NHS

The Association of Greater Manchester Primary Care Trusts

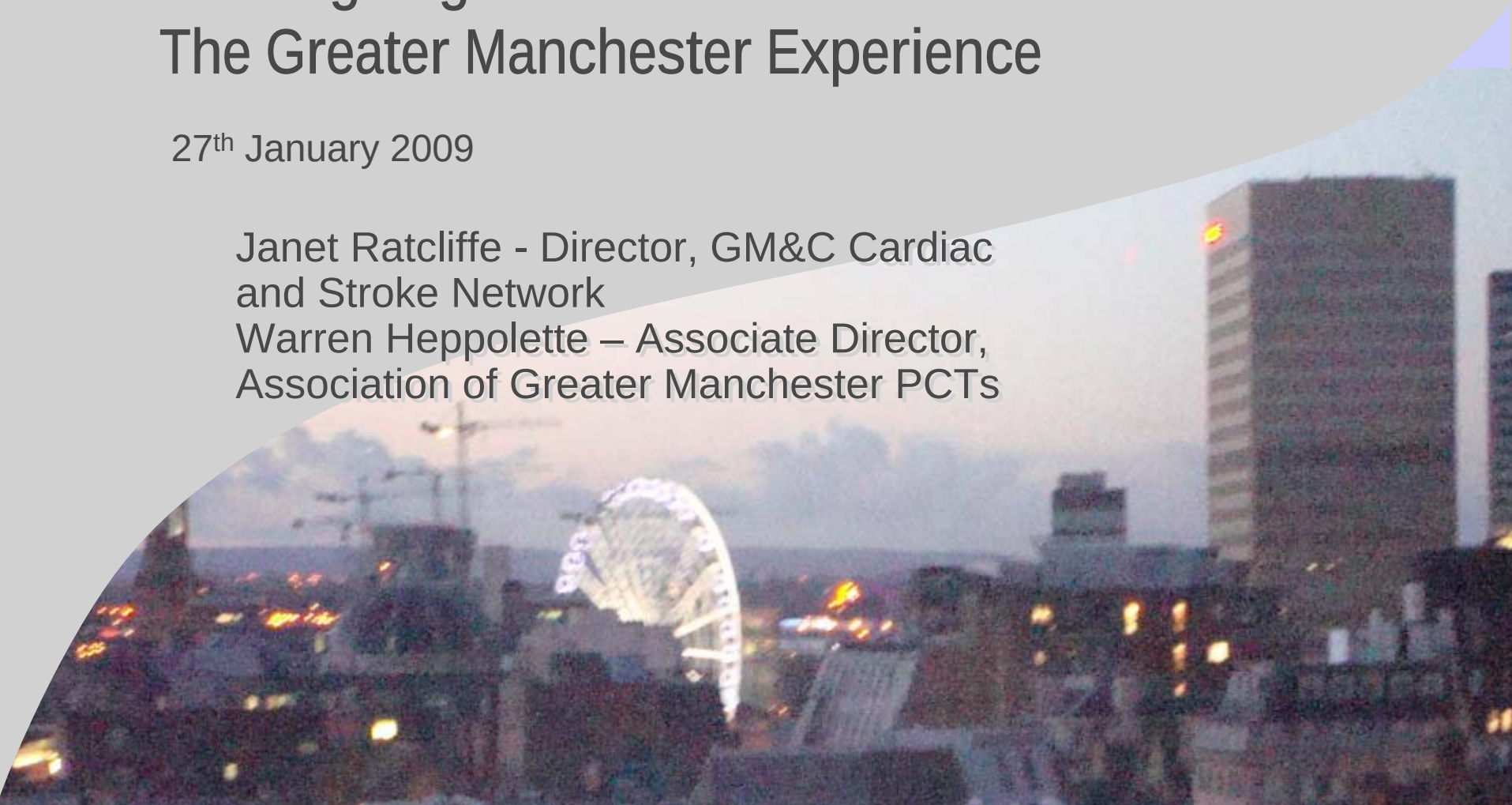
in collaboration with

Greater Manchester & Cheshire NHS
Cardiac and Stroke Network

Redesigning Acute Stroke Care
The Greater Manchester Experience

27th January 2009

Janet Ratcliffe - Director, GM&C Cardiac and Stroke Network
Warren Heppolette – Associate Director, Association of Greater Manchester PCTs



We are presenting on behalf of the Greater Manchester and Cheshire Cardiac and Stroke Network & The Greater Manchester PCTs

- This presentation covers our recent work on putting in place an Acute Stroke Service for Greater Manchester – which is only a part of the Network's scope of responsibility
- The Network is carrying out this work on behalf of the Association of Greater Manchester PCTs

The scope of the National Stroke Strategy covers a number of areas, the Acute Stroke Service sits significantly in Urgent Response

- Public awareness
- TIA and minor stroke services
- **Urgent response**
- Hospital stroke care
- Post hospital stroke care
- Early supported discharge
- Workforce

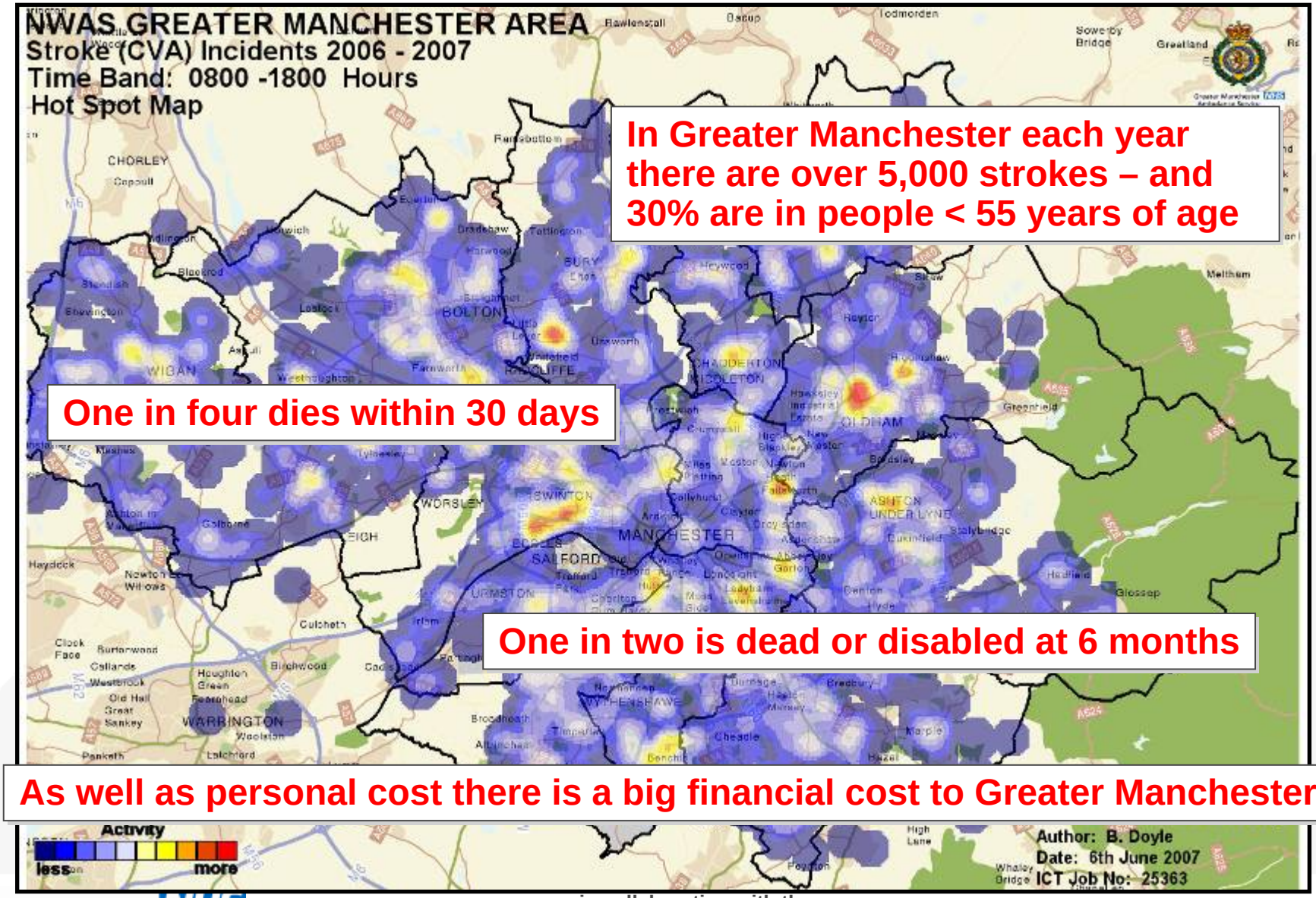
… though our work does impact within other areas

Objectives for this session

- **Demonstrate the managerial, commissioning and clinical aspects of this work and how the Association & the Network have brought these together**
- **Link our work to the Stroke Strategy**
- **Tell the story of our journey**
- **Update you on where we are up to and what we will be doing next**
- **Share key lessons learned**

- **Answer your questions (hopefully!)**
  - **What are your expectations?**

We know that stroke outcomes across Greater Manchester have great scope for improvement



The National Stroke Strategy demands that we work collaboratively to deliver its desired clinical outcomes and quality markers

- To have structures in place which ensure a focus on quality of services and continuous service improvement, across all the organisations in the pathway

- To grow a workforce that enables all people with stroke, and at risk of stroke, to receive care from staff with appropriate level of knowledge, skills and experience

- Quality Marker 17
  - Networks are established covering populations of 0.5 to 2 million to review and organise delivery of stroke services across the care pathway

- Quality Marker 4
  - People who have had a stroke and their carers are meaningfully involved in the planning, development, delivery and monitoring of services. People are regularly informed about how their views have influenced services

The GM Cardiac Network formally took over Stroke from the Older People's Network during 2007

… and NICE Guidelines give us the clinical standards we must meet (locally interpreted)

- ‘Immediate’ (how defined?) admission to an ASU
- Seen by stroke physician within 24 hours
- Swallow assessment within 12 hours
- Administer aspirin to eligible patients as soon as possible but with 24 hours maximum
- CT scan preferably immediately but within 24 hours maximum
- Malnutrition universal screening tool (MUST) within 24 hours
- Carotid Doppler for all appropriate TIA patient within 24 hours
- Call to Needle time…
- All eligible thrombolysis patients achieve call to door time 60 minutes (unless legitimate reason for delay? – what would these be??)

What does this mean for Greater Manchester?

The Vision for this Project is that every citizen in Greater Manchester presenting with stroke/TIA symptoms shall have equal access to a fully integrated, evidence-based hyper-acute and acute specialist stroke care pathway.

