Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review for the Working Together Programme on Hyper Acute Stroke Services

Version 1.0
August 2015

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Yorkshire and the Humber Clinical Senate
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Version Control

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Version 0.1	8th July 2015	Based on Working Group comments	Joanne Poole
Version 0.2	15th July 2015	Revised following Working Group comments	Joanne Poole
Final Version 1.0	10th August 2015	Agreed as final version following commissioner comments and Council ratification	Joanne Poole

1. Chair's Foreword

1.1 The Senate welcomes the opportunity to review the Case for Change and Scenario Appraisal. It is clear to the Senate that it is necessary to transform Hyper Acute Stroke Unit (HASU) provision. It is noted that the work is in the early stages and there is detailed analysis and discussion to be had within stage 2 of the programme. The Senate hopes that this report assists commissioners in those future discussions to develop the detail of the changes needed to improve stroke services to patients across the Working Together footprint.

2. Summary Recommendations

2.1 The Senate agrees that there are no major changes required to the Case for Change in terms of its review of the issues facing the Hyper Acute Stroke Service as it provides a solid and comprehensive analysis. The Case for Change, however, focuses on the Hyper Acute Stroke part of the pathway and the Senate advises commissioners that the anticipated benefits of service change will not be achieved unless all aspects of the pathway are brought under the remit of the review.

2.2 The Senate recommends that the Case for Change could be strengthened with greater use of the SSNAP (Stroke Sentinel National Audit Programme) data, further reference to the financial implications of change and greater clarity on the Early Supported Discharge (ESD) models and Repatriation Policy.

2.3 The Senate has clinical concerns with Scenario 1 and 2 and commissioners are therefore recommended to focus on the development of Scenario 3. A centralised model of HASU care is the only option the Senate can support to improve patient care in line with national guidance.

2.4 The Senate strongly recommends that commissioners reach agreement on how to bring together the recommendations from the stroke reviews occurring concurrently across Yorkshire and the Humber as the boundary issues need to be addressed to provide a coherent service.

2.5 Discussions are in the early stages and the Senate recommends the need for a clear commitment from Trusts and Clinical Commissioning Groups (CCGs) to a set of principles to be achieved with regard to improving quality and patients outcomes, and therefore a commitment not to retract support as the details of the service develop, even if the local roles may change in order to deliver the service. These principles need to be agreed across the entirety of the stroke pathway.

2.6 The Senate supports the need for a comprehensive communications programme with service users in the next stage of the work programme.

3. Background

Clinical Area

3.1 The Working Together Programme for the review of stroke services is a collaboration of Health Commissioning Organisations across South Yorkshire and Bassetlaw and North Derbyshire.

3.2 Nationally there are a number of programmes that have transformed stroke services and have resulted in improvements in quality, experience and outcomes. Stroke services across the Yorkshire and the Humber have received formal review as part of the national peer review process. Commissioning organisations have received clear advice to give consideration to how services could be improved. Hyper acute stroke services in South Yorkshire and North Derbyshire were described as 'mediocre at best' following review.

3.3 Stroke services have therefore been identified as a priority for all 23 CCGs in Yorkshire and the Humber due to the challenges in meeting national standards, particularly with regard to workforce and acute assessment. Across Yorkshire and the Humber it has therefore been agreed to undertake an assurance review to ascertain the resilience of the current hyper acute stroke services provision. For South Yorkshire, Bassetlaw and North Derbyshire, the review is being undertaken as part of the Working Together Transformation Programme.

3.4 The first stage of this review has been to undertake a current state assessment with the following objectives:

i. Developing a detailed understanding of the current HASU operating model. This includes a baseline of service provision and configuration, performance (e.g. against stroke care standards), quality and outcomes, capacity and workforce, patient journeys/flows, demand and financial position

ii. To work with key stakeholders to develop high-level options that will ensure resilient services for the future and identify improvements to the current model.

Role of the Senate

3.5 The Senate was approached by the Working Together Programme to provide independent clinical advice of their Case for Change and Scenario Appraisal. The specific question the Senate was asked to address is:

"Could the Senate advise on the HASU Case for Change and whether this provides a comprehensive review of the issues facing the services. Considering the Case for Change, can the Senate review the three proposed scenarios for service change and advise on any clinical concerns relating to any individual scenario?"

3.6 The Senate advice will inform the Working Together Programme of the recommended approach for phase 2 of this work and commissioners hope that the Senate advice will assist with stakeholder buy-in for the next phase of work.

