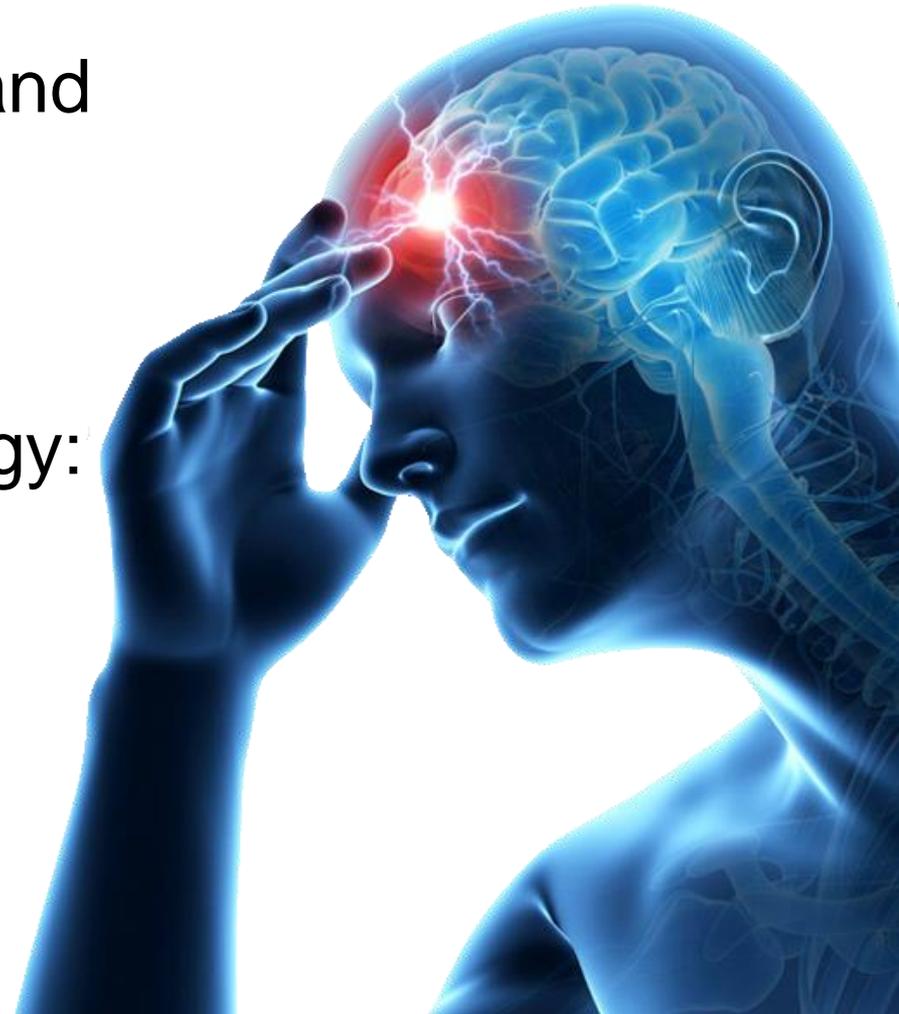


Choosing the best model of stroke services for patients

*Difficult commissioning decisions:
how to navigate changing and challenging times*
The King's Fund, 5th July, 2017

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- Stroke: major cause of death and disability
- Links between care quality and patients outcomes
- **BUT: postcode lottery**
- **2007:** National stroke strategy: benefits of reconfiguration?
- **2010:** London and Greater Manchester centralised



After

Before

London

Greater Manchester 'A'

Suspected stroke

Suspected stroke

Suspected stroke

Stroke unit/ward
Greater Manchester (x12)
London (x30)

8 HASUs (24/7)

≤4 hrs

>4 hrs

24 SUs

1x 24/7 HASU
2x IH HASUs

11
DSCs

Community
rehabilitation services

Community
rehabilitation services

Community
rehabilitation services

Innovations in major system reconfiguration in England: a study of the effectiveness, acceptability, and processes of implementation of different models of stroke care

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*The views and opinions expressed therein are those of the authors and do not
necessarily reflect those of the HS&DR, NIHR, NHS or the Department of Health*



