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

Angus Ramsay
UCL Department of Applied Health Research
Background

- 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
What the changes involved

**Before**
- Suspected stroke
  - Stroke unit/ward
    - Greater Manchester (x12)
    - London (x30)
  - Community rehabilitation services

**After**

**London**
- Suspected stroke
  - 8 HASUs (24/7)
  - 24 SUs
  - Community rehabilitation services

**Greater Manchester ‘A’**
- Suspected stroke
  - ≤4 hrs
  - 1x 24/7 HASU
  - 2x IH HASUs
  - >4 hrs
  - 11 DSCs
  - 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

Funded by the NIHR Health Services & Delivery Research programme (HS&DR) (Project number 10/1009/09)

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
<table>
<thead>
<tr>
<th>Outcome</th>
<th>London</th>
<th>Greater Manchester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood of dying</td>
<td>Reduced more than elsewhere</td>
<td>No different from elsewhere</td>
</tr>
<tr>
<td>Length of hospital stay</td>
<td>Reduced more than elsewhere</td>
<td>Reduced more than elsewhere</td>
</tr>
<tr>
<td>Did patients get the right care?</td>
<td>More likely to receive than elsewhere</td>
<td>No more likely than elsewhere</td>
</tr>
<tr>
<td>Patients treated in HASU</td>
<td>93%</td>
<td>39%</td>
</tr>
</tbody>
</table>

Factors influencing selection of different models of centralisation
1. How change is led

**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)

Turner et al (2016) *JHSRP*
2. Beyond engaging physicians?

**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)

Turner et al (2016) *JHSRP*
3. Dealing with resistance

**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)

Turner et al (2016) *JHSRP*
How model and implementation approaches influenced outcomes
1. The model matters

- **Greater Manchester**: ‘You can’t say you can get this type of care between 8 and 5 Monday to Friday but not on the second Wednesday of the month because there’s a meeting: crews don’t work that way.’
  (London ambulance)

- **London**: ‘It’s not about “can you do it right?” its about, “how consistently can you do it, and will everybody get that care?”’
  (London regional health authority)

- **Greater Manchester**: ‘We need to have a definite time of onset […] if that time exceeds the four hours then we won’t be taking them to the Hyper Acute Stroke Unit’
  (GM ambulance)

- **London**: ‘I don’t understand who’s supposed to be going here and who’s supposed to be going there, and if I don’t, I bet other people don’t know’
  (GM stroke physician)

Factors influencing different outcomes

**London**
- Inclusive, simple model
- ‘Big bang’
- Links to standards & financial incentives
- Hands on support
  - 93% eligible patients treated in HASU
  - All services provide the right care
  - More likely to receive care
  - MORTALITY reduced significantly more

**Greater Manchester**
- Selective model
- Complex model
- Put into action in phases
- Standards not linked to financial incentives
- Less hands on
  - Many patients not eligible for HASU
  - 33% eligible patients not treated in HASU
  - Limited development of non-HASUs
  - Less likely to receive care
  - MORTALITY No significant difference

Further changes in Greater Manchester

• **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)
Emerging findings

- 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
Lessons for major system change in stroke

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
Who we are

Naomi Fulop, Steve Morris, Angus Ramsay, Rachael Hunter, Simon Turner

Tony Rudd, Charles Wolfe, Christopher McKeivitt

Pippa Tyrrell, Ruth Boaden, Catherine Perry
Morris et al. (2014) Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis. *BMJ*;349:g4757


Turner et al. (2016) Lessons for major system change: centralisation of stroke services in two metropolitan areas of England. *J Health Serv Res Policy*

THANK YOU!
ANY QUESTIONS?

More information?
angus.ramsay@ucl.ac.uk
www.ucl.ac.uk/dahhr/research-pages/stroke_study