Our challenge is to improve equality and quality of acute care for all citizens of Greater Manchester who suffer stroke symptoms

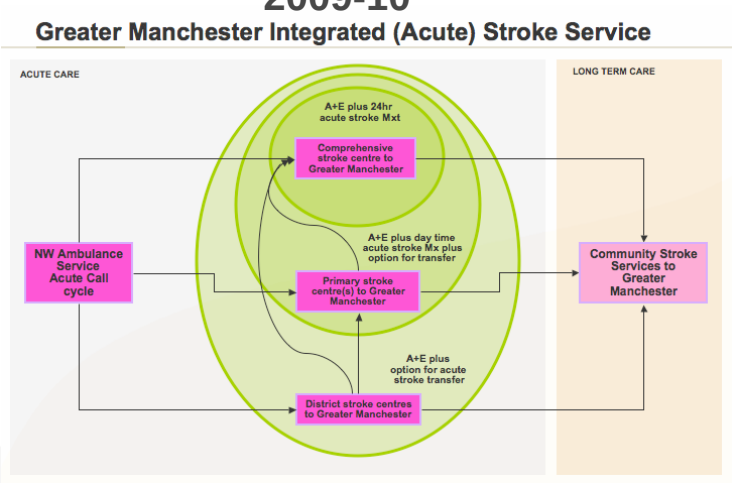
- Currently care varies across the conurbation
- In future instead of being taken to a local A&E those with suspected stroke those who present within 24 hours of onset of symptoms will be taken to one of 3 specialist centres which will between them give 24/7 cover
  - Ambulance staff will make preliminary diagnosis using “FAST”
  - “Call to door” target will be no more than 70 minutes max
- In specialist centres patients will be properly assessed (Swallow/Scan etc.) and if suitable will be thrombolysed
  - “Door to needle” target will be 30 minutes with a maximum of 60 minutes
- After acute care has been provided patients will be repatriated to their local Acute Stroke Unit (or discharged)
- There are SIGNIFICANT implications for all PCTS, Acute Trusts, Ambulance Trust …… as well as GPs, other Healthcare Professionals and the Public

The need for an integrated approach for this time-critical hyper acute stroke care changes the way the service is delivered

2008

- Local commissioning of stroke services - 10 PCTs commission services on behalf of their populations
- 9 NHS and Foundation Trusts provide acute services from 13 hospital sites
- North West Ambulance Service cover whole population of Greater Manchester
- Patients and treated in local Acute Trusts.

2009-10



- Collaborative commissioning of parts of the service
- Centralised specialist hyper acute stroke care - hub and spoke / treat and return approach for better stroke services
- Patients taken initially to CSC / PSCs and then repatriated to ASU in DSCs
- Seamless flow of activities and information to enhance patient journey and outcomes.

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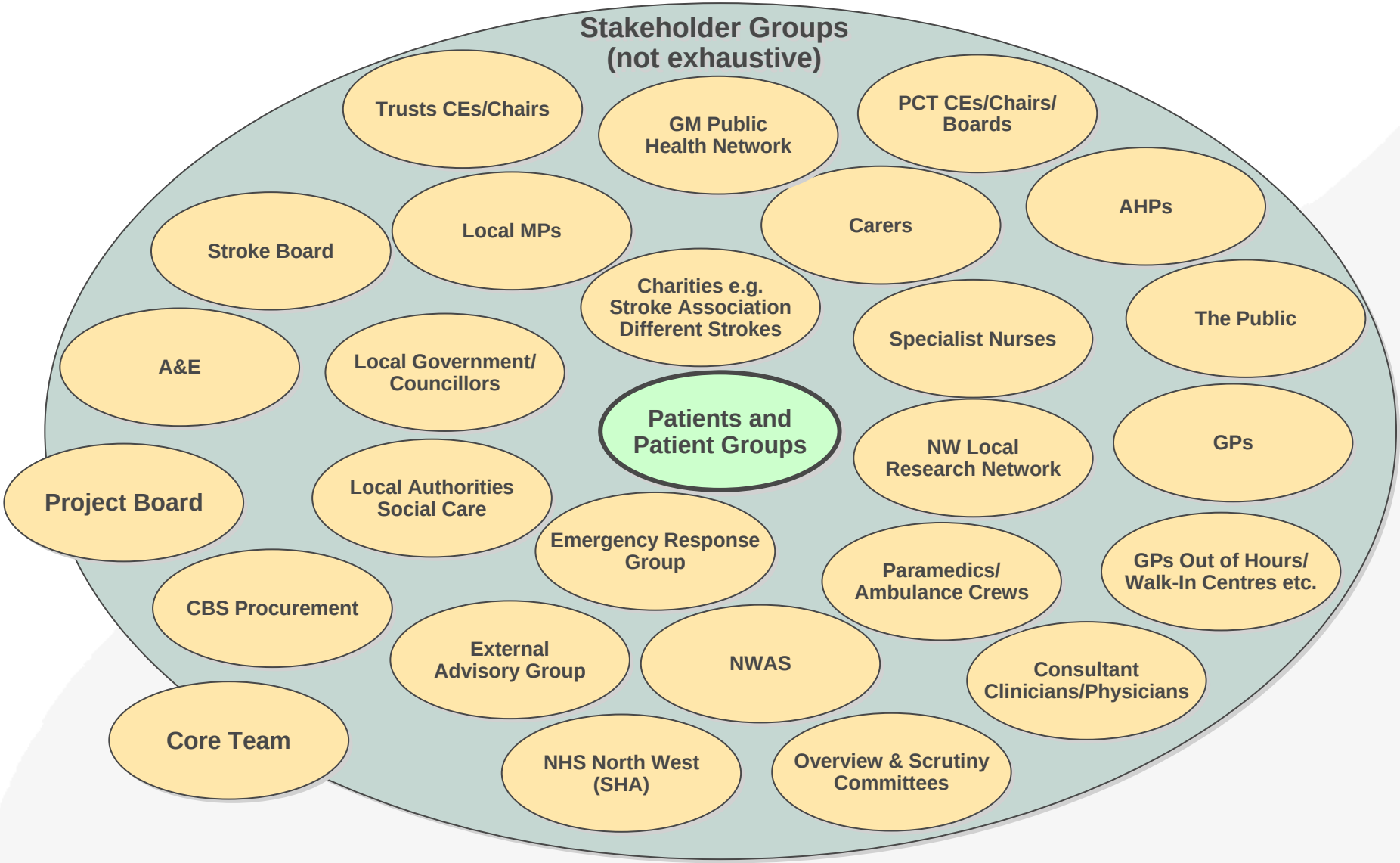
Progress so far

Through collaborative efforts we have over the last year …

- Gathered the local Stroke Community behind this initiative and gained everyone's support to proceed and agreement on key principles;
- Built the Strategic Outline Case for transforming the services;
- Launched our Emergency Response Group which has developed the Stroke and TIA Clinical Pathway to a high level of detail;
- Designed specifications for the service and selected specialist centres;
- Designed and built a data model that represents the patient and financial flows;
- Designed and developed high level detail of the future Operating Model and high level organisation design to deliver the new service;
- Started to work out how much it will all cost the system as a whole and what benefits will be accrued and where;
- Begun the negotiations for the procurement and commissioning of the new service;
- Developed the long, mid and short term plans for implementation.

There are many different groups to involve and we have worked hard to understand the links and relationships between these groups and their different needs



Capgemini CONSULTING.TECHNOLOGY.OUTSOURCING

A set of overarching principles was established at our Autumn 07 consensus event

Overarching principles

- Improve patient outcomes
- Provide equitable access to the services
- Ensure the integrated approach to stroke services demonstrates Value for Money
- Demonstrate openness and probity in the orchestration of services
  - Provide a level playing field for competition amongst providers in GM
  - Provide effective integration of service activity of providers in GM
- Patient services remain stable and safe during transition

Governance	▪ Clear accountability and responsibility in governing both individual trusts and the overall network ▪ Open and transparent processes for governing the GM integrated acute Stroke service, supported by both evidence and negotiation to inform effective decision making
Finance	▪ Openness and fairness of the payment for acute provider services – Clarity is given to decisions making about the fixed and variable elements of acute provider payments – Distribution of payment rewards both excellence and activity (volume and capacity) across the system ▪ Demonstrate-able value for money for the integrated acute stroke services at system and individual trust level ▪ Financial viability (tariffs able to cover the costs) at CSC, PSCs and DSCs ▪ Transparency of the budgetary process and resources allocation
Organisational /IT	▪ Effective coordination of activities across parties involved to plan and deliver the services ▪ Seamless transfer of care
Clinical	▪ Demonstration of safe delivery of clinical services ▪ Ability to meet the national and local clinical standards and guidelines

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The Strategic Outline Case is the first step in "Office of Government Commerce" guidelines for business case preparation

- **Purpose:**
  - **Initiate and scope the process of effective decision making to achieve the strategic objectives of the Primary Care Trusts, NHS Trusts and Foundation Trusts**
  - **Provides foundation document upon which the health care system can determine the steps of how best to progress**
- **Approach:**
  - **Comes from the treasury Green Book (OGC)**
  - **Highlights primary issues; patient need, strategic case, economic case, financial case and project management case, which will deliver the ongoing decision making process.**
- **Supports:**
  - **alignment between the clinical corporate and financial functions across purchasers and providers in pursuit of improved acute stroke services;**
  - **approach to an options appraisal for deciding site(s) of Acute Stroke Services;**
  - **outline of benefits and costs related to the options appraisal;**
  - **framework that will support legitimate and functional decision making processes**
  - **preparation for the process of effective consensus building with Stakeholders**

The Financial Case and Economic Case have just been completed

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Our Emergency Response Group provides independent input to the Stroke Board on clinical matters

- Lead Clinicians
- Network staff
- Stroke Physicians
- Public Health clinicians
- Neurologist
- A+E Consultants
- Patient and carer representative
- Vascular surgeons
- Physiotherapists
- Stroke Nurse
- Ambulance operational managers
- PCT and Acute Trust managers

