Local Members' Interest

Staffordshire County Council Health Select Committee – 19 March 2019

Proposal for the Provision of an Integrated stroke service at University Hospitals of Derby and Burton

Recommendation/s

1.) Staffordshire Health Select Committee is invited to:

1.1) Consider the proposal for an integrated stroke pathway at the University Hospitals of Derby and Burton as outlined within the body of this report.

1.2) Consider whether, as defined in section 242 of the NHS Act 2006 (as amended) the proposals amount to a substantive variation in service delivery and as such, to advise whether patients, public and stakeholders should be involved in the development and consideration of change.

Summary

2.) Staffordshire Health Select Committee is invited to:

2.1) Consider the proposal for an integrated stroke pathway at the University Hospitals of Derby and Burton as outlined within the body of this report.

2.2) In accordance with the NHS Act 2006 Sec244 (as amended), and expanded further by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, the Clinical Commissioning Group (CCG) of East Staffordshire requests that the Healthy Staffordshire Select Committee receives the information and determines whether it considers that the proposals outlined are considered to be a substantive variation.

If so, Under Section 242(1B) of the NHS Act (2006), the CCGs will make the necessary arrangements to ensure that the public and our patients are informed, involved and consulted in the:

- planning the provision of services
- development and consideration of proposals for change in the way services are provided
- any decisions to be made affecting the operation of services

2.3) The comments of the Select Committee will be reported to the Trust Board and the CCG Governing Body. This will inform of any changes to the reconfiguration of the stroke pathway prior to the desired implementation date in September 2019.

Report

3.) Background

3.1) In line with the national direction of travel to concentrate specialist services, the provision of high quality stroke care formed part of the Full Business Case (FBC) and Patient Benefit Case (PBC) for the proposed merger of Burton Hospitals Foundation Trust and Derby Teaching Hospitals into the University Hospitals of Derby & Burton NHS Foundation Trust (UHDB).

3.2) The CCG are aware of its statutory duty that states that regulations under the Health and Social Care Act 2001 created duties on the NHS which require the NHS to: Provide information about the planning, provision and operation of health services as reasonably required by local authorities to enable them to carry out health scrutiny; to consult on any proposed substantial developments or variations in the provision the health service. Further guidance is available here

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

3.3) The Full Business Case for the merger, which was approved by NHS Improvement (NHSI) and the Competitions & Marketing Authority (CMA) in March 2018, set out the proposal to deliver a centralised service model for Stroke at the Royal Derby Hospital (RDH) site, via a seven day hyper acute stroke unit (HASU) for the first 72 hours of care. After this time, patients will either be discharged or repatriated where relevant to local facilities (for acute and rehabilitation care (equivalent care to that currently provided).

3.4) Improving outcomes for patients with long term conditions, including stroke, is a key priority for the CCG, as outlined in the CCG's Delivery of Change Plan 2012 - 2016 and its Improving Lives Programme.

3.5) Over a time period of 4 years there has been an option explored of centralising hyper-acute stroke services at RDH, allowing an equitable service based on nationally agreed best practice with patients returning to Queens Hospital Burton (QHB) and local community bases for their acute care and rehabilitation.

3.6) This proposal was part of the UHDB financial sustainability plan, however no final decisions have been made about changes to stroke services

3.7) The national trend, led by London Acute Trusts, is towards fewer, larger stroke sites. Delivering services to the local population of Derby and Burton in line with this model would ensure that UHDB, is able to future proof the expected increase in minimum numbers of stroke patients based on national assumption profiles.

3.8) The proposal has been discussed at various committees and was supported subject to the QIA's and EIA's being completed (please see section 13).

