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UPDATE: SINGLE STROKE SERVICE PROJECT AND SSNAP OUTCOMES PERFORMANCE

Meeting:	Board of Directors – Airedale NHSFT and Bradford THFT			
Date of Meeting:	November 2018			
Report Title:	**Update - Single Stroke Service Project and SSNAP outcomes performance**			
Status: (tick one box)	Information ☒	Discussion ☐	Approval ☐	Regulatory ☐
Classification	NHS Confidential	Yes ☒	No ☐	
Lead Director	Stacey Hunter – Chief Operating Officer ANHSFT			
Report Author	Sayma Mirza – Head of Collaboration ANHSFT and BTHFT Dr Bryan Gill – MD BTHFT Dr Alan Hart Thomas – DMD ANHSFT Dr Brad Wilson – CD BTHFT			
Appendices	Appendix 1. SSNAP Improvement plan Appendix 2. BTHFT SSNAP results April to June 2018 Appendix 3. ANHSFT SSNAP results April to June 2018 Appendix 4. Greengage Single Stroke Service Vision and Narrative Slides Appendix 5. Greengage Single Stroke Service Work Plan			
Links to strategic objectives	Board Assurance Framework Reference and description	To be the hospitals chosen by the community for putting patients first, providing excellent, innovative and diverse services, delivering safe standards of care, all underpinned by the constant pursuit of efficiency The relentless pursuit of achieving the best possible outcomes for patients, whilst maximising our efficiency To develop both existing and new service provision, changing the models of service delivery and the requisite shape of the workforce in the years ahead		
Links to corporate risks	Corporate Risk Register Reference and description	Risk: Med84		

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Purpose of the Report

To provide the Board Of Directors with a single update in relation to the improvements on the single stroke service across Bradford and Airedale; as well as an update on areas of non-compliance in the latest Sentinel Stroke National Audit Programme (SSNAP) outcomes.

Key points for discussion

Key points for discussion:

The aim of this paper is to update the Board of Directors on:

1. The progress being made by the collaboration project to the single stroke service across both the Bradford and Airedale sites
2. The ongoing improvements to the stroke service in relation to SSNAP whilst highlighting areas of non-compliance regarding SSNAP outcomes.
3. The reasons why some SSNAP outcomes are not where we would wish, along with the agreed improvement plans to get us to a joint sustainable SSNAP level B at both sites.
4. Progress towards a reliable live SSNAP dashboard for both sites. This will aid the teams to respond to SSNAP domain breaches in a timely fashion
5. Our work towards a 7 day transient ischemic attack (TIA) clinic provision for both sites.

Analysis

Work has been progressing with the support of the Greengage consultancy company on improved collaboration to support the further development of a single sustainable stroke service for Bradford and Airedale. Some of this work has included:

- Establishment of a single stroke project board and single stroke operational group.
- A workforce survey and 1:1 interviews with our senior colleagues to establish the teams views on the progress made so far towards a truly single service and areas still requiring further refinement
- A collaborative workshop with invites to the stroke operational group, stroke project board and other senior executive colleagues to identify key priorities for further development of the single stroke service including articulating the vision and road map to deliver this
- Focus on relationship building
- Undertaking a single approach to patient engagement
- Exploring the possibility of a single SSNAP dashboard and single submission for both sites; as well as establishing a SSNAP data analyst to work across both sites

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- Establishing joint training and shared learning across the clinical teams including work to explore a single patient passport that would follow the patient through their journey of the single stroke pathway across the two sites
- Discussions on single workforce models; with medical on call rotas already in place for thrombolysis to cover both sites out of hours, further considerations are required for the in-patient model, plans to design a single digital nursing recruitment campaign to attract new nurses into rotational posts across both sites, cross working between new therapy colleagues during induction periods.
- Exploring the current TIA provision across both sites and working on plans to extend this service to a 7 day service across Bradford and Airedale
- Comparing the existing community provision at both sites to exploring ways to provide an equitable seven day service for our patients
- Further work and input from senior executive colleagues to gather ideas on establishing a single governance structure and finance structure for collaborative services such as a structured partnership board or joint venture company, needs to take place

In relation to progress made against the SSNAP outcomes, the latest SSNAP reports for the period April 2018 to June 2018 were published on the 29th of August 2018 (Appendix 2. and 3.)

The results showed:

Site	Airedale	Bradford
Overall Team Centred SSNAP Score	**D** **47.5**	**B** **72**
Overall Patient Centred SSNAP Score	**D** **41.8**	**C** **69**

SSNAP scores and levels breakdown
A= over 80 B= between 70 and <80 C= between 60 and <70 D= between 40 and <60 E= less than 40

- A **significant improvement** in BTHFT patient centered SSNAP score from **38 to 69**; this translates into an increase from a level **E** to a level **C**.
- A **significant improvement** in BTHFT team centered SSNAP score from **40 to 72**; this translates into an increase from a level **D** to a level **B**.
- A **slight increase** in ANHSFT patient centered SSNAP score from **40 to 41.8**; this translates into no change from a level **D** attainment.
- A **slight decrease** in ANHSFT team centered SSNAP score from **50 to 47.5**; this translate into no change from a level **D** attainment.

Additional focus to improve SSNAP performance across the two sites includes:

- The front end of the stroke pathway at the BTHFT site – relates to SSNAP scanning, stroke unit and thrombolysis domains
- The provision of therapy at ANHSFT – relates to SSNAP O.T, physio and SALT domains
- Review of ESD provision at both sites – relates to SSNAP discharge processes domain
- Refinement of a live dashboard for both sites which supports the trajectory of SSNAP improvements
- TIA 7 day provision for Bradford and Airedale patients

Implementation of a live SSNAP dashboard for each site so far, is giving early indications of improvement. It is aiding the teams to interpret the SSNAP data in real time and amend processes

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accordingly, where possible. It is anticipated these improvements will improve the effectiveness of the whole pathway and translate into improved SSNAP levels for both sites for the Oct 2018 to Dec 2018 reporting period (February 2019 report).

Recommendation

The Board of Directors is asked to:

- Note the significant progress being made to the collaboration project to achieve a truly single stroke service
- Note current position with regard to SSNAP performance
- Note the significant improvement the single stroke service has made in the delivery of the SSNAP at its BTHFT site

1 PURPOSE/ AIM

The purpose of this single paper is to update the Board of Directors on the progress being made to the collaboration project that further supports the development of a single sustainable stroke service for Bradford and Airedale; whilst highlighting areas of non-compliance regarding SSNAP outcomes. The purpose is to also articulate the trajectory of the evolving plan to deliver improvements in SNNAP outcomes and collaborative work streams across the two sites. The board is asked to receive and note this paper.

