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MANCHESTER CITY COUNCIL

Health Scrutiny Committee

Date: Tuesday, 18 June 2019
Time: 2.00 pm
Venue: Council Antechamber, Level 2, Town Hall Extension

This is a **Supplementary Agenda** containing additional information about the business of the meeting that was not available when the agenda was published.

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Membership of the Health Scrutiny Committee

Councillors - Farrell (Chair), Curley, Holt, Mary Monaghan, Newman, Riasat, Watson and Wills

Supplementary Agenda

5. [02.05-02.35] Delivering the Our Manchester Strategy 3 - 12
Report of the Executive Member for Adults, Health and Well Being

This report provides an overview of work undertaken and progress towards the delivery of the Council's priorities as set out in the Our Manchester Strategy for those areas within the portfolio of the Executive Member for Adults, Health and Well Being.

7. [03.05-03.35] Stroke Services – Quality and Performance update 13 - 20
Report of The Director of Performance and Quality Improvement, MHCC and Trafford CCG

A new centralised model of stroke services was implemented across Greater Manchester in 2015. This paper outlines the positive impact this has had for the people of Greater Manchester and focuses on the city of Manchester provider units at Manchester Royal Infirmary, Wythenshawe Hospital and Trafford General Hospital.

Further Information

For help, advice and information about this meeting please contact the Committee Officer:

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This supplementary agenda was issued on **Wednesday 12 June 2019** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 3, Town Hall Extension , Manchester M60 2LA

Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 18 June 2019

Subject: Delivering the Our Manchester Strategy

Report of: Executive Member for Adults, Health and Well Being

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Summary

This report provides an overview of work undertaken and progress towards the delivery of the Council's priorities as set out in the Our Manchester Strategy for those areas within the portfolio of the Executive Member for Adults, Health and Well Being.

Recommendations

The Committee is asked to note and comment on the report.

Contact:

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1.0 Introduction

The Our Manchester Strategy was formally adopted by the Council in January 2016 and sets the ambitions for the city for the next ten years, to 2025, for Manchester to be:

- Thriving – creating great jobs and healthy businesses;
- Filled with talent – both home-grown talent and attracting the best in the world;
- Fair – with equal chances for all to unlock their potential;
- A great place to live – with lots of things to do and
- Buzzing with connections – including world-class transport and broadband.

Executive Members are collectively and individually responsible for supporting the delivery of the Our Manchester Strategy and for providing political oversight and direction to officers for the better outcomes for Manchester residents. Our priorities are aligned to the Our Manchester Strategy and the Council adopts the political manifesto

This report sets out how I as the Executive Member for Adults, Health and Well Being have sought to deliver these priorities since taking up my post on in May 2017, and is the latest of my six monthly updates.

2.0 Executive Member for Adults, Health and Well Being - Portfolio

As Executive Member for Adults, Health and Well-Being, my portfolio includes:

- Adult Social Care;
- Population Health and Prevention;
- Learning Disabilities;
- Mental Health;
- Supporting People;
- Advice Services
- Health Services as part of MHCC and MLCO
- Health and Social Care Integration (Manchester and GM)
- Public Service Reform (Health and Social Care);
- Asylum Seekers and Refugees

3.0 Progress and action update in the last 6 months

I took up this position in May 2017 and from Day 1 have focused my attentions on the role in a full time capacity. I regularly visit staff and front line teams, take part in Our Manchester Listening in Actions Sessions and the Our Manchester work, while encouraging colleagues from across the council and health to do the same.

As I have said before I'm passionate that as a council we talk more about the positive and great work that our health and social care do, helping to boost morale and increase the reputation and appeal of the sector. I want to take this opportunity to thank all of our staff across health and adults services for the valuable jobs they do.

4.0 Overview and Improvement journey

Since taking up this role in 2017, I have spent time working with our staff to understand what areas of our service need the most focus, attention and in places improvement. Eight years of austerity and local government cuts have impacted on our services, and indeed the lives of Manchester people and we see this on the front line in adult social care. In 2010 the Council spent £188m on Adult Social Care, in 2018 this figure was £192m, rising to c £200m in 2019 -using a crude indication of inflation alone (before adding additional demographic growth and funding) the 2010 budget would have risen to over £240m. This is why the Council took the decision in 2017 to invest £35m over 3 years in the adult's budget and provide extra investment for the Improvement plan this year.

