NHS Improvement
Stroke

Accelerating Stroke Improvement

Notes for briefing presentation

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The **Accelerating Stroke Improvement** programme is a national initiative designed to ensure that maximum implementation of the Quality Markers in the National Stroke Strategy is achieved before the end of the financial year 2010/11. The programme does not redefine existing ambitions and goals, but does provide renewed emphasis and urgency, and values and spreads best practice accomplished to date.

Accelerating Stroke Improvement will provide intensive whole-system support to services to accelerate implementation of the strategy during 2010/11, with the aim of achieving key 'milestones' in care across the stroke pathway covering prevention, acute and long-term care and better joint working across the health and social care interface**.**

The methods will combine the efforts and activities of Stroke Networks, the Stroke Improvement Programme (SIP) and the Department of Health (DH) to mobilise local improvement initiatives, supported by SHA, PCT and Trust senior management. The learning from the 5 programmes that SIP has run over the past year will be distilled and spread. Data will be reported on a regular basis, and this will be monitored at national, regional and Network level. Networks will work with local teams to support service improvement and data management in order to deliver the key measures and aims by April 2011.

There is another one year with stroke as a national priority and dedicated DH programme funding available, and the **Accelerating Stroke Improvement** programme is designed to make the very best use of these opportunities. This will also provide a firmer grounding for work beyond 2010/11.

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The need for reconsidering emphasis and timescales in the implementation of the National Stroke Strategy stems from two major factors.

Firstly, the recent National Audit Office (NAO; 3 February 2010) report made clear that whilst good progress has been made in public awareness and acute care, much remains to be done to join up preventative strategies – particularly in management of atrial fibrillation (AF) - and in transfer of care, early supported discharge, long term support and follow-up. The Public Accounts Committee held the Department of Health to account for progress in stroke care to date against the Stroke Strategy on 24th February, (video viewable at http://www.parliamentlive.tv/Main/Player.aspx?meetingId=5941) and whilst they commended the rate of change in the acute parts of the pathway, they also demanded a clear commitment to address the outstanding needs in a short timescale. At the hearing Sir David Nicholson, Chief Executive of the NHS and Accountable Officer and Professor Roger Boyle National Director for Stroke pledged health and social care prioritisation of the work.

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Secondly, financial opportunities to implement the outstanding quality markers in the Stroke Strategy are set to dwindle from April 2011. Warnings of £15-20bn savings needed across the NHS are being made, whilst demand and costs are set to continue to rise.

Whilst progress is being made in improving stroke care – for example, both commissioners and providers are taking notice of the vital signs, and major reconfiguration of acute services, as in London, Manchester and the East Midlands, is occurring – a lot more needs to be done on the quality of the rest of the stroke pathway. Progress in rehabilitation and long term care is particularly behind; in large part attributable to the complexity of that part of the pathway, the relative shortage of good trial evidence, and a lack of clarity of the cost-effectiveness of interventions at this part of the pathway.

The economic downturn will pose a special threat to the implementation of these services unless we prioritise them and rearticulate their value both in terms of effectiveness and also cost-effectiveness. Importantly, sustainable changes in systems and culture need to be embedded before April 2011.

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The ambitions contained within the National Stroke Strategy must be rearticulated in terms consistent with this changing context. In particular, the **Accelerating Stroke Improvement** programme will ensure that all we do in stroke is consistent with the QIPP principles of Quality, Innovation, Productivity and Prevention.

Business plans and proposals in stroke need to: describe the quality of the intervention (the supporting evidence); support innovative solutions and practice; clearly outline the productivity of the intervention (e.g. reduced dependency and length of stay) and emphasise the place of prevention.

Part of the work of the **Accelerating Stroke Improvement** programme will be to produce toolkits to facilitate local implementation, through explicit description of the benefits to be realised both by patients and by the system through increased productivity. Examples will include toolkits for the anticoagulation of patients in AF, for commissioning of Early Supported Discharge (ESD) teams, and for establishment of 7-day working patterns.

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The **Accelerating Stroke Improvement** programme will provide renewed emphasis and focus through whole-system alignment of objectives and timescale, in which everyone has a role to play.

The *Department of Health* (DH) has set the strategic direction for the programme and will provide central financial support to facilitate it, working closely with the Stroke Improvement Programme.

The *Strategic Health Authorities* (SHAs) have already been approached by David Nicholson and Roger Boyle to support the programme. The SHAs will be critical in the monitoring and performance management of the metrics.

Primary Care Trusts (PCTs) are absolutely key, and will need to embed stroke pathways now before finances change dramatically. Local Authorities will be critically important in ensuring commitment of social care services and other community services.

Providers – a wide term encompassing hospitals, community services, GPs, and ambulance services – will need to understand what the benefits of best quality stroke care are both for their local populations, and also for the health economy.

Stroke Networks will play a critical role in supporting work at the interface between commissioners, providers, local people, the voluntary sector and non-statutory bodies. Their important role will include the genuine engagement of PCTs and providers to realise major service change within the next 12 months.

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The three major domains of emphasis for the **Accelerating Stroke Improvement** programme are **Joining Up Prevention**, **Implementing Best Practice in Acute Care**, and **Improving Post Hospital and Long Term Care**.

Joining Up Prevention provides focus on the timely and appropriate management of patients AF in patients leaving secondary care after an admission with stroke. Currently, only 24% of patients with AF discharged from an episode following stroke are on warfarin, and only a further 9% are planned to receive it in the future. Other work through NHS Improvement is focussing on AF management in primary care, and this piece of work is designed to complement that. This domain also includes the timely and effective management of people with high-risk Transient Ischaemic Attack (TIA).