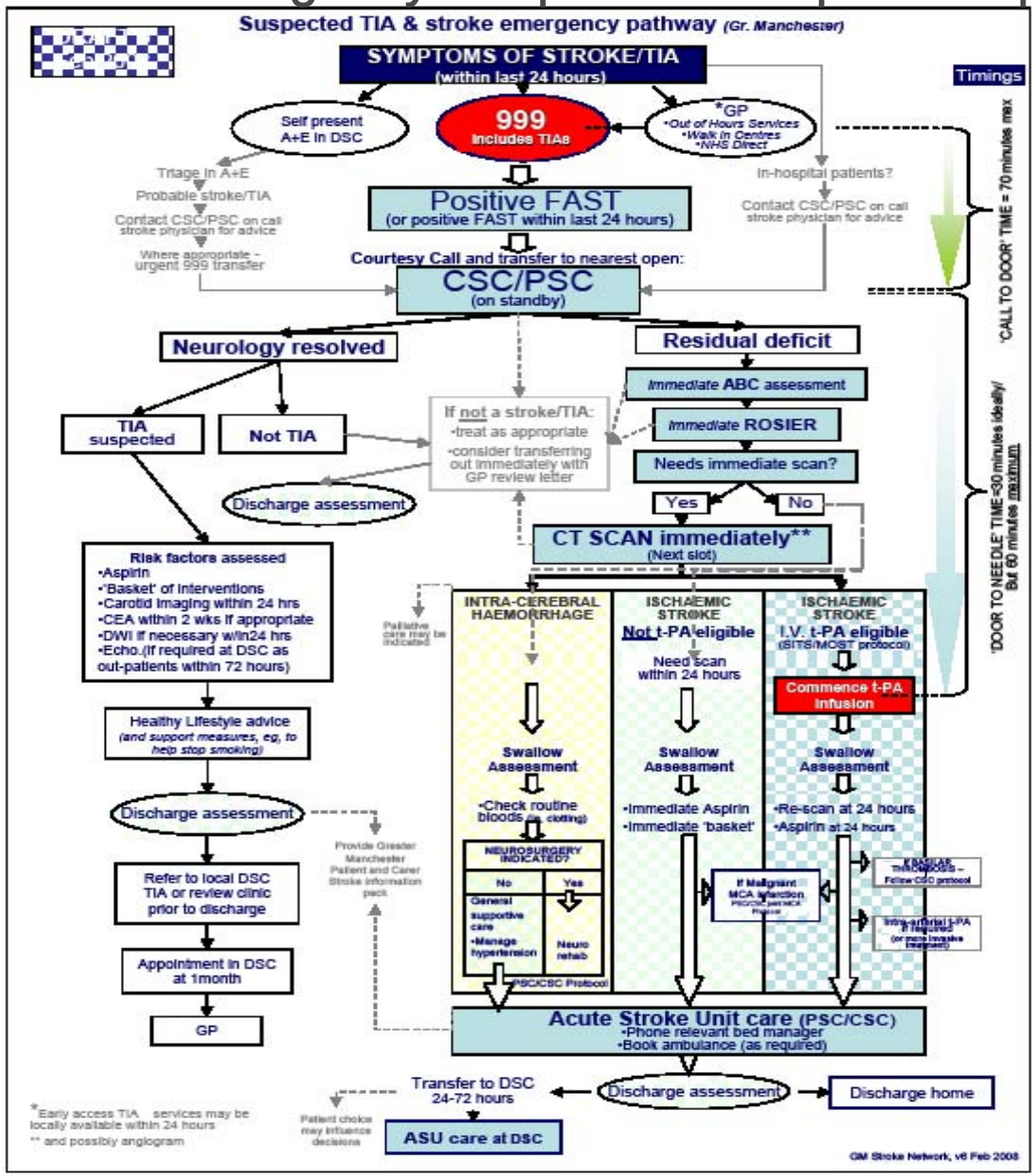
First of all we agreed principles informing stroke/ TIA pathway…

- **Equal access to hyperacute and acute treatment**
- **Every eligible patient gets CT within 24 hours of onset of symptoms**
- **All acute stroke patients should receive 24 hour specialist care**
- **“High risk” TIAs should be formally assessed within 24 hours**

... and our own objectives as the ERG:

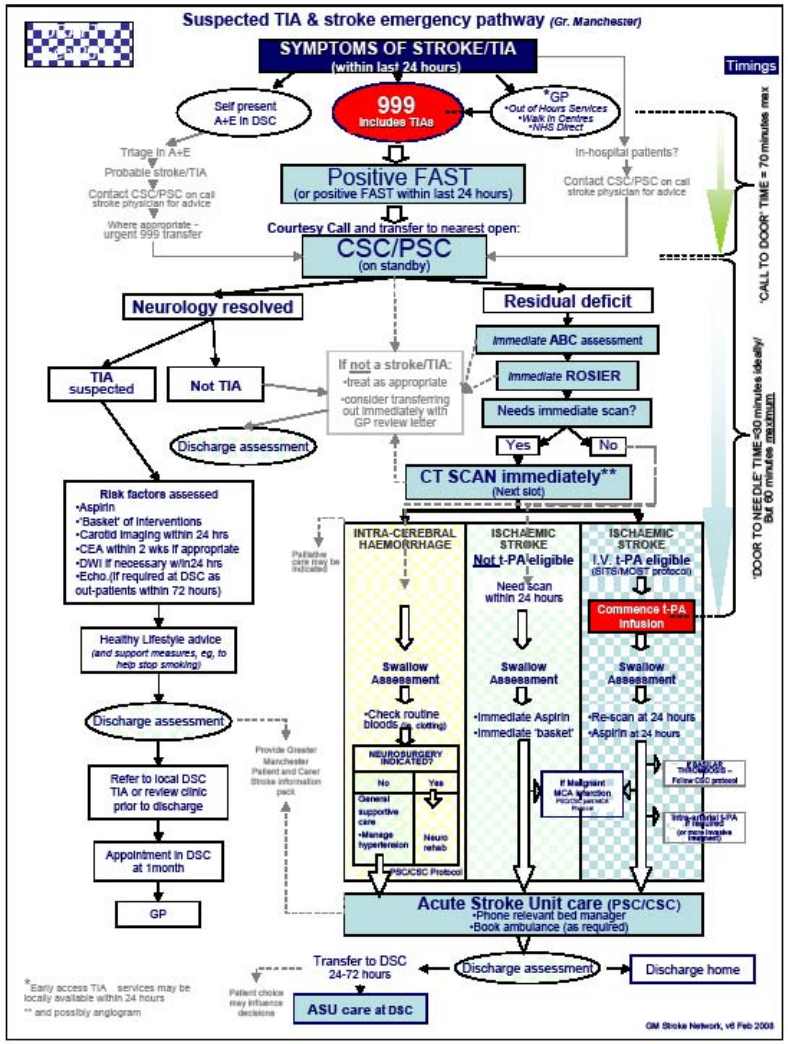
- **To define the optimum clinical pathway for early care of acute stroke**
- **To facilitate the establishment of primary and comprehensive centres to allow early access to CT scan and consideration for 'clot-busting' thrombolysis therapy.**
- **To ensure that all patients with stroke (irrespective of thrombolysis eligibility) or TIA will receive early, evidence-based interventions aimed at reducing mortality and disability.**
- **To ensure that district centres will be a fully integral component of this "Early Hours" model.**

The Emergency Response Group developed the Clinical Pathway

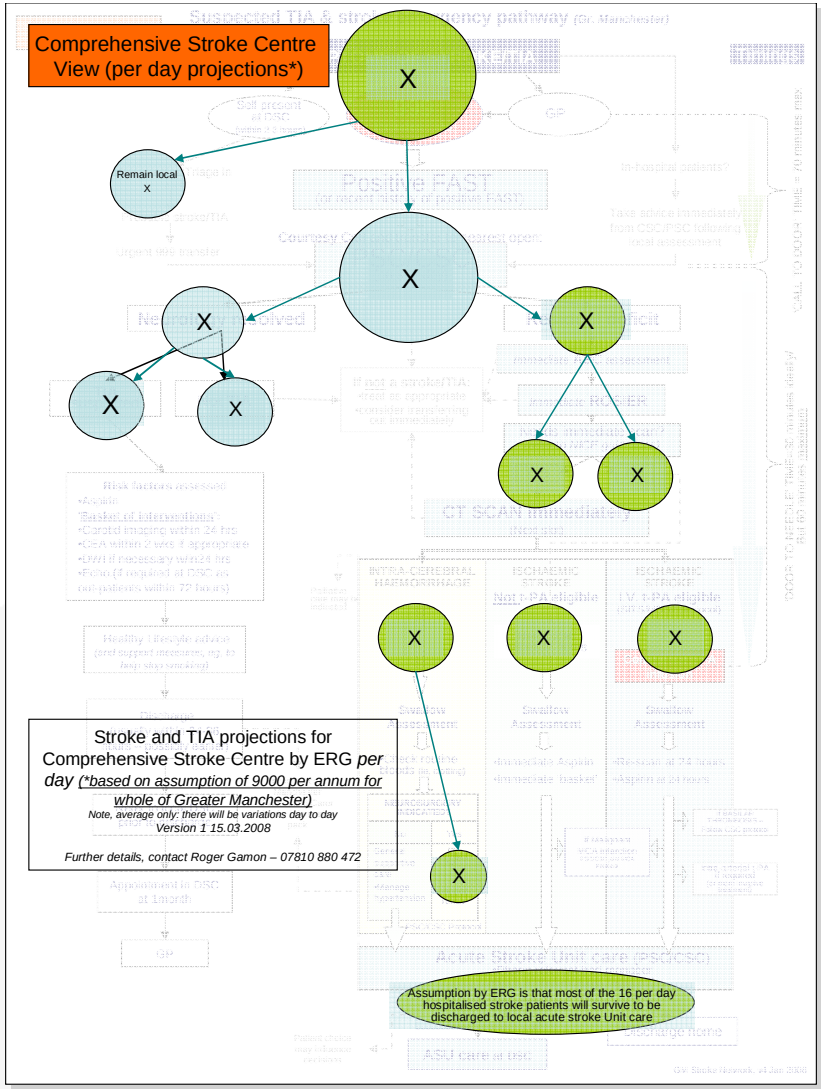


All subsequent service design and modelling activity has been based on this Pathway

