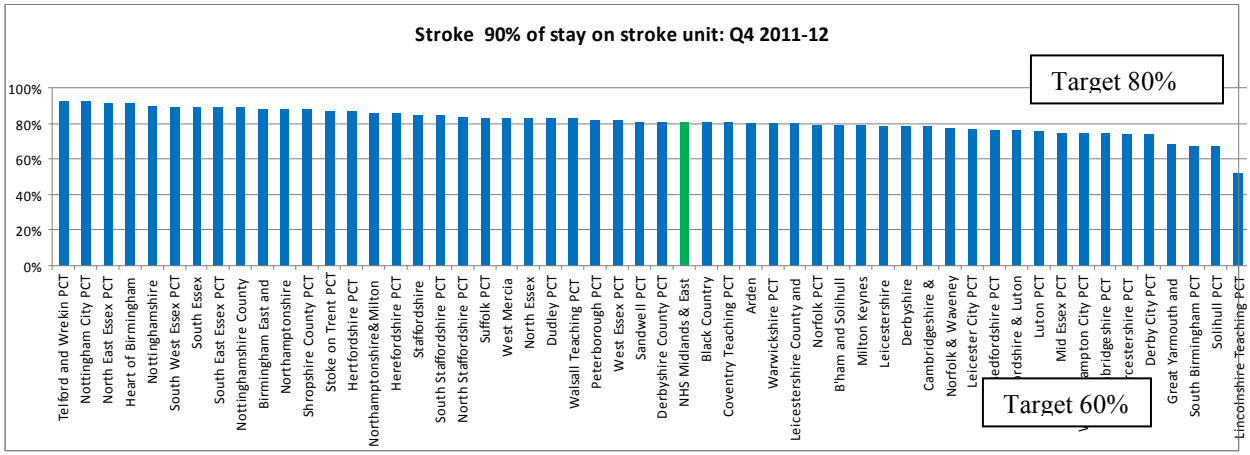
2.2 The UK does not compare favourably with international performance in the management of stroke:

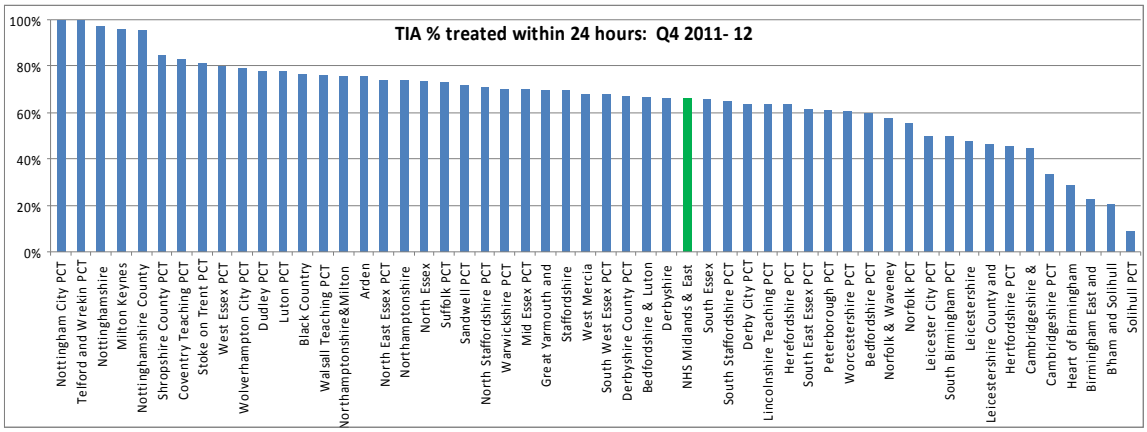
- league tables rank Britain's survival rates for the most common type of stroke as the worst in the developed world;
- OECD statistics comparing 30 developed Western countries, rank UK's death rates after hospital admission for an ischaemic stroke as twice the OECD average, and three times worse than those in Denmark.

2.3 At its meeting in January 2012, the Regional Cluster Board noted the shortfall in performance compared to national standards of best practice, articulated as long ago as 2008 in the National Stroke Strategy e.g. only 30% of patients receiving a brain scan in under 1 hour (SINAP 2011); only 17% of patients admitted to a stroke unit in under 4 hours of arrival (NAO 2010).

