Greater Manchester
Neurorehabilitation & Integrated
Stroke Delivery Network

Strategy 2024-2026

Part of Greater Manchester
Integrated Care Partnership

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Approved by the GMNISDN Board on 12th March 2024

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1. Introduction

1 in **6** or **16.5million** people live with a neurological disorder in the UK[1]

Over **90,000** people have a stroke in the UK each year

Around **4,500** people affected in Greater Manchester[2]

Stroke is the **4th LARGEST** cause of death and single greatest cause of disability

Most neurological cases are complex to manage, requiring timely access to NHS inpatient and community based multidisciplinary teams with neurological expertise, supported by primary care and other NHS services such as orthotics. Specialist rehabilitation is a key facet of recovery post stroke or after an acquired brain injury and ensures those with progressive conditions live well for as long as possible. Care pathways should be holistic and are most effective when augmented by other longer-term support which is often provided by the voluntary sector or local authorities but may include private/independent sector services.

The effect on people's lives of a neurological condition can be significant and usually life changing, with impacts also felt by family members and carers. Resulting disabilities can vary greatly from person to person and can include mobility, cognition, vision and communication, with emotional wellbeing also greatly affected in many.

Although many neurological conditions are unavoidable, stroke along with other cardiovascular diseases (CVD) is highly preventable. Whilst the majority of strokes occur in people over 70, strokes are becoming more common in middle age. Around 80% of strokes could be prevented through modifying risks linked to a lifestyle factors such lack of exercise, poor diet, obesity and alcohol/smoking intake. Some countries with similar populations as the UK have considerably lower death rates and we need to do better in supporting people to reduce their risk of having a stroke.

[1] www.neural.org.uk/publication/together-for-the-1-in-6-uk-findings-from-my-neuro-survey/

[2] www.hqip.org.uk/wp-content/uploads/2023/11/Ref.-408-SSNAP-Annual-Report-2023-FINAL.pdf

2. Our Place in the Wider System

In 2021, the Greater Manchester Integrated Stroke Delivery and Greater Manchester Neuro-Rehabilitation Networks merged to form a single organisation. The Greater Manchester Neurorehabilitation & Integrated Stroke Delivery Network (GMNISDN) remains a non-statutory body, constituted from key stakeholders including all Greater Manchester and Eastern Cheshire stroke and neurorehabilitation NHS providers, North West Ambulance Service (NWAS), the voluntary sector as well as patient and carer representation.

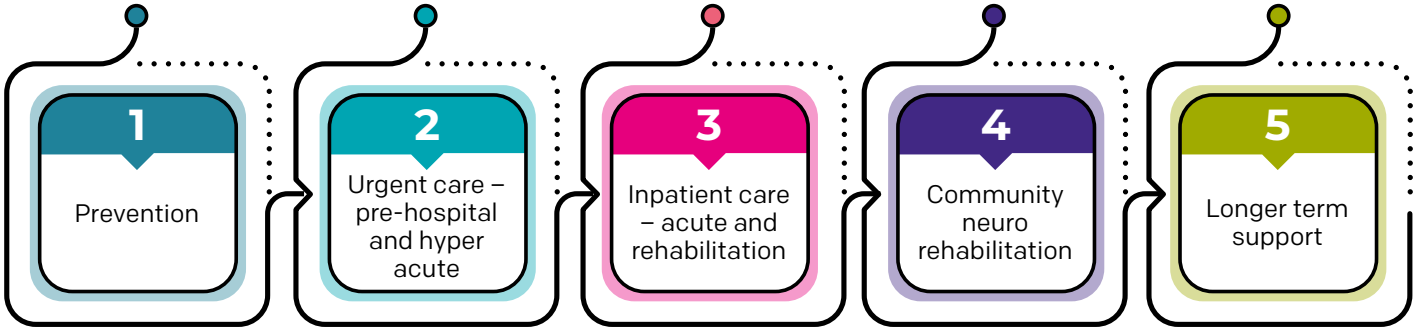
We continue to be hosted by the Northern Care Alliance NHS Foundation Trust on behalf of Greater Manchester with a mixed funding model including a "fair share" local NHS provider contribution plus NHS England (NHSE) stroke monies as well as other ad hoc sources such as charitable grants.