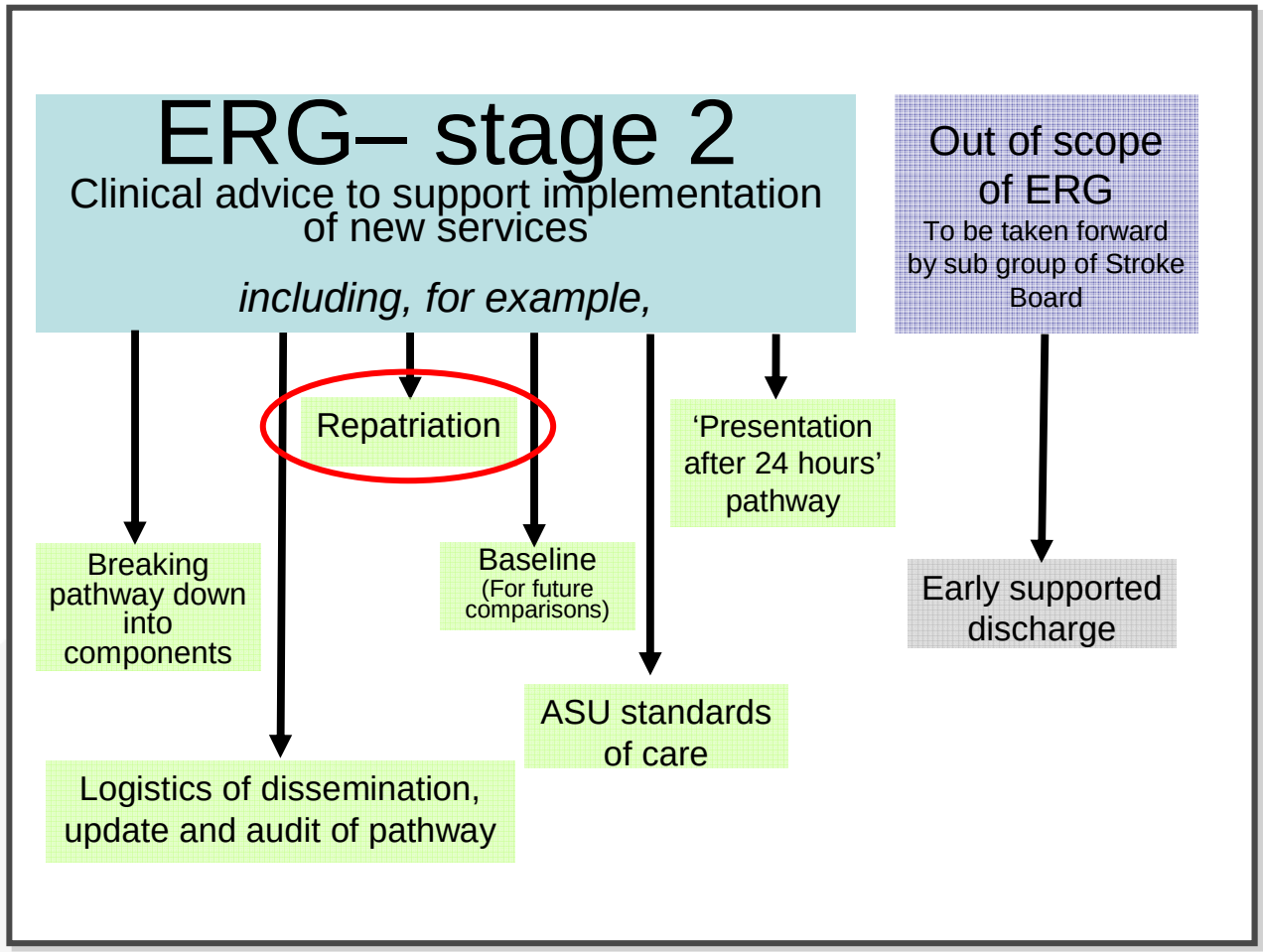
We used various inputs to determine expected numbers through the pathway across Greater Manchester and developed a data model



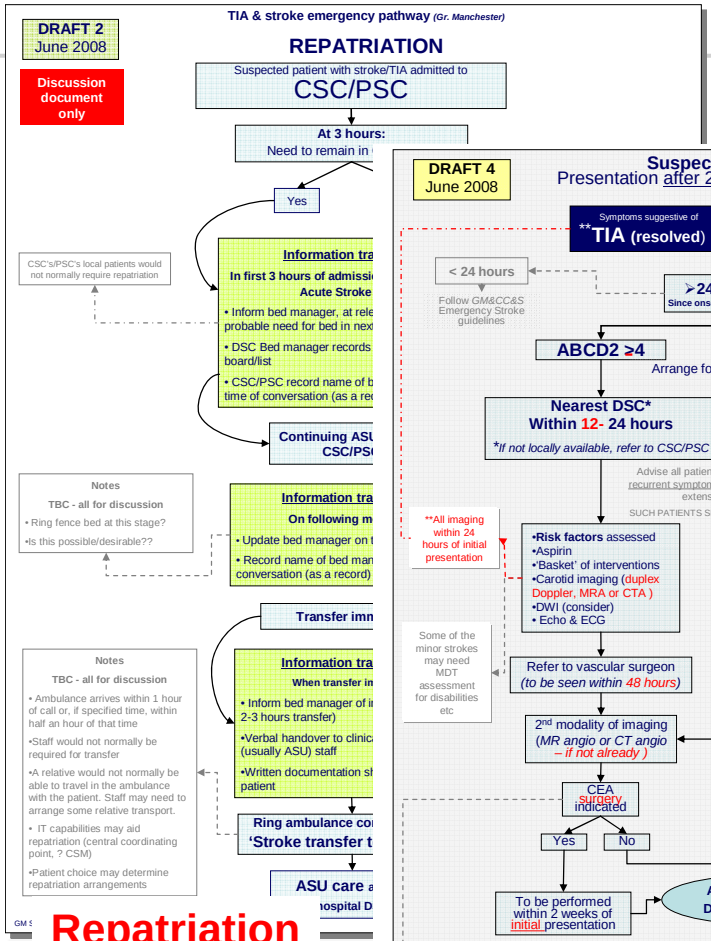
… and the numbers are being utilised to enable providers to confirm their business cases

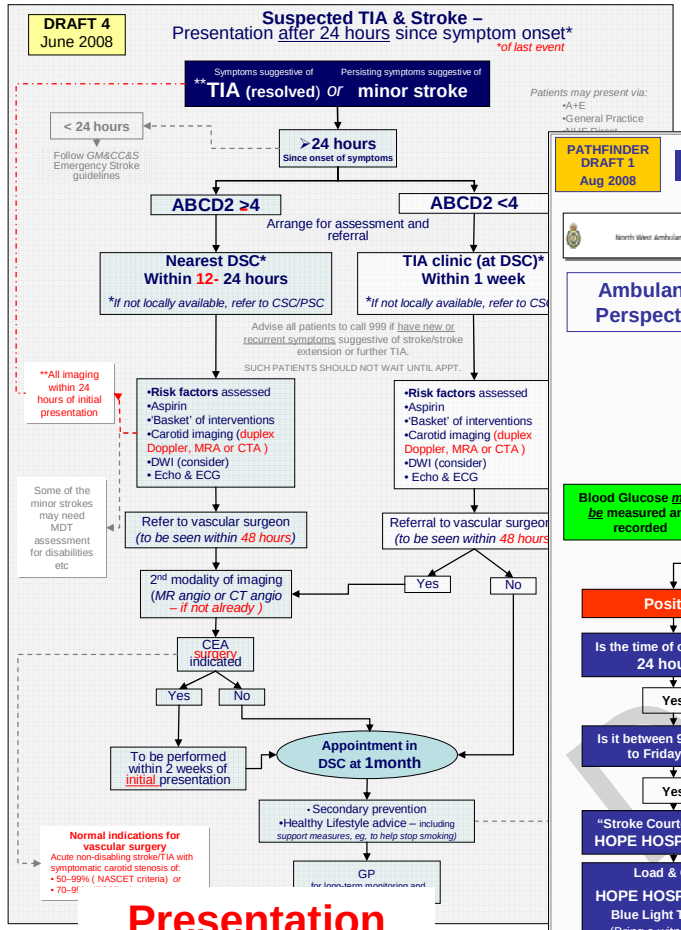


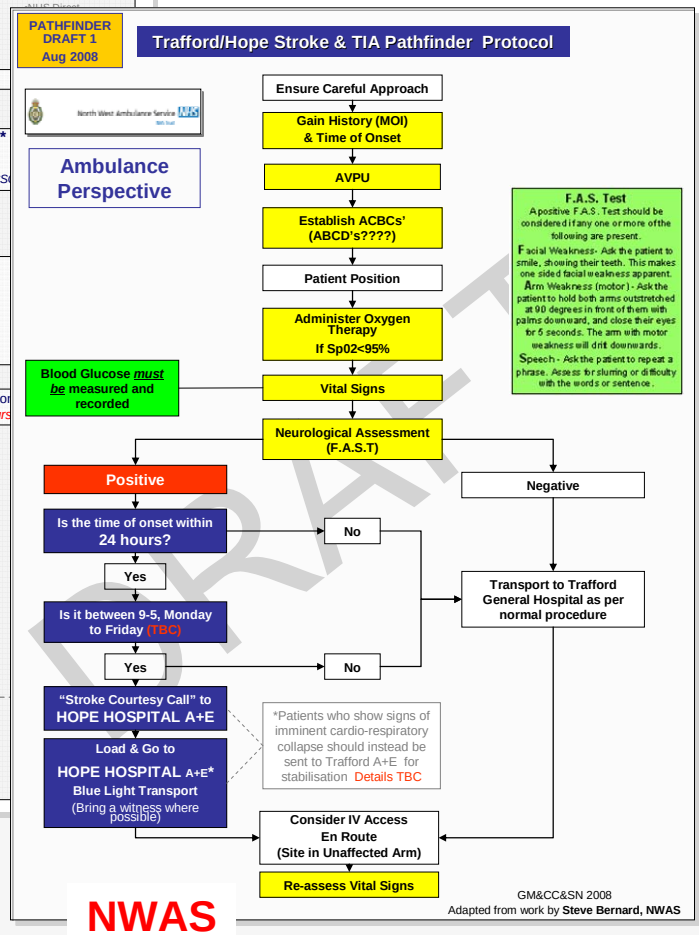
Stage 2 of the ERG work is to identify and start to resolve implementation issues



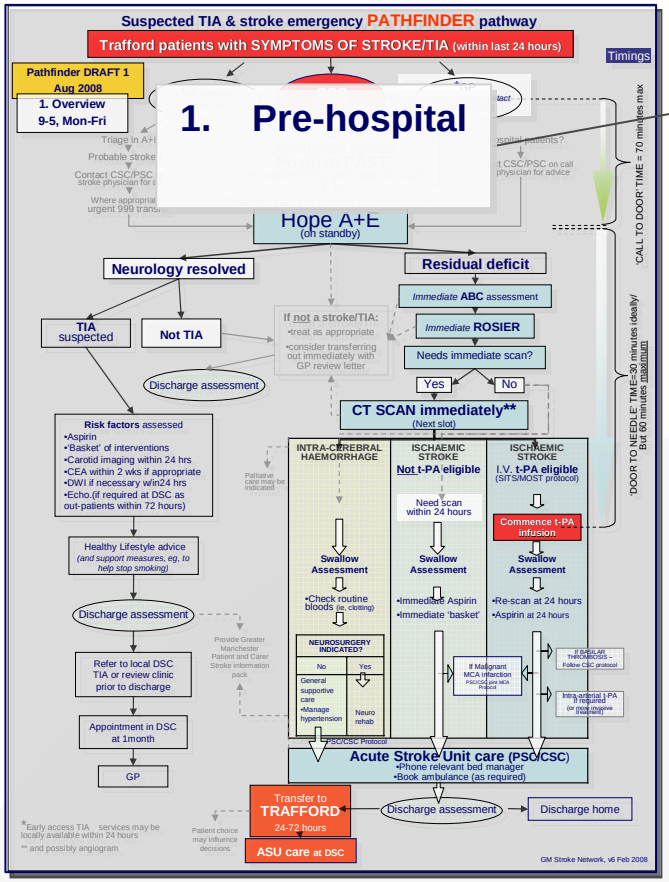
For instance we have detailed lower level component pathways…







.. and drafted the Audit fields we intend to use to demonstrate the system via our initial Pathfinder phase



NWAS Perspective	**Pre-hospital** *(to be collected retrospectively - not on hospital data sheet)*	FIELD
Not on audit form	Ambulance Job Number	Integer
	Date and Time of 1st call for help	Date/Time
	Date and Time of arrival of 1st professional help	Date/Time
	Date and Time on scene	Date/Time
	Positive FAST assessment (not currently collected - possible to collect?)	Yes/No
	Date and time 'Courtesy call' given to main centre	Date/Time
	Time left scene	Date/Time
	Time crew 'cleared'	Date/Time

Note, these pre-hospital fields would ***not*** be on any audit form – proposal is that they will be collected retrospectively from existing ambulance data (TBC)

Many thanks to Claire Hollingworth, Essex Cardiac & Stroke Network, for her permission to use her work as a starting point for this locally attuned database.

