West Midlands Clinical Senate
Walsall Stroke Services Review

Stage 2 Clinical Assurance Review
Panel Report
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1. **Clinical Senate Chair Foreword**

Stroke units have a strong evidence base supporting better outcomes for patients. This is due to many inter-related factors from better direct clinical care and rehabilitation to IV thrombolysis - and most recently mechanical thrombectomy for selected patients. They also have a major function in diagnosing and treating stroke mimics in collaboration with other specialties such as general medicine and neurology. In addition, Stroke units have a role in promoting primary and secondary preventive strategies and that includes running responsive Transient Ischaemic Attacks (TIA) clinics with access to carotid imaging and surgery. The national trend is toward a reduction in the number of stroke units as higher numbers of patient’s per unit improves outcomes in this very successfully audited area through Sentinel Stroke National Audit Programme (SSNAP). This also makes recruitment of staff to onerous rotas easier – although a national shortage of stroke physicians and neurologists makes this a continuing problem that is likely to persist. The recommendation to combine two stroke units on to one site for Walsall Stoke Services acute care is therefore in line with national policy and trends.

A full and multi-disciplinary panel sat for 3 days one of which was spent on a very helpful site visit. This helped us understand the acute end of the pathway both for stroke and the mimics in more detail and subject to some suggestions should be a considerable improvement. Significant debate occurred particularly over the repatriation and rehabilitation pathway resulting in very significant movement from the Clinical Commissioning Group (CCG) and Trusts during the course of the review. All sides believe this modified plan will be in the patient’s interest and should improve the quality of care; though not a guarantee as this is subject to recruitment of key posts across the whole pathway, including stroke physicians, nurses or therapists.

2. **Advice Request**

The West Midlands Clinical Senate was asked by Walsall CCG to provide independent clinical advice on the reconfiguration of Walsall Stroke Services.

The request was made in July 2017 and clarification of the scope of the request was developed during September and October 2017.

The West Midlands Clinical Senate was asked to review the documentation and evidence to consider, assess and confirm the clinical quality, safety and sustainability of the reconfiguration of Walsall Stroke Services.

The scope of the review did not include consideration of any financial implications, either negative or positive.

The evidence and information provided for the clinical review panel was provided by Walsall CCG and Royal Wolverhampton NHS Trust.

(NB. The **background** for the Walsall Stroke Service reconfiguration programme is detailed in **Section 5** of the report).
3. Summary of Key Findings and Recommendations

The summary of key findings and recommendations are presented as themes below.

**Case for Change**

**KEY FINDING**

Wolverhampton and Walsall combined acute stroke services should see circa 1000 confirmed stroke patients per year, and as such the thrombolysis rate for the Wolverhampton and Walsall population will increase.

Success of the centralisation will be dependent upon ensuring the provision of a consistent and equitable stroke service across the whole pathway for all users regardless of whether they live in Wolverhampton, Staffordshire or Walsall.

**RECOMMENDATION 1**

Walsall CCG should now develop a robust business case for an equitable stroke service provision across the whole pathway for Walsall stroke patients.

**Governance**

**KEY FINDING**

The panel has received evidence from Royal Wolverhampton Trust (RWT) of executive agreement and approval for the case for taking hyper-acute and acute stroke services from Walsall Manor Hospital (Managed by Walsall Healthcare NHS Trust). RWT suggests taking on Walsall acute stroke services will strengthen stroke services for the Wolverhampton and Staffordshire population as well. A steering group has been established for the Transfer of Stroke Services Project.

**RECOMMENDATION 2**

A joint mobilisation and implementation plan is developed between Walsall CCG Walsall Healthcare NHS Trust (WHT) and RWT.

**Engagement Clinical and Patient and Public**

**RECOMMENDATION 3**

Walsall CCG should now demonstrate how the outcome of the Healthwatch consultation (2017) has informed or contributed to the reconfiguration of Walsall stroke service provision.
RECOMMENDATION 4

Walsall CCG to encourage patient participation on the CCG’s reconfiguration of stroke services working groups to provide a stronger patient voice.

KEY FINDING

Through the site visits the panel was able to form an opinion that the RWT demonstrated full staff engagement with the centralising of stroke services in Wolverhampton for Walsall stroke patients.

KEY FINDING

The staff on Ward 1 at Walsall Manor Hospital was informed about the plans for the ward to remain open shortly before the panel visit.

RECOMMENDATION 5

An open and honest discussion is required with Walsall Stoke Services staff where change management and organisational change principles are applied in a fair, equitable and transparent way; providing clear communications and engagement activities, ensuring the continuation of skills, experience and knowledge of staff.

Workforce

KEY FINDING

The panel was of the view that there are a series of workforce assumptions within the Walsall Stroke Services reconfiguration programme. These were with regard to job roles, recruitment, retention, training, supervision, sustainability and succession planning for medical consultants, junior doctors, nurses, and allied health professionals (AHPs) which need to be further clarified and supported with Health Education England (HEE) West Midlands.

RECOMMENDATION 6

A comprehensive workforce plan is developed which reflects national guidance to achieve a service that is delivering 7 day services, and meeting the needs of SSNAP domains.

KEY FINDING

RWH plan to recruit extra consultants to address the increased workload in the HASU and ASU. The panel supports the need for further recruitment however; the current situation nationally suggests a shortage of applicants for these posts. RWT are optimistic about being able to fill the posts.
RECOMMENDATION 7

RWT and Walsall CCG to develop workforce mitigation plans should the recruitment of extra consultant posts not be realised or not filled to full complement.

