NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

Our Ref:
Your Ref:

NHS England – North (Yorkshire and the Humber)
Oak House
Moorhead Way
Bramley
Rotherham
S66 1YY

21st April 2017

To:
Linda Driver
Head of Service Transformation and Development, NHS Wakefield CCG
and Healthy Futures PMO Project Lead

Dear Linda

Thank you for the opportunity for the Yorkshire and the Humber Clinical Senate to review the West Yorkshire and Harrogate Hyper Acute Stroke and Acute Stroke Strategic Case for Change V6.0. The Senate reconvened members of the Expert Working Group who have previously reviewed the Working Together HASU Case for Change, the Yorkshire and the Humber HASU blueprint and the Working Together HASU Options Appraisal. Their details are listed in the Terms of Reference contained at Appendix A. The Senate Council also had opportunity to comment on the Case for Change at their Council meeting on 15th March and any conflicts of interest of the Council members and their management of them is listed in Appendix B.

The question you asked us to consider is:

In view of the latest available clinical guidelines referenced in our Strategic Case for Change and the work undertaken to date, does the Clinical Senate support our recommendation that we now need to undertake further work to develop our proposals to determine the optimal service delivery models for the population of West Yorkshire and Harrogate?

If so, what key areas would the Clinical Senate recommend we focus on in order to strengthen our discussions with key stakeholders to inform the development of our proposals?

We agreed that due to our previous work on HASU across Yorkshire and the Humber, we would feed back our advice via a Chair's letter rather than a full report.

The Working Group developed its advice through a review of the documentation and discussion via email and teleconference. I also had a very helpful conversation with you and your colleagues on 6th April to discuss our advice prior to finalising this letter.

I hope that this letter provides a balanced clinical overview of the Case for Change and assists commissioners in moving forward to achieve the changes required.

Our Advice and Recommendations

In view of the latest available clinical guidelines referenced in our Strategic Case for Change and the work undertaken to date, does the Clinical Senate support our recommendation that we now need to undertake further work to develop our proposals to determine the optimal service delivery models for the population of West Yorkshire and Harrogate.

1. With reference to your first question, we do support your recommendation to undertake further work to develop your proposals to determine the optimal service delivery models for the population of West Yorkshire and Harrogate. Broadly, we agree that the Case for Change is a well written document that has looked at the issues and there is nothing in the paper that we disagree with.

2. The Senate is in full agreement that there is a clear clinical evidence base to support the reduction in the number of HASUs and this evidence base is well documented both in your Case for Change and in our August 2015 report to the Working Together project. Given the very clear evidence base which demonstrates that networked organised services deliver better outcomes, and the need to improve outcomes in this geography, we advise that there is scope to improve the tone and language of the Case for Change. This will better reflect your commitment to that centralised model, a commitment that you clearly held in our conversation with you.

3. Senate members also commented that they did not feel able to get a sense of the vision for this service from the paper or see a route as to how commissioners and providers will make a decision on the service model. In our discussion with you, you confirmed that you are committed to designing a service to improve outcomes which will result in the appropriate number of HASU's needed to be fit for the future and that you have a clear programme from May to September of stakeholder events and clinical meetings to reach agreement on your preferred option. The Senate welcomes this timescale and would urge commissioners to ensure that this timescale is adhered to as this geography needs to draw some conclusions on the future stroke services at pace. There may be some difficult clinical discussions ahead and commissioners need to ensure that the discussion maintains its focus on the clinical evidence base. Our Senate Chair and members of our Expert Working Group would be very willing to attend meetings to assist with this discussion as agreed in our telephone call.

If so, what key areas would the Clinical Senate recommend we focus on in order to strengthen our discussions with key stakeholders to inform the development of our proposals?

4. With regard to the second part of the question, we would recommend that commissioners do not lose the focus on the whole stroke pathway. The concerns expressed by the members of our Expert Working Group were that there may be a focus on the hyper acute and acute elements of the stroke pathway and a disproportionate focus on newer technologies, e.g. mechanical thrombectomy over rehabilitation (stroke unit and ESD) and longer-term support. Within the Case for Change there is detailed reference to stroke incidence, workforce planning, attainment of key indicators and SSNAP results to inform future plans but there is no data about long term outcomes (e.g. disability rates, how many stroke patients return to work, incidence of cognitive problems/depression). Ongoing support and therapy is really important to the patient and commissioners need to be clear how the patient is going to be supported across the whole pathway including end of life and palliative care.

5. Our panel also commented that there was limited reference to stroke prevention in the pathway and commissioners need clear agreement of how they are going to identify and manage those at risk patients. We understand that commissioners are cited on the management of patients with atrial fibrillation (AF) in primary care as referred to in the Next Steps on the 5Year Forward View[1] which references the importance of providing anticoagulants to patients with AF which can reduce stroke risk by two thirds. You will be aware of the need to consider that a large proportion of patients with stroke also have undiagnosed AF.

6. In our discussion you provided very helpful reassurance that you recognise the importance of the whole system working together through to discharge and longer term rehabilitation. You were clear that other parts of the pathway are an equally important part of the business model and that you are committed to ensuring this work is also complete, recognising that the success of the acute model is dependent upon all parts of the system working effectively.

7. We recommend that further focus is given to the workforce and the skill mix required at each unit. With our knowledge of the service, Council members questioned the accuracy of the workforce tables in page 32 of the document, particularly figure 7 which details the consultant and junior doctor numbers, which appear to arise from a historical audit. Our Council member representing Health Education England, working across Yorkshire and the Humber, would be very happy to discuss this further with you and our Senate Manager can provide his contact details to you.