2.4 The Board also noted that although there had been improvements in stroke care relating to the two national vital signs for acute care (figure 1), there remained a variation in practice across the cluster, and considerable shortfall in performance in relation to the whole stroke pathway.

Figure 1





2.5 The Board noted the significant improvement in stroke outcomes achieved in London, following its review of acute stroke services; albeit with recognition that the geography and configuration of Midlands and East differs considerably to that of London.

e.g. Stroke mortality, adjusted for case mix and other factors, was 25% lower in London in 2010/11 than the national average;

e.g. Performance against the two national stroke/TIA vital signs (see figures 2 and 3).

Figure 2:

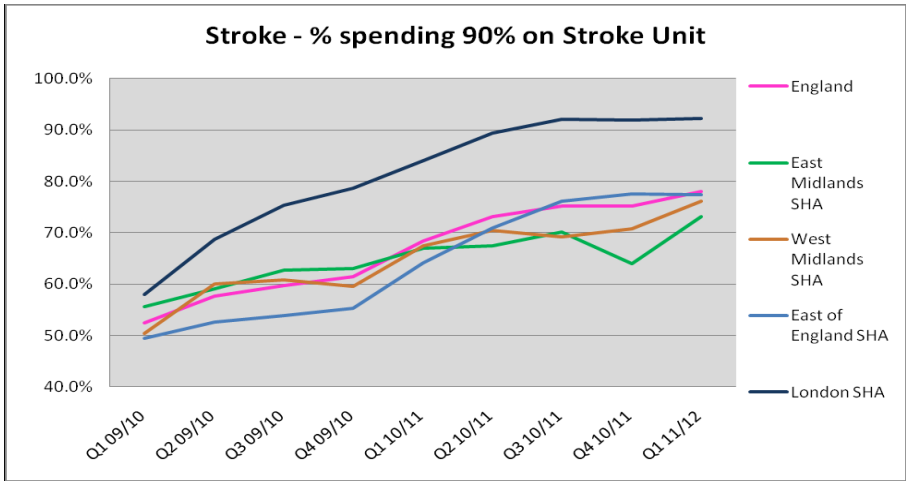
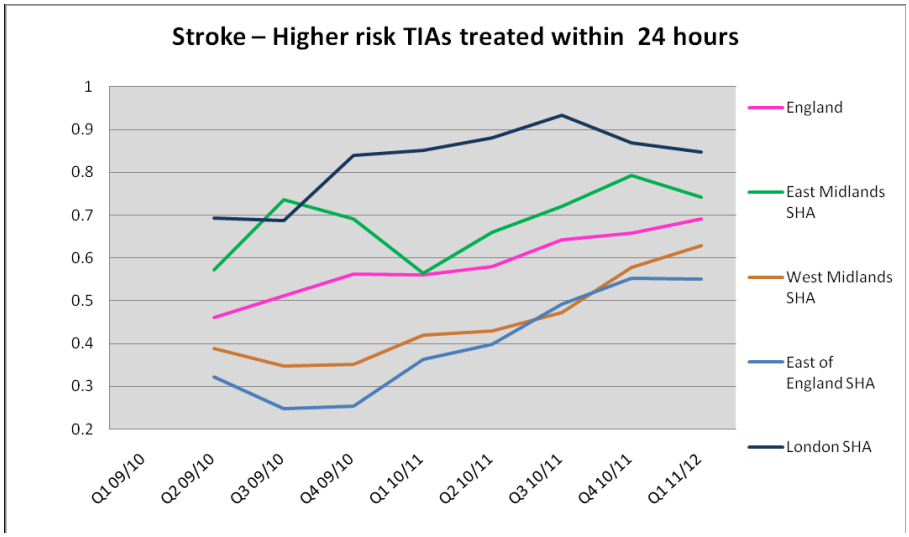
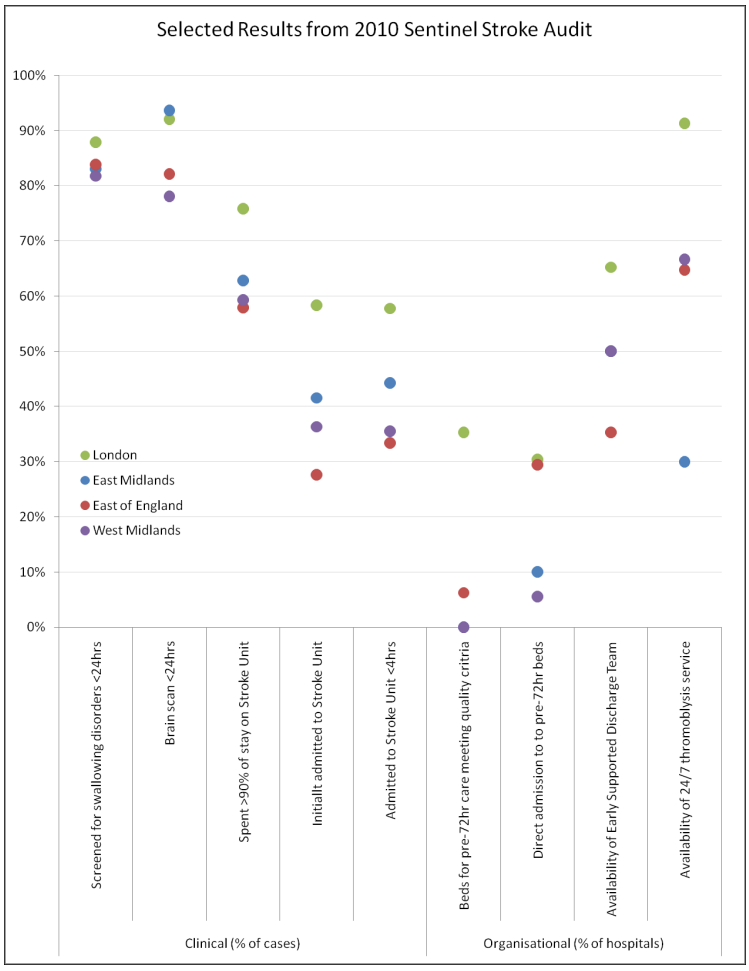