KEY FINDING

The panel was of the view that there were some concerns in relation to out of hours reporting of imaging in the Emergency Department at New Cross Hospital, in Wolverhampton. The time between the scan being completed and the formal radiology report seems to be extensive putting patients and trainees at risk.

RECOMMENDATION 8

The Royal Wolverhampton NHS Trust and Walsall CCG to revisit out of hours reporting of imaging in the Emergency Department at New Cross Hospital, Wolverhampton as this is a potential clinical risk. RWT and Walsall CCG to ensure current guidance ‘Implementing the National StrokE Strategy – imaging guidelines (2008)’ are being met.

RECOMMENDATION 9

Further resources are needed to ensure adequate staffing to provide the level of rehabilitation care required to support repatriation of Walsall patients back to Ward 1 at Walsall Manor Hospital, to enable the unit to cope with demand. Mitigation plans to be put in place should extra staffing posts not be realised or not filled to full complement.

RECOMMENDATION 10

Therapist workforce requirements need to be calculated using guidance from Royal College of Physicians (RCP) stroke guidelines for ASU bed numbers per therapist and percentage of patients requiring Early Supportive Discharge (ESD), to ensure that the teams are adequately staffed to cope with the potential demand.

RECOMMENDATION 11

A workforce gap analysis of ESD and Stroke Rehabilitation should be performed to inform workforce planning to deliver these services across Walsall that can be used to inform business case development for an equitable and sustainable ESD and Stroke Rehabilitation service. The gap analysis should also take into consideration social services and local authority personnel for an integrated service.
Pathways

RECOMMENDATION 12

Provide a clear description of the full stroke and TIA pathways, from primary and secondary prevention, through to pre-hospital, hyper-acute and acute care, rehabilitation and recovery in the community.

RECOMMENDATION 13

Out of hours thrombolysis at New Cross Hospital in Wolverhampton needs to be reviewed and changed to ensure it is stroke consultant rather than Emergency Department (ED) led in terms of thrombolysis decision making

RECOMMENDATION 14

There is a clear agreement and pathway for Computed Tomography Angiography (CTA) 9am-5pm for thrombectomy patients and full 24/7 when the service is commissioned

RECOMMENDATION 15

All staff ratios – nursing, medical and therapist are at least at the standards set nationally for what is acceptable for stroke rehab and not adjusted allowing for potential workforce shortfall/recruitment

Early Supportive Discharge and Rehabilitation

RECOMMENDATION 16

Rehabilitation and ESD should be available for Wolverhampton, Staffordshire and Walsall patients alike, and access should not be compromised by their usual place of residence.

RECOMMENDATION 17

Rehabilitation and ESD planning should be integrated with that of the acute stroke unit inpatient rehabilitation and other community services, as a whole pathway approach to stroke patient care. This is essential to achieve best outcomes, best value and coherent planning.

KEY FINDING

Walsall Healthcare NHS Trust has an established and comprehensive ESD service. There is currently no community bed facility to support ESD and no community bed stock. Current arrangements are delivered through excess bed days being incurred at Walsall Manor Hospital.
RECOMMENDATION 18

The panel was of the view that a comprehensive inpatient community rehabilitation facility can be established through Phase 1 and should negotiate and contract directly with WHT to provide an inpatient community rehabilitation service.

RECOMMENDATION 19

Commissioners and providers should refer to ‘Rehabilitation Commissioning Guidelines’ (NHS England 16-17) to guide the quality and specification of the service, which should be built in to the financial modelling.

RECOMMENDATION 20

Walsall CCG should provide a detailed clinical model of Phase 1 (inpatient community rehabilitation), revisiting terminology used to describe patients on the proposed pathway and clarifying the proposed model of care for all levels of patients, but in particular level 4 and 5 patients. Medical cover for Ward 1 (rehabilitation unit) will need to be explicitly identified as this is a clinically vulnerable area. The revised clinical model will need to be presented to the Clinical Senate for clinical assurance.

RECOMMENDATION 21

Should Walsall CCG decide to progress to Phase 2 for the community rehabilitation, then the proposed clinical model will need to be taken back to the Clinical Senate for sign off.

RECOMMENDATION 22

An urgent dialogue is required with relevant local authorities’ social services to understand the support required and to achieve joint planning for the service.

RECOMMENDATION 23

Walsall CCG to develop plans about how patients and families will be engaged in decision making in the pathways. For example how mental capacity to consent to interventions will be assessed. Those not having the mental capacity to be able to make a decision about interventions will have a best interest decision made in accordance with the principles of the MCA 2005.

West Midlands Ambulance Service NHS FT (WMAS)

RECOMMENDATION 24

The financial implications that a centralised stroke services at RWH will have on the ambulance service will need to be more fully understood. Walsall CCG should consider the cost involved for an additional ambulance resource and how this will be funded.
RECOMMENDATION 25

Walsall CCG to develop a plan for the transfer by emergency ambulance of stroke patients from WHT to RWT. This plan should also include patients for whom it is not clinically appropriate for HASU intervention and therefore define what would be in the best interests of such patients.

KEY FINDING

The panel was particularly concerned with regards to the provision of the Patient Transport Service (PTS) for patients as the contract is still in negotiation. The panel was not assured regarding the transfer of patients with medical interventions such as Percutaneous endoscopic gastrostomy (PEG), Tracheostomies and need to be assured of what was in place to ensure safe transfer of such patients from Wolverhampton to Walsall.