2 BACKGROUND/CONTEXT

Given stroke is the third leading single cause of death in the United Kingdom and is responsible for 7% of all deaths in the UK resulting in devastating impacts on the lives of people, their families and carers; it is imperative the stroke outcomes for people are improved.

Nationally and locally work has been taking place to improve the stroke outcomes for people who have had a stroke. In a national context the National Stroke Strategy published by the Department of Health (DoH) in 2007 provided a national quality framework to secure improvements across the stroke pathway over a period of ten years. The document's main recommendations were to provide hyper-acute stroke units for rapid patient access and then transfer to dedicated stroke units for rehabilitation once patients are stabilised.

The NHS Five Year Forward View published by NHS England (2014) set out a clear direction for the NHS, showing why change was needed and what it will look like. It highlighted for some services there is a compelling case for greater concentration of care; identifying there is a strong relationship between the number of patients and quality of care derived from the greater experience these more practised clinicians have, access to specialised facilities and equipment, and the greater standardisation of care that tends to occur.

The National Clinical Director for Stroke published The Stroke Service Guidance for the Sustainability and Transformation Plan (2016) which provided further guidance on the recommended standards for Acute Stroke Services. Based on the Royal College of

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Physician National Clinical Guidelines for Stroke, 5th edition 2016; the document intended to describe the services that all acute stroke patients in England should expect to receive.

The guidance emphasised that while the major purpose for the stroke transformation plan was to deliver high quality urgent and emergency care, it was essential that the whole pathway works efficiently to optimise patient outcomes and experience and encourage effective flow across all parts of the stroke pathway including longer term management, services and wider system. It however, noted that if patients could not be discharged to effective well organised community services then the inpatient stroke beds would quickly fill and new admissions would be denied high quality evidence based care.

The Sentinel Stroke Audit Project (SSNAP) reports indicated at national level, improvements were being seen period-on-period in the results for stroke care, both in the acute processes of care, including rapid scanning, thrombolysis provision, and access to a stroke unit, and in the standards and processes of care by discharge. However, unacceptable variation across the country remained.

Locally across the West Yorkshire and Harrogate (WY&H) footprint; Hyper Acute Stroke Unit (HASU) provision has been consolidated resulting in fewer HASU units. The West Yorkshire Strategic Case for Change paper (2017) identified further stroke improvement work that has taken place such as provider participation in the SSNAP audit; roll out and application of GRASP-AF tool for identifying atrial fibrillation, and implementation of local CCG initiatives such as “hot clinics” that enable direct access to stroke consultants.

In line with the recommended national guidance in 2015, the decision was taken to consolidate the hyper-acute stroke beds in Airedale NHSFT into a single Hyper Acute Stroke Unit based at Bradford Teaching Hospitals NHSFT.

The vision was to have a single collaborative pathway where effective 7 day hyper-acute stroke services could be delivered to ensure access to hyper-acute stroke care, including thrombolysis. Airedale patients suspected of having a stroke would be taken directly to Bradford for HASU care before being repatriated to Airedale for the acute and rehabilitation phases of their care.

A constraint to the progress made to stroke services, as highlighted by the West Yorkshire Strategic Case for Change paper (2017) in improving stroke care over the last ten to fifteen years, identified an increase in demand for the provision of specialist hyper acute stroke services (HASU); led to difficulties with recruitment and retention of the skilled workforce needed to meet these demands. This impact has been seen across the BTHFT and ANHSFT sites however the teams have been working on reviewing existing resources and roles to continue to improve patient outcomes.

Using the Sentinel Stroke National Audit Programme (SSNAP); which is a measure of the care processes from the admission to discharge of patients with a diagnosis of a stroke, the BTHFT and ANHSFT stroke teams have been benchmarking the stroke service against other high performing stroke units.

The Board of Directors at BTHFT, ANHSFT and the CCG’s were previously made aware of two consecutive reporting periods where poor SSNAP results where attained. For the period

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August 2017 to November 2017 and December 2017 to March 2018; BTHFT attained a patient centred level **E** score and ANHSFT attained a patient centred level **D** score.

Following the development of an acute collaboration programme between ANHSFT and BTHFT it was decided that the stroke service presented the best opportunity to develop a model of working to improve the outcomes for stroke patients.

3 PROPOSAL

3.1 Single Stroke Service

A comprehensive collaborative improvement programme with the support of the Greengage consultancy company is in place and includes:

- Working through the key priorities identified by the stroke teams to further the development of a truly single service such as:

1. Exploring a single approach to workforce recruitment and retention
2. Exploring roles that could be undertaken via skill mix such as healthcare support workers and therapy assistants. Together we will work through learning competencies for each other's roles
3. Establishing a single dashboard and single SSNAP submission; by building on the live dashboard for both sites
4. Working through finances ensuring financial flows are developed to support a single service
5. Understand and implement the HR elements of employing a single data analyst role for both sites
6. Introducing a single/standardised approach to training with focus on rehabilitation
7. Actively integrating nursing and therapy teams to make roles more attractive from a recruitment and retention point of view
8. Exploring and progressing quality improvement initiatives including a patient passport that would follow the patient during their journey through a single stroke pathway across the two sites
9. Streamline I.T processes where possible (Cerner and S1 can now interface for read only rights) and review the existing I.T programme plans for the roll out of electronic patient records at the ANHSFT and BDCFT sites
10. Exploring a single community model that can provide ESD provision 7 days a week across Bradford and Airedale.
11. Designing a single integrated stroke patient survey to obtain the current patient voice; as well as working towards a patient story at a single stroke study day with the support of the stroke association.
12. Proposal to have a Healthwatch representative at the Stroke Operational Group
13. Exploring the possibility of a senior executives meeting to obtain further clarity on the most appropriate structure for example a structured partnership board or joint venture company so that, financial systems and HR systems opportunities are identified to help create transparent and integrated processes to support the development and management of the single service

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14. Towards the end of the financial year, arranging a workshop for the both Trust's Executive Directors plus key members of the CCG to receive a review of the stroke collaboration. The workshop will identify and celebrate what has worked well along with ascertaining how executive teams can remove blockages to greater collaboration.