We are formally accountable to the Greater Manchester Integrated Care Partnership (ICP) as one of the Strategic Clinical Network's quality improvement programmes - our governance structure is outlined here. The network helps inform the ICP's joint forward plan, with CVD prevention a key focus and we are involved a wider collaboration to bring together prevention strategy and activities that are part of the NHSE post pandemic recovery initiative Core20PLUS5 for adults.

The GMNISDN is one of 20 NHS England Integrated Stroke Delivery Networks and part of the national stroke programme, responsible for delivering the stroke elements of NHSE's Long Term Plan. NHSE has also commenced a programme to transform neurology services, including community neurorehabilitation. As a pioneer of specialist community service development, we are supporting the national team in this work and all Integrated Care Systems will be expected to implement the recommendations in due course.

3. Scope of Our Work

The network is responsible for delivering quality improvement for the whole stroke care pathway including:



In 2023, work was restarted by the ICP to fully implement transformation of the region's inpatient neurorehabilitation care pathway. We continue to support the community neurorehabilitation and longer-term support aspects of this endeavour. Where possible inpatient neurorehabilitation services are included in our improvement programme due to the overlapping nature of care provision and stakeholders.

You can view a summary of some of our work programmes here.

4. Our Vision and Key Objectives

We support the development of high quality and equitable stroke and community neurorehabilitation services in Greater Manchester, to achieve the best outcomes and experience for patients. We do this by:

- **Being patient centred**
- **Working collaboratively with our stakeholders**
- **Facilitating transformational change through effective partnership working**
- **Encouraging the early adoption of evidence in stroke and community neurorehabilitation services**

We actively engage with patients and carers to ensure their voices are heard, working closely with relevant voluntary sector organisations in our area. There is more about our involvement activities later in the report.

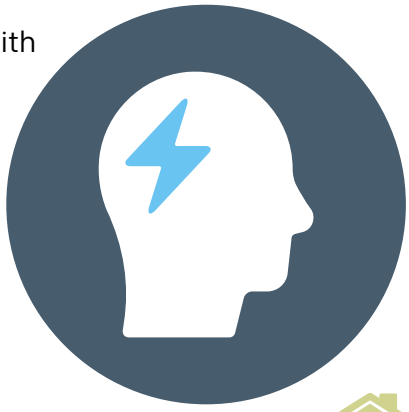
Our primary purpose is to bring key stakeholders together to facilitate a collaborative approach to the service improvement of stroke and community neurorehabilitation services. Our approach will always be clinically led, patient centred, evidenced based and focused on delivering long lasting and meaningful change. We do this by:

- Providing robust clinical and programme leadership and support
- Facilitating quality improvement of our local care pathways in line with the national service models and other relevant guidelines/policies
- Ensuring the patient and carer voice is heard in service development
- Supporting the transformation programme for inpatient neurorehabilitation services to ensure there is a whole pathway approach
- Supporting wider system initiatives to prevent CVD
- Ensuring full engagement with the Sentinel Stroke National Audit Programme (SSNAP) and support for performance management of our local services
- Leading workforce development initiatives to help manage system capacity and demand
- Horizon scanning and ensuring evidence based, innovative practice is at the heart of our services

Given the ongoing severe financial challenges faced by the ICP we will also focus on health economics within our portfolio of projects and prioritise initiatives that are cost neutral or cost saving to the system.

The network must reflect the deliverables within the NHSE Long Term Plan for Integrated Stroke Delivery Networks:

- By 2020 - begin improved post-hospital stroke rehabilitation models, with full roll-out over the period of this Long Term Plan
- By 2022 - deliver a ten-fold increase in the proportion of patients who receive a thrombectomy after a stroke so that each year 1,600 more people will be independent after their stroke
- By 2025 - have amongst the best performance in Europe for delivering thrombolysis to all patients who could benefit



5. Our Service Improvement Programme

The network's Board is responsible for ensuring successful delivery of our strategy and plans of work, with the Groups that feed into the Board helping steer and deliver output. The strategy reflects both national (including NICE and clinical guidelines) as well as local/regional requirements and priorities which may also be economic in nature. It encompasses areas identified and prioritised by the network through its own structures and activities, and via its Patient and Carer Group. A summary of the network's workplan can be found in Appendix 1.