RECOMMENDATION 26

Walsall CCG to develop a repatriation policy.

RECOMMENDATION 27

Walsall CCG should collaborate with the ambulance services to map out the stroke patient pathways, there is also a need to further understand and update travel and clinical activity modelling.

Public Transport

RECOMMENDATION 28

Walsall CCG to map out the availability of public transport and develop robust communication with Walsall residents promoting the need for stroke services in Wolverhampton and how to access public transportation links.

Wider Engagement and Partners

RECOMMENDATION 29

Analysis is undertaken by Walsall CCG to set the proposed changes within a broader health economy context.

Equality Impact Assessment

KEY FINDING

The panel was concerned that attention to potential impacts of the proposed stroke service reconfiguration upon deprived populations of Walsall had not been evidenced.
RECOMMENDATION 30

Walsall CCG to consider using the Health Equity Assessment Tool (HEAT) tool to provide a systematic way to assess potential impacts upon deprived populations of proposed health service reconfigurations.

RECOMMENDATION 31

Walsall CCG should continue to build on the Equality Impact Assessment through engagement with the people that will ultimately be affected – patients, their families, carers and the wider public.
4. Methodology and Governance

4.1 Terms of Reference

4.1.1 Walsall CCG Reconfiguration of Stroke Services was formally adopted onto the Clinical Senate work programme by the Clinical Senate Council in July 2017, following a presentation to the council and request for NHS England Stage II Clinical Assurance. The Independent Clinical Review Team (ICRT) Chair and Vice Chair was appointed by the council. A request to the West Midlands Clinical Senate from Walsall CCG for NHS England Stage II Clinical Assurance was formally received on 27th July 2017.

4.1.2 Terms of reference for the Council’s work were developed as per NHS England guidance (See Appendix 1). This included the approach for formulating the advice and the overall process through which advice and recommendations would be developed. The initial draft of the terms of reference stated the aim as ‘to assess and confirm the clinical quality, safety and sustainability of the reconfiguration of Walsall Stroke Services’ as agreed by the clinical senate council in July 2017 and was shared with Walsall CCG, this ensured that the advice which the Clinical Senate had been asked to provide, and the approach to formulating it, was transparent to all stakeholders. Discussions took place from 2nd October to 23rd October 2017 between the sponsoring organisation, the clinical senate, Royal Wolverhampton Trust (RWT) to agree the TOR. NHS England sense checked the TOR at the Executive Directors Meeting 18th October 2017. The Terms of Reference for the review were signed off by Professor Simon Brake, Chief Officer Walsall CCG and Professor Adrian Williams Chair of West Midlands Clinical Senate.

4.2 Process

4.2.1 The process to formulate the advice was led by Professor Adrian Williams Chair, West Midlands Clinical Senate, and Vice Chair Susanne Nicholl, Clinical Senate Council Member. The process was guided by the Clinical Senate Review Process Guidance Notes (2014).

4.2.2 The Clinical Senate formulated advice between October to December 2017. An Independent Clinical Review Team (ICRT) was established to assist the Senate. This included members from professional groups with specific knowledge and expertise in the areas which the Clinical Senate had been asked to provide advice. To ensure any advice given was robust, transparent and credible; the team included clinical experts from within and outside the West Midlands area (see Table 1) and (Appendix 2). A Confidentiality agreement and potential conflicts and associations were declared during the process. These are recorded in Appendix 3.

4.2.3 Review dates were held on 30th October, 9th and 23rd November 2017 (see Appendix 4). The ICRT review documentation was provided by Walsall CCG Stroke Service Review Team (See Appendix 5).
Presentations relevant to the review were made from key members of the Walsall Stroke Service Reconfiguration Programme and RWT.

The panel undertook a planned site visit on 9th November to meet the multi-disciplinary teams involved in the stroke pathway at designated RWT and WHT sites. The panel had an opportunity to meet with ESD and Community Rehabilitation nurses and therapists.

4.2.4 This report presents the key issues that were discussed and emergent themes from the evidence presented (documentary and verbally). It is not intended to be a comprehensive record of the discussion.

4.3 Scope and Limitations

4.3.1 The scope of the review was agreed between Walsall CCG and the West Midlands Clinical Senate as per TOR. The conclusions are limited to the evidence presented, and are not exhaustive.

Table 1 Independent Clinical Review Team Members

<table>
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5. Background

a) The extract below has been taken and adapted from Walsall Stroke Service Sustainability Review (2017) and Walsall Stroke Services Business Case for Public Consultation (2017)

b) The National Stroke Strategy (2007) identified that service improvements for stroke would save lives, reduce disability and make services safer for patients. The strategy identifies major stages in a stroke patient’s pathway and stresses a need to reorganise the way in which stroke services are delivered from prevention through to support for those who have experienced a stroke. The publication proposed a hub and spoke approach, with the hyper-acute hubs being able to deliver 24 hour CT scans and rapid thrombolysis treatment to improve patient outcomes. This approach has been successfully implemented in London, where all patients displaying stroke symptoms are taken to hyper-acute units which has demonstrated significant improvements to patient care. In fact, a recent study found that the service in London has directly saved an additional 94 lives per year since its inception when compared to other variations of the hub and spoke model, such as in Manchester, where only patients displaying stroke symptoms for less than four hours are conveyed to a hyper acute unit and which has had no effect on mortality rates in the four years of operation in the Manchester area. Both approaches however have led to earlier discharges of stroke patients from hospital.