8. In our discussion, we shared your concerns about the impact of the reconfiguration on the workforce and you recognise the challenges ahead. You agreed the need to ensure that your plans robustly model the likely impact on the workforce, as experience in other reconfigurations has shown that staff are less willing to transfer across a reconfigured service than is often assumed.

9. In your future discussions, we recommend that commissioners ensure that units who put themselves forward for HASUs have the commitment to the workload 24/7 and 365 days a year and are able to manage the additional workload due to stroke mimics. In our discussion, you confirmed that the impact of stroke mimics was very much part of your thinking and that your data showed that mimic numbers were currently just below 30%. We advised that the reconfiguration will bring a greater focus on the stroke service which is likely to increase the number of stroke mimics by up to a further 20% and that we would advise your modelling to take account of that.

10. From reading the Case for Change, we also questioned your communications with staff, the Ambulance Service and patients and the public and our conversation was very helpful in detailing the work that you have done in these areas. We understand that there has been extensive public engagement and a range of engagement events for hospital staff and community staff, the voluntary sector and social care. The engagement has also extended to politicians and OSCs and local and regional press associations. You also confirmed that the Ambulance Service is a key member of your task and finish groups and clinical forum. You also have good working relationships with colleagues from the South Yorkshire and Bassetlaw stroke programme to ensure those cross boundary issues are addressed. There are also cross boundary issues to the North across East Lancashire which will also need to

[1] Next Steps on the 5 year Forward View March 2017 NHS England » NHS Five Year Forward View

be considered. Overall, we commend your approach and suggest that this extensive engagement is reflected in the document.

11. Members of the Stroke Association are part of our Working Group and offered to provide you with Patient and Public Information which they have produced as part of service changes in other parts of the country which can help to settle the public on their concerns and put the impact into context. As agreed in our conversation, the Senate Manager will provide you with the members' contact details.

12. In conclusion, we very much support your Case for Change and support your recommendation to develop proposals for a more centralised model for the delivery of Hyper Acute Stroke services. We welcome your proposed timescales to reach a decision on this and urge you to adhere to this timescale. In the next stages we recommend you maintain your focus on the whole stroke pathway and strengthen your workforce modelling.

I hope that this advice is of assistance to commissioners. We would very much welcome the opportunity to continue to work with you as the options on the service model develop, so please do get in touch if we can be of further assistance.

Yours sincerely

Chris Welsh
Senate Chair
Yorkshire and the Humber Clinical Senate

Appendix - A

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CLINICAL REVIEW

TERMS OF REFERENCE

TITLE:

Review of West Yorkshire Hyper Acute Stroke services Strategic Case for Change

Sponsoring Organisation: Healthy Futures

Terms of reference agreed by: Linda Driver, Head of Service Transformation and Development NHS Wakefield CCG and Healthy Futures PMO Project Lead and Joanne Poole, Senate Manager

Date: February 2017

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Professor Chris Welsh

Citizen Representative: Peter Allen

Clinical Senate Review Team 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

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

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

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:
In view of the latest available clinical guidelines referenced in our Strategic Case for Change and the work undertaken to date does the Clinical Senate support our recommendation that we now need to undertake further work to develop our proposals to determine the optimal service delivery models for the population of West Yorkshire and Harrogate.

If so, what key areas would the Clinical Senate recommend we focus on in order to strengthen our discussions with key stakeholders to inform the development of our proposals?

***Objectives of the clinical review (from the information provided by the commissioning* sponsor):**
To gain a view from the Clinical Senate that they support the development of proposals to optimise stroke services and pathways so they are resilient and fit for the future in order to maximise opportunities to further improve quality and outcomes for the population of West Yorkshire and Harrogate.

To ensure the activities as outlined in our Strategic Case for Change next steps, reflects the Clinical Senates expectations in relation to the development of our proposals.

Scope of the review:

- To consider the Strategic Case for Change recommendation and provide a clinical view to inform our next steps
- To support ongoing dialogue between Clinical Senate members and key stakeholders in West Yorkshire and Harrogate in relation to the development of our proposals
- To review the outcome of our proposals and provide a clinical view on them to inform our next steps
- Subject to the outcome of the above provide a formal clinical view on proposals as part of the NHS England Stage 2 Assurance process

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: Not applicable

Agree the Terms of Reference: end February 2017

Receive the evidence and distribute to review team: Friday 10th March 2017

Teleconferences: Working Group Teleconference 21st March. Teleconference with commissioners 6th April

Draft report submitted to commissioners: 18th April

Commissioner Comments Received: 2nd May

Senate Council ratification; 18th May meeting

Final report agreed: end May 2017

Publication of the report on the website: to be agreed with commissioners but if possible not later than by the 21st July Council meeting.

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

Strategic Case for Change Version 6.0, 1st March 2017

The review team will review the evidence within this document and supplement their understanding with a clinical discussion.

6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days. The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

Clinical senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical senate council will:

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix - B

Conflicts of Interest

Name	Title	Organisation	Date of Declaration	Reason for Declaration	Date of Response	Proposed way of Managing Conflict
Dr Steve Ollerton	CCG Chair	Greater Huddersfield CCG	At Senate Council meeting in March 2017	Chair of the CCG that will be seeking advice from the Senate	At the March Senate Council meeting	To manage this conflict of interest we will ensure that Steve does not take part in any Council or sub group discussions as they relate to this matter