Working Together Programme

HASU – Scenario Appraisal

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Contents

1. Executive Summary

It is important that commissioners review the case for change for Hyper Acute Stroke Units (HASU) services to determine what is right for their health communities for the long term benefit of the population of the working together footprint. This case for change takes into consideration the safety and quality aspects of the service, drawing on national and regional guidance and clinical best practice recommendations for hyper-acute stroke services, which set out the national direction of travel for stroke services.

If a transformation scenario is supported, then location considerations will draw on demographic information, and take into account the impact of provision in different locations according to access, deliverability and cost.

The purpose of this document is not to provide the detail of the next phase of work but to add to the case for change and provide commissioners with a limited number of options on which to progress this project to the next phase. At which point there will be much wider stakeholder engagement and extensive patient and public involvement.

The options to be considered by commissioners are:

Scenario 1.	Do nothing
Scenario 2.	Continue to deliver the hyper-acute service from 5 provider sites across the working together footprint, with a focus on improving performance against standards
Scenario 3.	Transform HASU provision in the wider context of Yorkshire and Humber Stroke services

1.1 Preferred option

The project team have reviewed this high level options appraisal, taking on board feedback from the clinical community and sub groups within the Working Together programme.

It is the recommendation to the Program Executive Group that option 3: Transform HASU provision in the wider context of Yorkshire and Humber Stroke services is the option of choice. A regional appraisal of options is considered appropriate because this would enable a consideration of service configurations beyond present stroke catchment boundaries, and because further hospital and stroke outcome gains may become available from a larger

scale of base population[1].The rationale for this recommendation is included in this high level options scenario document.

2 Evaluating the high level scenarios

For the purpose of the HASU high level scenario appraisal, Working Together programme commissioners have developed an evaluation criteria to use as part of the decision making process to highlight risks and issues and benefits with the various scenarios.

These criteria are shown below:

Table 1 – Working Together scenario evaluation criteria

Criteria	Indicator
Quality	Impact on premature / avoidable deaths Impact on staffing levels Impact on incidence of subsequent strokes Patient safety – conforming with best practice/Guidelines and standards Patient experience e.g. complaints and feedback
Access	Impact on population weighted average travel time Feedback from patients and public – i.e. acceptability, willingness to travel
Affordability	Up front capital and other non-recurring costs required to implement reconfiguration Assessment of ongoing financial viability of hospital sites Assessment of affordability within commissioners allocations Total value of each option incorporating future capital and revenue implications
Deliverability	Workforce experience/quality (attractiveness for employment) Assessment of ease of delivering option in terms of public and stakeholder acceptability Assessment of ease of creating required capacity shifts within timescales (workforce and physical facilities) Degree of integration across acute, primary, and community services

[1] Morris Stephen, Hunter Rachael M., Ramsay Angus I. G., et al. Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis BMJ. 2014;349:g4757+.

3. Scenario Appraisal

3.1 Scenario 1- Do nothing

As is clear from the phase 1 HASU report/case for change, the variation in quality and performance against standards across the Working together footprint is of concern to commissioners. The key messages from the phase 1 review are as follows:

- 3/5 of HASU centres admit fewer than 600 strokes per annum
- There is a shortage of medical, nursing & therapy staffing in all provider organisations
- Door to needle times of over 1 hour in most cases
- Very low thrombolysis rates across all providers
- Not achieving 1 hour scanning
- Unsustainable medical rotas
- Education & training required for delegated staff
- Gaps in Early Supported Discharge
- Delays in endarterectomy
- 2 units within 15 miles of each other
- There is further work required to ensure effective use of telemedicine

We also know that:

- Services must comply with published quality standards and provide immediate specialist care with 24 hour availability.
- Adoption of larger specialised units may improve some health outcomes and reduce length of stay but the impact on mortality is less clear. The majority of evidence reviewed supports their cost effectiveness; and
- Evidence to date suggest that the adoption of larger specialised units into a hub and spoke model has been successful in improving outcomes urban areas but there is inconclusive evidence to support its applicability in rural areas.

Risks and Issues - Scenario 1- Do nothing

Category	Risk/Issue	RAG	Mitigation
Quality	Part of the rationale for transforming the service is the shortfall of specialised staff, including stroke consultants, nursing and therapy staff to provide the service. This is due to ongoing challenges in recruitment and retention. If the service continued to be offered on all 5 sites the trusts may not be able to recruit adequate numbers of staff to run a safe service. Gaps in staffing levels was one of the issues highlighted in the case for change		None identified - challenges given the aging profile of the workforce, and the national shortage of specialised staff.
Quality and Safety	Provision of hyper-acute care at all 5 hospital sites would be contrary to the National Stroke Strategy, and national direction of travel. Recommendations in the national strategy are for quality and safety purposes, and failure to follow them could reduce the		None identified

	quality of service provided. This could also adversely impact on peer review and accreditation processes.		
Quality and Safety	There needs to be a critical mass of patients receiving thrombolysis treatment to ensure that staff have enough exposure to thrombolyse patients regularly.		Reduce the number of people that deliver thrombolysis treatment so they each treat more patients. However this would reduce the flexibility and skillset of the team and may make it more difficult to cover rotas 24/7.
Deliverability	Staffing shortages will ensure HASU or HASS services provision continue to be challenging		None identified