Figure 3:



e.g. Performance against the 2010 National Stroke Sentinel Audit. Although the data is now outdated, it shows that even during the period of transition, the London service compared favourably with the SHAs in the NHS Midlands and East.

Figure 4:



2.6 It was agreed that a major review of stroke services should be undertaken in NHS M&E, to establish the means to make a step change improvement in stroke care across the Cluster; making clear recommendations before the SHA's abolition in March 2013. There is a significant challenge in the timescale, even before taking account of the structural change in many of the key stakeholder organisations, i.e. the abolition of the SHA and PCTs; emergence of Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards; and the in year changes to Stroke Networks and Observatories, the details of which are both not yet clear. None the less, partners have agreed to work together to deliver this in the expected timescale, in the interests of improving patient care.

3 Structure and Process of the Review.

3.1 The Review has been commissioned by NHS Midlands and East. It will establish a clear strategic vision and implementation plan, and make an explicit recommendation, as a 'strategic steer', to CCGs to guide their commissioning in 2013/14 and beyond. In commissioning stroke services, and working to achieve best practice and an improved return on investment, the CCGs will be performance managed by the National Commissioning Board (NCB)

3.2 The Review is being led by Cambridge University Health Partners (CUHP); one of the five academic health science partnerships (AHSC) in the country, and the only one in NHS Midlands and East. It is being undertaken with local leadership of the nine clinically managed Stroke Networks across NHS M&E. Deloitte have been commissioned to undertaken elements of the Review which the NHS partners do not have capacity for in the timescale, in particular the modelling associated with the Review, and supporting documentation of a best practice specification, against which the review is being undertaken.#

3.3 To supplement the NHS M&E Board's recommendation to CCGs, commissioners will receive a Commissioning Toolkit which will include the health economics for investment; guidance for inclusion in contracts to optimise delivery and outcome; and guidance on splitting tariffs where necessary.