3.2 SSNAP Improvement Work

A comprehensive programme to improve SSNAP performance is also in place and includes:

- Trust based regular stroke improvement group meetings at both sites chaired by the Medical and Deputy Medical Directors for BTHFT and ANHSFT respectively.
- Breach analysis of the stroke SSNAP data and shared learning has aided improvements across the patient pathway; with the trajectory of improvements anticipated to take effective for the October 2018 to December 2018 reporting period.
- External visits and ongoing relationships with colleagues from high performing stroke units
- Staff engagement events around the quality of care
- Staff education on SSNAP and the outcomes measures for the audit
- Detailed tracking of high level SSNAP metrics of performance
- Identification of operational challenges to effective delivery of the service
- Establishment of single stroke meetings namely; the Bradford and Airedale Acute Provider Collaboration Stroke Board as well as the Single Stroke Operational Group
- A single medical workforce recruitment plan including plans to extend the weekend provision of a telephone consultation TIA clinic to patients from Bradford and Airedale
- A single nursing workforce recruitment plan
- Single action plan for therapies services with a medium to long term plan for a 7 day service provision for both sites
- Review of community provision across both sites with a single business case currently being drafted for Early Support Discharge Team provision across both sites

SSNAP Results April to June 2018

The latest SSNAP reports for the period April to June 2018 were published on the 29th of August 2018 (Appendix 1. and 2.)

The results showed:

Site	Airedale	Bradford
Overall Team Centred SSNAP Score	**D** **47.5**	**B** **72**
Overall Patient Centred SSNAP Score	**D** **41.8**	**C** **69**

SSNAP scores and levels breakdown
A= over 80 B= between 70 and <80 C= between 60 and <70 D= between 40 and <60 E= less than 40

There are further planned works in place relating to:

1. The front end of the stroke pathway at the BTHFT site

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2. The provision of therapy at ANHSFT
3. Review of ESD provision at both sites
4. TIA 7 day provision for Bradford and Airedale patients
5. Refinement of a live dashboard for both sites which supports the trajectory of SSNAP improvements

Implementation of a live SSNAP dashboard for each site so far, is giving early indications of improvement. It is aiding the teams to interpret the SSNAP data in real time and amend processes accordingly, where possible. It is anticipated these improvements will improve the effectiveness of the whole pathway and translate into improved SSNAP levels for both sites for the Oct 2018 to Dec 2018 reporting period (February 2019 report).

Trajectory of improvement to SSNAP
There are clear areas in need of improvement and improvement plans are in place for a collaborative stroke pathway. The aim of the planned work is to improve the SSNAP outcomes to at least a sustainable **B** level for both sites.

Difficulties with recruitment, clinical capacity and the delay in producing a live dashboard to view up to date SSNAP data are hindering the pace of the progress required. However shared learning from high performing units, increased staff engagement and increased staff education about SSNAP; has led the teams to change their way of working. Utilising existing roles and resources differently has demonstrated a significant increase in SSNAP outcomes for the BTHFT site for the Apr 18 to Jun 18 reporting period. It is anticipated the shared learning will likely translate into improved SSNAP results for the ANHSFT site too, by the October 2018 to December 2018 reporting period.

In terms of a joint TIA clinic provision at the weekend; capacity to perform TIA investigations out of hours is currently a challenge due to workforce gaps across the medical and diagnostic workforce; however plans are being developed to offer a TIA telephone consultation clinic for TIA assessments on the weekends using existing resources at the BTHFT site from Dec 2018. This telephone consultation clinic will initially offer provision for Bradford patients and will be extended to Airedale patients by the New Year (Jan 2019).

Further work is required to explore the possibility of weekend TIA investigation provision; a task and finish group for the TIA pathway has been established with the first meeting due to take place in Nov 2018. It is difficult to offer a trajectory on this element of the TIA provision at this present time.

Appendix 1. of this report outlines the operational actions being taken at both sites to attain an improved SSNAP score per domain that is currently non-compliant; and key actions required for a joint TIA clinic provision at the weekend.

4 RISK ASSESSMENT

There are current risks on the corporate risk registers for each Trust in relation to the stroke service (which are reviewed at the Stroke Operational Group meetings).

The Stroke Project Board is working on the detail of the risks relating to the Single Stroke Service Project.

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5 RECOMMENDATIONS

The Board of Directors is asked to:

- Note the significant progress being made to the collaboration project to achieve a truly single stroke service
- Note current position with regard to SSNAP performance
- Note the significant improvement the Single Stroke Service has made in the delivery of the SSNAP performance at its BTHFT site

6 Appendices

Appendix 1.

SSNAP Domains One to Three - Scanning, Stroke Unit, Thrombolysis

Patients currently presenting at Bradford with stroke symptoms are assessed via the Emergency Department (ED) who notify the Stroke Responders (SR) and the stroke pathway is commenced. Time critical delays ensue when patients are presenting at ED for a variety of reasons namely; delays from door to needle if thrombolysis is required, delays in requesting CT scans, delays in transfers to the Hyper Acute Stroke Unit (HASU) and so forth.

In response to these time critical delays, after consultation with the Yorkshire Ambulance Service (YAS) and a review of other high performing stroke units; the decision has been taken to have direct access to HASU via CT scanning from the 29th October 2018. It is envisaged YAS will contact the SR's directly who will meet the crew at the ED doors; following a quick stroke assessment the patient will be taken straight to CT and subsequently to HASU for thrombolysis as appropriate.

It is anticipated a constant review of patient flow in HASU will be undertaken, so that appropriate patients can be identified early to move out of HASU in order for new patients to be accommodated. The stroke responders are currently undergoing competence based assessment training to request CT scans without the need for medical input.

It is anticipated this will have a dramatic impact on improving the three front end domains on the stroke pathway and the trajectory is that this should translate into improvements for the Jan 19 to Mar 19 reporting period for the BTHFT site.

It seems imperative to note, there are also a number of patients who present to ANHSFT with a stroke who are not transferred to the HASU in BTHFT. This may be due to clinically appropriate reasons, for example:

- End of life care appropriate at presentation
- Atypical presentation, such as patients presenting with acute confusion subsequently found to be due to a stroke
- Late presentation

Patients who present to the Emergency Department (ED) at ANHSFT who are not transferred to HASU have been following the traditional medical patient flow model of

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admission to the Acute Assessment Unit. A new pathway has now been agreed with the ANHSFT ED team, the stroke team, ward 5 team, and the Acute Physicians to ensure that patients admitted to ANHSFT with a stroke are admitted directly to Ward 5, with a clear plan for subsequent timely consultant review. The ANHSFT stroke nursing teams are ensuring the appropriate front end assessments are undertaken for these patients in a timely fashion; this new pathway is currently being embedded.

A small number of patients have also been declined for transfer by the on-call stroke consultant for transfer to HASU, who do fit the criteria for transfer. A detailed record of these cases is being kept, and Dr Alan Hart-Thomas (Deputy Medical Director, Airedale) is liaising with Dr Brad Wilson (Divisional Clinical Director, Bradford) to gain a detailed understanding of this with the stroke teams.

