Kent and Medway Stroke Services Review.

Decision making process
and
Decision tree/criteria.

1.0 Introduction:

This document is a key component of the current Kent and Medway review of Stroke services and needs to be read within the background of the review process as a whole. This includes the:
Case for Change,
Communication and Engagement plan,
Project Initiation Document and
Process Assurance document.

The aim of the paper is to illustrate the process that will be undertaken to ensure a systematic and transparent decision making process.

2.0 The decision making process.

The following decision making process will be undertaken in a systematic approach and will be clinically led.
Central to the decision making process will be regular and robust public engagement. The decision making process will reflect the involvement and feedback from patients and the public , in particular ensuring that the outcome of the review is improved outcomes for patients.
The process will reflect national best practice and guidance.

The decision making process will be implemented at key decision points in the process. This will include:

- Approving the Case for Change
- Agreeing the Long List of Options
- Agreeing the Short List of Options
- The preferred option(s)
- Additional information
- Provider response
- The decision making tree –

2.1 Case for Change:

The Case for Change was developed to reflect the national context, regional influences and local variables. The key focus will relate to the delivery of the best practice guidance, the National Stroke Strategy 2007 and the (soon to be published) Stroke Configuration Guidance 2015 (NHSE).

The Case for Change has been developed with the Programme Advisory Board (PAB) members and the Clinical Reference Group and informed through the CCG clinical forums.

Listening events with the public will raise awareness and assess understanding of the need for change and the publics key issues/concerns. These will inform the Case for Change and in particular to ensure that it is easily understood and recognisable.

The wider clinical community for Stroke will be involved through local provider Trusts and engagement from the review programme director with workshops planned as the review process develops.

The SEC Clinical Senate are providing a 'critical friend' role in reviewing the Case for Change and the PAB will embrace recommendations made. Independent patient and public engagement is also a part of the clinical senate process.

The draft Case for Change will be shared with the CCG clinical forums, ensuring that it is transparent and clinical leadership can challenge and support the process. The final Case for Change will be ratified at the CCG Governing Bodies.

This document was approved in principle at the Review Programme Board (RPB) on 13th May 2015. Additional information will be added as indicated within the document.

3.0 Options Decision making process.

A systematic process will be in place to enable transparency on the identification of the possible options and assessment of the option range.
Central to the decision making process will be the need to ensure that the future delivery of hyper acute/acute stroke delivers real benefits for patients.
The review will listen to the public and patients through out and adapt and amend the process and findings accordingly.

This will be undertaken within a staged process;

Stage 1 – The Long List

The first stage will Identify and register all possible pathway and service configurations for hyper acute Stroke services for the population of Kent and Medway.

The Clinical Reference group will scope and consider the possible options and feedback from the public listening events and engagement events.

Stage 2 – The Long List Revised to the Short List

The second stage will reduce the long list to a shorter list of options. This will be achieved by applying the key indicators within a decision making tree. These will be identified and informed by:

- National guidance
- Best practice (Midlands Specification/Birmingham review)
- NHSEngland guidance on Stroke Services configuration
- Local and external clinical guidance
- Patient/public views
- Achieving the ambition of the review programme board of sustainable quality improvement , benefits for patients and a sustainable workforce plan.

The possible options will be assessed against the decision making tree and the process will remove options that are not able to deliver these key indicators . This will be undertaken through a prioritisation process, however consideration will be applied to borderline results and will be evaluated in the context of its impact.

The short list will be informed by:

- The public and patients through public engagement feedback.(listening events, focus groups, stakeholder groups, national voice)
- The clinical reference group to the Board (appendix 1).
- Board members and their constituency (for example Kent and Medway CCGs, NHS England, SEC Clinical network, Public Health and the Local Authorities,).

Stage 3 _ Options Appraisal.

Once a short list is identified further detailed assessment will be undertaken to determine the feasibility and impact of the options.
This will include ;
A quality review,
Capacity modeling,
Cost benefit analysis including financial modeling
Health needs impact assessment.
The appraisal process will develop to include public, clinical and external feedback re key issues.

Engagement will be undertaken with the public throughout the detailed assessment to identify key priorities and concerns of the public and to test the findings of the assessments.

Clinical engagement will be ongoing to test the clinical validity of the developing options. This includes at CCG clinical lead level.

The Quality review will assess the provider capability both within the context of the Stroke service and within the Trusts wider Quality priorities.
The capacity and financial modeling will consider the ability of both the options and the providers to respond to the demand in a sustainable and financially viable way.