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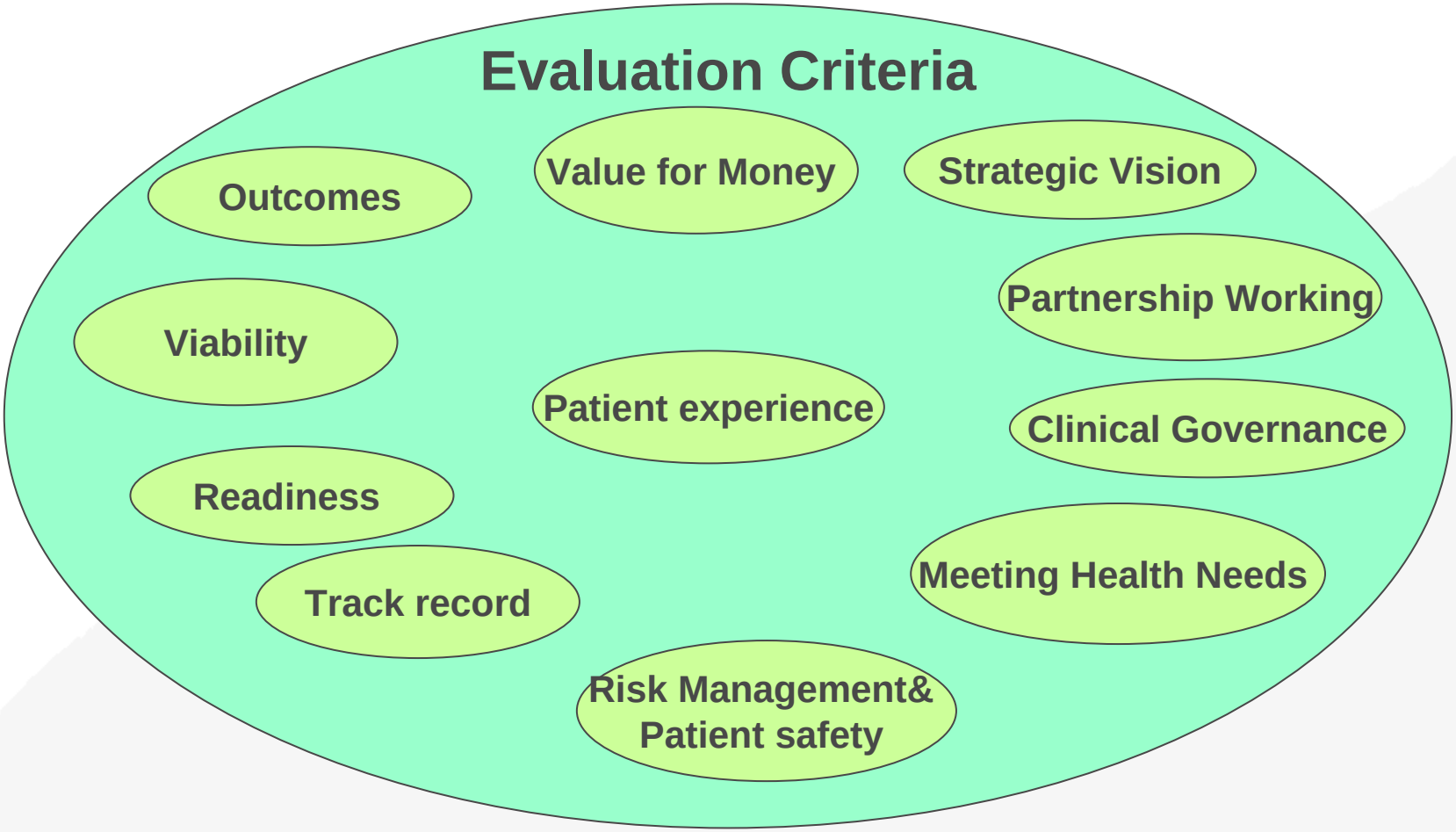
We determined the criteria to be used to inform our decision making in selecting Specialist Acute Stroke Providers (CSC and PSCs)

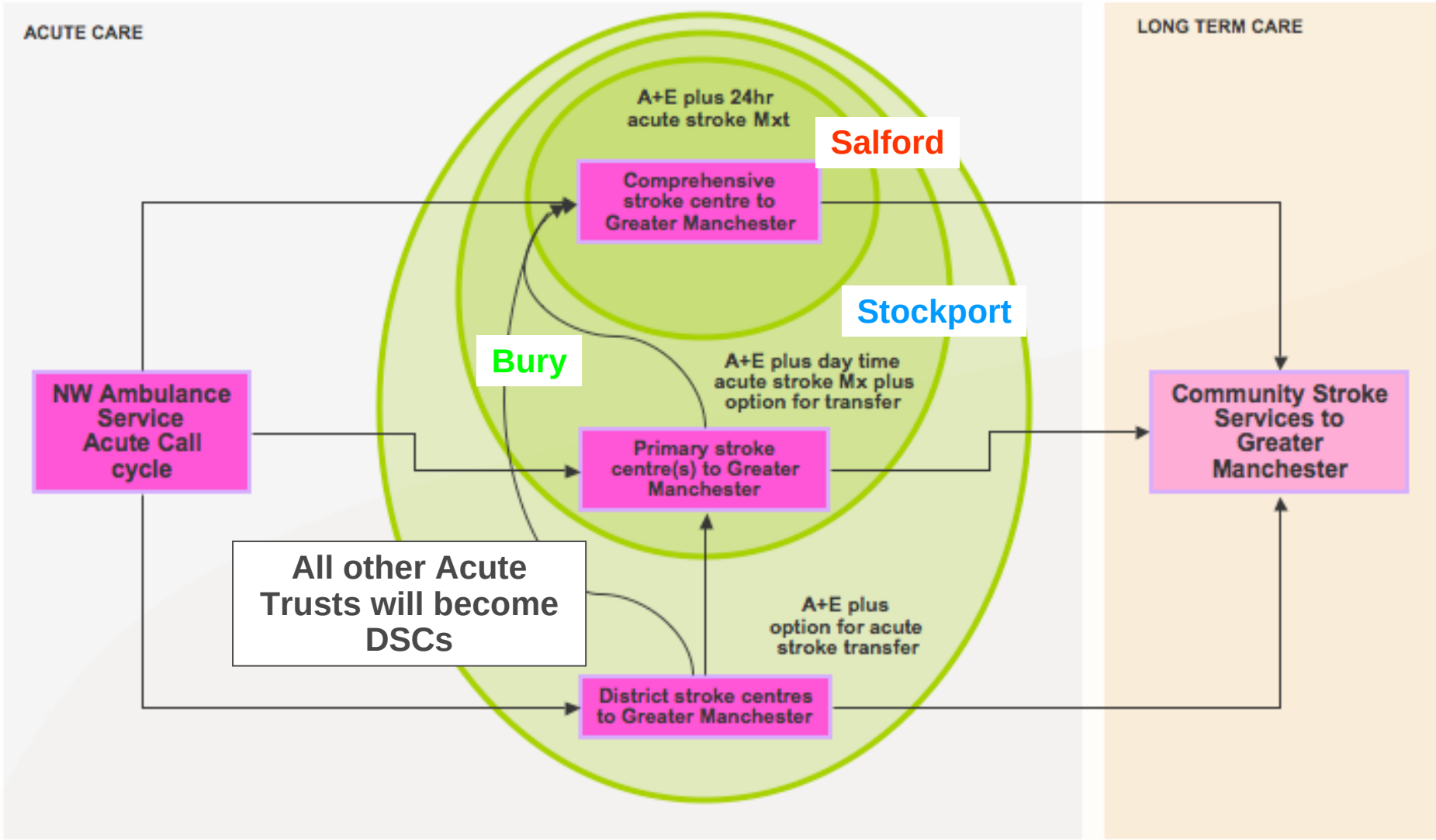


Our External Advisory Group weighted the criteria and then participated in the business case review and selection process itself

The EAG was an independent body of experts drawn from all areas within GM and including External Advisors Anthony Rudd and Damian Jenkinson

Order of Importance	Initial Score	Relative Weighting	Expressed as %
Track Record	12	19.92	**15%**
Outcomes and process indicators	14	17.07	**15%**
Readiness	15	15.93	**15%**
Viability	17	14.06	**15%**
Clinical Governance and quality Improvement	25	9.56	**7.5%**
Value for Money	26	9.19	**7.5%**
Strategic Vision included in Charter	31	7.71	**6.25%**
Partnership Working	32	7.47	**6.25%**
Patient Experience	33	7.24	**6.25%**
Risk Management and Patient Safety	34	7.03	**6.25%**
total	**239**	**115.18**	**100.0%**

The Comprehensive and Primary Stroke Centres were assessed and appointed through this independently verified selection process



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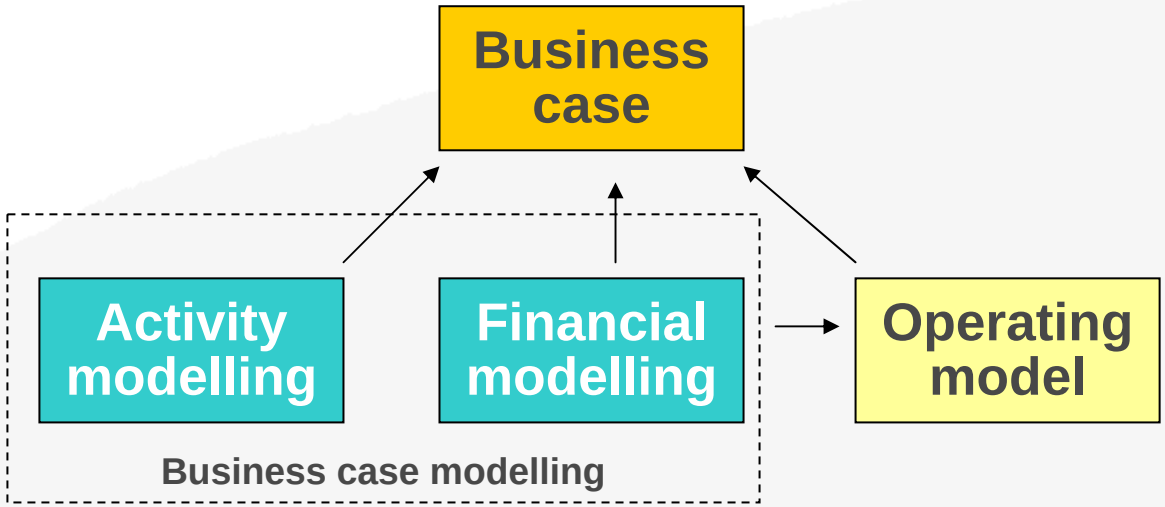
The aim of the data model is to provide the evidence base for reorganisation of the GM Acute Stroke services