Benefits - Scenario 1- Do nothing

Category	Benefit
Access	The impact on people from low incomes and deprived areas is assumed to be minimal with this option as it would not involve changes to their current healthcare provision.
Affordability	There would be no expected outflows of patients to other sites, so the viability of the local service and the local acute hospital trusts would be maintained.
Deliverability	Offering a HASU service at all 5 sites could be considered a more acceptable solution from a local political and public perspective as they wouldn't need to travel as much.
Deliverability	Staff would not have to move to another site – they could continue to work at their local hospital site.

Risks and Issues - Scenario 2- Continue to deliver the hyper-acute service from 5 provider sites across the working together footprint, with a focus on improving performance against standards

Category	Risk/Issue	RAG	Mitigation
Quality	Staffing shortages		Investment in services – although national challenges given the aging profile of the workforce, and the national shortage of specialised staff.
Affordability	Currently commissioners and providers are required to deliver significant cost savings, and this investment in existing services may prove to be prohibitive.		None identified
Deliverability	Staffing shortages will ensure HASU or HASS services provision continues to be challenging		None identified Even with investment, the HASU staffing pool is a national challenge and recruitment may still not be possible.

Benefits – Scenario 2 - Continue to deliver the hyper-acute service from 5 provider sites across the working together footprint, with a focus on improving performance against standards

Category	Benefit
Access	The impact on people from low incomes and deprived areas is assumed to be minimal with this option as it would not involve changes to their current healthcare provision.
Affordability	There would be no expected outflows of patients to other sites, so the viability of the local service and the local acute hospital trusts would be maintained.

Deliverability	Offering a HASU service at all 5 sites could be considered a more acceptable solution from a local political and public perspective as they wouldn't need to travel as much.
Deliverability	Staff would not have to move to another site – they could continue to work at their local hospital site.

Risks and Issues - Scenario 3 - Transformation of HASU provision in the wider context of Yorkshire and Humber Stroke services

Category	Risk/Issue	RAG	Mitigation
Quality & Safety	Public may find a centralised/reconfigured service less acceptable. Concerns over transportation and access if services are moved.		It should be noted that this only applies to (up to) the first 72 hours of care, and after that time patients would be repatriated to their local site for rehabilitation and ongoing treatment.
Access	If services were to be reconfigured, there would be a proportion of patients who may have to travel further. Including possibly longer ambulance travel times		This needs to be investigated further as part of the next phase of work looking at possible options. Patients and the public would need to be reassured that travel times by blue light ambulance would only be impacted slightly.

Benefits - Scenario 3 - Transformation of HASU provision in the wider context of Yorkshire and Humber Stroke services

Category	Benefit
Quality and Safety	Reconfiguration of services, to a more centralised model has the potential to deliver improvements to quality and safety to the service. Also to make the service more resilient. A regional appraisal of options is considered appropriate because this would enable a consideration of service configurations beyond present stroke catchment boundaries, and because further hospital and stroke outcome gains may become available from a larger scale of base population[2].
Quality and Safety	A more specialist site configuration fits with the national direction of travel for hyper-acute stroke services which has been designed to improve quality and outcomes. This should contribute to a much improved peer review outcome
Quality and Safety	Combining the services onto fewer site will give the critical mass to provide safe and effective 24/7 hyper-acute stroke care including thrombolysis.
Affordability	There are economies of scale to be sought from this transformation/reconfiguration (learning from elsewhere suggests these benefits begin to have an impact when services see 900 strokes per annum), however it should be noted that a full cost benefit analysis should be made available as part of the option appraisal phase of the project.

4. Conclusion and recommendations

This high level options appraisal sets out the options, risks and benefits for the hyper-acute stroke service within the Working Together footprint. The project team have reviewed this work, and undertaken a high level criteria assessment to form a preferred option for phase 2 of the project.

[2] Morris Stephen, Hunter Rachael M., Ramsay Angus I. G., et al. Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis BMJ. 2014;349:g4757+.

Through consideration of these criteria, and careful review of the benefits and risks associated with service delivery the project team recommend that Option 3 (Transformation of HASU provision in the wider context of Yorkshire and Humber Stroke services) should be considered by Programme Executive Group (PEG) as the preferred option.

The PEG is asked to review and endorse the proposal that option 3 be taken for Clinical Senate approval.