Process of Review

3.7 The Senate received the Case for Change and the Scenario Appraisal on the 3rd June 2015. The Terms of Reference for the review were agreed on the 4th June. It was agreed that the Senate would convene a Working Group comprised of clinicians from outside Yorkshire and the Humber geography. This would allow the same

Working Group to review the proposals for West Yorkshire and North Yorkshire and the Humber if requested, and therefore provide greater continuity in our understanding of how the 3 sub-regional approaches will combine to provide a coherent stroke services across the Yorkshire and the Humber geography.

3.8 Work commenced to draw together the external Working Group and the membership was largely confirmed by mid-June. The Senate Working Group held a teleconference to aid their discussions on the 1st July and held a teleconference with commissioners and clinical representatives on 10th July to clarify outstanding questions formed from those discussions. The report was drafted by the Working Group following those discussions and provided to the Council for comment at the July meeting. The final draft report was submitted to the Working Together programme on the 24th July. This was to allow discussion at the Working Together Programme Executive Board on 3rd August. The CCG have opportunity to comment on the report prior to its final ratification by the Council.

4. Evidence Base

4.1 The Senate has referred to the National Institute for Health Research Report[1] to identify the evidence base. The following information is extracted from that report.

4.2 In 2007, the Department of Health set out a national strategy for stroke[2] drawing on the available evidence. This included two systematic reviews[3] [4] that demonstrated better outcomes for patients with stroke if treated by multidisciplinary teams that exclusively manage stroke patients in a dedicated ward (stroke, acute, rehabilitation, comprehensive), compared with a mobile stroke team or within a generic disability service (mixed rehabilitation ward).

4.3 The Department of Health strategy set out their expected standards of care (Box 1), including the following:

[1] Insights from the Clinical Assurance of Service Reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed method study. National Institute for Health Research.
[2] Department of Health. National Stroke Strategy. London: Department of Health; 2007.
[3] Stroke Unit Trialists' Collaboration. Collaborative systematic review of the randomised trials of organised inpatient (stroke unit) care after stroke. BMJ 1997;314:1151.
[4] Stroke Unit Trialists' Collaboration. Organised inpatient (stroke unit) care for stroke. Cochrane Database Syst Rev 2007;4:CD000197

Box 1

Extracts from the Department of Health's National Stroke Strategy[1]

- *All stroke patients have prompt access to an acute stroke unit and spend the majority of their time at hospital in a stroke unit with high-quality stroke specialist care.*

- *Hyper-acute stroke services provide, as a minimum, 24-hour access to brain imaging, expert interpretation and the opinion of a consultant stroke specialist, and thrombolysis is given to those who can benefit.*
- *Specialist neuro-intensivist care including interventional neuroradiology/neurosurgery expertise is rapidly available.*
- *Specialist nursing is available for monitoring of patients.*
- *'Appropriately qualified clinicians are available to address respiratory, swallowing, dietary and communication issues' (p. 30).*

'The majority of stroke patients will require high-dependency care on an acute stroke unit for the first 24 hours of the illness. Most stroke progression occurs within the first 24 hours and so prompt access to an acute stroke unit is needed. Effective early management of stroke will reduce the need for intensive care beds. However, a small proportion of patients will require intensive care during the duration of their hospital admission' (p. 31).

'Commissioners to ensure that protocols are in place for the rapid transfer of people with suspected acute stroke to a hyper-acute stroke unit. This will need discussion across a network of stroke service providers to agree which centre(s) will provide these services (and their catchment areas)' (p. 27).

'People who have had strokes access high-quality rehabilitation and, with their carer, receive support from stroke-skilled services as soon as possible after they have a stroke, available in hospital, immediately after transfer from hospital and for as long as they need it' (p. 36).

4.4 The Department of Health strategy acknowledged that the existing pattern of services with limited numbers of specialist staff would make it difficult to implement the model proposed for rapid thrombolysis treatment in all hospitals. They proposed the development of hyper-acute centres in a 'hub-and-spoke model' supported by an increase in the range of clinicians able to provide specialist acute input, for example acute physicians and specialist nurses.

4.5 The hub-and-spoke model proposed by the Department of Health has since been implemented in London. The new model has been formally evaluated[5]. The conclusion of this before-and-after study was that London's centralised model for acute stroke care had reduced mortality for a reduced cost per patient, predominantly as a result of reduced hospital length of stay. However, the authors recognise the limitations of a before-and-after study versus a randomised control trial and noted that further research would be required to assess whether or not the London model is viable in other geographical and clinical settings.