Project Board

3.4 A Project Board has been established, chaired by Professor Tony Rudd, Royal College of Physicians Stroke Lead, and stroke physician at Guys and St Thomas' NHS Foundation Trust. Membership reflects representation of key stakeholders, and provides governance to the Review. Membership is set out at Annex A.

3.5 There are three sub groups working to the Project Board:

- **Data and modelling:** this includes establishing a baseline and evaluation of the outcome of the review; modelling to identify the optimum configuration of services, and to ensure that the impact of any proposals have been identified and taken into account'. The group is chaired by Matt Ward, West Midlands Ambulance Service;
- **Service User and Carer Forum:** this helps shape and provide comment on emerging proposals for the review overall, and supplements local service user and carer engagement at a network level;
- **Education, Training and Workforce:** this includes production of toolkits to support providers in responding to the outcome of the review; and a commissioner toolkit to support CCG's in commissioning its implementation.

External Expert Advisory Group

3.6 An External Expert Advisory Group (EEAG) has been established; chaired by Dr Damian Jenkinson, the DH's Interim Director for Stroke; and NHS Improvement Lead for Stroke. The Group has produced 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 outcomes. Deloitte has worked with the EEAG to help document this vision.

3.7 EAAG has a strong membership, with a combination of national expertise, and experience in the major review and implementation of improvement to stroke services, in both urban and rural areas. Membership is set out at Annex B.

Clinical Leads within NHS M&E

3.8 The 9 Stroke NHS M&E Networks have each identified a medical, nursing, and therapy clinical lead, to lead engagement at a local level. They are supported by the Network Director and other network team members. The Networks in each region (ie. E Midlands, W Midland and East of England) have identified a medical, nursing and therapy lead, drawn from the nine, who can represent the region at the Project Board, and in discussions with the EEAG and other fora.

Communication and engagement

3.9 Professional communication and engagement expertise is provided from the Strategic Health Authority, working closely with local stroke networks. A Review Bulletin is produced; and 'flash reports' from Project Board meetings setting out key decision and actions. All papers (Project Initiation Document (PID), terms of reference, minutes etc), and the source documents which have informed the EEAGs best practice specifications are available on the SHA's public facing web site: https://www.eoe.nhs.uk/page.php?page_id=2266 .

3.10 Local engagement is being driven by the 9 Stroke Networks, each of which has refreshed the membership of its Stroke Advisory Group to ensure representation from all relevant stakeholders; and developing a locally appropriate set of arrangements to maximise engagement to contribute to the review. We are working to make the review as open and transparent as possible.

3.11 If as part of the review it is necessary to undertake a period of formal consultation on the emerging recommendations, this will take place for the area concerned, rather than be part of a regional cluster wide consultation process. This will maximise local opportunity to engage in issues relevant and pertinent to the area, and avoid an unnecessary process being undertaken for the remainder of the region.

The focus of the review.

3.12 The Review is being undertaken with the following guiding 'principles':

- It will cover the whole stroke pathway from primary prevention to end of life. To achieve gains in health outcome, and productivity, it is essential that the whole pathway of care is reviewed, not just the provision or configuration of acute services;
- It will work to build on existing work, rather than duplicate or start work again. This is particularly pertinent to E Midland and W Midlands, and around Hinchinbrook Hospital in the East of England where considerable work has recently been undertaken to review acute stroke care;
- The work will be driven and undertaken where ever possible through the auspices of the 9 Stroke Networks. They already have strong clinical leadership for stroke; established relationships with local providers and commissioners (albeit with the latter changing from PCT to CCG in

2012/13); and a clear understanding of the strengths and weaknesses of current provision;

- The solutions for the three regions within the Cluster may differ considerably; one size will not be expected to fit all, not least because of urban and rural differences;
- It will draw learning from existing work undertake in the regional cluster, and from other parts of the county which have recently undertaken effective review and improvement to stroke care.

The process of the review

3.13 The EEAG has developed an evidence based Best Practice Specification covering the whole stroke pathway, divided into 8 phases:

a) Primary prevention

b) Pre hospital

c) Acute: i) hyper acute, ii) acute, iii)TIA, iv) tertiary care (neuro surgery)

d) In hospital rehabilitation

e) Community rehabilitation (inc Early Supported discharge)

f) Long term care and support

g) Secondary prevention

h) End of life

This sets out the expected features of care provided at each point on the pathway, workforce requirements, metrics for monitoring performance etc.