5.1 National standards

National Standards (2007) for the provision of stroke services in England state the following:

5.1.1 Hyper Acute Stroke Units (HASUs) – Timescale 0-3 Days

a) These units provide specialist acute stroke care for the first 72 hours, by a multi-disciplinary team, providing immediate specialist response to a stroke with timely access to specialist stroke assessment and diagnostic services to provide the primary intervention to stabilise the patient. These are best practice centres on the timeliness of specialist stroke services on a 24/7 basis, including consultants, radiology services and thrombolysis services. All “FAST positive” patients should be admitted to a stroke unit within 4 hours of identification for patients presenting at A&E managed by a stroke specialist resource from presentation of symptoms.

b) It is recommended that HASUs have a recommend activity of circa 600 patients a year to be viable, as recommended by the National Clinical Director for Stroke, and viability assumes a high level of achievement against Best Practice Tariff (BPT) at around 80%.

c) The current standard for HASU patients to be reviewed by a consultant within 24 hours is being revised to 14 hours in 2017/18.
5.1.2 Acute Stroke Unit (ASU) – Timescale 1 – 7/10 days

a) Where clinically appropriate, after the first 72 hours the patient is transferred to an ASU. During this phase of care patient should also have access to specialist neurosurgical and vascular treatments where necessary to prevent further damage.

b) The HASU and ASU may be co-located in the same hospital or split between sites.

5.1.3 Early Supported Discharge (ESD) Timescale 7-14 Days

a) Once stable patients are discharged from the acute setting, their care is provided either at a community based rehabilitation centre or at home with a package of community wraparound care.

b) WHT currently operates across all three stroke service domains providing a range of specialist end-to-end clinical services that meet the needs of patients with stroke and transient ischemic disease (TIA). Its stroke services span both the acute and community settings, including urgent assessment / treatment in A&E and HASU to the Acute Stroke Unit (ASU) for on-going specialist Multi-Disciplinary Team stroke care to outpatient and specialist community stroke services, including bed-based rehabilitation.

5.2 Context

5.2.1 Extract below taken from Stroke Services Sustainability Walsall CCG (2017). Following the guidance for the operation of HASU, there was a region-wide review of stroke services (WM Clinical Senate Stroke Review 2014). At that time, the assumptions around local stroke services provision were as follows:

a) Heart of England Foundation Trust (HEFT) reconfigured services at Good Hope Hospital and Solihull Hospital and transferred activity to Heartlands Hospital, which is now working to capacity.

b) Burton Hospital to downgrade from a HASU (and possible acute stroke services) and end all admissions of stroke patients within the first 72 hours of the initial diagnosis.

c) South Staffordshire patients to be dispersed among other Trusts.

d) Sandwell Hospital HASU to relocate to the new Metropolitan Hospital in 2018/9.

5.2.2 The result of these changes would bring an additional 250-300 FAST positive, stroke patients to Walsall. The bulk of these patients would be as a result of the changes proposed at Burton Hospital and would bring the WHT service demand in line with the c600 patients thresholds recommended for HASUs. The assumptions around Burton Hospital did not materialise, which meant that Walsall could not reach the levels of demand and, therefore, the sustainability of a HASU.
Even with the additional Staffordshire activity, Walsall would be a relatively small HASU.

5.2.3 The WHT has worked with its partners in the Black Country Alliance (BCA) with the aim of setting up a clinical network across the region to support stroke services within each organisation. Work with clinical leads however concluded that a model in which a single stroke team covered multiple sites was unlikely to be clinically sustainable and posed a series of operational and clinical pathway challenges.

5.2.4 Discussions with RWT have been positive with a proposal for public consultation on establishing a HASU/ASU service at RWT to include provision for Walsall residents. WHT will continue to provide the rehabilitation/community stroke services in Walsall. WHT already provides community rehabilitation services for South Staffordshire residents.

5.2.5 The tariff for stroke services assumes the HASU and ASU are provided by the same provider, transferring the HASU / ASU to RWT will require proper commissioning and funding of an effective community stroke rehabilitation service for Walsall.

5.3 Case for Change

5.3.1 Extract taken from Business Case for Public Consultation (Walsall CCG 2017) Good quality stroke services, as defined by the National Stroke Strategy (2007), require 7 day, 24 hour access to thrombolysis treatment and a 7 day high risk TIA clinic. These services require a reasonable scale to ensure that there is sufficient consultant coverage to provide comprehensive, sustainable services. For this reason, stroke networks across the country have reviewed stroke provision and concentrated it on fewer, larger centres as it has a direct correlation with improved outcomes for patients.

5.3.2 Currently all patients in Walsall CCG area exhibiting symptoms of stroke are conveyed to and dealt with by WHT at the Walsall Manor Hospital, and according to the Sentinel Stroke National Audit Programme (SSNAP) report for financial year 2015/16, WHT treated 375 stroke patients. Whilst overall WHT was rated as ‘good’ (and ‘improving’ over the last two years), the mainly low scoring domains (D or E average) were related to the stroke unit and thrombolysis provision.
Table 1: SSNAP Data – at November 2016

Figure 1: Extract from SSNAP Report on Manor Hospital Stroke Service, November 2016

5.3.3 The NHS Right Care Commissioning for Value Focus Pack for Cardiovascular Disease (April 2016) shows that Walsall is worse in a number of areas of the pathway compared to CCG’s of similar size and demographics. In the main these outcomes pertain to lack of clinical resource and lack of capital resource, in particular with regards community beds.