Part of that dialogue is also focussed on the ability of ANHSFT to repatriate patients back to ANHSFT from BTHFT HASU in a timely way, to improve HASU patient flow. Risks on both sites risk registers relating to the failure to meet the required SSNAP level are in place.

Key Actions:

- Review impact of direct admissions to HASU pathway from the 29/10/18 identifying any operational challenges and escalate accordingly at the BTHFT site
- Embed new front end pathway at the ANHSFT site for patients not seen in HASU and not clinically appropriate to transfer to HASU; completing adverse event forms for any exceptions which will need to be reviewed at the fortnightly stroke improvement group meetings
- Regular meetings between both senior operational and clinical managers to ensure day to day operational interactions and exchanges adhere to that agreed with regard both admission to HASU, and repatriation from HASU/BTHFT to ANHSFT
- 'Ring fencing' of stroke beds at the ANHSFT site to facilitate efficient repatriation

SSNAP Domains Five to Eight – Therapies

The SSNAP domains where performance has often been poor for both sites over the recent reporting periods, has been related to the provision of therapies (Physiotherapy, Occupational Therapy, and Speech and Language Therapy).

Risks on both sites risk registers relating to the quality of care delivered on the stroke wards in terms of therapy availability are in place. The service at ANHSFT has previously received PALs concerns and verbal complaints relating to the availability of therapy support and also to the lack of availability of therapy support at weekends.

The RCP guidelines state that there is good quality evidence that more therapy improves the rate of recovery and outcome within the first six months after stroke. The RCP guidance and NICE quality standards recommend that a total of 45 minutes of active treatment each working day was a reasonable and achievable target and these are the standards measured by SSNAP in relation to Physiotherapy, Occupational Therapy and Speech and Language Therapy.

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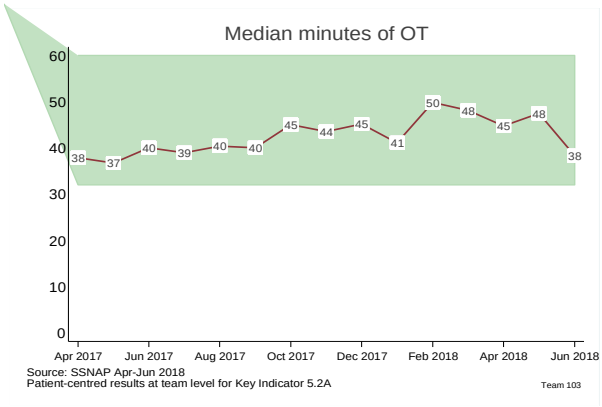
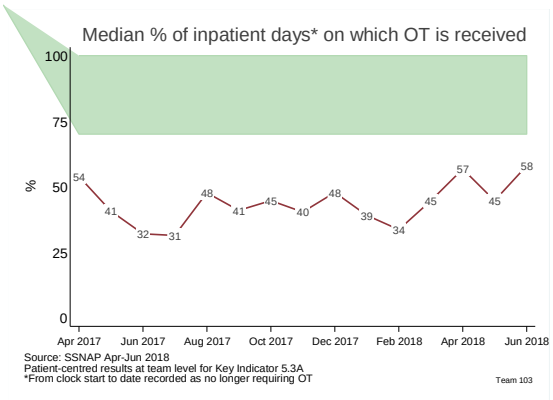
SSNAP standards relevant to therapy provision are a measure of how many times per week the patient receives therapy input and the duration of these therapy contacts. There is a strong correlation between the number of therapy staff available and the frequency and duration of therapy input. Recent reporting trends have shown both sites often manage to see patients for the recommended amount of time per session however are unable to offer the sessions on the recommended amount of days.

Figure 1. The reporting period Apr 18 to Jun 18 at the **ANHSFT** site, shows when a patient has received input from the Occupational Therapists. It demonstrates the recommended time for therapy in terms of minutes per session is achieved; however, the adequate number of days per session has not been achieved. This has been mainly due to the demands on the therapy resource. A similar pattern is also seen in Physiotherapy and Speech and Language Therapy at the ANHSFT site.





With the approval of business cases for additional staffing, reduction of the bed base at the ANHSFT site, shared learning from high performing stroke units, staff education on SSNAP, closer working between the clinical teams and the stroke data officer, return of staff from maternity leave and a review of existing resources and roles; the BTHFT site has already seen a significant improvement to the therapy SSNAP domains for the Apr 18 to June 18 reporting period. It is anticipated therapy SSNAP domain improvements should also be seen for the Oct 18 to Dec 18 reporting period for the ANHSFT site.

Figure 2. Shows the improvements at the **BTHFT** site for Occupational Therapy provision for the Apr 18 to Jun 18 reporting period.

When a patient received input from the Occupational Therapists, the recommended time for therapy in terms of minutes per session was slightly lower than the recommended 45 mins per session. However, the adequate number of days per session is showing a significant upward trend. This is because the recommend number of days has been achieved for the last reporting period. A similar pattern is also seen in Physiotherapy at the BTHFT site however Speech and Language Therapy still needs to increase the number of days per session.

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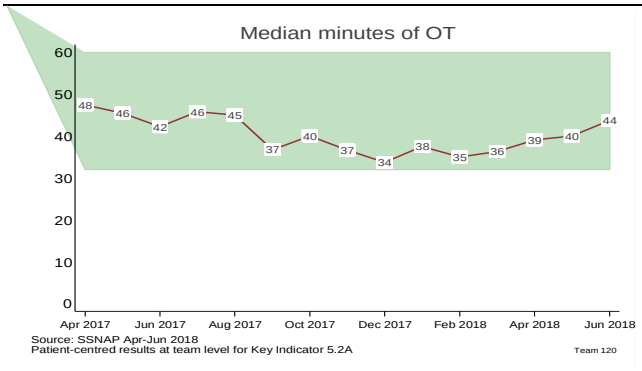

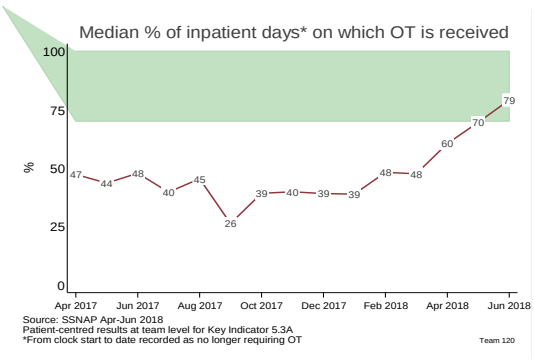

At the BTHFT site, the therapy teams now use a bleep system to be notified of new stroke patients and are often able to commence their therapy assessments in the ED or HASU department. Embargoed slots on a Friday afternoon and Monday morning also help to prioritise patients admitted over the weekend. Therapy assistant input whilst working under the guidance of a therapist is also now counted towards session minutes for the patients; and group therapy sessions have also helped. Cross training is also underway across healthcare support workers (HCSW) and therapy assistants (TA) at the BTHFT site, so that once the training is complete, staff from both roles will be able to cross cover tasks required from each discipline. At the ANHSFT site similar processes are emerging with closer working between the nursing and therapy teams; and plans for 7 day therapy provision is being discussed.