[5] Hunter RM, Davie C, Rudd A. Impact on clinical and cost outcomes of a centralized approach to acute stroke care in London: a comparative effectiveness before and after model. PLOS ONE 2013;8:e70420. http://dx.doi.org/10.1371/journal.pone.0070420

4.6 A recent Cochrane review[6] of stroke care concluded the following:

People with acute stroke are more likely to survive, return home and regain independence if they receive organised inpatient (stroke unit) care. This is typically provided by a co-ordinated multidisciplinary team operating within a discrete stroke ward that can offer a substantial period of rehabilitation if required . . .

4.7 Since the original publication of this review, stroke services in many developed countries have undergone substantial reorganisation in line with national strategies and clinical practice guidelines to enable improvements in access to stroke unit care. More recently, stroke services in many countries have been further reorganised to reflect a two-tiered (or hub-and-spoke) model of care in which a central 'comprehensive stroke centre' (or 'hyper-acute stroke unit') is equipped with facilities for acute intravenous or intra-arterial treatments, intensive monitoring, advanced imaging and neurosurgery.

4.8 These then serve a number of 'primary stroke centres' or stroke units within a hospital network or geographical location. This approach has never been formally tested in randomised controlled trials.

4.9 A key issue in stroke care is the time to treatment. The current evidence points to benefits for patients being treated with thrombolysis within a 4.5 hour window but that a more favourable outcome may be achieved if delivered within 90 minutes of stroke onset[7] [8]

4.10 Cochrane has also looked at the evidence for early supported discharge, which offers people rehabilitation in their own homes. The review[9] concluded that early supported discharge services could reduce long-term dependency as well as reduce length of hospital stay.

[6] Stroke Unit Trialists' Collaboration. Organised inpatient (stroke unit) care for stroke. Cochrane Database Syst Rev 2013;9:CD000197.

[7] Jonathan Emberson*, Kennedy R Lees*, Patrick Lyden*, Lisa Blackwell, Gregory Albers, Erich Bluhmki, Thomas Brott, Geoff Cohen, Stephen Davis,Geoff rey Donnan, James Grotta, George Howard, Markku Kaste, Masatoshi Koga, Ruediger von Kummer, Maarten Lansberg, Richard I Lindley,Gordon Murray, Jean Marc Olivot, Mark Parsons, Barbara Tilley, Danilo Toni, Kazunori Toyoda, Nils Wahlgren, Joanna Wardlaw, William Whiteley,Gregory J del Zoppo, Colin Baigent†, Peter Sandercock†, Werner Hacke†; for the Stroke Thrombolysis Trialists' Collaborative Group . Eff ect of treatment delay, age, and stroke severity on the eff ects of intravenous thrombolysis with alteplase for acute ischaemic stroke: a meta-analysis of individual patient data from randomised trials Lancet 2014; 384: 1929–35. Published Online August 6, 2014 http://dx.doi.org/10.1016/S0140-6736(14)60584-5

[8] Royal College of Physicians, National Clinical Guidelines for Stroke 4th Edition 2012

[9] Fearon P, Langhorne P, Early Supported Discharge Trialists. Services for reducing duration of hospital care for acute stroke patients. Cochrane Database Syst Rev 2012;9:CD000443.

5. Recommendations

5.1 The Senate considered the following question:

Does the HASU Case for Change provide a comprehensive review of the issues facing the service?

5.2 The Senate agreed that there are no major changes required to the Case for Change in terms of its review of the issues facing the Hyper Acute Stroke Service as it provides a solid and comprehensive analysis.

5.3 The case for change, however, focuses on the hyper acute stroke part of the pathway and the Senate has concerns at how this part of the pathway is looked at in isolation. The Senate advises commissioners that they may lose the opportunity to develop the stroke units and the community services unless the service is looked at in its entirety. The Senate also advises that the anticipated benefits of service change will not be achieved unless all aspects of the pathway are brought under the remit of the review. HASU only works well if beds are available through the pathway and this needs active bed management and the use of Early Supported Discharge models. This issue was discussed with commissioners and the Senate understands that the next stage of the review will broaden the scope beyond hyper acute stroke. The Senate suggests that this is made clearer within the Case for Change. Section 1.2 in the Case for Change makes reference to the need to consider the end to end pathway, but this is not referred to in the remainder of the report.