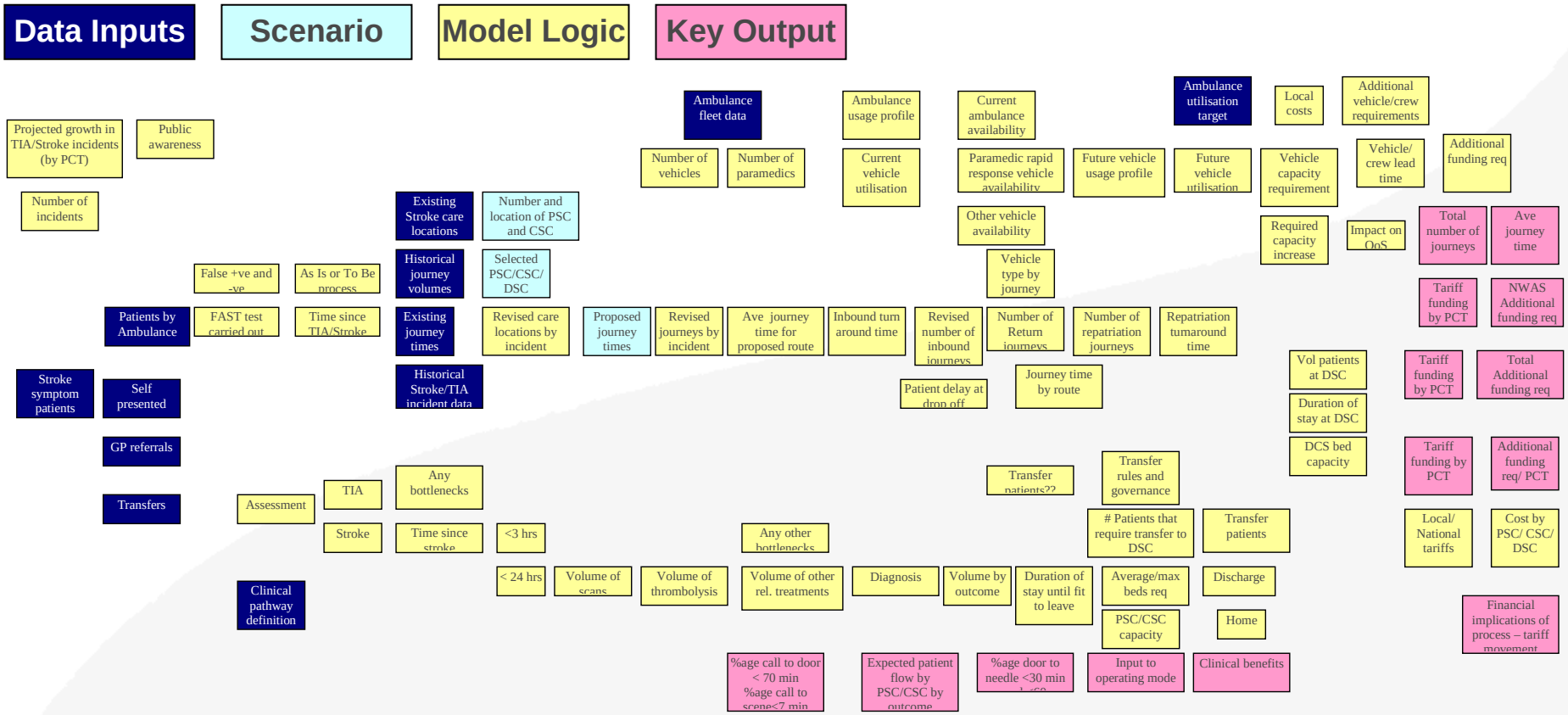
- **Data model is a dynamic platform**
  - **informs business case options**
  - **provides evidence base for the re-commissioning of acute stroke services**

- **The model also demonstrates how different stakeholders will be impacted by the new stroke network and has helped obtain their buy-in**



This modelling together with the Operating Model will inform the Full Business Case

The Conceptual Model is an illustration of the system showing data in, logic, outputs and scope and was developed and validated with a number of stakeholders



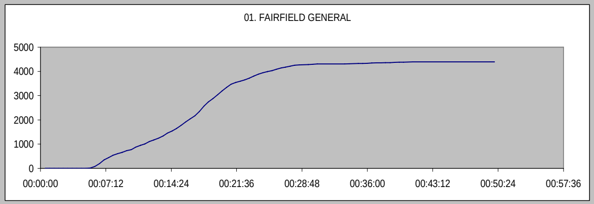
After validation, this conceptual model formed the basis of the design for the data model and therefore the input to the business case.

The model provides financial details for the current state and for the scenarios developed to represent the future state

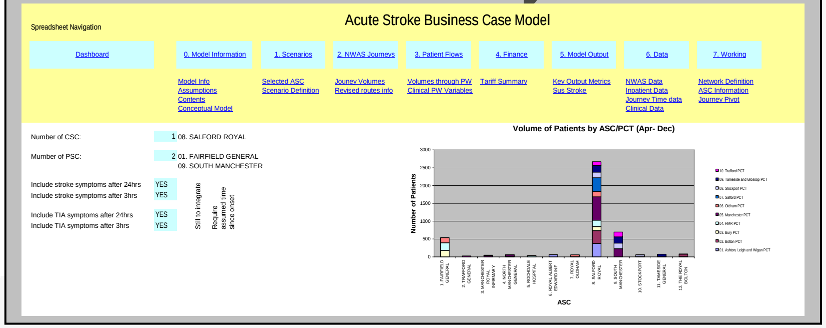
NWAS Journey Output

01. FAIRFIELD GENERAL

00:00:30	0	#######	0
00:01:00	0	0	0
00:01:30	0	0	0
00:02:00	0	0	0
00:02:30	0	0	0
00:03:00	0	0	0
00:03:30	0	0	0
00:04:00	0	0	0
00:04:30	0	0	0
00:05:00	0	0	0
00:05:30	13	13	0
00:06:00	80	67	0.02
00:06:30	191	111	0.04
00:07:00	350	159	0.08
00:07:30	438	88	0.1
00:08:00	540	102	0.12



Patient Flow Data by Outcome



Full Financial Analysis

ASC

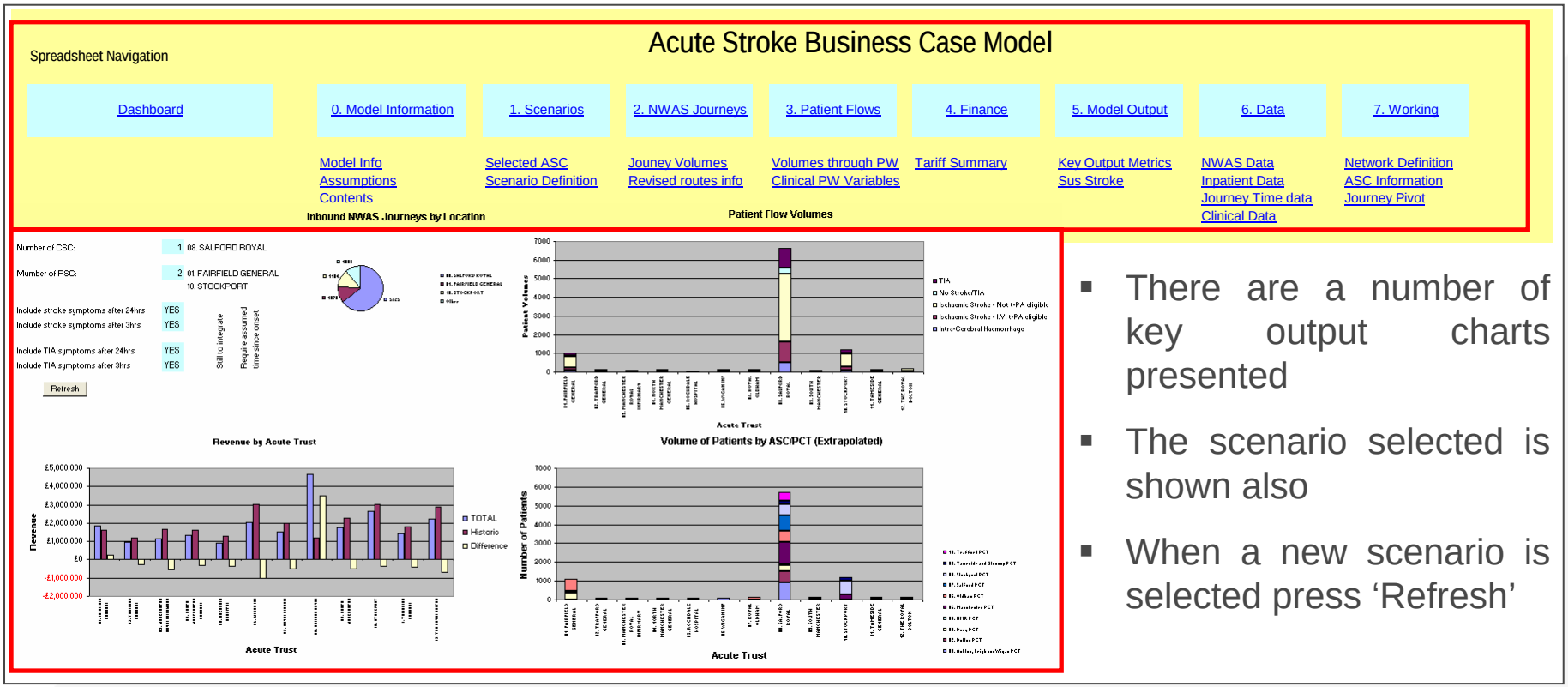
	01. FAIRFIELD GENERAL	02. TRAFFORD GENERAL	03. MANCHESTER ROYAL INFIRMARY	04. NORTH MANCHESTER GENERAL	05. ROCHDALE HOSPITAL	06. WIGAN INF	07. ROYAL OLDHAM	08. SALFORD ROYAL	09. SOUTH MANCHESTER	10. STOCKPORT	11. TAMESIDE GENERAL	12. THE ROYAL BOLTON	Grand Total
01. Ashton, Leigh and Wigan PCT	£ -	£ -	£ -	£ -	£ -	£ 117,409	£ -	£ 614,480	£ -	£ -	£ -	£ 14,547	£ 746,436
02. Bolton PCT	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 441,583	£ -	£ -	£ -	£ 83,227	£ 524,810
03. Bury PCT	£ 214,010	£ -	£ -	£ 2,471	£ -	£ -	£ -	£ 158,049	£ -	£ -	£ -	£ 1,115	£ 375,645
04. HMR PCT	£ 207,664	£ -	£ -	£ 12,197	£ 26,726	£ -	£ 2,397	£ 164,604	£ -	£ -	£ -	£ -	£ 413,588
05. Manchester PCT	£ -	£ -	£ 36,095	£ 36,439	£ -	£ -	£ -	£ 507,835	£ 185,650	£ 9,378	£ 642	£ -	£ 776,039
06. Oldham PCT	£ 203,932	£ -	£ -	£ -	£ 1,446	£ -	£ 72,462	£ 224,572	£ -	£ -	£ 1,115	£ -	£ 503,527
07. Salford PCT	£ -	£ -	£ -	£ 951	£ -	£ -	£ -	£ 293,942	£ -	£ -	£ -	£ 6,030	£ 300,923
08. Stockport PCT	£ -	£ -	£ 3,573	£ -	£ -	£ -	£ -	£ 228,350	£ 282,622	£ 64,483	£ 642	£ -	£ 579,670
09. Tameside and Glossop PCT	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 169,893	£ 185,417	£ 3,878	£ 63,121	£ -	£ 422,309
10. Trafford PCT	£ -	£ 44,026	£ 9,020	£ -	£ -	£ -	£ -	£ 177,498	£ 252,034	£ -	£ -	£ -	£ 482,578
OTHER PCT	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 301,636	£ -	£ -	£ -	£ -	£ 301,636
	£625,606	£44,026	£48,688	£52,058	£28,172	£117,409	£74,859	£3,282,442	£905,723	£77,739	£65,520	£104,919	£5,427,161