Key Actions:

- Embed shared learning from high performing stroke units for therapy domains; such as stopping the SSNAP clock when patient no longer require active rehab
- Continue to review different ways of working to identify any further efficiencies using existing roles and resources
- Recruit to vacant posts and pursue rotational posts
- Explore 7 day working provision for both sites
- ANHSFT to shadow BTHFT group therapy sessions and explore ways of introducing at ANHSFT when workforce numbers are adequate

SSNAP Domain Ten – Discharge Processes

The ANHSFT site does not have an Early Support Discharge (ESD) team therefore is non-compliant with this SSNAP quality indicator. It does provide a community support team service for a period of six weeks post discharge. Work is currently taking place to map the differences between the BTHFT and ANHSFT community provision and a joint business case is being drafted. It is envisaged if this business case is approved and appropriate staffing recruited; this indicator should improve; a timescale is difficult to predict at this present time.

Key Actions:

- Finish joint ESD business case and progress via existing governance structures

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Joint TIA Service Provision Plans

Currently both sites offer a 5 day TIA clinic provision but do not have a weekend TIA clinic provision. Patients referred late on Friday can often be accommodated on a Friday afternoon however those referred over the weekend are often seen on a Monday morning which is non-compliant with the 24hr specialist assessment requirement.

Staffing and capacity issues across the medical and diagnostics workforce at both sites make it difficult to offer TIA investigations out of hours at the current time; however plans are afoot for a telephone consultation clinic provision at the BTHFT site that will run on the weekend to offer TIA assessment and advice. Full TIA investigations will take place on Monday morning.

It is envisaged this will use existing stroke consultant specialist resource; and will commence in Dec 2018 for the Bradford patients initially and when it is established the provision will be extended to Airedale patients too; possibly by January 2019. Given the geography of the Bradford and Airedale catchment area; clinics will be held at both sites through the week to maintain good patient experience; those patients assessed at the weekends via the telephone clinic will be asked to attend the closest site for further TIA investigations on Monday mornings.

A task and finish group to review this pathway has been established and referral processes out of hours (OOH) from ED or OOH's GP's will also be reviewed. Work is currently being undertaken to establish TIA e-referrals into the ANHSFT System One software. A further work stream for the task and finish group will be to explore the possibility of undertaking TIA investigations at the weekends.

Key Actions:

- Establish weekend TIA telephone consultation clinics at the BTHFT site for Bradford patients with roll out to Airedale patients in the New Year; review impact of clinic
- Progress TIA task and finish group ensuring referral processes are standardised where possible
- Ensure communication to all key stakeholders is undertaken
- Explore capacity to undertake TIA investigations at the weekend

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Appendix 2:

BTHFT SSNAP Results April 18 to June 18:

Bradford Teaching Hospitals NHSFT	April to June 2018	
SSNAP level	C	
Case ascertainment band	A	
Audit compliance band	A	
Combined Total Key Indicator level	C	B
Combined Total Key Indicator score	69	72
	Patient Centred	Team Centred
1) Scanning	C	C
2) Stroke unit	D	D
3) Thrombolysis	E	E
4) Specialist Assessments	B	B
5) Occupational therapy	A	A
6) Physiotherapy	B	A
7) Speech and Language therapy	D	C
8) MDT working	B	B
9) Standards by discharge	B	B
10) Discharge processes	B	A

Appendix 3.

ANHSFT SSNAP Results April 18 to June 18:

Airedale NHSFT	April to June 2018	
SSNAP level	D	
Case ascertainment band	B	
Audit compliance band	A	
Combined Total Key Indicator level	D	D
Combined Total Key Indicator Score	41.8	47.5
	Patient Centred	Team Centred
1) Scanning	C	N/A
2) Stroke unit	E	D
3) Thrombolysis	E	N/A
4) Specialist Assessments	E	N/A
5) Occupational therapy	B	C
6) Physiotherapy	D	D
7) Speech and Language therapy	E	E
8) MDT working	D	N/A
9) Standards by discharge	A	A
10) Discharge processes	D	D

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Appendix 4.

Greengage – Single Stroke Service Vision and Narrative Slides

Bradford and Airedale Single Stroke Service

Vision and Narrative

Nov 2018

Purpose of the vision and narrative

To ensure that all staff involved in a single stroke service for BDHFT and ANHSFT knows what success looks like for a single stroke service and what needs to happen to deliver that vision.

Mission

What we are trying to achieve

To deliver a single, comprehensive, sustainable stroke service that provides for the needs of all patients within the Bradford and Airedale Wharfedale & Craven catchment areas.

Impact

What difference will a single stroke service make?

- ✓ Stroke patients will experience high care quality and health outcomes *(reflected in improved outcomes, SSNAP results of at least B, high patient satisfaction)*
- ✓ Patients will experience the same pathway and service no matter where they live in Bradford and Airedale Wharfedale & Craven
- ✓ The lessons learnt on effective collaboration will be disseminated across the Trusts and applied in other settings

Vision – what does success look like?

- A single, sustainable stroke service with:
  - A single dashboard
  - A single workforce with adequate staff to deliver a single seven day service which will include rotational posts and joint recruitment leading to improved patient experience, improved staff satisfaction and fewer vacancy gaps
  - A single approach to patient engagement
  - A single approach to training and education for our teams
  - A single, clear, safe and integrated management and governance structure for the service across the two trusts
  - A co-ordinated pathway from time of stroke through to the end of rehabilitation with seamless transition and communication
  - Clearly defined roles and responsibilities on the entire pathway ... playing to the strengths of each trust and avoiding duplication
  - Colleagues working together to identify and make improvements including a single model of ESD including community partners, improve TIA provision across the area and develop seven day services

