Quality Impact Assessment & QI Project Prioritisation

Project Title	Somerset Acute Hospital-based Stroke Services Reconfiguration
Project Lead	Julie Jones
Project Overview	Following the 2019 stroke strategy, we are taking forward the recommendation about the provision of acute hospital-based services providing stroke care. This specifically includes Hyper Acute Stroke Units (HASU) and Transient Ischaemic Attack (TIA) services. Provision for both services are required to meet National Stroke Guidance to maximise outcomes for patients. Currently Somerset has HASU and TIA services at both Musgrove Park and Yeovil District Hospitals. A review of neuro rehabilitation services is underway in parallel to the acute stroke work. Acute stroke care is not considered optimal in Somerset: The provision of acute stroke services currently does not meet National Guidance resulting in variable outcomes for patients and there are variations in provision of care and access to specialist services in Somerset. Poorer outcomes from stroke result in higher financial costs for health and care. To address this, the Stroke Core Team (along with the Stroke Steering Group, Clinical reference Group and Lived Experience Group) have been tasked to update the case for change for service reconfiguration, map the existing clinical pathways and activity, develop and consider a long-list of options, work through hurdle criteria to reach a shortlist and preferred option, and produce a Pre-Consultation Business Case ahead of a public consulation.

Month of Delivery/Start (QIA sign off must precede this date)	May-23	**Organisational Risk Score**	**4**
Completed By	Julie Jones	**Quality Impact Score**	**1**
Completion Date			

Risk to Patient Safety *Could the project impact on the safety of patients, staff or any other person?*		**Patient Safety Impact Score** *(move scroller)*
Risks	**Mitigations & Comments:**	**Major Positive Impact**
The reconfigeration may create in region inequalities and increased travel times for out of county acute stroke patients.	Ongoing cross border discussions are being held to assess, review and mitigate this risk.	Minor Positive Impact
		Neutral Impact
Longer travel time to specialist hyper acute care units	Although there is an increased travel time to a HASU nationally evidence has shown that having specialist stroke teams in larger units leads to better outcomes.	Minor Negative Impact
		Major Negative Impact
		0

Risk to Clinical Effectiveness *Have clinicians been involved in developing the project? Is there evidence to support the project (case studies, best practice, NICE guidelines etc.)?*		**Clinical Effectiveness Impact Score** *(move scroller)*
Risks	**Mitigations & Comments:**	**Major Positive Impact**
Current cross county service provision does not meet national standards for stroek and TIA.	The aim of the proposed Stroke reconfigeration is to improve the service provision and outcomes for patients suffering from acute Stroke/TIA within Somerset, as current service provision does not meet current national standards (nice Guidance 128 and CG 162)and best practice guidance.	Minor Positive Impact
	Clinical experts part of the stroke steering group	Neutral Impact
		Minor Negative Impact
Longer call to door times	Increased travel time to HASU would lead to better outcomes and early specialist care for patient as per national evidence.	Major Negative Impact
		0

Risk to Patient Experience *Consider healthcare environment, dignity and respect of patients, families and carers etc. waiting times, access to services and equality and diversity*		**Patient Experience Impact Score** *(move scroller)*
Risks	**Mitigations & Comments:**	Major Positive Impact
Increased patient journey times for patients and relatives/carers	Although some patients may face increased travel times the emergency treatment they receive will meet national standards, once emergency procedures performed and patient stable they will be moved back to relevent stroke unit.	**Minor Positive Impact**
		Neutral Impact
More transfers of care between hospitals	The plan is to move the patient as cose to home as possible as early as possible either into a local ASU or stroke rehabilitation unit or onto early supoortive disharge.	**Minor Negative Impact**
		Major Negative Impact
Reduced continuity of care	The stroke team across the county will become one team with shared governance and team meetings and the ability to contact the stroke clinicians remotely.	1

CCG 5 year Strategic Objectives

1. Encouraging Communities and Individuals to take more control of their own Health and Wellbeing
2. Developing Joined up Person Centred Care
3. Transforming the effectiveness and efficiency of Urgent and Acute care across all Services
4. Sustaining and continuously improving the Quality of all our services