5.4 The financial situation is not referred to in the Case for Change. There is reference in Section 3.3 of the Case for Change of the need to develop a detailed understanding of the HASU operating model including the financial position, but there is no further reference within the Case for Change to the financial situation. Changes to one part of the pathway may impact on the financial viability of other parts of the service and the Senate recommends that there needs to be greater referral to the financial position and the risks in the Case for Change. Following discussion with Commissioners, the Senate understanding is that the financial position will come in the next stage of analysis.

5.5 There is some reference within the Case for Change on the need to provide a sustainable stroke service for the future, but the Senate recommends that the issue of sustainability is given more focus within the Case for Change.

5.6 The Case for Change does use the Sentinel Stroke National Audit Programme (SSNAP) data to demonstrate the variation in performance against standards. The Senate recommends greater use of this well respected national dataset to allow further comparison between the providers and to name the providers within the report, as this is often not clear. It is noted that there is reference to collating additional data outside of SSNAP but the Senate recommends that the focus should remain on the providers collecting all fields within the SSNAP dataset.

5.7 The Senate recommends that the Repatriation Policy could be made clearer in the case for change to set out that from HASU patients will flow back to their local stroke units for ongoing care.

5.8 There are varied models of Early Supported Discharge (ESD) and it may be helpful to provide more detail on the models referred to in the report. It is not clear how many staff and what skill mix is employed with the ESD services as well as community stroke rehabilitation teams. It is unclear if there are identified reasons for Sheffield's high proportion of patients being treated by ESD. Commissioners may want to consider including the evidence for the effectiveness of the ESD teams e.g. SSNAP data and the effect on acute hospital length of stay. The Senate also notes that there is no mention of end of life care within the Case for Change.

Question -

"Can the Senate review the 3 proposed scenarios for service change and advise on any clinical concerns relating to any individual scenario?"

5.9 The Senate is in agreement that Scenarios 1 and 2 raise many clinical concerns and commissioners are therefore recommended to focus on the development of Scenario 3.

Scenario 1 "Do Nothing"

5.10 The Senate feels that the resources are spread too thinly and for the reasons outlined in the Case for Change, this would be an unacceptable option and would not provide a quality service to patients.

Scenario 2 "Continue to deliver the Hyper Acute Service from 5 provider sites across the Working Together footprint, with a focus on improving performance against standards"

5.11 The Senate agrees that this option has its advantages in terms of providing local care and less burden on the ambulance service, but to make this option work, medical, nursing and therapy staffing would need to be improved across all 5 units and within the current climate this is not feasible. Provision of hyper acute care at all five hospital sites would be contrary to the National Stroke Strategy. The current national clinical view is that Hyper Acute Stroke Units need to see between 650 and 1500 confirmed strokes a year. The NHS 5 Year Forward View (Dec 2014) emphasises this approach stating that *"for specialised care where quality and patient volumes are strongly related, such as trauma, stroke and some surgery, the NHS will continue to move towards consolidated centres of excellence".* There is not sufficient flow of patients into 3 of the units (where admission numbers are around 400 a year over 5 years) for this to be a clinically acceptable option in terms of maintaining staff expertise. The Senate has concerns that this scenario would drift into becoming Scenario 1 as the changes needed are not possible to implement and therefore progress would halt.

Scenario 3 "Transform HASU provision in the wider context of Yorkshire and Humber stroke services"

5.12 A centralised model of HASU care is the only option the Senate can support to improve patient care in line with national guidance. The Senate understands that there are baseline reviews of stroke services happening across the 3 sub regions of Yorkshire and the Humber at differing pace. The Senate sought assurance that the impact of the other service reconfigurations has been taken into account by the Working Together Programme. We are aware that commissioners are considering how to bring these 3 strands of stroke work together into a coherent review of Yorkshire and the Humber stroke services. The Senate strongly recommends that commissioners agree the way forward on this as a priority. The boundary issues between the 3 sub regions, and with the East Midlands, are such that the need to take a Yorkshire and Humber wide view is essential before local plans become too far developed. The Senate was also assured that other service changes, urgent care and paediatric surgery for example, are also being considered in synergy with the stroke proposals.