- The Staffordshire Sustainability and Transformation Board on the 11th October 2018
- Tamworth, Lichfield and Burntwood Joint Locality Board on 13th November 2018
- East Staffordshire CCG GP Steering Group 20th November 2018
- South East Staffordshire and Seisdon Divisional Committee on the 28th November 2018
- University Hospitals of Derby & Burton NHS Foundation Trust Board at their meeting on the 4th of December 2018
- East Staffordshire Patient Board on the 11th December 2018

- East Staffordshire Governing Body 10th January 2019 (As host commissioner on the BHFT contract)

4.) The Current Model of Delivery

4.1) Currently, both RDH and QHB provide hyper-acute stroke care, acute stroke care and stroke rehabilitation services on site. Both sites also currently provide Transient Ischaemic Attack (TIA) clinics.

4.2) QHB admits a much smaller number of stroke patients per year than RDH.

4.3) RDH currently delivers a stroke service to the population of Derbyshire, inclusive of a 7 day hyper acute stroke service and high risk 7 day TIA service.

4.4) QHB Stroke services are delivered to patients from East Staffordshire, South East Staffordshire and the Swadlincote area of Southern Derbyshire. This is inclusive of a hyper acute stroke service and a 5 day TIA service.

5.) Case for change

5.1) According to the National Stroke Strategy, key changes in stroke care have contributed to a reduction in the chances of a patient dying within 10 years of having a stroke, from a 71% chance in 2006 to a 67% chance in 2010. For example, based on the National Stroke Strategy, the London Stroke Model (which is the model used for the Derby & Burton proposal) was developed to look at care throughout the stroke service, including the establishment of Hyper-Acute Stroke Units (HASUs), with the treatment of patients taking place in fewer specialist HASUs, Acute Stroke Units (ASUs), and being provided with improved Early Supported Discharge. This reduction is largely due to improved co-ordination in stroke care, more patients receiving thrombolysis when needed, and more patients receiving scans within 24 hours of admission to hospital, so that the optimum treatment and care can start as soon as possible. This approach would be supported through the UHDB combined cross site model.

5.2) The Sentinel Stroke National Audit Programme (SSNAP) has highlighted that hyper-acute stroke services are more likely to be clinically effective if they are admitting between 600 and 1500 cases per year.

5.3) QHB site admits fewer than 500 hyper acute stroke unit (HASU) patients a year (405 in 2017/18. 393 patients in 2016/17, and 410 patients in 2015/16). This is below the national best practice minimum of 600, meaning stroke doctors and nurses in some of our units risk becoming deskilled.

5.4) There is evidence to show that stroke patients treated at hospitals which provide 24/7 specialist stroke consultant-delivered care have lower mortality rates and lower rates of long term disability post stroke event.

5.5) National evidence shows that patients are 25% more likely to survive or recover from a stroke if treated in a specialist centre. Patients need fast access to high-quality scanning facilities in order to diagnose the type of stroke, and assess those who are suitable for thrombolysis and those who would benefit from other treatments.

5.6) The Sentinel Stroke National Audit Programme (SSNAP) also notes that larger services are more likely to be financially viable, with a typical breakeven point of approximately 900 admissions per year (on the assumption that all patients were eligible for the best practice

tariff). NHS England's 7 Day Services Clinical Guidance also notes these findings in relation to larger facilities.

5.7) QHB has a higher than expected mortality for confirmed strokes, with a Summary Hospital-level Mortality Indicator (SHMI) of 1.21 which implies 20 per cent more deaths than expected.

5.8) Centralisation of clinical services is a nationally recognised service model for delivery of stroke services. This model ensures clinical sustainability and quality care for patients.

5.9) Overall, this proposed new model would provide a 'Centre of Excellence' for patients in the whole of the Burton and Derby area, meaning that all stroke patients would receive the same level of specialist care in hospital, and the same level of rehabilitation, as near to their homes as possible. All the hospitals, community beds and care in people's homes would have their part to play in providing this 'Centre of Excellence'.

6.) The Proposed Future Model

6.1) The proposed future model is that hyper-acute stroke medicine will be delivered via a centralised service model at the RDH site, and a single referral point for TIA will be established, allowing for a seven day service for all patients currently in RDH or QHB catchment.