There is a growing demand for our services, and similar to Children's Services the number of people being referred for safeguarding concerns has grown, almost doubling in the last 3 years. Detailed analysis of our services has been pulled together as part of the Adults Services Improvement Plan which was passed in February using extra investment to ensure that improvements happen in the right place- this is covered in more detail later on in the agenda.

The 2019 Manifesto committed the following pledges, and these are covered in more detail in this report.

1. **Investing to support the most vulnerable, improving core services and recruiting over 100 frontline staff: Ongoing**
2. **Support for unpaid carers: On track**
3. **Improving mental health services and fighting discrimination: On track**
4. **Protect our public services: Ongoing**
5. **Building a workforce for the future: Ongoing**

In addition to these, some other priority areas for me this year are:

- Continuing Health and Care integration that works for our residents, improving services and health outcomes.
- Developing our new Learning disability plan and services for people with autism.
- Improving Homecare and Residential Care: our ambitious new homecare model will deliver improvements both for our citizens receiving care and our workers delivering it.

5.0 People and HR

In the last 6 months Bernie Enright was formally appointed as the permanent Strategic Director of Adult Services in the Local Care Organisation following a period as interim Director (having originally been appointed as Director of Adult Services in the LCO). Bernie will be working across MCC, Manchester Health and Care Commissioning and the Local Care Organisation. She now has a full management team in place within the LCO and will be recruiting to the final Deputy post to provide additional capacity within MHCC over the summer.

Since taking over this portfolio I have made staff morale and engagement a key priority, recognising that amidst the difficulties of local government and social care- we need to demonstrate the value we place on all our staff. Following on from the annual Bheard survey this year were we saw a massive boost in number of responses and positivity of responses from Adults Services- making us the second highest rated area of the Council, we want to make sure this continues to improve.

The directorate does a lot of work around engagement through traditional 'you said, we did' work but also through the likes of the Activators programmes and a regular programme of engagement. We have Activators involved in all sorts of areas and 10 new Activators who have signed up to be TEC Champions. From September we hope to roll the programme out across Health too.

A key priority is the Strengths Based Development Programme which is a way of working that improves outcomes for citizens. Testing concluded and evaluation shows that 94% of respondents said they were doing something different as a result of participating 6-8 weeks later. This work is to be rolled out across the adult social care and then health with the first priority area being Adults Social Care assessment staff aligned to the introduction of a strengths based model of assessment.

6.0 Our Healthier Manchester Plan

Good progress has been made on the integration of Health and Social Care at a Manchester level. Progress is overseen by myself and through the Health and wellbeing Board and the Transformation and Accountability Board.

6.1 Manchester Health and Care Commissioning

Manchester Health & Care Commissioning (MHCC) was formally established in May 2017, between Manchester City Council and NHS Manchester Clinical Commissioning Group to jointly commission health and wellbeing services for the city. I sit on the Board as Deputy Chair (non-remunerated of course), chair the newly formed strategy committee and sit on the finance committee.

The ambition of our work was that MHCC became a strategic commissioner, and the LCO over time gained more responsibility. We are calling this work Phase 2, where we grow the LCO and were we try and break down unnecessary arbitrary NHS boundaries and make sure that the LCO has the right resources to take on new responsibilities and improve lives. A practical example of this is that some responsibilities, staff and budgets will move in to the LCO in 2019 such as some of the population health team.

7.0 Local Care Organisation

The Manchester Local Care Organisation, a public sector partnership between MCC, Manchester Foundation Trust, GPs and the Mental Health Trust went live on 1st April 2018. As a city we are committed to this being delivered on a firm basis of a publically funded and publically delivered health and social care system. I sit as one of the council's two places on the Shadow Provider Board (made up equally of the 4 partners; MCC, Manchester Foundation Trust; GP Federations and the Mental Health

Trust). This involves monthly board meetings, and frequent meetings with senior LCO staff to monitor progress and shape services.

The Care Quality Commission inspected the MLCO and awarded it as Good. This is an excellent achievement for a new organisation and I want to thank the staff for their hard work.

7.1 Neighbourhood Teams and Working:

The key mission of the LCO is the integration of health and care services into 12 integrated Neighbourhood Teams. This is an enormous programme of change which impacts on front line staff in the council and we have made a strategic decision to do this over a longer period to ensure that staff are properly prepared.