**National Institute for
Health Research**

	London	Greater Manchester
Likelihood of dying ¹	<u>Reduced more</u> than elsewhere	<u>No different</u> from elsewhere
Length of hospital stay ¹	<u>Reduced more</u> than elsewhere	<u>Reduced more</u> than elsewhere
Did patients get the right care? ²	<u>More likely</u> to receive than elsewhere	<u>No more likely</u> than elsewhere
Patients treated in HASU ²	93%	39%

1. Morris et al (2014) *BMJ*
2. Ramsay et al (2015) *Stroke*

Factors influencing selection of different models of centralisation

London: combined top-down with bottom-up leadership

“...if you don’t have the commissioners’ support it [...] sits on a shelf. If [SHA] won’t take the bullets when it gets sticky, then you won’t implement it. If you can’t convince people by making the clinical argument on behalf of patients [...] then **you won’t get it through however powerful your argument is.**”

(Stroke Project Board member)

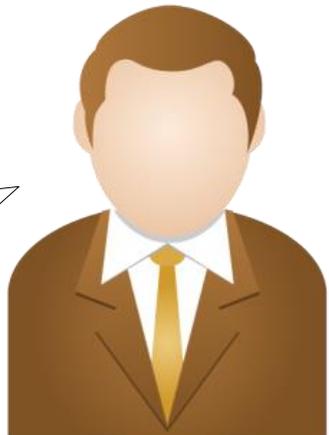


Manchester: bottom-up, clinical network-led



“[the network] was able to organise all these meetings and get everybody on board, and go through those processes so that everybody’s informed and **no one feels like, ‘Oh, this is all a done job’.**” (Stroke physician)

London: ambulance staff, local politicians



“It wouldn’t have happened if the ambulance service hadn’t been fully on board with it” (stroke network board member)

“Every elected councillor wants to protect their area” (local politician)

Manchester: senior hospital management



Due to A&E pressure in one hospital:
“senior management had told [the consultant] not to, that the bid shouldn’t go in” (Stroke physician)

London: holding the line



“Stroke was their [clinician representatives’] life, and they wanted to get the best for stroke [...] but actually what got it through was being straight with them, trying to explain it to them, but in the end **holding the line.**”
(Commissioner and Project Board Member)