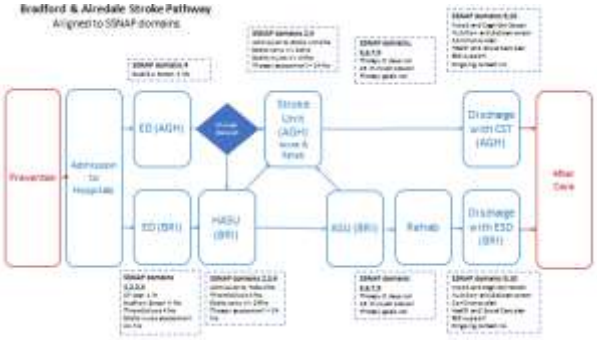
Outcome measures

How we will measure success

- SNAAP – B or above
- Workforce survey
- Patient satisfaction

Bradford & Airedale Stroke Pathway

Aligned to SSNAP domains



Priorities for action

1. Communicate the narrative for the single stroke service and ensure that all colleagues understand their role in delivering it
   - engage with partners to test and refine the vision and narrative
   - Engage with all staff to ensure understanding and clarify their roles
2. Align communication and information to support a single team
   - Implement regular meetings to provide single, integrated management of the service
   - Implement a single, integrated SSNAAP live dashboard
   - Develop interoperability of IT including EPR data for a single IT system
3. Map the service and survey patients so that we have an accurate picture of where to focus our attention
   - Process map the service to clarify what's in place, where there are gaps and target improvements
   - Survey patients to ensure we have a patient centred approach to all that we do
4. Support staff to work collaboratively on specific problems and improvements
   - Improving ESD in collaboration with partners
   - Improving TIA provision
   - Developing seven day services
   - Staff transport
5. Develop innovative approaches to filling posts including joint posts and integration of therapy and nursing teams
6. Work with Senior HR and Finance colleagues to explore how they can support the collaboration
7. Agree a clear, integrated governance and management structure for the single service
8. Draw out the lessons from the collaboration to disseminate more widely in both trusts

Appendix 5.

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Greengage – Single Stroke Service Work Plan

Bradford and Airedale NHS trusts

Draft work programme for supporting development of a Single Stroke Service

Report from Greengage Consulting Limited

Draft v3

25th October 2018

Revised 2nd Nov

Bradford and Airedale Single Stroke Service

Draft Work Plan

Purpose of the report

This report sets of a draft work plan for improved collaboration to support the further development of a single stroke-service for Bradford and Airedale together with a summary of the sources and rationale for the work plan.

This report is based on

- Interviews conducted between 22nd September and 24th October 2018.[1]

[1] **Contributors**

Brendan Brown – Chief Executive AGH

Bryan Gill – Medical Director BRI

Karl Mainprize – Medical Director AGH

Brad Wilson - Medical Manager for Stroke BRI

Alan Hart-Thomas - Medical Manager for Stroke AGH

Pam Beaumont - Stroke Clinical Nurse Specialist AGH

Stuart Macquire - Stroke Consultant BRI

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- A questionnaire completed by 26 people across the combined stroke service.
- A workshop for the Stroke Operational Group held on 15th October.
-

Next steps

We will talk this report through with Sayma, Alan and Brad with a view to refining it for presentation to the stroke board on 5th November.

1. Result – how do we want things to be?

Below is a summary of comments made setting out where we want to get to in respect of a single stroke service.

The impact of the single stroke service

- Stroke patients experience high care quality and health **outcomes (reflected in high SSNAP results)**
- Patients experience the same pathway and service no matter where they live in Bradford, Craven and Wharfedale
- The wider system lessons are understood and the approaches to more effective collaboration piloted in the single stroke service are being used by the Trust and partners in other settings

Our vision for the future of the single stroke service

- **One data-set that both Boards have agreed to**.
  - a single SSNAP dashboard agreed by both Executive Boards and, ideally, by Kings College[2]. If the approval of Kings takes time then the teams can create their own integrated SSNAP dashboard and begin to use it
- **Clearly defined roles, activities and responsibilities for staff and teams on the pathway from suspected stroke through to community rehabilitation**
  - staff view the stroke as one service, not 'two organisations'
  - playing to strengths, avoiding duplication and driving efficiencies
  - working effectively across organisational boundaries
- **Top-down with bottom-up' leadership that empowers and enables decision-making close to the patient and encourages effective collaboration**
  - governance, systems and management-styles support collaboration and do not 'get in the way'
- **Highly motivated and well-supported staff**
  - staff at all levels in both Trusts understand the value of a single stroke service for patients and are fully committed to achieving it
  - correct staffing levels with vacancies filled

Alex Stenhouse - Data Officer BRI

James Thomas - Clinical Chair AWCCCG

Freya Sledding - Therapy Service Manager AGH

[2] SSNAP has been based at King's College London University in the Department of Population Health Sciences since Spring 2018

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- integrated therapy and nursing teams
- sharing and transferring staff is seen as the norm

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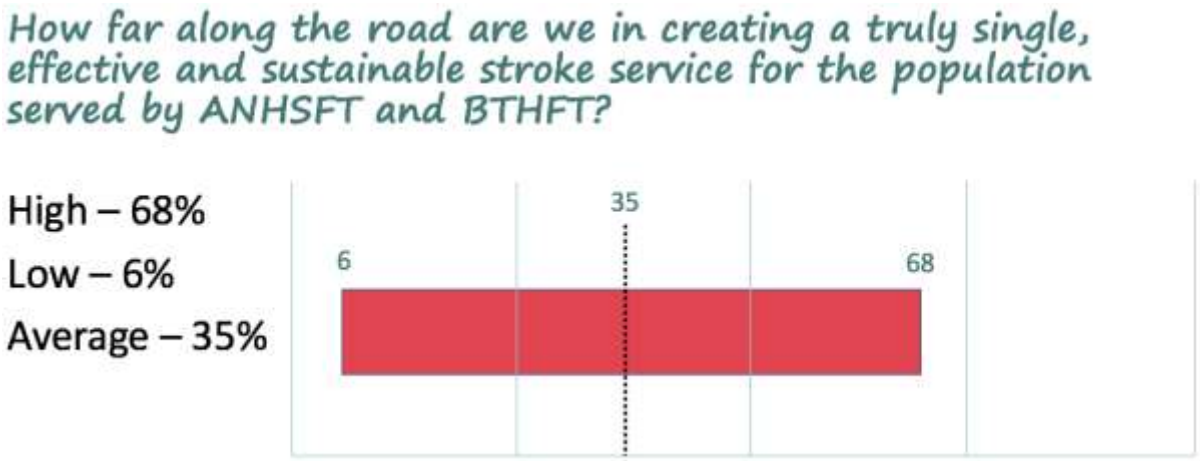
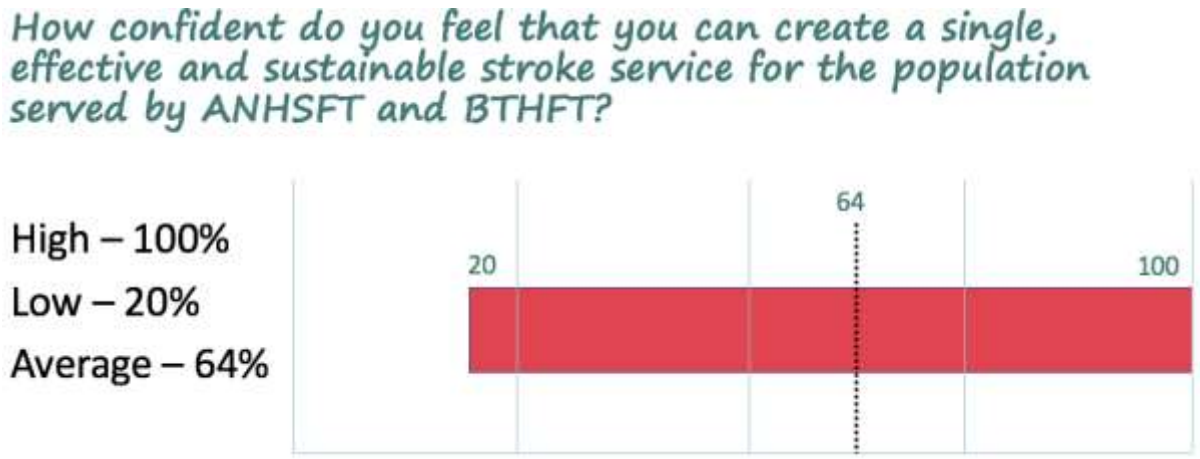
1. Reality – where are we now?