The Neighbourhoods are led by Neighbourhood Team Managers, and a 'quintet' of professional leadership; a lead GP, lead Social Worker, Lead nurse and Lead Mental health worker, there is also a Health Development Coordinator in each Neighbourhood. Recruitment to the Neighbourhood roles was slower than anticipated, but most of the teams are now operational and contact has been made with local Councillors. This is an evolving piece of work and there are a number of neighbourhoods that may change over time to accommodate boundary changes or neighbourhood preferences. The important this is that the primary reason is for the organisation of services, and this will fit in to the Council's wider emerging work on Bringing Services Together.

8.0 Update on Priority Areas:

8.1 Investing to support the most vulnerable, improving core services and recruiting over 100 frontline staff: Ongoing

The Adults Service Improvement Plan is in place with a large recruitment programme underway.

A key service is the **reablement service**, which is vital to supporting people to live well in their own homes. Unlike some local authorities this is still provided by committed City Council staff and evidence shows how well it works, so the service is being expanded with additional funding for over 90 new staff. Recruitment: To date 82 people have been recruited with interviews in place for remaining posts. A key piece of this work was also helping Manchester residents who had been unemployed get access to these jobs. In a joint partnership with the work and Skills Team and the Manchester Growth Company we ran a Pre-Employment Development course recruiting a number of people who were previously struggling to access work.

Success: The North Reablement team was recently awarded a GOOD CQC rating. Well done to the team.

Success: Our new staff have supported over 1000 people to stay in their homes. this alongside our extra care schemes and neighbourhood apartments (short stays) has seen more people able to stay at home with the right level of support.

The Neighbourhood Apartments which is a reablement focused short stay in an existing extra care scheme, for example in Wythenshawe 135 Village we have 6 apartments for people requiring something different to hospital, home or a residential home with beds across the city. This scheme continues to do well and we continue to expand as more extra care sites come on board.

Equipment, adaptations and Blue Badge Team: Recruitment of the additional 6 occupational therapists and 2 blue badge assessors in February increased the number of assessments completed each month and will also help to reduce the waiting times for complex assessments and Blue Badge Assessments.

Shared Lives – Shared Lives is an in house service that can support any one, aged 16 and up with care and support needs. Following additional investment which was well received by staff we have recently recruited 2 new placement staff to the Shared Lives team (recruited on a values based approach)

8.2 Support for unpaid carers: On track

I previously brought a report to Scrutiny outlining our ambitious new approach for supporting carers in the city, both in terms of a new charter and also a new model of service. This will require significant investment of over £1million over 3 years. I can now confirm that we have been able to find the funding and are working with our hard working carers groups in the city to finalise the model of support which will come back to scrutiny in early autumn.

8.3 Improving mental health services and fighting discrimination: On track

I meet regularly with GMMH and Manchester Commissioners to monitor the progress of the ambitious two-year programme of service transformation, to improve both the mental health outcomes for people receiving services and support the wider mental wellbeing of Manchester residents. Regular updates come to scrutiny on services, areas of progress include access to therapies and the significant reduction of Out of Area bed placements which have thankfully reduced dramatically.

I have previously updated on the work to improve Harpurhey Wellbeing Centre led by GMMH, supported by council and health commissioners to improve access to services for people in the North of the city. This will see an investment of over £800,000 for services that support people with mental health difficulties and local wellbeing groups. Following the ongoing issues being raised with scrutiny, issues were resolved and there have been no reported issues since. Construction work is still ongoing on the building and will launch in July 2019, in the mean-time existing services and groups are operating out of the Harpurhey Neighbourhood Project (with necessary rental being paid to HNP, helping with their sustainability).

There has been a specific piece of work to review of the transition between young peoples and adults services for mental health, with a number of recommendations that are being implemented through a joint Transitions.

8.4 Developing our new Learning disability plan and services for people with autism

I Chair the Learning Disability Board. We have been working with colleagues across GM to see where we can work together to improve outcomes and services for people with Learning Disabilities and have signed up to a new GM Plan. We are focusing on developing and implementing a new Learning Disability Plan and a truly integrated health and care learning disability service. This work will come to scrutiny in the Autumn.

Autism and ASD- we are currently reviewed what we can do to make Manchester an Autism friendly city and looking at the services and support we have available

8.5 Improving Homecare and Residential Care: our ambitious new homecare model will deliver improvements both for our citizens receiving care and our workers delivering it

Manchester people tell us repeatedly they want good quality care, close to home to help keep them active and independent for as long as possible to get the most out of life. A priority for me of the last 2 years has been to look specifically at how we deliver homecare in the city.