The review will consider the impact of possible options and enable a risk assessment of the balancing factors by the CCG's. This will include;

- considering the impact of longer travel times either due to length of journey or traffic issues on effective thrombolysis.
- Understanding the benefits of the hyper acute principle of centralisation for patients in rural areas.
- The impact on repatriation rates, ED activity and pressures.
- The possible solutions within the context of wider K&M and Trust's strategic plans.

The initial work undertaken by Public Health on projected growth, prevalence and incidence and the impact of primary prevention for key risk factors on stroke

prevalence will be considered in greater detail at this stage. This will inform the options appraisal and subsequent recommendation(s)

The Programme Advisory Board will evaluate the options and identify the final recommendation(s). The Board will be advised by the Clinical reference group and discussions with the wider clinical stroke community.

The Communication and Engagement sub group of the Programme Board will ensure active public participation at all stages of the process including membership of modeling groups.

The findings of the options appraisal will seek to identify an agreed preferred option or options that achieve;

- **Improved patient outcomes and experience.**
- **Clinical viability.**
- **Long term sustainability .**
- **Recommended best practice.**
- **Workforce planning supporting effective recruitment and retention.**

The short list will also be considered within the context of strategic planning and interdependencies across Kent and Medway.

There will be a stakeholder challenge session undertaken following identification of the preferred option/recommendation(s).
This stakeholder session will include:
Public and patients.
Clinical leads from stroke services, medical services and ambulance/ transport services.
CCG clinical leads.
External clinical leads.
SEC CVD network.
SEC Clinical Senate.
Key stakeholders ie Stroke Association.
HWB representation.
K&M concillors and MPs.
K&M CCG leads.

This event will reflect the review process and talk through the decision making process enabling debate and challenge to the findings. The session will proceed with the CCG's and RPB to consider the feedback from the challenge session and advice from the SEC Clinical Senate to confirm and/or amend the final option/recommendation(s).

Stage 4; Preferred option approval.

The option/recommendation(s) will be reviewed through the Kent and Medway Commissioning Assembly to consider a K&M solution and to ensure strategic fit.

The preferred option/recommendation(s) will be presented for approval to the Kent and Medway CCG governing bodies via individual Clinical/business forums.

Public and Clinical engagement will be reflected in the final recommendation(s). Consultation on the preferred option(s) will be undertaken as advised by the Kent HOSC and Medway HASC, who will also advise on the need for a joint HOSC

The clinical reference group will consider models of care based on clinical best practice identifying issues and barriers for consideration.

Appendix 1: Decision Making Tree

This criteria is based on/and reflects the national recommendations for hyper acute/acute stroke services. It is comparable to the DMT used by Birmingham in their review.

The criteria has been discussed and developed in the Clinical reference group and will be further developed with the learning from the public engagement and feedback from the SEC Clinical Senate.

Stage one process:

- Access < 30 mins (95%) ; this relates to travel time of 30 mins allowing the ambulance Trust 30 minutes for the call to patient transfer and therefore meeting the one hour call to door target.
  (The access time will contribute to ensuring the total 120 call to needle time)
- 7 day stroke consultant cover, 7 day Stroke trained nurses with adequate senior staff skill mix and therapists.
- Workforce configuration that meets the HASU requirements (noted in the SEC quality standards);
- Volume >600 < 1500 confirmed stroke admissions (K&M Clinicians keen not to exclude a high performing option that may be slightly below the volumes noted)
- Clinically safe HASU options as assessed through the SEC Quality standards.
- HASU options configurations moderated by EIA
- Negative cost benefit.
- .

Stage two process:

- Detailed appraisal of provider configuration/capacity/feasibility/quality
- Detailed assessment of ability to meet the 120 minutes call to needle time and impact analysis of options on travel times balanced with the benefits of centralisation.
- Cost analysis.*

- Benefit analysis
- Impact assessment.
- Detailed access/travel times review.
- Application of SEC senate Co-dependencies guidance to ensure no negative impact
- Workforce.

(This will consider the workforce requirements to deliver sustainable high quality Stroke services into the future)

- Review of the demographics and projected population growth to determine the impact on delivering a sustainable Hyper acute/acute stroke service.
- This will include consideration of key risk factors and population groups.

Appendix 2:

Recommendations from the Clinical Senate.

These will be reviewed and considered through the Stage two process., in particular reflecting these consideration in the final preferred options.

- Plans for a proposed HASU demonstrate it will be configured, staffed and of sufficient size to deliver its potential for optimal care and outcomes, with a clear aim of achieving >600 cases per annum in a defined period.