6.2) The proposal is for all hyper acute, mimic stroke and weekend TIA patients to be treated at RDH rather than QHB.

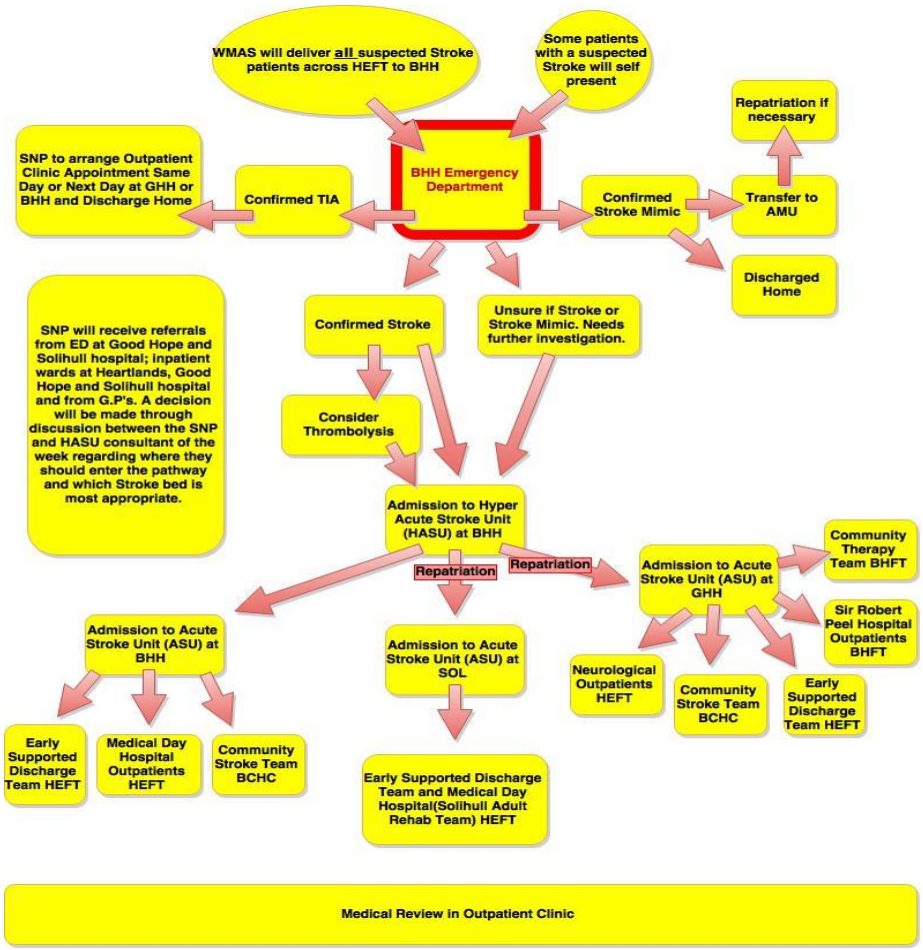
6.3) The proposed change to the patient pathway is as follows:

- All Hyper Acute (first 72 hours of care) patients would be treated at RDH and then stepped back down to QHB for acute care, rehabilitation and discharge to community services or care closer to home.
- Rehabilitation programmes following stroke would remain the same as they are currently
- All mimic stroke patients would be seen in derby and treated and discharged from Derby.
- All TIAs that present at the weekend would be treated at RDH and discharged to community or follow up care at QHB.
- Follow up clinics for Burton patients, post stroke or TIA would be provided at QHB.
- New treatment regimens for stroke patients, for example thrombectomy, would be supported by the RDH, but will mean patients follow a defined clinical pathway and this may include treatment at a very specialist hospital.
- West Midlands Ambulance Service (WMAS) and East Midlands Ambulance Service (EMAS) – the ambulance services that bring patients to QHB and RDH – have been engaged and are supportive in principle of the new hyper acute pathway and the requirement for conveyance to the Derby site as the acute/hyper site.