8.5.1 Homecare: Manchester hadn't reviewed its homecare model in a decade, and I was concerned that the model was outdated and deliver best for Manchester people so in June 2017 I made it a priority area of work. We began to review existing services, engage with people in receipt or caring for people in receipt of services, and began a new model. In April 2018 we brought in the Real Living Wage for Homecare Workers. I brought the transformation of Homecare to Scrutiny in the Autumn, and have kept members updated along the way.

Since then the procurement process took place. We chose to commission on a model of 50% Quality, 30% Social Value and 20% Cost. The legal process is being finalised and a mobilisation plan and team is in place for roll out after the summer (after our new ICT system Liquid Logic is in place).

This remains an area of complexity and risk, but to do nothing and simply allow the old model to continue does a disservice to the citizens of Manchester and the staff working in this industry.

8.5.2 Residential and nursing care remains under pressure, and in the way we approached homecare from an evidence based way- and we are looking at what can be done in this sector. For too long we have had too many inadequate and requires improvement nursing and residentially homes in this city, and I have set an ambitious target of getting all homes to Good or Outstanding. Starting with inadequate homes we have been reducing them, and are developing targeted programmes to get Requires improvement Homes to Good or Outstanding. Pieces of work to be rolled out include the Teaching Care Homes Programme and Registered Manager development work.

9.0 Population Health and Prevention of ill-health

The Population Health and Wellbeing Directorate at Manchester Health and Care Commissioning (MHCC) have led the co-production of the Manchester Population Health Plan with a wide range of stakeholders. As Executive Members for Adult Health and Wellbeing I maintain oversight of the statutory functions (e.g. health protection) and mandated responsibilities (e.g. sexual health services) of the Director Public Health at MCC who is also the Director of Population Health for MHCC. This year's annual report focused on Air Quality and was the national winner of the Association of Directors of Public Health Annual Conference- so well done to David and the team.

9.1 Teenage Pregnancy

The under 18 conception data for 2017 was published by the Office for National Statistics In April and shows another reduction in the Manchester rate. We have now achieved a reduction of 61.7% from the 1998 baseline.

- The rate for Manchester is now 23.5 (per 1,000 15-17 year old females) this is a reduction from 25.9 in 2016
- The number of under 18 conceptions in 2017 was 185 - 22 fewer than the number of 207 in 2016
- For comparison, the England rate is now 17.8 per 1,000 and the Greater Manchester rate is 21.4. Within GM two authorities have higher rates than us - Oldham (25.7) and Salford (30.7)

This success is for a range of reasons including accessible sexual health services for young people, high quality relationship and sex education in our schools and support programmes for teenage parents.

9.2 Lung Health Checks

On Tuesday 28th May, 2019 the Lung Health Check Nurses, working on the mobile facility based at the Etihad Stadium, completed the 1,000th Lung Health Check with local residents since the service opened in April 2019. A fantastic achievement in just two months. The service will also move to three other sites in north and east Manchester over the next year and a business case is currently under development for a service for south and central Manchester.

9.3 CURE

This programme based at Wythenshawe Hospital offers in-patients who are smokers, tailored pharmacotherapy and support and is achieving excellent quit rates. I visited the service on Monday 10 June and heard first hand from patients and nurses what a valued service this is. The service has now been mainstreamed and there are plans to roll in out to the MRI and North Manchester General Hospital site.

9.4 The Be Well Social Prescribing Service is now fully operational across the city with the south and central service commencing in November 2018. The service is designed to improve the health and wellbeing of local residents with long term

health conditions or whose social circumstances mean that they are at increased risk of poor health. Following a referral from their GP, people will be offered one to one support tailored to their needs. The service is an integral part of the Prevention Programme, delivered through the Manchester Local Care Organisation and has a strong neighbourhood focus.

9.5 Winning Hearts and Minds is a programme of work to improve heart and mental health outcomes in the city, with an initial focus in north Manchester. In this part of the city, the rate of early deaths from heart disease is 96.2 deaths per 100,000 people compared to the England rate of only 40 deaths per 100,000 people. Funding for the programme from NHS resources has just been agreed by the Manchester Health and Care Commissioning Board to roll this out primarily across North and East Manchester. I sit on the steering group and I will ensure that local Councillors receive regular briefings on the implementation of the programme and have proper involvement in projects in their area.