3.14 Before being completed, Networks have had opportunity to ensure that its content is clear, and to comment on any areas of query or omission. This has also had the advantage of extending the period of the networks being familiar with its content, which is otherwise very challenging.

3.15 The Specification was being presented to local system at the end of June to encourage their local proposals of how they can achieve the required step change improvement in outcome. Local systems will have a six week period over the summer to consider this. They will also be given a framework for the response, and the high level criteria against which EEAG will make a recommendation.

3.16 The timescale is challenging, particularly as it is over the summer months, but extending beyond this is not possible if the Review is to conclude with a formal recommendation by March 2013. Networks are coordinating and supporting this process as a local level, and are responsible for maximising local engagement. Responses are being presented back to the EEAG for consideration, along side other scenarios that emerge from the modelling.

3.17 In making its recommendations, EAAG will link with the Network clusters' clinical leads (i.e. 3 x 3) for clarification of proposals where necessary. Where issues relate specifically to an individual network's area, and EEAG requires clarification, or where consensus hasn't been reached at a local level, EAAG may want to meet with the relevant network's clinical leads themselves rather than the network cluster clinical leads (s).

3.18 EEAG will make a formal recommendation to the Project Board, which will consider whether the proposals constitute major change for any part of the NHS M&E. The SHA will consider this conclusion, and if necessary require a period of formal consultation; after which it will consider the formal response to consultation and make a decision about the outcome of the review. The SHA's decision will take the form of a 'strategic steer' to the CCGs which will take on responsibility for commissioning Stroke services from April 2013.

Timeline for the Review

3.19 Key points in the time line include:

- June 2012 EEAG develops the evidence base best practice specification; distributed to local systems by the end of June
- June to August 2012, **6 weeks period during which local systems respond to the Specification**
- August 2012 EEAG develops its recommendations
- Sept 2012 Project Board considers the recommendation and identifies the need for a period of formal consultation
- Oct-Dec 2012 period of formal consultation (3 months)
- January 2013 response to consultation, and further work if necessary to refine proposals
- March 2013, SHA Board meeting to consider the outcome of the Review, and make recommendation to CCGs.

3.20 The full Review timetable is presented as a Gant chart in Annex C.

Criteria against which EEAG will make its recommendations

3.21 A set of high level criteria have been proposed, to inform EEAG's recommendations. Comment is welcomed on these criteria before they are finalised.

a) Service configurations meet best practice, and can demonstrably improve:
   - clinical outcomes *e.g. 30 day mortality*
   - quality of life outcomes *e.g. Level of disability at 30 days*
   - patient experience of stroke services *e.g. Patient satisfaction of rehabilitation services*

b) Services are cost effective and financially sustainable

c) Service provision is geographically and socio-economically equitable, reaching the whole area population

d) Service provision effectively handles and manages population flows into, and out-of, area

e) Services support the whole stroke pathway, end-to-end, from prevention to long term care or end of life care

f) Services are coordinated by local stroke networks demonstrating collaboration between providers along the whole stroke pathway

g) Stroke service configurations support the delivery of other, in particular acute, services

h) Service provision is clinically sustainable.

3.22 Comment is sought by 1 August 2012 on whether these are the right criteria.

4 Engagement of Health and Well Being Boards, and Overview and Scrutiny Committees

4.1 Directors of Public Health are acting as the key conduit to health and wellbeing boards, in particular to support effective primary prevention activities and interventions. The Herefordshire and Worcestershire Cardiac and Stroke Network will be briefing you and supporting local commissioners (PCTs and CCGs) in engaging with our local OSC.

4.2 OSCs, amongst other stakeholders, are therefore invited to comment on the high level criteria against which the EAAG will make a recommendation for NHS M&E achieving a step change improvement in stroke outcome. This will need to take place before EEAG's deliberations in late August/early September 2012.