5.1 Clinical Pathway Improvement

5.1.1 CVD Prevention

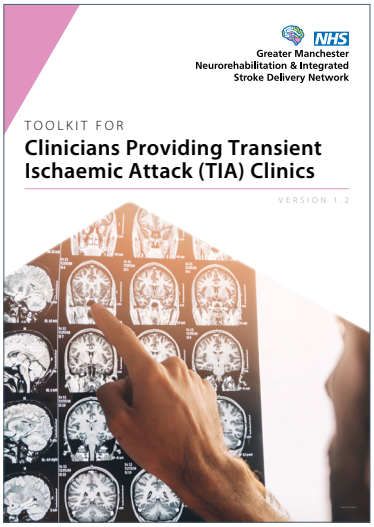
Following the pandemic there has been an increase in health inequalities, especially in more deprived regions such as Greater Manchester. CVD prevention remains a key national priority, with an emphasis on early detection and treatment of Atrial Fibrillation (AF), high blood pressure and cholesterol with diabetes also a considerable focus of activity. Primary prevention targets the general population including those known to be at higher risk such as people who are more deprived, ethnicity minorities (especially South Asian and Black Afro Caribbean), older people or the disabled. Secondary prevention focuses on patients already diagnosed with a CVD who are at high risk of a cardiovascular event or those that have already experienced a stroke or heart attack and are at high risk of further events.

In conjunction with the Strategic Clinical Network's cardiac programme, we have appointed a CVD Prevention Clinical Lead to work at a Greater Manchester and regional level. NHS Greater Manchester will launch a Multiyear Prevention Plan in 2024. It takes a comprehensive and whole system approach to prevention, with CVD and diabetes prevention the focus for 2024/25. By 2029, Greater Manchester aims to have:

- Achieved the national ambitions for the detection, diagnosis, management and control of AF, high blood pressure, and high cholesterol
- Improved access to, and the uptake of opportunistic screening and other CVD prevention interventions, particularly in currently underserved communities and groups where unwarranted variation in care and outcomes is most evident
- Full system recognition for the importance of 'upstream' preventative activity, by supporting the ethos of "Making Every Contact Count" across our localities
- Improved the relationships and driven better partnerships across system level programmes that support communities to be healthier
- A cohesive approach to the reduction in CVD health inequalities across our system through the delivery of a population health improvement ethos
- Helped reduce the risks in higher risk populations including those in lower socio-economic groups and local ethnic minority communities

There are local initiatives to help support these aims including the CURE programme to reduce smoking and others to support alcohol intake which is associated with a higher risk of stroke. Additionally, there needs to be promotion of Covid and flu immunisation uptake for stroke and TIA patients who are considered at risk population at all health interactions whether in community or secondary care.

We have established our own CVD Prevention Subgroup to oversee specific projects related to secondary prevention in stroke and Transient Ischaemic Attack (TIA). These include:



- Implementing monitoring of AF post stroke/TIA utilising technology such as Electro-cardiogram patches and risk stratification software, especially in Hyper Acute Strokes Units (HASU)
- Improving the quality of TIA clinics including developing 7 day services and developing an educational toolkit to maximise patient support for lifestyle and sustained behavioural change to reduce risks
- Improving and standardising Embolic Stroke of Undetermined Source (ESUS) clinics whilst increasing access for patients
- Supporting timely diagnosis and treatment of Obstructive Sleep Apnoea
- Ensuring relevant patients are referred to the region's Patent Foramen Ovale closure service
- Screening for non-diabetic hyperglycemia and diabetes in TIA and stroke clinics
- Educating professionals, especially promoting behavioural and lifestyle change through motivational techniques

5.1.2 Urgent Care

The NHSE National Stroke Service Model requires local care pathways to deliver accurate identification of potential stroke and TIA patients and their timely assessment, transfer and treatment. Our centralised care pathway helps ensure we deliver these objectives in both pre-hospital and urgent care settings.