9.6 Smoking Services I have recently raised concerns at Scrutiny that due to cuts to public health funding our Smoking Services have been hit hard and given that Manchester has one of the highest rates of smoking in the country we need effective stop smoking services. Funding has recently been approved for additional services which will see a new Stop Smoking Service across the city from October.

9.7 Sexual Health Sexual health services in Manchester are under increasing pressure from a growing population and rising demand. In my last report I referenced a recent visit with the leadership team of Northern Sexual Health Services at the Hathersage Centre in Central Manchester. We discussed a number of important issues, including some of the work they are doing to reduce queuing times for drop in services by allowing some advance bookings.

Manchester has signed up to be a Fast Track City to eradicate the new infections of HIV, and this is an important component of our success. I have met with the Greater Manchester Health and Social Care Partnership to discuss joint plans for GM and Manchester work.

The issue of PrEP (a treatment aimed at preventing the contraction of HIV) has come up at this committee and I have reported on the progress being made to see the current NHS England pilot being expanded. Manchester were clear that while we believe this should be accessible beyond the pilot, we were keen to have it expanded while campaigning for fairer access.

10.0 Greater Manchester Health and Social Care Board and Executive

I attend this strategic partnership board on behalf of Manchester and sit as one of two local government representatives on the GM HSC Executive (meeting monthly). This body covers a range of issues around health and social care devolution across GM. We have formed a GM Joint Commissioning Board which brings political and GP accountability to the decisions made by Commissioners at a GM level.

Some of the issues we have made decisions on and discussed include: Population health, Hospital Services, Mental Health, the VSCE, Learning Disabilities; Autism; Population Health; Stopping Smoking and Acute Hospital Services.

The Board meetings are live streamed and I presented at the last meeting on Manchester's successes in the area of action around respiratory services. I am the elected member lead for Workforce development in Social care at GM.

11.0 Ongoing issues and commitments

Multi-Agency Adults Safeguarding Board: I regularly attend the Manchester Safeguarding Adults Board last week and meet regularly with our Independent Chair. We also took the decision to record and monitor the number of deaths of people who were homeless and/ rough sleeping and are ensuring that every single case is reviewed on the basis that one preventable death, is one too many. Nationally there are changes to how Children's Board work so we are reviewing our current structures to make sure they are in line with Children's developments and ensure that we have the most effective model to keep adults safe. These new structures will be reported on and come in to place after the summer.

I continue to attend **Our Manchester Listening in Action Events** with staff, continue to be very impressed by the contributions and commitment of our staff.

Visits to services: I like to visit staff and partner organisations such as hospitals as much as possible and am currently working through a cycle of front line visits to see what staff have to say. If you have an issue or service in your ward, I am more than happy to arrange a visit.

I welcome any feedback and suggestions from members of Scrutiny on the information in this document or other areas of work in this portfolio.

Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 18 June 2019

Subject: Stroke Services – Quality and Performance update

Report of: The Director of Performance and Quality Improvement, MHCC and Trafford CCG

Summary

A new centralised model of stroke services was implemented across Greater Manchester in 2015. This paper outlines the positive impact this has had for the people of Greater Manchester and focuses on the city of Manchester provider units at Manchester Royal Infirmary, Wythenshawe Hospital and Trafford General Hospital.

Recommendations

The Committee is asked to note the improvements in the quality and performance of stroke services across Greater Manchester since the implementation of a centralised model in 2015 and the positive position of the city of Manchester provider units.

Wards Affected: All

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Background documents (available for public inspection):

None

1. Introduction

This paper aims to revisit the stroke model of care for Greater Manchester, highlighting the positive progress made since the 2015 centralisation of stroke services. It will provide an update for Scrutiny Committee members on the city of Manchester stroke units' quality of care and performance improvements/challenges.

It is well known the devastating effects a stroke can have on people's lives and on the wider health economy. The Stroke Association reported in 2018 that there are more than 100,000 people who have a stroke every year. Stroke is the fourth biggest killer in the in the UK leading to 32,000 deaths per year.

The first phase of centralisation of acute stroke services began in Greater Manchester in December 2008 and was operational by April 2010. It set out to ensure that all patients presenting within 4 hours of the symptoms of a stroke were taken to one of three local Hyper Acute Stroke Units (HASUs). Research published in 2014 indicated that a fully centralised model where all patients presenting with a stroke are taken to a HASU, regardless of time of onset, offered significant benefits for patients in terms of mortality and length of stay.