Health and Wellbeing Boards Strategic Priorities

1. People, families and communities take responsibility for their own health and wellbeing
2. Families and communities are thriving and resilient
3. Somerset people are able to live independently for as long as possible

Strategic Fit *(based on Strategic Objectives on the left)*
Critical link to strategy or supports delivery of multiple strategic priorities (>3)
Directly links to strategy or supports the delivery of multiple strategic priorities up to 3
Minor link to strategy or supports the delivery of 2 strategic priorities
Tenuous link to strategy or supports the delivery of a single strategic priority
No link to strategic priorities but will enhance operational efficiency.
0

Complexity	**Evidence Base**	**Financial Impact**

Relatively simple and likely to be delivered within planned parameters	**Substantiated evidence to support projected outcomes and approach**	Quality Improvement Efficiency/Productivity/Savings to be realised within 2021/22
Low complexity should be delivered within planned parameters	Substantiated evidence to support the projected outcomes	Quality Improvement Efficiency/Productivity/Savings to be realised within 2022/23
Moderate complexity spanning multiple departments	Documented evidence to support some of the projected outcomes	**Quality Improvement Efficiency/Productivity/Savings won't be realised until after 2023/24**
Very complex spanning the majority of the organisation	Unsubstantiated evidence to support projected outcomes	There are no savings/efficiencies to be achieved through the project
Highly complex across the majority of the organisation and third party organisations	No evidence base to support projected outcomes	There will be a negative impact on costs/efficiencies
4	0	2

What benefits does the programme / project bring to the patient?
Robust 24/7 specialist cover, specialist staff development, development of advanced practice roles, direct access to specialist Vascular surgical team, one team cross stroke, Hyperacute care on one site woudl meet the national guidance of number of admissions. Centralisation of HASUs has been associated with the following improvements in clinical outcomes and benefits for patients and their families: •Reduced time from admission to thrombolysis •Improved time from admission to brain imaging for thrombolysed patients •Reduced total length of inpatient stay •Reduced mortality

How will success be measured? What Quality Metrics will be measured (Ensure they are SMART)?
We will measure the impact of the proposals using a set of outcome measures that reflect NICE guidance (NG128 & CG162) and include all the new NICE standards for stroke, as has already been developed by Greater Manchester and Plymouth . They will enable assessment of patient outcomes/experience to provide a broader understanding of the impacts of stroke care and will inform local service improvements. •Reflect the updated NICE Quality Standard for stroke (QS2) •Be as evidence based as possible (i.e. include NICE and RCP guidelines) •Reflect the patient journey during hyperacute and acute phases of care •Be balanced and include process and patient outcome/experience measures to better assess the impacts of stroke care, especially in the longer term •Be implemented by all acute and community stroke teams to enable benchmarking of services locally •Be manageable in terms of data collection, ideally reducing the existing burden of data entry for teams •Utilise the SSNAP audit tool to collect any additional data using custom fields •Provide information for a local dashboard to help identify areas of poor compliance/practice to inform improvement plans

Are there any interdependencies with / support required from other departments
Imaging- Increased demand for 24/7 imaging, A&E- Increased conveyances to A&E, Vascular surgery- Inceased on call demand for vasular surgery team Increase in the number having thrombectomy at Bristol which is workings towards a 24/7 service. Increase in the number having thrombectomy at Southampton (as a result of increase activity going to Dorset) which is working towards 24/7 but will not be in place before our changes are implemented.

Are there any other non patient risks to be considered
Ambulance travel times and increased costs, Additional estates capacity to meet additional bed demand, Delivering the workforce to meet the national stroke staffing guidance. Increase need for patient transport to convey patients between hospitals following episode of acute stroke care Robust workforce plan to develop but also retain current specialist staff.

Clinical Sign off

Designation	Name	Version Reviewed	Date of Review	Signature
Director of Nursing	Val Janson			
Clinical Director	Alex Murray			
Director of Nursing				
Clinical Director				
Director of Nursing				
Clinical Director				

Further considerations / comments from Director of Nursing and / or Clinical Director