5.3.4 At present Wolverhampton and Walsall see approximately 600 and 400 respectively, confirmed stroke patients each year. To be a viable Hyper-acute Stroke service it is recommended that there are a minimum of 600 confirmed stroke patients each year. For WHT the income from activity of 400 confirmed stroke patients is insufficient to fund staffing levels to meet the HASU requirements and there is no potential to increase stroke numbers in future, despite considerations of patient flow arising from other stroke reconfigured areas.

5.3.5 NHS England previously wrote to all providers of urgent care network specialist services requesting an audit of compliance against the seven day services standards for acute stroke, STEMI heart attack, major trauma, emergency vascular and paediatric intensive care services. The aim of this audit was to identify those individual services where attention and action was needed to ensure that all patients requiring services for stroke receive the best possible care on a 24/7 basis.
5.3.6 The results of the audit have identified that WHT are below the standard expected for time to first consultant review (60% not met) and ongoing consultant-directed review (40% not met). Whilst the formal response from the Trust to how it will manage to achieve these standards by November 2017 is awaited, it is expected to advise that it is not able to meet these standards, due to reduced numbers and the inability to fund and support the clinical capacity required by that time, therefore the service is unsustainable.

5.4 Guidance

The panel recognised that the model of care proposed is aligned nationally, as evidenced by the:

- Implementing the National Stroke Strategy- Imaging Guide. (DoH , 2008)
- NICE guidelines ‘Diagnosis and initial management of acute stroke and transient ischaemic attack’ (2008) and the draft NICE Quality Standard for Stroke (2009)
- Stroke Service Standards (2010) British Association of Stroke Physicians
- The 2012/13 Adult Social Care Outcomes Framework
- Department of Health Supporting Life after Stroke (2011) Care Quality Commission
- Everyone Counts: Planning for Patients 2014/15 NHS England
- Cardiovascular Disease Outcomes Strategy – Improving Outcomes for People with or at risk of Cardiovascular Disease (2013) Department of Health
- RCP (2016) Stroke Guidelines Royal college of Physicians

Regionally, as evidenced by the:

- West Midlands Service Specification for the Management of Stroke Thrombolysis and Acute Care (Hyper-Acute) (2009)
- West Midlands Specification of Services for Patients with Transient Ischaemic Attack and Non-Disabling / Minor Stroke (2010)
- West Midlands Acute Stroke Steering Group Accelerated Standards
• West Midlands Quality Review Service Quality Standards (2010)
• NHS Midlands and East Stroke Service Specification (2012)

Locally, as evidenced by the:

• Walsall CCG (2017) Stroke Services Business Case for Public Consultation (v1.9 SR/DW)
• Walsall Healthcare Trust (2017) Stroke Service Sustainability Review

6. Walsall Stroke Service Review (preferred options)

6.1 Extract taken from Business Case for Public Consultation (2017) 6.1 At the Walsall CCG Governing Body meeting on 24th November 2016 ‘The Governing Body also gave approval to explore all options, including engaging with RWT on options with them’. Subsequent CCG discussions with RWT and WHT, and discussions between both Trusts, have led to Option 5 (see below) becoming the emerging preferred option between all three organisations, and supported by Wolverhampton CCG. Other options considered and discounted by the CCG included.

6.2 Option 1: Maintain status quo continue to operate a HASU service, using existing WHT infrastructure and staffing, with resolution of the gaps as finances allow. This option is no longer sustainable, the current service delivery model would continue to be only partially compliant with the HASU specifications, in particular with regards to overall stroke activity being less than nationally recommended, consultant capacity limited and no arrangements in place for community stroke rehabilitation beds and lacks system resilience with regards 24/7 cover.

6.3 Option 2: Financial investment by WHT, in a phased approach, to 'fill' the key gaps in the current HASU service delivery model to satisfy the HASU specification requirements and achieve the required performance. This option would require additional funding and investment by WHT to recruit additional staff to bring the service up to the acceptable HASU standard (as much as £650K) with the CCG possibly asked to provide funding for approximately 22 additional beds in community care. Given the current financially challenged position of both trusts this is not a current option. The option also only becomes viable if there is an increased attendance to 600 stroke patients per year. As shown above it has recently become apparent that stroke services in Burton are to continue due to Burton and Derby hospitals working more closely together, so the anticipated numbers attending WHT are unlikely to materialise, thereby making this option unviable.

6.4 Option 3: Fusion of capabilities with Black Country partners under a ‘Black Country Alliance’ proposal would be ‘utilised' to ‘share’ staff to fill WHT gaps to enable WHT to satisfy the HASU specification
requirements and performance targets. The comments relating to option 2 above are applicable here, with the added complication that this option is not in keeping with the move towards an STP footprint for the Black Country, as the Black Country Alliance does not include Royal Wolverhampton Hospital Trust, a provider that some Walsall patients, particularly on the West of the borough would naturally flow to.

6.5 **Option 4: Outsource the HASU service to Royal Wolverhampton Hospital** (RWT) with patients being repatriated back to the WHT ASU to provide on-going acute bed based care. The community stroke services would be provided by WHT. The implementation of this option would entail the apportioning of the national tariff for stroke between the hyper acute and acute phases of the pathway. The report indicates that the pathway apportionment generally operates on a 70/30 split, so may bring into question the ability of WHT to provide the acute part of the pathway on 30% of the tariff. Negotiations for similar arrangements in other areas state it is financially not financially viable for the Provider of the acute part for the pathway. The business case for the same set of negotiations also placed the cost of a two site option at around 40% above the national tariffs for the whole pathway.