On 30 March 2015, the pathway for stroke was fully centralised across Greater Manchester so that all FAST positive (face, arm, speech test) suspected stroke patients assessed by paramedics are taken by ambulance to a HASU. There, they receive specialist acute stroke care, which may include thrombolysis and other interventions, before being discharged home or repatriated to a District Stroke Centre (DSC) in their local hospital. GM lent itself well to the centralised model due to geography and allowing all areas access to a hyper acute stroke unit (HASU) within 30 minutes of travel.

The three GM HASU are at Salford Royal, Fairfield General Hospital and Stepping Hill, giving access to all patients within 30 minutes in an ambulance.

In October 2015, following advice from Professor Tony Rudd (National Clinical Director for stroke) the pathway was modified so that only patients presenting with a time of onset <48 hours would be taken to a HASU, with those >48 hours discussed with a HASU and moved if felt to be of benefit. Research has shown that fully centralised stroke services could save the lives of an extra 69 patients per year who would have died under standard hospital treatment (reported by BMJ).

Before the centralisation of stroke services took place, any suspected stroke patients were taken to the nearest emergency department to receive stroke care and then treated on a stroke unit or general ward. While this offered a wide coverage of care, unfortunately the consistent offer of high care could not be guaranteed.

2. National Stroke Quality Performance

The performance and quality of stroke services are measured nationally by the Sentinel Stroke National Audit Programme (SSNAP). SSNAP collects information from hospitals about the care provided to stroke patients from the time they arrive at hospital up until 6 months after their stroke. This assigns providers a performance

level based on a range of 10 care domains with an A to E score. The A score Hospital or CCG meets highest standards for almost all patients, while the E score does not meet highest standards for many patients and has a lower performance.

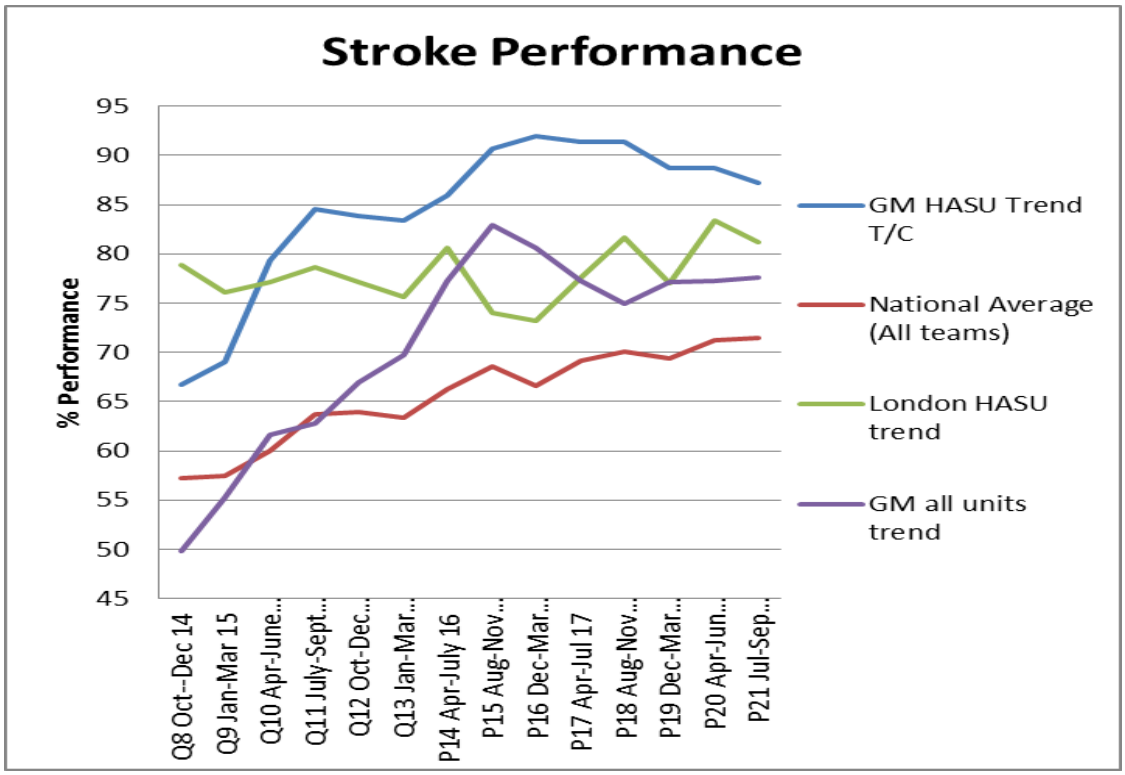
Domains for SSNAP Key Indicators scoring are:
Domain 1: Scanning
Domain 2: Stroke unit
Domain 3: Thrombolysis
Domain 4: Specialist assessments
Domain 5: Occupational therapy
Domain 6: Physiotherapy
Domain 7: Speech and language therapy
Domain 8: Multidisciplinary team working
Domain 9: Standards by discharge
Domain 10: Discharge processes