DSC

	01. FAIRFIELD GENERAL	02. TRAFFORD GENERAL	03. MANCHESTER ROYAL INFIRMARY	04. NORTH MANCHESTER GENERAL	05. ROCHDALE HOSPITAL	06. WIGAN INF	07. ROYAL OLDHAM	08. SALFORD ROYAL	09. SOUTH MANCHESTER	10. STOCKPORT	11. TAMESIDE GENERAL	12. THE ROYAL BOLTON	Grand Total
01. Ashton, Leigh and Wigan PCT	£ -	£ -	£ -	£ -	£ -	£ 152,243	£ -	£ 818,937	£ -	£ -	£ -	£ 19,692	£ 990,872
02. Bolton PCT	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 547,737	£ -	£ -	£ -	£ 106,879	£ 654,616
03. Bury PCT	£ 267,360	£ -	£ -	£ 6,063	£ -	£ -	£ -	£ 203,132	£ -	£ -	£ -	£ -	£ 476,555
04. HMR PCT	£ 249,052	£ -	£ -	£ 12,154	£ 41,282	£ -	£ 7,866	£ 244,001	£ -	£ -	£ -	£ -	£ 554,355
05. Manchester PCT	£ -	£ -	£ 27,886	£ 70,142	£ -	£ -	£ -	£ 708,270	£ 256,090	£ 11,148	£ 473	£ -	£ 1,074,009
06. Oldham PCT	£ 259,037	£ -	£ -	£ -	£ 4,584	£ -	£ 99,028	£ 280,665	£ -	£ -	£ -	£ -	£ 643,314
07. Salford PCT	£ -	£ -	£ -	£ 3,282	£ -	£ -	£ -	£ 411,926	£ -	£ -	£ -	£ -	£ 415,208
08. Stockport PCT	£ -	£ -	£ 8,963	£ -	£ -	£ -	£ -	£ 308,984	£ 397,225	£ 97,877	£ 473	£ -	£ 813,522
09. Tameside and Glossop PCT	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 235,543	£ 231,277	£ 11,325	£ 80,743	£ -	£ 558,888
10. Trafford PCT	£ -	£ 54,738	£ 29,188	£ -	£ -	£ -	£ -	£ 274,179	£ 337,042	£ -	£ -	£ -	£ 695,147
OTHER PCT	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ 398,558	£ -	£ -	£ -	£ -	£ 398,558
	£775,449	£54,738	£66,037	£91,641	£45,866	£152,243	£106,894	£4,431,932	£1,221,634	£120,350	£81,689	£126,571	£7,275,044

Scenario analysis informed the range of output values expected taking all uncertainties into account.

The Dashboard gives a one page view of the patient volumes and enables navigation through the model



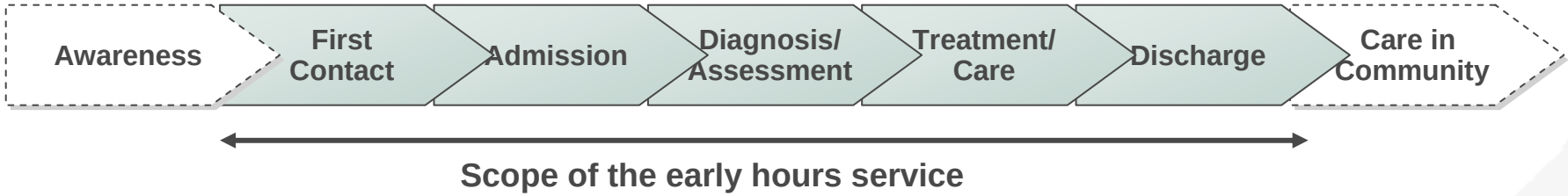
- There are a number of key output charts presented
- The scenario selected is shown also
- When a new scenario is selected press ‘Refresh’

The outcomes from the modelling work have been used to aid negotiations with Providers, especially NWAS (enabling funds were based on model outputs)

Though collaborative efforts we have over the last year …

- Gathered the local Stroke Community behind this initiative and gained everyone's support to proceed and agreement on key principles;
- Built the Strategic Outline Case for transforming the services;
- Launched our Emergency Response Group which has developed the Stroke and TIA Clinical Pathway to a high level of detail;
- Designed specifications for the service and selected specialist centres;
- Designed and built a data model that represents the patient and financial flows;
- Designed and developed high level detail of the future Operating Model and high level organisation design to deliver the new service;
- Started to work out how much it will all cost the system as a whole and what benefits will be accrued and where;
- Begun the negotiations for the procurement and commissioning of the new service;
- Developed the long, mid and short term plans for implementation.

We identified key elements in the new service design / service reconfiguration within the early hours of care (examples only)



Governance

- Effective governance framework for whole system
- Contract and performance management.

Financial policy and management

- Funding to pay for the new services
- Financial policy and planning
- Negotiating and agreeing tariffs

Knowledge and Information

- Infrastructure for information
- Knowledge capture, analysis and sharing.

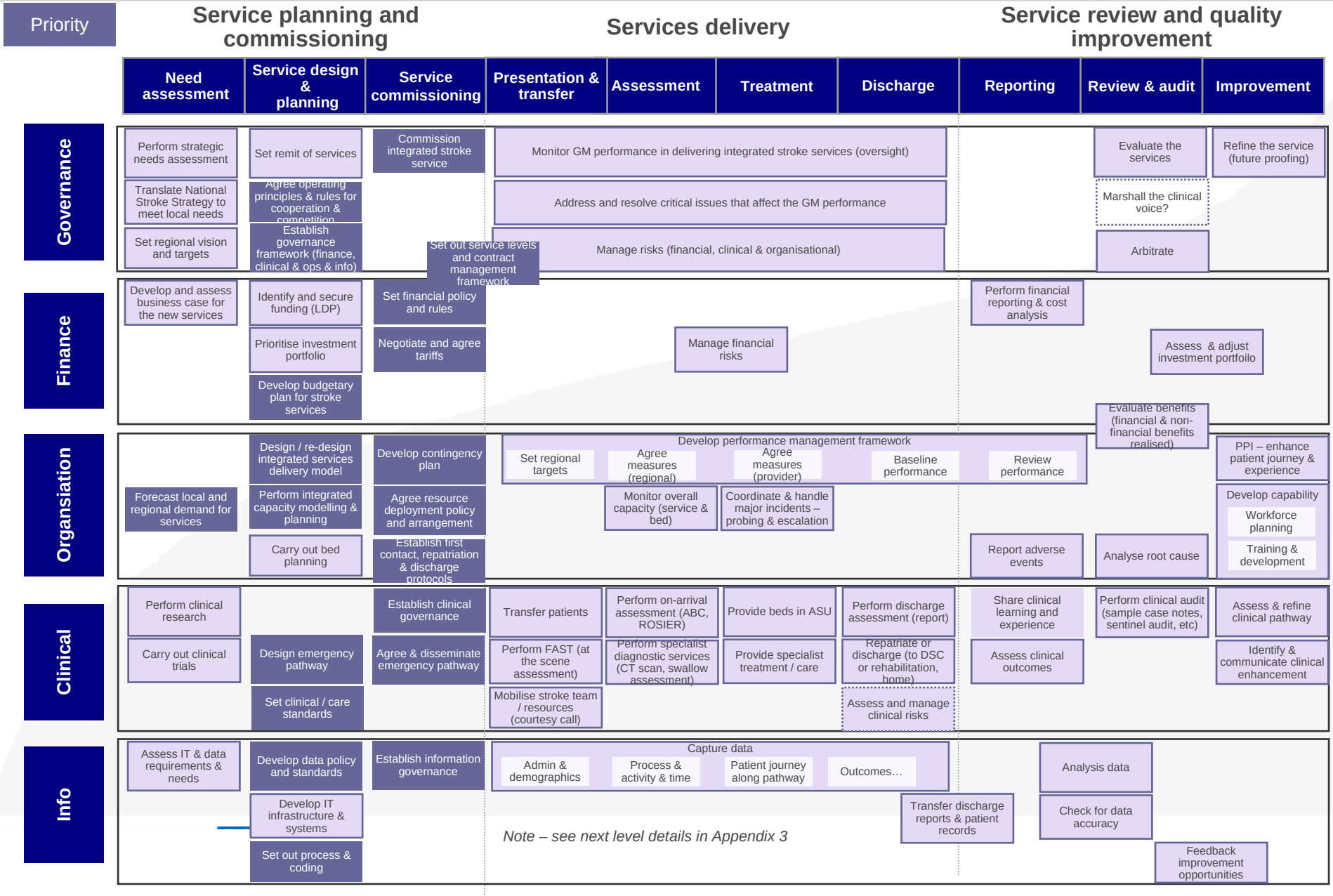
Process (Organisational and clinical management):

- Mapping key activities and processing time
- Agreeing process owners
- Establishing effective handovers (eg repatriation).