6.4) To Note

- There are a number of details which will need to be further modelled and planned prior to delivering this change with partner organisations looking at patient flow and the impact on contracts within the Stroke pathway.
- Discussions with East Midlands Ambulance Service and West Midlands Ambulance Service have been ongoing prior to and during the merger transaction.
- Modelling in relation to the changes to ambulance services for patients residing in North West Leicestershire to transport hyper acute stroke patients is currently taking place.

- Travel between sites (for purposes of repatriation to Queen's site for hyper acute patients, typically 72 hours post-stroke) will be via Patient Transport Service providers. A separate workstream is focussing on Patient Transport providers.
- Modelling has been completed for South East Staffordshire patients which does indicate that there is a hyper acute stroke unit at Birmingham Heartlands Foundation Trust (BHFT) with repatriation to an acute unit at Good Hope. This is where Burntwood, Lichfield and Tamworth patients will be transported to if they are not going to UHDB, a decision that will be made by the ambulance crew. The pathway is similar to that being proposed by UHDB.



7.) Benefits of Proposed Model

7.1) The benefits to patients, the local health care system and staff have been considered by UHDB as part of the proposal and are presented as follows:

7.2) Benefits identified for hyper acute patients include; reduced mortality rates, improved quality of life, reduced length of stay, and for the TIA patients reduced mortality and morbidity rates and improved quality of life.

7.3) The proposed model will secure the sustainability of local stroke services for all patients. Without this change to the stroke pathway, the long term viability of the current stroke pathway to the Burton population is exposed from a patient quality of care and performance perspective.

7.4) From a clinical perspective, there will be a joint on call rota and an investment in consultant medical, nursing and therapy staff in order to create capacity for an increased number of patients at Royal Derby Hospital

7.5) The same and equitable seven day service will be delivered to Burton patient population which is now provided to the Derby patient population at the RDH site.

7.6) RDH would continue to provide a seven day stroke consultant delivered service which will be available for patients across the merged Trust. This includes consultant stroke physician, delivered thrombolysis and ward rounds seven days per week which QHB is not currently able to deliver with its current consultant numbers.

7.7) In addition, RDH delivers a seven day TIA service and QHB patients will be able to access this at weekends, expanding the seven-day TIA service to the whole population of the merged Trust.

8.) Engagement undertaken to Date

8.1) During the Acute Trust merger consultation process, Engaging Communities Staffordshire (ECS) were commissioned to take this work forward on behalf of both Trusts. ECS is an independent, not-for-profit, community Interest Company that works to give the public a voice in the way services are delivered. The Engaging Communities work had a broad focus regarding the proposed merger of Burton and Derby Hospitals.

8.2) A number of workshops for patient representatives took place. The focus was to give the patient representatives a broad overview and discussion of what their role as patient representatives may involve.

8.3) This included a workshop which took place 20th September 2017 where patient representatives had initial discussions with clinicians representing the 6 clinical review areas, including Stroke. Patient representatives were recruited to become involved in the stroke clinical review.

8.4) The purpose of the workshop was to give the patient representatives updates on the collaboration and to hear more about each review area from clinicians. 23 patients attended the event; along with over 20 clinicians representing both Trusts.

8.5) Clinicians representing both Trusts led table discussions around clinical pathways including Stroke. The aim of the discussions was to give an overview of the clinical reviews; any key themes/issues that have emerged or been discussed; the vision for the service and patient benefits– to start to give the patient representatives an insight into the process and flavour of the discussions. It was also an opportunity for them to ask questions; to give their views; and to start to talk to them about their future involvement as patient representatives.

9.) Feedback

9.1) The Majority of the conversation was around the pathway and logistics of hyper acute stroke patients initially going to Derby (first 72 hours) and then receiving after care at Burton (if from the Burton/East Staffs area).