Further details on domains can be found at https://www.Strokeaudit.org/. Having 10 domains gives a balanced view to quality and performance in various areas of care and audit compliance.

All 10 domains apply to routinely admitting teams. These are the hospitals where a patient is usually taken for treatment immediately after their stroke at a Hyper Acute Stroke Unit. For the non-routinely admitting acute teams only 6 of the 10 domains are applicable (2, 5, 6, 7, 9, 10). The non-routinely admitting acute teams (i.e. DSC) are expected to have fewer than 50% directly admitted patients and do not offer thrombolysis for example. This applies to Trafford General Hospital (TGH), Manchester Royal Infirmary (MRI) and Wythenshawe Hospital (WH).
Stroke quality and performance is measured over a 3 month period; the latest performance period is from July – September 2018. This information was released in January 2019.

The performance and quality improvement team monitor and support the stroke service delivery for MHCC. The following section outlines that good stroke care is offered across GM and across the city of Manchester and demonstrates the improvements over time.

Overall stroke quality and performance for GM has improved considerably since 2015; the graph below shows how the performance of HASUs in GM has remained A level SSNAP (above 80%) and surpassed the performance of London HASU and the national average for the time period.



The long term quality and performance of each hospital in GM is shown in the table below:

Overall SSNAP score	Apr - Jun 2014	Jul - Sep 2014	Oct - Dec 2014	Jan - Mar 2015	Apr - Jun 2015	Jul - Sep 2015	Oct - Dec 2015	Jan - Mar 2016	Apr - Jul 2016	Aug - Nov 2016	Dec-Mar 2017	Apr - Jul 2017	Aug - Nov 17	Dec-Mar 2018	Apr-Jun 2018	July-Sept 2018
Fairfield General Hospital	C	C	C	B	A	A	A	A	A	A	A	A	A	A	A	A
Salford Royal Hospital	C	B	B	B	B	A	A	B	A	A	A	A	A	A	A	A
Stepping Hill Hospital	D	C	C	D	C	B	B	A	B	A	A	A	A	A	A	A
Royal Bolton Hospital	D	D	X	D	D	D	C	B	B	B	C	B	B	B	B	B
Manchester Royal Infirmary	D	E	D	D	B	C	C	C	C	B	B	B	B	B	D	B
Trafford General Hospital	X	D	C	D	C	B	C	A	A	A	B	A	A	C	B	A
Tameside General Hospital	D	D	D	D	D	D	B	D	C	B	C	D	C	B	C	C
Wythenshawe Hospital	D	D	D	D	D	D	D	C	B	B	B	C	D	C	B	B
Royal Albert Edward Infirmary	D	D	D	D	D	C	B	C	A	B	B	B	C	C	B	C

The table shows how quality and performance has improved across all hospitals since the centralisation of stroke services. The consistent delivery of services can be a challenge due to multiple factors including the availability of beds on a stroke ward and specialised staffing.

The long term performance of Manchester CCGs/CCG is shown in the table below:

	2014				2015				2016			2017			2018	
CCG	Apr-Jun 14	Jul-Sep 14	Oct-Dec 14	Jan-Mar 15	Apr-Jun 15	Jul-Sep 15	Oct-Dec 15	Jan-Mar 16	Apr-Jul 16	Aug-Nov 16	Dec 16-Mar 17	Apr - Jul 17	Aug - Nov 17	Dec 17-Mar 18	Apr-Jun 18	July-Sept 2018
Manchester (North)	D	C	C	B	A	A	A	A	A	A	A	A	A	A	tbc	tbc
Manchester (Central)	D	D	D	C	B	B	B	B	A	A	A					
Manchester (South)	D	D	D	D	C	B	B	B	B	A	A					

The CCG level performance demonstrates a positive change over the time. In 2018 the reporting of CCG level performance changed to annual; this has allowed the national team to concentrate on returning to quarterly stoke unit performance. We know that most of our patients attend a HASU and expect the CCG level to remain as an A. The next published CCG level data will be in summer 2019.