PRE-HOSPITAL

Urgent care includes clinical assessment by pre-hospital staff, timely ambulance conveyance to hospital and effective inter-hospital transfers. Our inpatient stroke service re-organisation in 2015 and ongoing improvement work has ensured that most of the requirements have already been realised or are being addressed within existing plans. One of our Facilitators is an experienced Paramedic and is involved with national work on the pre-hospital pathway and liaises closely with NWAS. Going forward, work will include:

- Exploring assessment tools and use of telemedicine in pre-hospital phase following the national pilot at Salford Royal during 2022/23
- Updating pre-hospital pathway and use of exclusions
- Reviewing NWAS transfers and response times and work to educate staff

HYPERACUTE

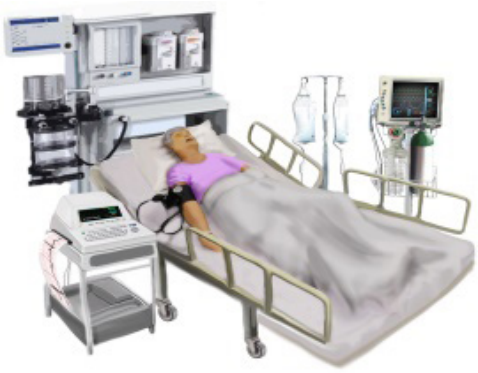
Centralisation of the regions hyper acute pathway in 2015 continues to ensure 85-90% of patients access timely care that continues to be highly rated by SSNAP. Thrombolysis intervention rates have historically been below the national average (~11.5%) with a decline seen in Greater Manchester and also across the country during the pandemic. In 2023, the network re focused efforts on identifying and addressing the underlying causes of its lower rates which centred on the clinical practice, culture and behaviours of teams. We will continue to monitor and encourage clinicians in adopting consistent practice to help increase rates to above 15%.

A 24/7 regional thrombectomy service has been available for all residents since March 2022, with increasing numbers accessing the treatment and rates above national (~3%). During 2024, we will support the phased implementation of CT Perfusion – a key requirement of the National Optimal Stroke Imaging Pathway. This imaging is necessary to enact new eligibility recommendations in the National Clinical Guideline for Stroke 2023, at all three HASUs.

The network will also monitor the long-term sustainability of the region's centralised model of hyper acute care, in light of emerging evidence that may impact patient flow.

Urgent care projects are primarily supported by the network's HASU Forum and Clinical Effectiveness Group.

5.1.3 Acute Care



All of the region's eight stroke units deliver acute care, with our District Stroke Centres more focused on providing inpatient rehabilitation following a short hyper acute spell at a HASU. All units meet most or all of the key elements of the NHSE National Stroke Service Model as a result of our centralised model, and generally perform well on SSNAP metrics.

Improvement of inpatient neurorehabilitation provision is outside the network's remit, however, where possible projects encompass these services. Our acute projects will focus on:

- Enhancing discharge processes and review Discharge to Assess pathways in localities to better engage with social care and other stakeholders
- Improving in reach into neurorehabilitation inpatient services
- Implementing My Stroke document (personalised information document) in all stroke units
- Supporting development and implementation of the Patient Pass online referral system for stroke – referral and repatriation modules
- Optimising the inpatient pathway for stroke patients presenting at Wythenshawe Hospital
- Continuing to support timely stroke repatriation and safe/appropriate use of mitigation steps such as compulsory transfer
- Improving stroke swallow screen and continence pathways in units
- Ensuring high quality basic care on wards, especially those that affect the elderly such as oral health, fractures risk assessment and management, falls etc

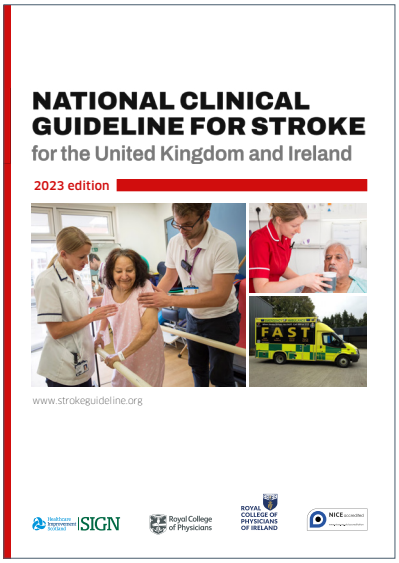
These projects are primarily supported via the network's Clinical Effectiveness Group and Sector Forums.