6.6 **Option 5: Walsall CCG actively considers commissioning Royal Wolverhampton Trust (Preferred Option)** RWT would provide both Hyper-acute and acute parts of the Stroke pathway for all Walsall patients, thereafter Early Supportive Discharge and a Community Stroke Service provided by WHT. This option was seen to be the most viable in the current circumstance to provide a stroke service for Walsall patients that complies with the CCG overarching principles and, satisfies the comments made by the WM clinical senate report (Oct 2014): ‘The panel are of the view that co-location of HASU and ASU across all units will improve integration of acute stroke care and patient flow in the acute phase and, on that basis, will work towards that the proposed service standard of transfer from HASU to ASU at 3 days and discharge / repatriation at 7 days’, and would be in line with the move towards an STP footprint for the Black Country.

6.6.1 If RWT were commissioned to provide a HASU/ASU service, the CCG envisaged the success of centralising HASU/ASU services by Heart of England FT could be replicated. RWT indicate that the annual flow would increase to around 1,100 patients per year, and they are confident they would be able to cope with these numbers.
7. Current Stroke Services Provision at the Royal Wolverhampton NHS Trust

7.1 Extract taken from RWT (2017) The Royal Wolverhampton NHS Trust serves a Wolverhampton resident population of circa 270k and in addition a significant proportion of neighbouring South East Staffordshire peninsula and Cannock Chase CCG. The Trust provides traditional acute services, as well as being the main provider of community care in Wolverhampton and serving a population of circa 48.6k though the vertical integration of 7 primary care practices. In patient non elective and elective services are provided from New Cross Hospital in Wolverhampton, whilst West Park Hospital provides rehabilitation care. Cannock Hospital provides some elective care and rehabilitation services primarily for patients referred from the Cannock area of Staffordshire. The stroke service provided by the Royal Wolverhampton NHS Trust is a consultant led, multi-disciplinary team with pathways established from pre-admission, via the emergency department and onto stroke specialist staff. The Trust provides hyper acute, acute and rehabilitation beds at three hospitals: New Cross, West Park Rehabilitation Hospital and Cannock Chase Hospital as well as an Early Supportive Discharge team and stroke co-ordinators in the community. The stroke service is delivered by a team of medical consultants, nursing staff, therapists, managerial and administrative staff. The Trust currently has 3 HASU beds, 21 ASU. The HASU and ASU bed compliment can be flexed as required. 22 rehabilitation beds are provided at community hospitals. The number of strokes treated through the stroke unit is as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Strokes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>696</td>
</tr>
<tr>
<td>2014/15</td>
<td>676</td>
</tr>
<tr>
<td>2015/16</td>
<td>583</td>
</tr>
<tr>
<td>2016/17</td>
<td>563</td>
</tr>
</tbody>
</table>

7.2 Stroke Management: Pathway from Ambulance to HASU/ASU
Patients enter the service via the recently built Emergency Department (ED). This service accommodates 135,000 patients each year and has ED consultant on site presence between 8am and 2am and acute medical consultant presence between 9am and 10pm. A paramedic pre-alert arrangement has been in place since 2007 with the inception of the thrombolysis service. Once alerted to the potential attendance of a stroke patient eligible for thrombolyis, the ED contacts the HASU via a dedicated phone line. Patients are assessed for suitability for thrombolysis by 1 of 5 stroke consultants between 8am and 8pm during the week and reduced on site presence at weekend. Outside of these hours this falls to the ED consultant initially. Stroke trained nurses are available 24/7 to take calls, support thrombolysis and admit patients to the HASU.
7.3 **CT Scanning and Reporting of Stroke Patients**
The Trust has a CT scanner in ED for the use of stroke patients which is available 24/7; the resident ED radiographers are all trained to perform CT head scan. There are 5 stroke consultants (4.4wte) competent to read plain CT head scans for thrombolysis. Currently ED consultants are competent to provide the overnight thrombolysis service with the support from Radiologists who are available to immediately report during the night if required. The new ED has facilities for immediate enhanced CT scanning (e.g. CT carotid angiography). Weekly stroke X-ray meetings are held with neuro-radiologists to review thrombolysis cases and difficult cases, which ensure CT and MRI scan interpretation skill is maintained. If the ED scanner is unavailable there are two other CT scanners available 24/7 in the main Radiology Department.

7.4 **Established Thrombolysis Pathway**
The Thrombolysis pathway has been existence since 2007 with circa 14% of patients being thrombolysed. A stroke specialist nurse attends ED immediately for all potential thrombolysis calls 24/7 as does the on-call stroke consultant between the hours of 8am-8pm each day. ED consultants provide the overnight thrombolysis service (and have performed 16% of all thrombolysis).

7.5 **HASU Bed Capacity and Timeliness of Transfer to ASU and Rehabilitation**
The Trust currently provides hyper acute and acute stroke cares which operate on the basis of a co-located HASU and ASU. Daily consultant ward round, including at weekends, identifies patients for transfer from HASU to ASU and any discharges. The HASU also discharges patients directly home and has developed pathways and working relationships with local early supported discharge services and other community teams. Patients suitable for rehabilitation at West Park Hospital or Cannock are identified at the twice weekly multidisciplinary team meetings and during ward rounds. Access to rehabilitation beds is supported by therapist assessment providing a clear rehabilitation goal and timeframe. Stroke mimics are also identified to ensure transfer to a more appropriate bed as required. Average length of stay for Stroke patients in an acute bed is 11 days.