6. General Comments

6.1 The National Stroke Strategy was published in 2007 and there have been opportunities since that date to change service delivery across Yorkshire and the Humber and these opportunities have not been taken. SSNAP data continues to reflect issues across Yorkshire and the Humber in the quality of the service. In discussion with commissioners, the Senate raised the question of commissioner and provider commitment to the Working Together Programme. If option 3 is progressed, there needs to be assurance that commissioners maintain commitment to the service change if it requires a change in status of their local Trust. Our understanding is that commissioners are committed to Stage 2 of the work but have no commitment beyond that to service change. The Senate recommends the need for a clear commitment from Trusts and CCGs to a set of principles to be achieved with regard to improving quality and patient outcomes, and therefore a commitment not to retract support, even if the local roles may change in order to deliver the service.

6.2 As discussed in paragraph 5.3, the Working Together scope needs to include the full patient pathway. Local re-organisation may result in patient repatriation from HASUs to Early Supported Discharge Services rather than a local stroke unit, and it may be that some local stroke units are also subject to review. The Senate recommends seeking commissioner commitment to considering the end to end pathway in Stage 2 of the work. Commissioners will also need to be prepared to look at a range of solutions to ensure that local stroke units have a sustainable work force under a centralised HASU model.

6.3 Once the preferred option has been agreed and the proposed model of care finalised, the Senate recommends that the Working Together Programme remains focused on the implementation to ensure that the reconfiguration is achieved. Previous history has shown that agreement in principle has not followed through to achievement of change.

6.4 The Senate understands that Stage 2 of the process will include full engagement with service users. The Senate supports the need for a comprehensive communications programme with service users including different approaches to assess patient feedback like the use of interviews and forums for example.

6.5 Patients will want to know that they can access a service that meets national standards in terms of accurate diagnosis within the recommended national time frame and that they will have access to the recommended medical, nursing and therapy staff. There can be significant benefits in informing patients about how the centralised model forms a relatively small part of the pathway and that the longer term care is delivered in the local stroke unit following repatriation.

7. Summary and Conclusions

7.1 The Yorkshire and the Humber Clinical Senate concludes that:

- The Working Together programme has produced a robust Case for Change reviewing the issues facing the Hyper Acute Stroke service. The Case for Change could be strengthened with greater use of the SSNAP data, further reference to the financial implications of change and greater clarity on the ESD models and Repatriation Policy
- Commissioners need to widen the scope of the review to include the end to end stroke pathway as the anticipated benefits of service change will not be achieved unless all aspects of the stroke pathway are considered
- Scenario 3 - The transformation of services into a centralised model of HASU care - is the only scenario which the Senate can support to improve patient care in line with national guidance.
- Commissioners need to reach agreement on how to bring together the recommendations from the stroke reviews occurring concurrently across Yorkshire and the Humber as the boundary issues need to be addressed to provide a coherent service.
- It would be beneficial for commissioners to provide a clear commitment to a set of principles to be achieved with regard to improving quality and patient outcomes to help maintain support and commitment as the details of the service changes are developed.
- The Working Together programme needs to design a comprehensive communications package with service users in their next stage of work.

7.2 The Yorkshire and the Humber Clinical Senate hopes that this report provides assistance to the Working Together programme in obtaining commitment from stakeholders to the need for service change as discussions develop in Stage 2 of the programme. Moving agreement in principle through to achievement of change will be challenging but the Senate fully endorses the need to transform Hyper Acute stroke services to ensure stroke patients receive high quality care in line with national guidance.

APPENDICES

Appendix 1

LIST OF SENATE WORKING GROUP MEMBERS

The Working Group developed for this review consists of:

Senate Council Members

Professor Chris Welsh, Senate Chair

Senate Assembly Members

Stephen Elsmere, Citizen Representative

Co-opted Members

Claire Fullbrook-Scanlon, Matron for Stroke & Neurology/Lead Stroke Nurse & Senior Lecturer in Stroke, Royal United Hospitals NHS FT

Dawn Good, Head of Stroke Service, Nottingham University Hospitals NHS Trust

Julia MacLeod, Regional Director, Yorkshire & East Midlands Stroke Association

Mark McGlinchey, Clinical Specialist Physiotherapist, Stroke and Neurorehabilitation, St Thomas' Hospital

Peter Moore, Regional Director, North East Stroke Association

Dr Indira Natarajan, Clinical Director, West Midlands Strategic Clinical Networks & Stroke Specialist, University Hospital of the North Midlands

Vats Patel, Pharmacist, member of Greater Manchester, Lancashire & South Cumbria Clinical Senate Council and member of the Manchester Local Pharmaceutical Committee