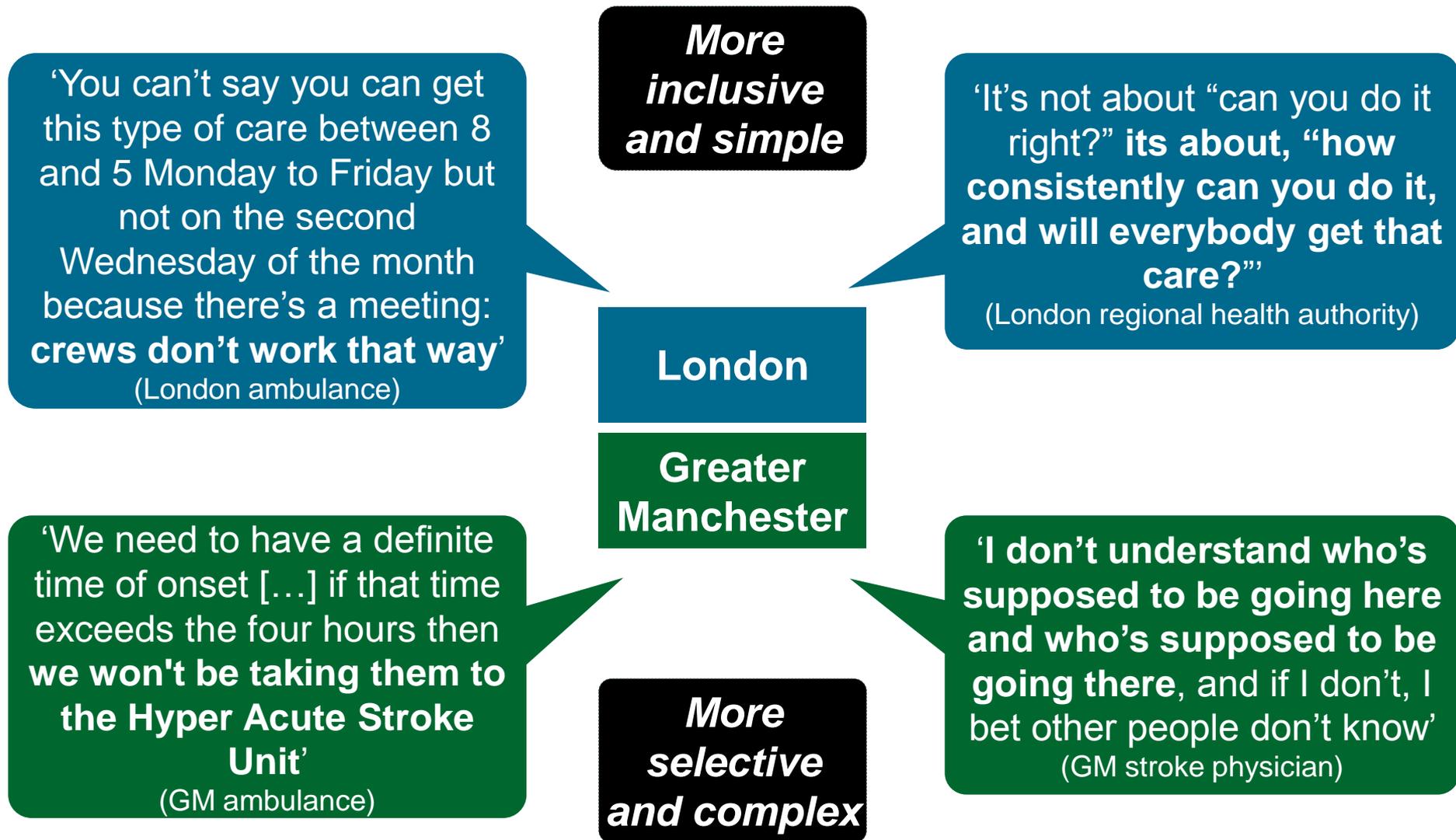
Manchester: consensus

“the minute it felt like unanimity was being compromised on that clinical discussion on the 24 versus the 4 hour pathway, I think **we were always going to be minded then to tilt towards holding unanimity** and taking what might be a small step, but still the right step.”
(Commissioner)