Taking stock

The two images below illustrate how people who responded to the questionnaire feel about progress towards a single stroke service so far. These are based on the responses from the questionnaire. The views from the operational group workshop were slightly more confident.





Participants were asked whether they agreed or disagreed with a series of positive statements about the collaboration. Below is a summary of participants responses.

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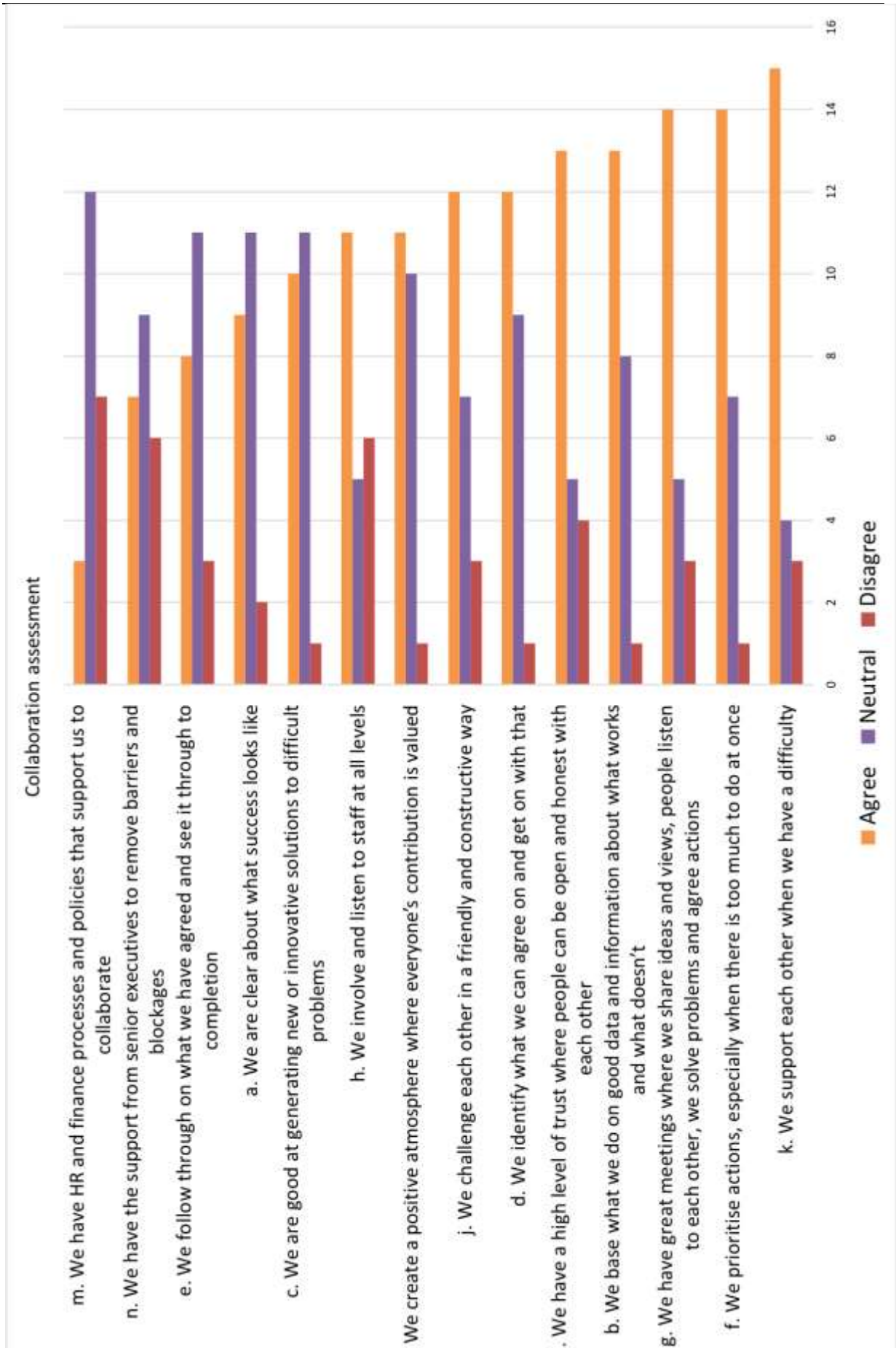

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The areas of highest agreement and lowest agreement (indicating a need for improvement) are outlined below.

Highest agreement	Lowest agreement
• We support each other • We prioritise actions • We have great meetings • What we do is based on good data • There is a high level of trust	• HR and finance policies support us • Support from senior executives • Follow through on decisions made • We are clear about what success looks like • We are good at generating innovative solutions

Below is a summary of comments made describing the current state of the single stroke service.

What is working well?