5 Evaluation

5.1 Over the summer the Review will establish the region's baseline to support evaluation of the Review's impact on improving clinical outcomes and return on investment. Discussions are underway to use the same parameters as the reviews of London, Manchester and other areas recently reviewing their stroke services.

6 Recommendation

6.1 Herefordshire OSC is asked to:

a) be aware the arrangements for the Stroke Review;

b) note that their primary points of contact are their local commissioners, supported by their local Stroke Network;

c) note that if consultation is required this will be determined in September/October 2012; proposals will be subject to a period of formal consultation; it is proposed that consultation be undertaken in the affected areas, rather than a region wide consultation;

d) comment on the high level criteria which will inform EEAG's recommendations.

Paul Edwards
Associate Director of Commissioning
NHS Herefordshire
July 2012

Annex A: Stroke Review Project Board Members:

Prof Tony Rudd, (Chair), Royal College of Physicians Stroke lead; Consultant Guy's and St Thomas' London

Barbara Zutshi, National Stroke Improvement Team

Chris Larkin, Stroke Association

Rebecca Larder, Network Link Director – East Midlands

Prof Tom Robinson, Clinical lead – East Midlands

Dawn Good, Nursing lead – East Midlands

Therapy lead – East Midlands

CCG rep – East Midlands

Jonathan Webb, Service User & carer rep, East Mids

Genevieve Dalton, Network Link Director – EoE

Dr Anthony O'Brien (interim), Clinical lead – EoE

Suzanne Helliwell, Therapy lead – EoE

Moira Keating, Nursing lead – EoE

Dr Brian Houston, CCG rep – EoE

Katrina Power Luton CCG

Jim Barker, NHS Norfolk and Waveney

Rob Wilson, Network Link Director – West Midlands

Dr David Sandler, Clinical lead – West Midlands

Dr Tony Kenton, Shared Clinical lead – West Midlands

Dr Indira Natarajan, Shared Clinical lead – West Midlands

Jacqui Winter, Therapy lead – West Midlands

Paula Bourke, Nursing lead – West Midlands

Dr Liz Pope, CCG rep – West Midlands

Janette Adams, Service User & carer rep, Herefords& Worcs

Norman Phillips Service User and Carer rep, Coventry and Warwickshire

Elaine Yardley, Social care, Nottingham

Matt Ward (Chair of data, modelling and information group) WM Ambulance Service

Prof Robert Harris, Director, NHS M&E

Jon Cook, Head of Reconfiguration, NHS M&E

Sally Standley, Stroke Review Programme Lead, NHS M&E; Cambridge University Health Partners

Alida Farmer, Project Manager NHS M&E

Helen Jackson, Communications Lead NHS M&E

Dr Anne McConville, Acting Regional Dir Public Health

Clare Hilitt ,North Trent Stroke Strategy Project (corresponding)

Chris Larkin, NW Stroke Association

ANNEX B: External Expert Advisory Group members:

Dr Damian Jenkinson, Interim Director, Stroke, NHS Improvement.
Prof Tony Rudd, Director of the Royal College of Physicians Stroke Programme Consultant Stroke Physician Guy's and St Thomas' NHS Foundation Trust
Peter Moore, Stroke Association
Dr Jane Williams, Consultant Nurse in Stroke Care at Portsmouth Hospitals NHS Trust
Prof Caroline Watkins, Professor of Stroke and Older People's Care and Director of Research. University of Central Lancashire
Dr Charlie Davey, Consultant Neurologist (with special interest in stroke), Royal Free Hospital
Adrian South, Deputy Medical Director, South Western Ambulance Service NHS Foundation Trust
Sarah Gillham, Stroke lead, NHS Improvement
Mirek Skrypak, Occupational Therapist, and Chair North Central London Stroke and Cardiovascular Network, Life after Stroke Group.
Claire Fulbrook-Scanlon, Joint Clinical Stroke lead, Avon, Gloucestershire, Wiltshire and Somerset Cardiac and Stroke Network
Barbara Zutshi, Stroke Lead, NHS Improvement
David Roberts, Director of Adult Social Services, London Borough of Bromley
Prof Helen Rodgers, Clinical Professor of Stroke Care, Newcastle University