Discussion themes also included:

- The importance of high quality aftercare including community rehabilitation. The CCG will look at current provision available.
- Concerns around staffing with the current nurse shortage and recruitment. The model

would allow for an increase in staff capacity for an increased number of patients.

- Integration of the two staff teams. The model would allow for an increase in staff capacity for an increased number of patients.
- Financial savings: The sustainability and viability of stroke services will be secured under the proposed model.
- Higher quality services for patients. All patients would receive equitable care in a 'centre of excellence' as near to their homes as possible.
- Ambulance services and communication of where to take patients will be vital. Talks are underway with the ambulance provider ooking at the modelling.

9.2) Feedback has been taken into consideration as part of the proposals. The outputs of the events held were all taken into account when designing the proposed pathway alongside the Midlands & East Stroke Strategy and the national picture and feedback from the London Model. The Integration Stroke workstream project group has two patient representatives in attendance who have advised on patient engagement and their views on the further design of the proposed model.

10.) **Staff Engagement**

10.1) A full and detailed consultation process has been followed with the Staff both before, during and post transactional merger.

11.) **Wider engagement**

11.1) Wider engagement has been held by UHDB regarding experiences of patients of the Trust as part of the merger process; and raising awareness of the Burton Derby Collaboration this has included:

- A series of around 30 events between May 2017 and July 2018 have focused on the collaboration focusing on the seldom heard and those with protected characteristics.
- Individual meetings with member of the LGBTQ, Polish and Muslim communities; and with Staffordshire ASSIST who support with sensory impairment.
- Burton youth Forum members have received regular updates regarding the proposed merger with members of the Senior Executive Team attending meetings to give an opportunity for members to ask any questions.

To note: this has not been specific to Stroke provision but part of the wider engagement on the merger.

Link to Trust's or Shared Strategic Objectives –

12.) Improved health and wellbeing

12.1) The proposed changes, alongside the changes to TIA provision, will, drive a number of significant patient benefits:

• Reduced mortality rates for hyper acute stroke patients in the QHB patient population;
• Improved quality of life for surviving hyper acute stroke patients in the QHB patient population;
• Reduced length of stay overall for hyper acute stroke patients in the QHB patient population;
• Reduced mortality and morbidity rates for TIA patients in the QHB patient population
• Improved quality of life for TIA patients in the QHB patient population

Link to Other Overview and Scrutiny Activity

13.) UHDB attended the meeting of the Healthy Staffordshire Select Committee on 1st December 2017 where the proposal for the Strategic Collaboration between Burton Hospitals NHS Foundation Trust and Derby Teaching Hospitals NHS Foundation Trust - Outline Business case was reported.

14.) Community Impact

14.1) Within the Trust Business plan and working with the West Midlands Ambulance team there will be an in depth piece of work undertaken looking at conveyancing times and community impact which will form part of the full business case and options.

14.2) There has been a stage 1 Equality Impact Assessment led by ESCCG (Appendix 1) which has advised a Stage 2 Equality Impact Assessment is required. Advice from the OSC meeting will inform the basis for consultation and engagement including any Community Impact required.

14.3) ESCCG are submitting a paper to the Local Equality Advisory Forum on 20 March 2019. The forum is a group of people who represent communities with protect and inform our decision making. The group also includes representatives from vulnerable communities such as the homeless and asylum seekers and refugees and it includes people who can help us to think more broadly about how we can reduce health inequalities. Feedback received will form part of the EIRA stage 2 assessment and will inform the basis for any further engagement and consultation required including clinical pathway redesign.

14.4) UHDB has completed the Quality Impact Assessment (QIA) (Appendix 2) that was signed off by the Trust's Quality Review Group on 21 February 2019. All impacts were assessed as either positive or neutral and this has therefore not triggered a requirement for a stage 2 QIA. The QIA will be submitted to the CCG's Care Quality Review Meeting (that includes UHDB) on 6 March for information only.

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Appendices/Background papers

Appendix 1 Equality Impact Assessment Stage 1
Appendix 2 UHDB Quality Impact Assessment