7.6 **Length of Time to Consultant Review after Admission**
Since 2008 the Trust has an established rota for 7 day working by stroke consultants. This has enabled the Trust to provide stroke patients with prompt senior doctor review. This service is clearly evidenced from SSNAP data, and national 7 day audit (April 2017 specialised services 7ds national audit).

7.7 **Daily Assessment of TIA patients and TIA Throughput and Admissions**
The current TIA service is well established and has been in place since 2011. It is led by a stroke physician and delivers TIA follow up supported by advance support workers. It operates 6 days per week and currently 1110 referrals per year are seen with approximately 41% being high risk.

The stroke service sees higher risk TIAs in an out-patient setting, enabling the Trust to avoid admissions where possible. Where emergency admission occurs these would be managed within 24 hours with same day carotid dopplers and same or next day MRI brain scan, as clinically appropriate. This is provided 7 days per week.

The stroke service sees higher risk TIAs in an out-patient setting, enabling the Trust to avoid admissions where possible. Where emergency admission occurs these would be managed within 24 hours with same day carotid dopplers and same or next day MRI brain scan, as clinically appropriate. This is provided 7 days per week.

The GP access to TIA clinics is via direct telephone booking through a generic booking service, Wolverhampton Urgent Care, Triage and Assessment Service (WUCTAS). ED access is via direct booking into the next clinic list (or, if the TIA clinic is in progress, via walk in). Both systems allow face- to- face clinic appointment to be given, ensuring higher risk patients are seen the same or next day.

7.8 Specialist Services including Neuro Surgery and Vascular Surgery

The Trust is a regional cardiothoracic centre and access for stroke patients is instant. The Trust has a number of established pathways to other Trusts for the delivery of specialist and tertiary services, these include:

a) Thrombectomy pathway, the Trust refers to UHN for thrombectomy.

b) University Hospital Birmingham for patients who require neuro-surgery.

c) Vascular surgery provided by Russells Hall Hospital in Dudley, the team liaises closely with two vascular surgeons who work across RWT and Russells Hall.

d) University Hospital North Staffordshire (Stoke) for patients requiring interventional neuro-radiology which is facilitated by one consultant from the Trust spending one day a week in Stoke.

7.9 Governance

The stroke service has a governance structure that meets the requirements set out in the Trust’s Clinical Governance Strategy. The Trust delivers its clinical and operational services through a divisional and directorate structure.
8. Review and Recommendations

a) The commissioners provided and presented evidence using the WM Clinical Senate Pre Assurance Framework with referenced appendices (see Appendix 5). This was an iterative process, as not all evidence was available for the panel to be able to assess and confirm the clinical quality, safety and sustainability of the Walsall Stroke Services Review preferred model. The panel was of the opinion that some parts of the pathway (ESD and rehabilitation) were being developed during the review which posed a challenge for the panel when trying to assure the stroke pathway.

b) The panel formed the following views, key findings and recommendations which are presented by emergent themes.

8.1 Case for Change

8.1.1 Walsall CCG presented a credible case for change and the panel concurred that the at present the current Walsall stroke services were below standard in terms of stroke activity c400 confirmed strokes pa, which is below the 600 threshold for financial sustainability and optimal clinical outcomes (Walsall CCG 2017 Business Case for Public Consultation).

8.1.2 The panel noted the "door to needle" time is the standard by which all hospital units in the UK are monitored using the SSNAP mandatory audit and this reflects how well the hospital service operates. The London re-organisation of stroke services showed that teams that are doing thrombolysis more frequently have better outcomes and that a reduction in door to needle times compensates for any increased travelling time. The current national view is that hyper-acute stroke units need to see between 600 and 1500 confirmed strokes per year to develop this expertise.

8.1.3 KEY FINDING Wolverhampton and Walsall combined acute stroke services should see circa 1000 confirmed stroke patients per year, and as such the thrombolysis rate for the Wolverhampton and Walsall population will increase. Success of the centralisation will be dependent upon ensuring the provision of a consistent and equitable stroke service across the whole pathway for all users regardless of whether they live in Wolverhampton, Staffordshire or Walsall.

8.1.4 The panel is assured from the analysis of the evidence presented and the site visits that RWT are offering a safe and effective Stroke service. From the evidence that has been presented the panel supports the preferred option to centralise Walsall Acute Stroke Services at the Wolverhampton site.
8.1.5 The panel was of the view that the model of centralising acute stroke services are in line with national guidance (National Standards for Stroke Provision England 2007).

8.1.6 RECOMMENDATION 1: Walsall CCG should now develop a robust business case for an equitable stroke service provision across the whole pathway for Walsall stroke patients

8.2 Governance

8.2.1 The panel noted the development of commissioning strategy and plans at Walsall CCG is the responsibility of the Commissioning Committee and the Governing Body, who will make the final decision regarding the transfer of Walsall Stroke Services.

8.2.2 KEY FINDING: The Panel has received evidence from Royal Wolverhampton Trust (RWT) of executive agreement and approval for the case for taking hyper-acute and acute stroke services from Walsall Manor Hospital (Managed by Walsall Healthcare NHS Trust). RWT suggests taking on Walsall acute stroke services will strengthen stroke services for the Wolverhampton and Staffordshire population as well. A steering group has been established for the ‘Transfer of Stroke Services Project’.