- There should be a clear aim, backed by robust demographic modelling, to treat at least 600 confirmed stroke patients per annum, within a defined period. The model should ensure provision is made for compliance with the recommended staffing levels of the full multi-disciplinary team, and will provide the bed capacity to deliver the planned activity (allowing for peaks in demand).

- There should be a clear and detailed description of how the proposed HASU would network with surrounding acute trusts and their ASUs to provide coordinated care for acute stroke patients.

- There should be a clear statement of ambition as to the quality of service and outcomes that will be delivered by the stroke units, and the entire stroke network.

- SSNAP level A across the board should be the aim, with stated time scales as to when these could be delivered (accepting that this could not be immediate).

- There should be explicit, realistic and acceptable patient pathways describing how patients with stroke mimic symptoms will be managed after transfer to the HASU and diagnosis of alternative pathology.

- There should be demonstrated an understanding of the key clinical co-dependencies of HASUs and ASUs, and how they will be addressed. Reference should be made to the SECS co-dependencies report (Dec 2014), and summarised for stroke units in Appendix C of this review.

- Proposed HASUs should be able to demonstrate how they will deliver a clinically appropriate 'call to needle' time for patients in their proposed catchment area, taking account of accurate ambulance travel times, and responsiveness on arrival at the HASU.

- This review proposes a call to needle time of 120 minutes as an appropriate standard to meet.

- There should be convincing proposals for how the multidisciplinary workforce (medical, nursing and therapies as required) will be delivered in the HASU, in order to deliver the required 24/7 and/or 7 day services.

- Robust and detailed workforce plans, including the multi-professional education and training needs, should be provided.

- There should be a description of how the overall stroke network in which the proposed HASU would be centred would look, including pre-hospital care, palliative care, and inpatient rehabilitation and community care post-stroke.

- Stroke care needs to be coordinated and integrated across the pathway between the various providers, and an outline model should be provided, demonstrating the network leadership role that HASUs can serve.

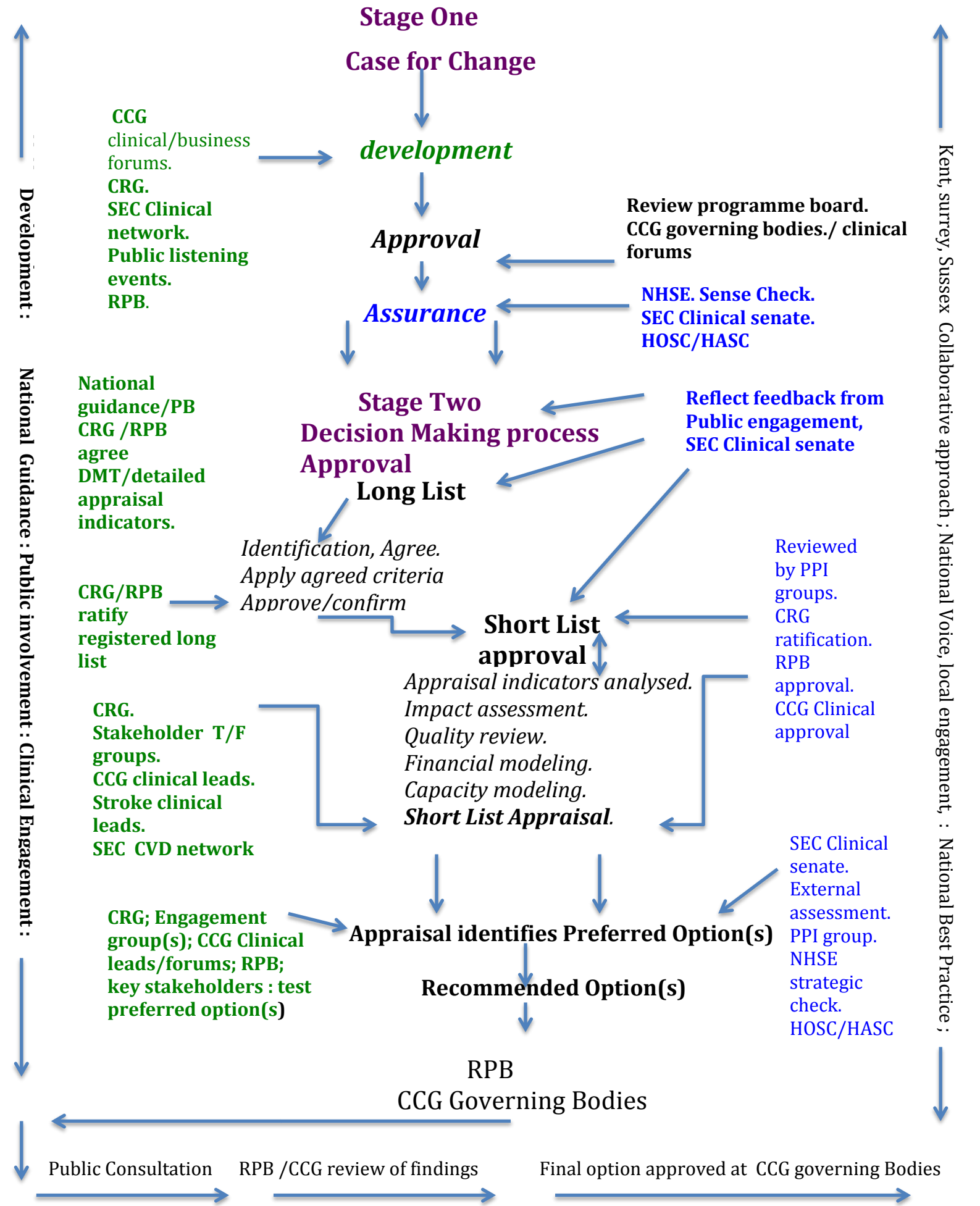
- The TIA pathways for the proposed stroke networks should be outlined, to demonstrate that the required rapidly responsive service would be delivered.