People (Organisational and clinical management):

- Allocating roles and responsibilities
- Assessing future vs. current workforce needs/competency
- Recruitment, deployment and training and development

The draft high level Operating Framework shows necessary business services and priority areas identified



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The initial phase Pathfinder phase of the service will be commencing in October 2008

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Commissioning & Financial Framework

- A prerequisite for a robust commissioning strategy to facilitate the movement from historic to a new model of care is an agreed evidence based clinical pathway
- Full stakeholder involvement including public health, clinical and public and patient consensus
- From this a new financial mechanism can be developed based on relevant HRGs
- Early monitoring is crucial to ensure implementation of the pathway and appropriate financial reimbursement

Indicative Tariffs for Redesign of Stroke Services - GM

Principles Adopted

- To take forward the funding of the Integrated Service will require a different approach on utilising the tariff. To take this forward the DH produced a fact sheet in July 2007 which can be found on the following web site http:/www.dh.gov.uk/publications.

- This document and the guidelines have been used to calculate the indicative tariffs for funding the redesign of the patient pathway

- A key factor that will need consideration is the materiality of the potential loss of income to Providers due to the redesign of the pathway which will become known when the model has been verified.

- The GM PCTs developed a Financial Policy to cover the change and address non-recurring cost issues & funding proposals (including services transferring to another provide, services due to expand/open anew

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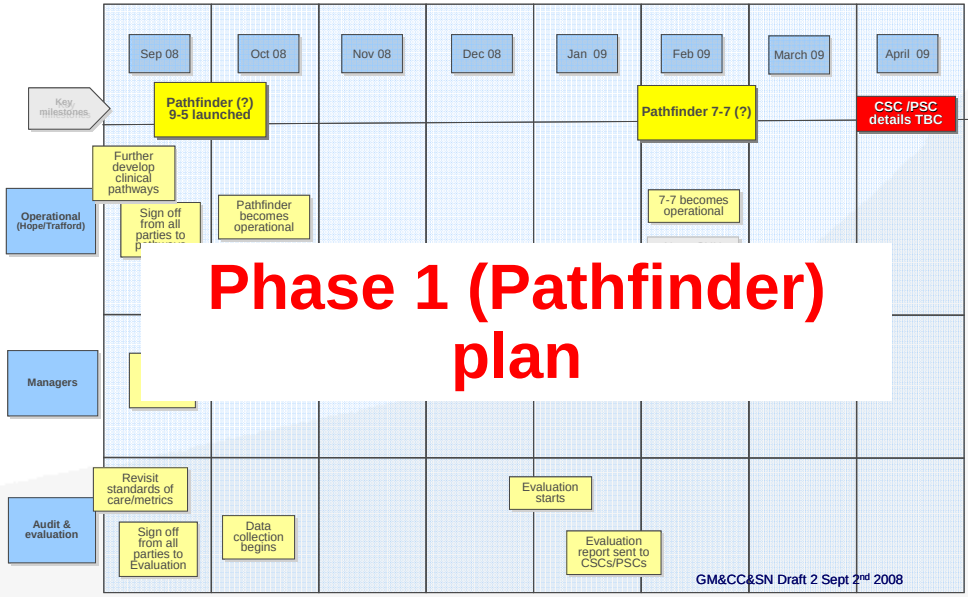
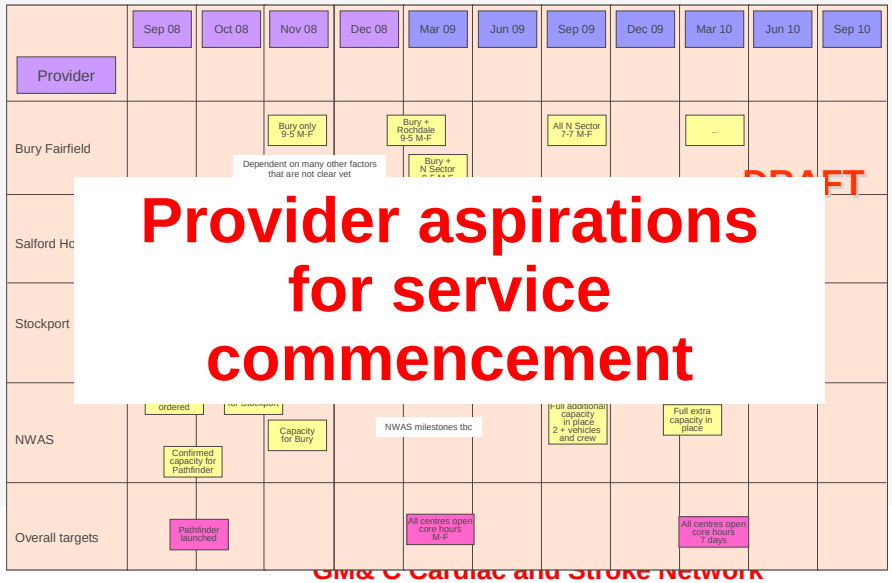
We have developed a long term milestone plan as well as short term Provider plans for early stages of implementation

Overall Milestones 2008 - 2011



Phase 1 (Pathfinder) plan



Provider aspirations for service commencement

DRAFT

GM& C Cardiac and Stroke Network

and

Last but by no means least:

- We have developed a communications plan
- Using communications expertise from across Greater Manchester
- Commissioned a PR agency to support this work
- Linked closely with Stroke Association and DH plans
- Using various types of media
- Expected launch date for professional and patient awareness in early March

NHS

The Association of Greater Manchester Primary Care Trusts

in collaboration with

Greater Manchester & Cheshire NHS
Cardiac and Stroke Network

Lessons Learned

We have learned some lessons along the way

1. The Commissioning Proposition

- Evidence based
- Clinically led
- Population focussed

The case for change was clear, compelling and evidence based. It has maintained solid support from commissioners across the 10 PCTs

2. Clarity of Intent

- Clear Chief Executive commitment
- Focussed, dedicated leadership
- Tested

Progress has relied on consistent Chief Executive leadership, and dedicated support within and beyond the network team. It has maintained momentum and withstood challenge.

3. Engagement

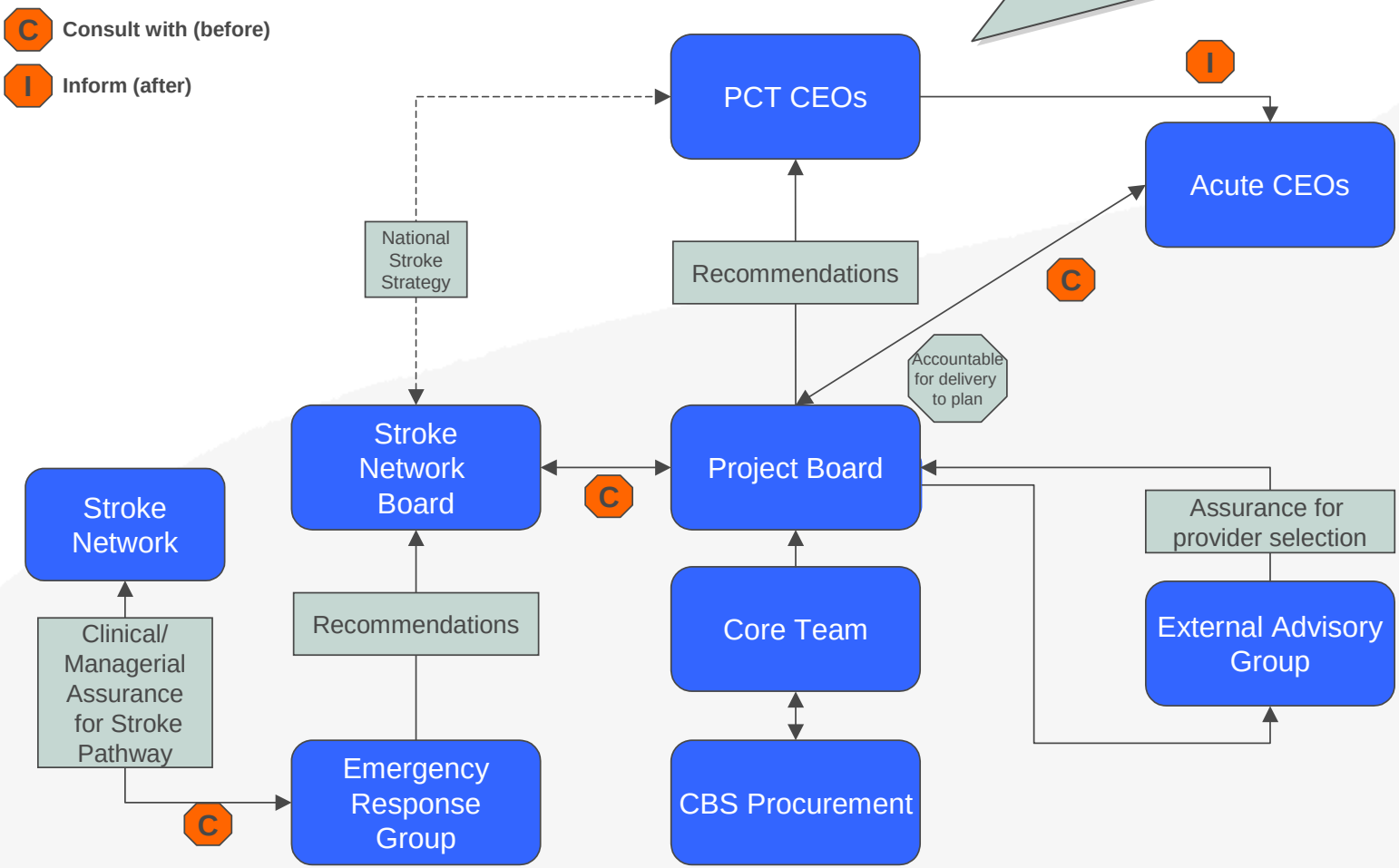
- Acute Support
- Tested and confirmed clinical consensus

1st stage work to establish broad clinical and organisational consensus has provided the most important element of the change process

We have learned some lessons along the way

Clarity of decision rights and processes and a clear analysis of accountability and responsibility is key to commissioning across boundaries

4. Project Governance



We have learned some lessons along the way

5. Procurement

- Principles and decision criteria
- External Advisory Group
- Open Competition
- Making the decision

The open application of clear principles. Let everyone know when and how sites were selected

6. Network Role

- Network Team and Project Support
- Network structures & role

Occupying the space between commissioner and provider – and the importance this has for the Governance of the overall model

And some tough lessons…

- The time from intent to implementation
- Maintaining engagement and active involvement across key stakeholders
- Little capacity for project support
- The effort of communications (Internal and External)
- The final steps to implementation are the hardest – resources required to implement
- The importance of advertising potential loss in the context of major reform projects

Thank you for listening

Any questions?

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