Implementing Best Practice in Acute Care supports direct admission to a stroke unit, as described in the National Stroke Strategy, NICE guidance and emphasised in the Best Practice Tariff. Likewise, this domain also supports the timely performance of brain imaging, again as described in national guidance, and again supported by the Best Practice Tariff .

Improving Post Hospital and Long Term Care. The greatest number of areas of focus are contained in this domain, underscoring the emphasis placed upon this part of the stroke pathway by the NAO and the PAC. Only 37% of sites in the 2009 Sentinel Audit of Stroke report having an early Supported Discharge (ESD) team,

despite ESD having a strong evidence base – in particular, challenges in unbundling the tariff to support ESD are perceived between commissioners and providers. This domain also emphasises the importance of having systems in place to ensure people with stroke receive joint care plans from health and social care, that they receive a review of needs at 6 weeks, 6 months and yearly, that carers' needs are considered and that adequate assessment and intervention for psychological needs are in place.

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The timescale for rolling out and fully realising the **Accelerating Stroke Improvement** programme is challengingly short. The intention is that the bulk of the ambitions will be realised by April 1st 2011.

Work to consult on and agree the metrics will be completed in April 2010 and a baseline assessment undertaken across England in May 2010. It is suggested that launch events, each with high-level executive endorsement and attendance, take place in each of the SHAs between May and June. Work on the 3 major workstreams will commence in May and continue through the year.

Currently being considered are three National Events to take place whilst the work is in progress, with the goal of sharing good practice and seeking solutions to common barriers, monitoring collated regional and national results, and continuing to engage stakeholders.

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The role, responsibilities and changes expected at each level of the system during the **Accelerated Stroke Improvement** programme are shown here.

Clinical teams are at the heart of the work and need to develop an ownership of the tasks ahead and the system of metrics recommended to measure change. SIP can provide training to naïve teams on a toolkit of service development techniques. National leadership support can be provided to selected sites on request.

Trusts – both PCTs and acute – are required to demonstrate board level commitment to the programme, with a nominated individual feeding data on progress to senior management, and with senior management supporting the tasks in hand.

PCTs are required to support commissioning of high quality stroke services to meet the unique needs of their local population. PCTs should work closely with their stroke clinical network to ensure the clinical/managerial interface is optimal to ensure the timely implementation of the required stroke services. Commissioning toolkits to PCTs, produced by SIP, will facilitate understanding of local needs. PCTs will work closely with their **Local Authority** counterparts to minimise the health and social care gap which threatens many post-acute and longer term stroke care services.

Networks are key to the coordination and support of all of the work required in the **Accelerated Stroke Improvement** programme. Networks will play a key supportive role in the collection of the necessary metrics by trusts, and by finding network level solutions to challenges (such as telemedicine).

The **SHAs** will play a vital role in hosting the regional 'consortium of interest', monitor overall performance, and, with Networks, liaise closely with SIP and DH.

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More details of how these processes may develop are given in this flowchart.

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Five major critical enablers will ensure the success of the **Accelerated Stroke Improvement** programme.

A new national initiative to **enhance leadership** in stroke care will ensure that clear direction and support is provided at local levels. This is discussed further later.

The overall ambitions for the programme and the metrics by which progress will be measured, have been defined through a concentrated period of consultation. As such, **goals and metrics will be common** across regions and nationally.

Experience and best practice from previous SIP national priority projects in TIA, acute care, rehabilitation, transfer of care and team and leadership development, plus experience from other projects such as CLAHRC (Collaboration for Leadership in Applied Health Research and Care), and the North West 90:10 programme will be captured, distilled and disseminated.

Focussed support will be available from SIP in the form of diagnostic visits and peer support.

National solutions to commonly experienced barriers in implementation of stroke care will be created as toolkits by SIP, including anticoagulation in AF, commissioning ESD and 7-day working.

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Details of 3 of the important critical enablers are given here.

Enhanced leadership

Enhanced leadership in stroke will be provided in a range of ways. Central funds will be used to create a national cadre of SIP Associates, who will each possess special experience in implementation of stroke care at one point of the care pathway, and will be backfilled for up to 20 days in the year, to visit sites and advise and support service change. SIP will centrally coordinate these staff activities.

A clinical lead for each of the three major domains **Joining Up Prevention**, **Implementing Best Practice in Acute Care**, and **Improving Post Hospital and Long Term Care** will be appointed and supported to steer the important work at a national level. Lastly, the SHAs have been approached to provide Stroke Leads, who will be invited to attend all national and local meetings in the **Accelerated Stroke Improvement** programme.

National Solutions

SIP is already working closely with other national organisations, including DH, CQC, Royal Colleges, Stroke Research Network and CLAHRC, to provide a range of practical solutions, mostly in the form of toolkits, to common problems. These will include commissioning ESD, follow-up reviews and psychological assessment.

Focussed Support

SIP has listened to the requirements of front-line staff and, as part of a range of supportive activities, will provide access to bespoke visits to selected sites by SIP clinical and improvement leads, as well as SIP Associates, to assist in problem solving in service change. This will include responding to challenged services and may extend to whole-systems solutions along stroke care pathways.

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The metrics to measure progress have deliberately challenging ambitions and timescales. Details of the rationale underlying each of the metrics and information on processes for gathering the appropriate information, is available as an Excel spreadsheet. Two of the metrics are already gathered by PCTs as the Vital Signs in stroke unit and TIA care.

The remainder represent a considered balance between the need to provide data that are meaningful and credible, and at the same time are measureable without the need for extensive complex new information systems.

Apart from the 2 Vital Signs metrics, all other data will be gathered at provider level, supported by networks, and monitored by SHAs. An Excel spread sheet is being produced by SIP to facilitate data collection and monitoring.