- There should be an articulation of the research role that the HASU would have, and a commitment to support staff (through job planning and other enablers) in participating in clinical trials and other forms of stroke research, in partnership where appropriate with universities, medical schools, the CLRN and KSS's AHS

Appendix 3: Key Governance/decision points.

	Development	Approval
Case for Change	**Developed through the RPB, CRG, Public listening events, CCG clinical feedback, SEC Clinical network .**	**Approved in principle by RPB, Formal approval by CCG Governing bodies/Clinical Committees.** **HOSC/HASC discussions** **NHSE Sense check**
	Up to June 15	***June/July 15*** ***July/August 15***
Decision Making process	**Developed through the CRG, Public listening events, national guidance, SEC Clinical network.**	**Approved through the RPB and the CCG Governing bodies/Clinical committees.**
	Up to July 15	***June/July 15***
Long list	**Developed through CRG,** **Informed through public feedback.**	**Discussed at RPB**
	July/August 15	***August 15***
Short List	**Assessed through CRG. (DMT applied)** **Discussed and developed through Listening events/focus groups and Engagement group.** **Developed with and**	**Agreed at RPB.**

	discussed at CCG clinical/business groups.	
	August 15	***Sept 15***
Options Appraisal	**Informed through public and clinical engagement.** **Assessed through CRG,** **Informed by the CCG clinical leads/forums.** **Stakeholder discussion inc Stroke association, HWB.**	**Approved in principle through the RPB, formally by the CCG governing bodies.** **?JOSC late Sept 15**
	Aug/Sept 15	***Sept 15***
Preferred option(s)	**CRG recommendation.** **Public and engagement groups feedback.** **Stakeholder Challenge session**	**NHSE Strategic check.** **Approved in principle through the RPB.** **Formally through the CCG governing bodies.** **JOSC**
	Late Sept 15	***Oct 15***


Development : National Guidance : Public involvement : Clinical Engagement :
Kent, surrey, Sussex Collaborative approach ; National Voice, local engagement, : National Best Practice ;
Stage One
Case for Change
development
CCG clinical/business forums.
CRG.
SEC Clinical network.
Public listening events.
RPB.
Approval
Review programme board.
CCG governing bodies./ clinical forums
Assurance
NHSE. Sense Check.
SEC Clinical senate.
HOSC/HASC
National guidance/PB
CRG /RPB agree
DMT/detailed appraisal indicators.
Stage Two
Decision Making process
Approval
Long List
Reflect feedback from Public engagement, SEC Clinical senate
Identification, Agree.
Apply agreed criteria
Approve/confirm
CRG/RPB ratify registered long list
Short List approval
Reviewed by PPI groups.
CRG ratification.
RPB approval.
CCG Clinical approval
Appraisal indicators analysed.
Impact assessment.
Quality review.
Financial modeling.
Capacity modeling.
Short List Appraisal.
CRG.
Stakeholder T/F groups.
CCG clinical leads.
Stroke clinical leads.
SEC CVD network
SEC Clinical senate.
External assessment.
PPI group.
NHSE strategic check.
HOSC/HASC
CRG; Engagement group(s); CCG Clinical leads/forums; RPB; key stakeholders : test preferred option(s)
Appraisal identifies Preferred Option(s)
Recommended Option(s)
RPB
CCG Governing Bodies
Public Consultation
RPB /CCG review of findings
Final option approved at CCG governing Bodies