5.1.4 Rehabilitation

Our District Stroke Centres and inpatient neurorehabilitation units are responsible for providing inpatient rehabilitation, with locality-based specialist community teams continuing to support patients at home or in a care home. Our stroke units deliver the key requirements of the NHSE National Stroke Service Model, with all Greater Manchester community stroke services now transformed to meet the NHSE Integrated Community Stroke Service model which is part of the wider NHSE model. No other region in the country has achieved this level of implementation.

There is no direct specific national model for neurorehabilitation inpatient or community services, although many national publications[3,4,5] provide an evidence base and steer service delivery for condition and intervention specific care in these settings. Since 2015, there has been a Greater Manchester programme to improve the neurorehabilitation pathway, with the network responsible for helping to implement its own community model in each locality. Only Eastern Cheshire now lacks a specialist team although funding of services is limited in other areas such as Bury and Oldham.

During 2022/23, the network collaboratively updated both stroke and neurorehabilitation community models and associated key performance indicators and continues to support performance monitoring of services via regular data collection and reporting as well as via peer review visits.



The National Clinical Guideline for Stroke 2023 included some new rehabilitation recommendations, the most significant being the step change in increasing the intensity and frequency of therapy in both hospital and community settings. We have developed a number of methods to help achieve these aims beyond simply improving staffing levels. These include the use of innovative technology, training of staff in self-management techniques and the use of unqualified therapy roles. The roll out of these initiatives will be explored by the network in the coming years.

Our Clinical Lead for Psychology has led efforts to support improvements in emotional wellbeing and cognition in hospital and community stroke and neurorehabilitation teams. This area of care is significantly under invested in and we know from patient surveys and our own Patient and Carer Groups that there continues to be significant unmet need. Our work will continue to focus on supporting the recruitment and retention of Psychologists, upskilling non-specialist staff, harmonising clinical practice amongst professionals, encouraging innovative ways of working e.g. using groups, developing greater peer support across the North West and engaging with trainees and local universities to improve the numbers entering the specialism.

An ongoing collaboration funded by the Motor Neurone Disease Association has proven highly successful in improving the region's inpatient and community care pathway for this condition. Many improvements have been cost neutral and have involved better communication/information sharing between teams, or the upskilling of staff. We will use the experience as an exemplar for pathway development in other neurorehabilitation conditions, starting with Multiple Sclerosis in 2024.

[3] www.bsprm.org.uk/resources/guideline-documents/

[4] www.nice.org.uk/guidance/conditions-and-diseases/neurological-conditions

[5] https://www.rcplondon.ac.uk/guidelines-policy/spasticity-adults-management-using-botulinum-toxin

Our key rehabilitation focused projects will be:

- Increasing the intensity and frequency of therapy in inpatient and community settings
- Supporting improvements in psychological rehabilitation and emotional wellbeing including improving Clinical Psychologist recruitment/retention, standardising and improving clinical practice, knowledge and skills as well as upskilling other care professionals to support patients
- Improving care pathways in: cardiac, facial and vestibular rehabilitation, Functional Neurological Disorder, neurogenic bladder and bowel, spasticity including splinting, neurorehabilitation paediatric transition, Out of Hospital Cardiac Arrest, seating/wheelchairs, visual impairment and vocational rehabilitation
- Improving psychological rehabilitation support in hospital and community settings
- Working collaboratively to develop and enhance care pathways in neurorehabilitation conditions using a collaborative approach

This programme of work is supported by the network's Clinical Effectiveness Group, Sector Forums and Rehabilitation Subgroup.