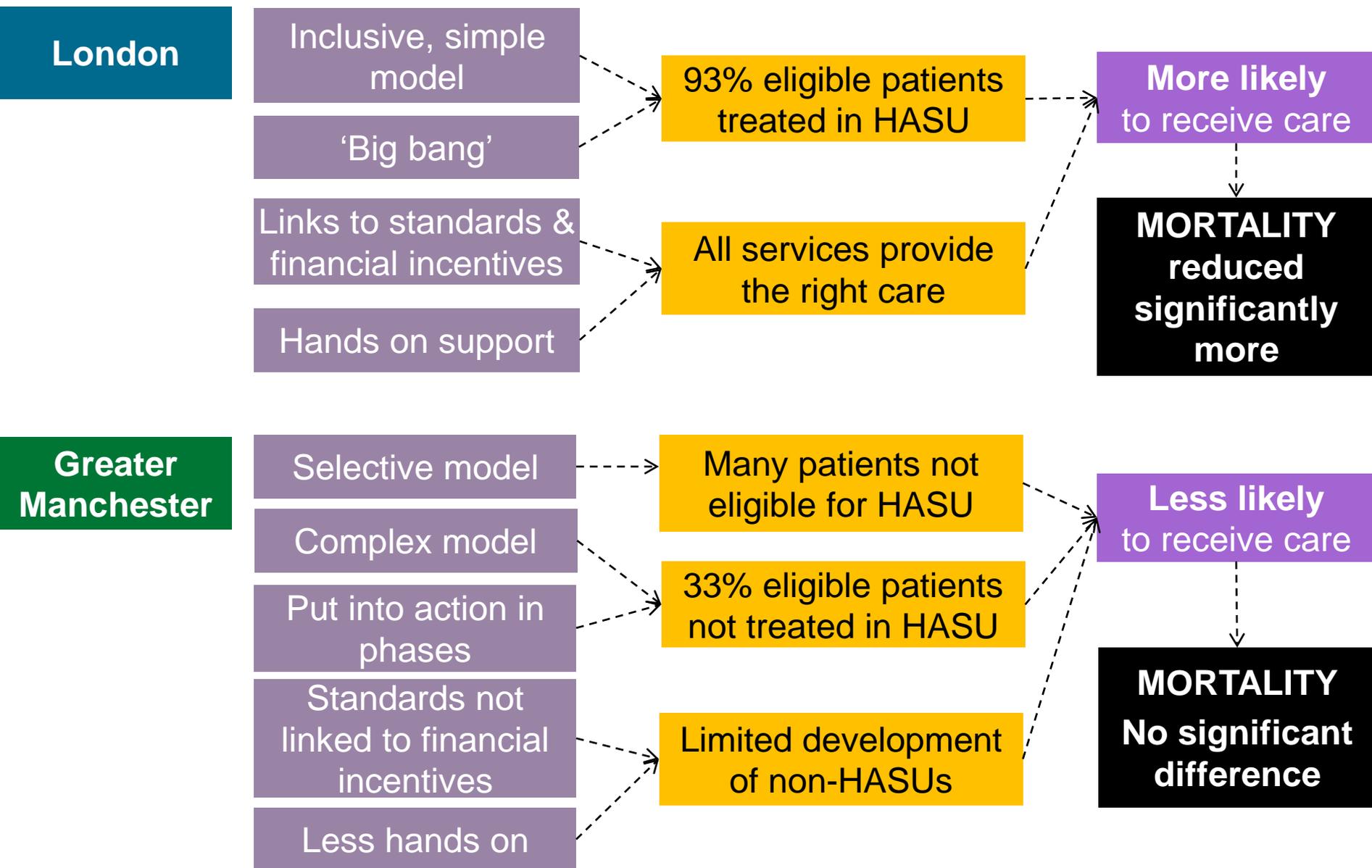


How model and implementation approaches influenced outcomes

1. The model matters



Factors influencing different outcomes



- ***Change is not a one-off***
- Leaders in Greater Manchester used a range of evidence (local & national audit + our findings on mortality) to make the case for further change in GM



- Further centralisation implemented March 2015
- Now studying GM 'B' – processes of change, impact

- ***Learning from MSC in other settings***
- MSC of specialist cancer surgery in implemented in...
 - London Cancer (NC, NE London; W Herts) (implemented 2016)
 - Greater Manchester Cancer (implementation ongoing)
- Studying in terms of
 - Stakeholder preferences (DCE)
 - Planning; implementation, sustainability (qualitative)
 - Impact on care, outcomes, costs (quantitative; CEA)
- **Key contrast:** changes conducted post-NHS reforms
- Opportunity to study MSC implemented in absence of system leadership (e.g. SHA)

- Network and clinical leadership key in facilitating changes:
 - London Cancer played an active role in designating, training, and supporting leaders
 - Actors across the networks occupied leadership roles
 - London Cancer managers supported leaders
- Stakeholder engagement from early stage; helped drive changes
- Patient views actively sought; patient representatives played a role in pathway boards
- Clinical pathway leaders drew from previous experience of MSC to anticipate challenges and maintain credibility

THE MODEL

- Reorganising can improve care and outcomes
- HASUs more likely to provide evidence-based care
- All stroke patients should go to HASU, not just a selection
- Findings most relevant to large towns and cities

LEADING CHANGE

- Combine 'top-down' **and** 'bottom-up' clinical leadership
- Engage all relevant stakeholders from planning onward
- System-wide authority needed to challenge resistance

IMPLEMENTING CHANGE

- **Staff:** necessary skills and numbers
- **Standards:** prioritised and linked to financial incentives
- **Support:** hands-on to ensure standards are met
- **Not a one-off:** attend to evidence, consider further change



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Tony Rudd, Charles Wolfe,
Christopher McKevitt



Pippa Tyrrell, Ruth Boaden,
Catherine Perry

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THANK YOU!
ANY QUESTIONS?

More information?

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www.ucl.ac.uk/dahr/research-pages/stroke_study