Professor Helen Rodgers, Clinical Professor of Stroke Care, Newcastle University

Professor Thompson G Robinson, Professor in Stroke Medicine, University Hospitals of Leicester & Clinical Director for East Midlands Cardiovascular Strategic Clinical Network

Professor Anthony Rudd, Professor in Stroke Medicine, Kings College London & National Clinical Director for Stroke, NHS England

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Working Group Members Declaration of Interests

None declared

Senate Council Members Declaration of Interests

None declared

Appendix 3

TERMS OF REFERENCE

Template to request advice from the Yorkshire and the Humber Clinical Senate

Name of the lead (sponsoring) body requesting advice: Working Together Programme

Type of organisation: Collaboration of Health Commissioning Organisations 8 CCGs and NHSE across South Yorkshire and Bassetlaw, North Derbyshire and Wakefield.

Name of main contact: Will Cleary-Gray

Designation: Working Together Director

Email: will.cleary-gray@nhs.net **Tel:** 07540 080994 **Date of request: 04/06/15**

Please note other organisations requesting this advice (if more than the lead body noted above):

Is the Senate being consulted for advice or as part of the formal assurance process?

No

Please state as clearly as possible what advice you are requesting from the Clinical Senate and what documentation you propose sharing with the Senate.

Could the Senate advise on the HASU case for change and whether this provides a comprehensive review of the issues facing the services. Considering the case for change can the Senate review the three proposed scenarios for service change and advise on any clinical concerns relating to any individual scenario

To share HASU case for change and HASU high level scenario appraisal.

Please state your rationale for requesting the advice? (What is the issue, what is its scope, what will it address, how important is it, what is the breadth of interest in it?).

Stroke has been identified as a priority for all 23 CCGs in Yorkshire and Humber (Y&H), services are challenged with meeting standards, due in part to workforce and acute assessment issues.

Nationally there are a number of programmes that have transformed Stroke services and have seen improvements in quality, experience and outcomes which follows a national direction of travel. Stroke Services across the Yorkshire and the Humber have received formal review as part of the national peer review process. Commissioning organisations have received clear advice to give consideration to how services could be improved. Our HASU services locally were described as 'Mediocre at best' following review.

What is the purpose of the advice? (How will the advice be used and by whom, how may it impact on individuals, NHS/other bodies etc.?).

The advise will allow the Working Together programme to be assured that there is Clinical Senate support for the recommended approach for phase 2 of this work, which will assist with stakeholder buy-in for the next phase of work.

Please provide a brief explanation of the current position in respect of this issue(s) (include background, key people already involved).

The three sub regions of Yorkshire and Humber have identified the need to undertake an assurance review to ascertain resilience of the current HASU provision. The review has been mandated by the Yorkshire and Humber CCG and their respective Chief Officers and is being delivered through existing sub-regional governing and accounting arrangements and collaborative programmes.

The base lining analysis included in the case for change has highlighted variations in the quality of HASU services across providers in the Working Together programme. There is also a lack of consistency in quality and performance across the HASU pathway when looking at individual provider datasets. All providers evidence areas for improvement.

Graham Venables has provided clinical leadership, SCN have supported the work to date and key individuals can be found in the case for change. The approach includes 1-1 engagement and validation with providers of HASU and workshops to achieve consensus on the issues and challenges.

The first phase of this sub-regional work is concluding and is proposing a Yorkshire and Humber approach and Transformation of HASU.

When is the advice required by? Please note any critical dates.

To be available for the 24th July – to allow discussion at Working Together Programme Executive Board on 3rd Aug.

Has any advice already been given about this issue? If so please state the advice received, from whom, what happened as a consequence and why further advice is being sought?

NA

Is the issue on which you are seeking advice subject to any other advisory or scrutiny processes? If yes please outline what this involves and where this request for advice from the Clinical Senate fits into that process (*state N/A if not applicable*)

NA

Please note any other information that you feel would be helpful to the Clinical Senate in considering this request.

Please send the completed template to: joanne.poole1@nhs.net. *For enquiries contact Joanne Poole, Yorkshire and the Humber Clinical Senate Manager at the above email or 01138253397 or 07900715369*

Version 2.0 April 2014

Appendix 4

BACKGROUND INFORMATION

The evidence received for this review is listed below:

- 2s – Draft HASU Case for Change May 2015
- Paper C – Draft HASU High Level Scenario Appraisal May 2015

The Senate supplemented this evidence with a 5 year summary of stroke admissions obtained from SSNAP data