5.1.5 Longer Term Support

For many patients, recovery after a stroke or traumatic brain condition can be over a long period and so access to long term support after their index event helps maximise their chances of continuing to improve. For those living with a more progressive neurological condition, it guarantees specialist care is available when needed which may span many years and potentially include periods when more intense support is required.

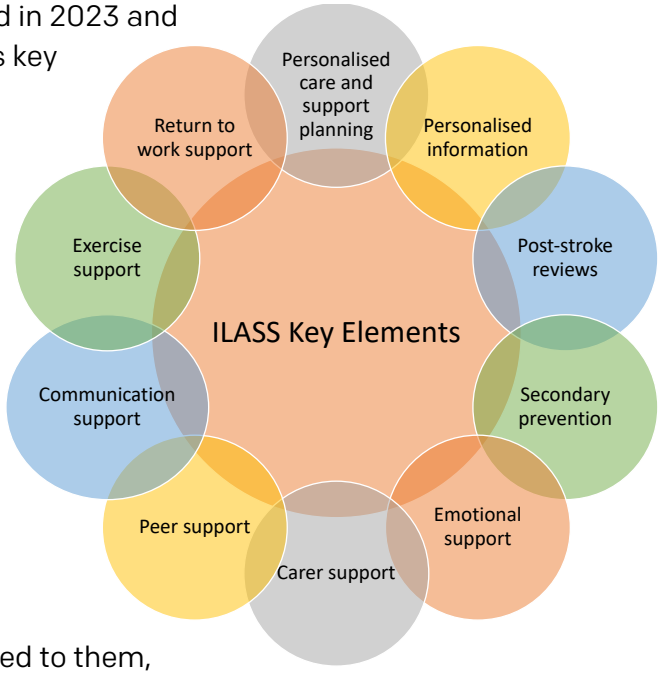
The NHS may provide some aspects of longer-term care, but other agencies such as the voluntary sector, local authorities and private/independent providers may also contribute. To ensure patients and their families and carers can access the support they need when they need it, pathways need to be both holistic and also joined up, with effective signposting and liaison between different organisations and teams. We know from patient surveys and our own Patient and Carer Groups, that we must improve our pathways of care as many people get lost in the system or are unable to navigate through the complexities of services to gain the support they need.

STROKE

The region has pioneered transforming services to integrated, needs-led models of care, with almost twice as many patients accessing specialist community stroke teams than nationally. The region also provides significantly more 6 month post stroke reviews than nationally, with over 70% having an assessment. The NHSE Integrated Community Stroke Service model is now in place in all our localities so patients can access services for up to 6 months, with re referral an option. Every borough now has a Stroke Association Recovery Service although in South Manchester and Bury these are not commissioned and will likely cease after a pilot due to end in early 2024. Three other local charities (BASIC, Speakeasy and Think Ahead) provide support to stroke survivors across Greater Manchester and continue to be fully engaged with the network.

The NHSE Integrated Life After Stroke model was launched in 2023 and is being implemented by the network across the region. Its key outcomes are:

- Enhanced quality of life
- Increased confidence, self-esteem and self-efficacy
- Increased physical and mental wellbeing
- Reduced risk of secondary stroke and other cardiovascular events
- Increased social connection, participation and involvement in purposeful activity
- Enhanced knowledge, skills and confidence to self-manage ('activation')
- Increased control, choice and independence
- More positive experience of care, which is personalised to them, their needs, preferences and individual circumstances



The model recommends key elements including: personalised care and support planning, personalised information provision, post stroke reviews, emotional support, secondary prevention, communication support, vocational rehabilitation and also peer and carer support. Several areas (personalised information provision, emotional wellbeing, vocational rehabilitation and secondary prevention) appear in other sections of this strategy.

To deliver the model across Greater Manchester, we have already:

- Developed a dashboard for each locality to map their services against key elements of the model to understand where transformation is needed
- Instigated a pilot in North Manchester to bring together stakeholders and map key pathways and services.

Learning from the pilot will be used to develop a toolkit to support roll out of the model in the other localities from Spring 2024 onwards.