3. Current Stroke Unit Quality and Performance

The current stroke units within MFT are at TGH, MRI and WH. They are all DSCs and take over the care of patients after being firstly admitted one of the GM HASUs or needing less intensive stroke care. The most recent performance is shown below and includes the performance rankings against the other 222 stroke wards.

TRAFFORD Quarter Results	*Dec-Mar 2018*	Apr-Jun 2018	Jul-Sep 2018
SSNAP level	C	B	A
Combined Total Key Indicator score	69	74.7	81.7
National league position after adjustments (222 Trusts)	124th	87th	47th

MRI Quarter Results	*Dec-Mar 2018*	Apr-Jun 2018	Jul-Sep 2018
SSNAP level	B	D	B
Combined Total Key Indicator score	70.3	60.7	70.3
National league position after adjustments (222 Trusts)	113th	181st	122nd

Wythenshawe Quarter Results	*Dec-Mar 2018*	Apr-Jun 2018	Jul-Sep 2018
SSNAP level	C	B	B
Combined Total Key Indicator score	68	77	75
National league position after adjustments (222 Trusts)	133rd	71st	85th

The national ranking does not represent the quality of care for patients like SSNAP, it does demonstrate the comparison to peers. The performance of the 3 DSCs have less opportunity to score more points in national ranking due to not having 10 domains and are within the expected national range.

During this period the overall performance for all 3 DSCs is at or above the expected SSNAP level of B. While each site has its own pressures e.g. access to beds on the stroke ward, demand has remained similar due to the centralised stroke model and overall bed availability has related to the sites not total stroke patients.

Current period July-Sept 2018	TRAFF	MRI	W/Shawe
1) Scanning	N/A	N/A	N/A
2) Stroke unit	A	D	C
3) Thrombolysis	N/A	N/A	N/A
4) Specialist Assessments	N/A	N/A	N/A
5) Occupational therapy	A	A	B
6) Physiotherapy	B	A	C
7) Speech and Language therapy	D	D	A
8) MDT working	N/A	N/A	N/A
9) Standards by discharge	B	A	B
10) Discharge processes	A	B	A
Team-centred Total KI level	A	B	B
Team-centred Total KI score	83.3	76.7	80
Team-centred SSNAP level (after adjustments)	A	B	B
Team-centred SSNAP score	83.3	76.7	80

The SSNAP domain information does show the challenged areas, these remain similar over time. Further analysis of SSNAP data at domain level highlights the challenges that remain in terms of delivery of quality and performance across all sites. The largest risks to performance are domains 2) Percentage of patients who spent at least 90% of their stay on stroke unit and 7) Percentage of patients reported as requiring speech and language therapy. We understand the challenges each site faces and know the reasons, for example the potential cohort of patients who have a stroke in conjunction with other comorbidities, and whose care is therefore most appropriately delivered at a different ward. Also key facts like Trafford not having an A&E helps them to ring fence beds and meet the length of stay on the stroke ward target.

The unintended consequence of SSNAP recording of therapy can result in reduced performance ranking due to data recording methodology, for example a patient may need 1 day of support from speech and langue therapy out of 5 day stay, however the national system expects 5 days of treatment and negatively scores the ward for this gap. The Stroke ODN is looking to address these concerns and is working with the national team, who oversee the SSNAP to help develop a fair way to monitor DSC therapy performance in 2019.

While demand on stroke services is high the centralised model does put more demand on HASU beds. This requires patient flow with them being discharged to DSC or community stroke services in a timely method. MFT is working to improve access to stroke beds by offering patients access to any stroke ward. Community stroke services allow on going support to patients and a 6 month review is completed to sign post patients to extra support if required.

4. Summary

The SSNAP scoring methodology is complex, however it does give a nationally recognised good guide to the level of care patients receive. Working with MFT and GMSODN ensures we understand the reasons for reported quality and performance levels and gain robust assurance of quality of care. If required, we work with MFT to establish quality and performance recovery plans.

The CCG level data provided by the SSNAP reports gives reassurance that the stroke services accessed by Manchester patients is some of the best in England (GM HASUs have been ranked number 1 in 2018/19 from 222 trusts), with the local stroke units at MRI, TGH and Wythenshawe meeting the expected overall SSNAP level of over a B level.

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