- The current collaboration is going well – relationships are good and we are making progress
- We are making progress - this piece of work should be positioned as a good-to-great exercise.
- The new joint business meetings are working well
- Airedale is inverting in a major overhaul of its stroke ward that will result in 24 ring-fenced stroke beds with a full contingent of nursing staff.
- There are clear examples of integration of services e.g. therapies
- There is effective collaboration between doctors, nurses and therapists "at the grassroots level". There is no problem at this level.
- The commitment of nurses, therapists and managerial staff is very high and colleagues are dedicated to providing a great service.
- Collaborative work – when we work together to solve problems we work well together

What needs to change or improve?

- We need to talk about a single service rather than a joint service
- More working together– more collaborative problem solving so we have a single way of working
- Agreed plans on how the service will look for the whole of the patient journey and what needs to change – staff aren't clear about what success looks like
- We have focussed a great deal of attention at the 'front-end' of the pathway (hyper-acute and acute care) but less at the end of the pathway (community-based therapies)
- There is a need for clearer management of the single service across the two trusts.
- The care teams and therapy teams operate separately and there is a need to support and train nursing staff to allow them be 'rehab-professionals'.
- At times the ward sisters and nursing colleagues are overwhelmed by the workload on the wards.
- There is a need for greater integration of activities between the Trusts. We are in danger of trying to do everything twice and this results in loss of efficiency – single service rather than joint service.
- There are some concerns at Executive level that "Bradford wants to consume Airedale" and that Airedale may have to fight to survive in the longer term. Historically, Airedale have viewed attempts to collaborate as a "take-over" from Bradford. A recent attempt to collaborate on gastric services became bogged down in "What's in it for me?" and "What will they take off us?"
- We need a way of transporting staff between sites

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- There is a culture of micro-management 'from the top' and too much emphasis on process that can undermine staff morale and commitment.

2. Response – Proposed work programme

Below is a summary of the key actions that we need to take together with an indication of who needs to be involved and timescales. Some dates need adding. We have also indicated where we believe Greengage can most beneficially support the development of the collaboration.

2.1 Articulate the vision and make sure it is well communicated and understood

Activity	Who	By
a) Work with colleagues to articulate the vision for what a highly effective single stroke service looks like and sets out how precisely what needs to happen to achieve this result. - Prepare a clear road-map describing patient access to the single stroke-service - Define the precise roles and responsibilities of each Trust in delivering a streamlined pathway. - Define what is in and what is out of scope (e.g AF/TIA, stroke prevention, rehab in community) - Clarify activities that can be stopped. - Create a precise and concise action plan for the improvement of the single service – what will change? - Identify top outcome measures for collaboration projects - Include risk analysis – first do no harm	Alan and Brad supported by Greengage	To be presented at 5th Nov stroke board meeting
b) Engage colleagues and partners (All staff/LA/Primary care/Pt/YAS) to refine the model and ensure there is buy-in. Use single patient-forum to refine the vision for the service	Alan and Brad + Stroke op group and Sayma – consult by 30th Nov	By end Nov
c) Communicate the vision and plan to all staff and others involved and ensure that all staff understand their role and what they will need to change to deliver the vision	Alan and Brad + Stroke op group and Sayma – consult by 30th Nov	?

2.2 Establish 'Task and Finish' groups to work collaboratively on important issues whilst building relationships and embedding the capacity for collaborative working.

Activity	Who	By
a) Single SNAAP data Work on establishing live dashboard • Establish what a single SSNAP team looks like – how many people, who is	Alex plus others as needed	End Nov

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responsible for what, who do they escalate to? • ADO to find budget to backfill Alex's data input role		
b) Process mapping • Map the process and identify service gaps • Segment the process – start with the backend	Members of stroke group and Sayma	
c) Workforce recruitment, training and retention • Progress integrated recruitment plans – Matrons, PSM, cons • Recruit therapy ward managers, Nurse consultants/AMPs, Middle grades to cover rota • Use a "who else could fill that post" approach to fil key posts • Introduce integrated recruitment of nurses. • Introduce single training focus on a creating a culture of rehabilitation • Actively integrate therapy and nursing teams to make nursing roles more attractive.	matrons/managers	
d) IT • Create intra-operability or a single system for record keeping –Digital Care Recovery • Streamline IT system • Review existing IT plan	Jim Welford plus others	
e) ESD • Develop ESD/CST shared business case – • Single model of ESD include community partners, Ops patients • Create consistent services in CST at both ends • Integrate Psychology in model – what does it mean for ESD/LT care?	Nicola and Freya plus others	
f) TIA • T&F group to improve TIA provision across B&A		
g) Patient survey • Design and roll out a single, integrated patient survey		
h) Stroke conference • Plan stroke conference including patient stories		
i) Support task and finish groups • Support the task and finish groups through a series of collaboration workshops – the first being used to kick off the task and finish groups and introduce some useful tools the groups can use • The support will focus on addressing the issues highlighted in the survey (following through on decisions made and creating innovative solutions) as well as building strong and productive relationships across the service. • We propose three workshops, one to kick off the task and finish groups in November, one in January to take stock and deal with any difficulties and one in March to draw out the key lessons to be disseminated more widely in the two trusts. • In addition we might also need to provide limited facilitation support to individual T&F groups if they a struggling to make progress.	Greengage	From end Nov

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2.3 **Put in place governance and systems consistent with a single service.**

Activity	Who	By
a) Clarify the most appropriate 'structure' (e.g. structured partnership board or joint venture company) for the development and management of the single stroke service that gives authority to staff to run and develop the service.	Stroke Board	5 Nov
b) Finance directors to meet to clarify the financial envelope, explore how to create a transparent system and look at system money opportunities	Alan and Brad plus finance directors Facilitated by Greengage	Dec
c) HR systems meeting to identify and remove blockages to integrated recruitment and training	Alan and Brad plus HR directors Facilitated by Greengage	Dec

2.4 **Disseminate lessons from the stroke collaboration**

Activity	Who	By
a) Executive System review Arrange a joint workshop of the Executive Boards plus key individuals from CCGS to receive a review of the stroke collaboration, what has worked well and how the Executive Teams can remove blockages to greater collaboration. The workshop might also agree behaviours that support effective collaboration.	Facilitated by Greengage	Early March 19

Appendix

Proposed Greengage Work Programme

Below is a summary of the ongoing support we propose from Greengage. This support can delivered within the cost envelope outlined in our original tender.

Activity	When
a) Support Brad and Alan to articulate the vision and present to Stroke board	End Oct
b) Design and deliver task and finish group collaboration KO workshop	End Nov
c) Design and deliver task and finish group collaboration progress review workshop	January
d) Design and deliver task and finish group collaboration – lessons learned workshop	Early March
e) Design and deliver FD workshop	Dec
f) Design and deliver HRD workshop	Dec
g) Design and deliver Executive system review workshop	Early March – after d above
h) Additional support to Task and Finish groups	From Nov

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