NEUROREHABILITATION

There is no national model for longer term support of other neurological conditions although there are a number of national guidelines. A project has started with our Patient and Carer Group and other key stakeholders including the voluntary sector to develop a local model. We will use the stroke work as a starting framework, but further encompass additional domains to ensure relevance for progressive neurological conditions.

Our longer-term support projects are supported by our Patient and Carer Group and Clinical Effectiveness Group.

5.2 Cross cutting themes

5.2.1 Patient and Carer Involvement

Hearing the patient voice is critical in ensuring we prioritise and deliver service improvements that matter to patients, their carers and families. Following the merger, the network established a neurorehabilitation group to run alongside the existing stroke forum. In early 2024, we decided to merge the Groups together as there was significant overlap in the work of each group, as most projects involved both cohorts of patients.

The new Group will meet up to 5 times a year and have between 12-15 members, with joint Chairs from the previous Groups. In March 2023, the network appointed a new Patient and Carer Involvement Co-ordinator role via a contract hosted by the Stroke Association. This role has been central in developing our involvement activities and taking us to the next level with a step change in approach. The key aims of this are:

- Patients are Empowered to have a greater say in the way involvement happens and how their lived experience is used in service improvement
- The network is Equipped to work to better/best practice involvement methods, that involve patients and carers in the right way and at the right time
- Build Capacity so that the network can sustain, develop and evolve its patient involvement offer into the future

The Co-ordinator will lead work to ensure these objectives are achieved which will include:

- Strengthening our Patient and Carer Group (merged January 2024) including recruitment of new members, support for the chairs and ensuring inclusivity of members
- Developing other ways for patient and carer voices to be heard - especially those in "harder to reach" groups often more affected by health inequalities
- Upskilling the network team in patient and carer involvement building on work already undertaken in our spasticity project
- Developing tools/resources to embed involvement more effectively in our projects

This work is overseen by the Patient and Carer Group who in turn report to the Board.

5.2.2 Data and Performance Outcomes

We know from experience that data is critical in helping to drive service change. However, timely access to high quality information can be challenging in the NHS outside of primary care where there are well-developed electronic care records. The network has led the way nationally in using SSNAP data to drive the performance management and quality improvement in our stroke teams, and one of our Facilitators continues to support the national SSNAP team in their work.

Some of our INRUs also return UK Rehabilitation Outcomes Collaboration data which helps understand performance and patient flow. We also regularly conduct region wide audits and scope services to better understand where we need to focus our energies.

We will continue to support our inpatient stroke teams in collecting and uploading accurate SSNAP data in a timely way and help them to use their information to underpin their own service improvement projects. High quality SSNAP data also ensures we have an accurate reflection of the quality of care being provided by teams.

In 2023, we updated the key performance indicators within the service specifications for our stroke units and regularly collate and report a range of inpatient data within our own governance structures to identify key issues that may need a focus. We also support the North West thrombectomy centres in collation of regional and centre based SSNAP data.

Traditionally, there has been a paucity of data for community services, with few meaningful metrics on SSNAP. Over the last 5 years, we have worked with our community teams to develop key performance indicators and dashboards to support transformation of stroke and neurorehabilitation services. In 2022/23, we collaboratively updated both sets of metrics to simplify and better align the specialities (as most teams manage both pathways) and to ensure teams collected data that is meaningful, reflects current performance and highlights achievement alongside challenge of service provision. Analysis of the information can help to steer change and service development alongside commissioning challenge, supporting a reduction in health inequalities across the region, leading to enhanced quality of care for all.

5.2.3 Worforce Development

Supporting workforce development is crucial in ensuring professionals are equipped with the knowledge, skills and resources to allow them to provide high-quality care for patients and their carers. It also helps address ongoing local and national issues with recruitment and retention of healthcare staff, especially those with specialist neurological expertise.

The network continues to run a comprehensive training programme at an introductory level for stroke, with further opportunities for more experienced staff in both specialities, with additional eLearning packages and other resources on its website. It has other workstreams including embedding more advanced practice and support worker type roles in our services as well as developing competencies. The network hosts a range of peer support groups for different clinical professions to encourage networking and sharing of best practice amongst local staff.

A separate workforce development strategy will be finalised in early 2024 and will shape this area in the future. Our approach to addressing the workforce agenda to deliver high quality and sustainable services will include:

- Focus on workforce - supply, recruitment and retention of professionals
- Working differently - new roles and ways of working including strengthening leadership

These projects are overseen by the Workforce Development Subgroup.

5.2.4 Research and Innovation

In November 2023, a collaborative event to help shape a strategy for research was held involving GMNISDN, the Greater Manchester NIHR Clinical Research Network, the Geoffrey Jefferson Institute and the Northern Care Alliance NHS FT R&I Office. The event identified key priorities:

1. **Encourage greater participation in NIHR portfolio research**
2. **Build research cultures in stroke and neurorehabilitation clinical teams**
3. **Embed research within the GMNISDN**
4. **Support development of clinical academic careers**
5. **Influence local researchers and their priorities**
6. **Improve patient, carer and the public's awareness of research**

A task and finish group of key stakeholders has been established to develop a workplan to deliver these objectives which will report to the network's Clinical Effectiveness Group.

Appendix 1. Summary of Network Strategy

Strategy and Work Programme (2024-2026)

NATIONAL RECRUITMENT (STROKE)

Prevention	Stroke Urgent Care	Stroke Acute Care	Rehabilitation	Longer Term Support
Patient information and engagement is consistent throughout the single system via a patient passport Data and information are digital, interactive and accessible to all, across the whole system Systems are aligned across the full pathway with strong clinical and network leadership Modernised and upskilled workforce are recruited in line with system need				
Improve detection, primary and secondary prevention	Effective, rapid pre-hospital pathway Increased availability of thrombectomy and thrombolysis	Clear transfer pathways Seven day nursing and therapy services	Comprehensive neurorehabilitation via a specialist multi-disciplinary team	Comprehensive rehabilitation and personalised care with support for as long as the persons needs it

GMNISDN SYSTEM IMPROVEMENTS & DELIVERABLES

Prevention	Stroke Urgent Care	Stroke Acute Care	Rehabilitation	Longer Term Support
• Support GM ICP CVD prevention programme • Implement monitoring AF post stroke/TIA utilising technology in stroke units • Improve quality of TIA clinics including developing 7 day services • Standardise ESUS pathways • Improve Sleep Apnea diagnosis and treatment • Support referral for PFO closure • Ensure screening for diabetes in clinics • Education of professionals, especially in behavioural change	• Explore assessment tools and use of telemedicine in pre-hospital phase • Update pre-hospital pathway and use of exclusions • Review NWAS transfers and response times and work to educate staff • Monitor IVT rates and support improvement of access through changes in culture and practice at HASUs • Support implementation of CT Perfusion at HASUs • Monitor sustainability of model in light of emerging evidence	• Enhance discharge processes and engagement with social care • Improve in reach into NR inpatient services • Implement My Stroke document • Implement Patient Pass referral system for stroke • Optimise pathway for South Manchester stroke patients • Support timely stroke repatriation and mitigations • Improve stroke swallow screen and continence pathways • Ensure basic care on wards including falls prevention	• Increase intensity and frequency of therapy • Support improvement in psychology recruitment, staffing and practice • Improve pathways in: cardiac and facial rehabilitation, FND, neurogenic bladder and bowel, spasticity including splinting, NR paediatric transition, OOHCA, seating/wheelchairs, vestibular rehabilitation, visual impairment and vocational rehabilitation • Work collaboratively to develop pathways in MND, MS and other NR conditions	• Pilot life after stroke model and develop pathways in North Manchester • Roll out life after stroke pilot learning and toolkit in other GM localities • Develop model for NR longer term support and pilot in localities

Implement a step change in patient and carer involvement and continue to foster effective working relationships and collaboration with the voluntary sector

Identify and reduce health inequalities across the care pathway

Collect, analyse and report data to drive service improvements and performance

Actively engage and involve local, regional and national stakeholders to encourage collaboration and sharing of best practice

Support workforce development via training programmes for professionals, supporting retention and recruitment of staff, developing new roles and facilitating peer support groups

Develop and deliver greater engagement and participation in research/innovation and implementation of evidenced based practice

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