8.2.3 RECOMMENDATION 2: A joint mobilisation and implementation plan is developed between Walsall CCG, Walsall Healthcare NHS Trust (WHT) and RWT.

8.3 Engagement with clinicians and patients and the public

8.3.1 The panel was of the view that Walsall CCG had undertaken adequate engagement with patients and public regarding the reconfiguration of stroke services. First, through the ‘Big Conversation’ a public engagement exercise dialoguing with local people about improving healthcare for patients and the challenges faced by the NHS and what the CCG is doing (Walsall CCG 2017; Healthwatch Walsall (2017)). Second, Walsall Stroke Consultation on changes to hospital stroke service document (Walsall CCG 2017).

8.3.2 RECOMMENDATION 3: Walsall CCG should now demonstrate how the outcome of the Healthwatch consultation (2017) has informed or contributed to the reconfiguration of Walsall stroke service provision.

8.3.3 RECOMMENDATION 4: Walsall CCG to encourage patient participation on the CCG’s reconfiguration of stroke services working groups to provide a stronger patient voice.

8.3.4 The panel noted the limited information supplied regarding staff engagement in the form of extracts from: stroke workshops, clinical pathway, data activity groups and the staff newsletter. The site visits
provided a good opportunity for the panel to gain a deeper understanding of the challenges and issues within the stroke pathway that are perceived by staff.

8.3.5 KEY FINDING: Through the site visits the panel was able to form an opinion that the RWT demonstrated full staff engagement with the centralising of stroke services in Wolverhampton for Walsall stroke patients.

8.3.6 The panel was of the view that staff engagement at Walsall Manor Hospital, Ward 1, was poor.

8.3.7 KEY FINDING: The staff on Ward 1 at Walsall Manor Hospital was informed about the plans for the ward to remain open shortly before the panel visit.

8.3.8 RECOMMENDATION 5: An open and honest discussion is required with Walsall Stroke Services staff where change management and organisational change principles are applied in a fair, equitable and transparent way; providing clear communications and engagement activities, ensuring the continuation of skills, experience and knowledge of staff.

8.3.9 The panel acknowledged the impact on family and friends of the proposed centralised stroke services, and is aware of the support a patient needs from family and friends within the first few hours and days. The panel is of the opinion that the benefits of providing patients with access to a high quality centralised service outweighs the convenience of providing a local service. The impact is minimised by the time frame needed for HASU and ASU care before repatriation to Walsall for rehabilitation.

8.4 Workforce

8.4.1 KEY FINDING: The panel was of the view that there are a series of workforce assumptions within the Walsall Stroke Services reconfiguration programme. These were with regard to job roles, recruitment, retention, training, supervision, sustainability and succession planning for medical consultants, junior doctors, nurses, and allied health professionals (AHPs) which need to be further clarified and supported with Health Education England (HEE) West Midlands.

8.4.2 RECOMMENDATION 6: A comprehensive workforce plan is developed which reflects national guidance to achieve a service that is delivering 7 day services, and meeting the needs of SSNAP domains.

8.4.3 KEY FINDING: RWH plan to recruit extra consultants to address the increased workload in the Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU). The panel supports the need for further recruitment however; the current situation nationally suggests a
shortage of applicants for these posts. RWT are optimistic about being able to fill the posts.

8.4.4 RECOMMENDATION 7: RWT and Walsall CCG to develop workforce mitigation plans should the recruitment of extra consultant posts not be realised or not filled to full complement.

8.4.5 KEY FINDING: The panel was of the view that there were some concerns in relation to out of hours reporting of imaging in the Emergency Department at New Cross Hospital, in Wolverhampton. The time between the scan being completed and the formal radiology report seems to be extensive putting patients and trainees at risk.

8.4.6 RECOMMENDATION 8: The Royal Wolverhampton NHS Trust and Walsall CCG to revisit out of hours reporting of imaging in the Emergency Department at New Cross Hospital, Wolverhampton as this is a potential clinical risk. RWT and Walsall CCG to ensure current guidance ‘Implementing the National StrokE Strategy – imaging guidelines (2008)’ are being met.

8.4.7 The panel noted from the site visit to Walsall Manor Hospital, Ward 1 that there had been a significant reduction in clinical staff, in particular nursing and therapist, due to uncertainties around employment. This will present difficulties in providing a seamless service.

8.4.8 RECOMMENDATION 9: Further resources are needed to ensure adequate staffing to provide the level of rehabilitation care required to support repatriation of Walsall patients back to Ward 1 at Walsall Manor Hospital, to enable the unit to cope with demand. Mitigation plans to be put in place should extra staffing posts not be realised or not filled to full complement.

8.4.9 RECOMMENDATION 10: Therapist workforce requirements need to be calculated using guidance from RCP stroke guidelines for ASU bed numbers per therapist and percentage of patients requiring ESD, to ensure that the teams are adequately staffed to cope with the potential demand.

8.4.10 RECOMMENDATION 11: A workforce gap analysis of ESD and Stroke Rehabilitation should be performed to inform workforce planning to deliver these services across Walsall that can be used to inform business case development for an equitable and sustainable ESD and Stroke Rehabilitation service. The gap analysis should also take into consideration social services and local authority personnel for an integrated service.
8.5 **Pathways**

8.5.1 The panel was of the view that there should be a clear outline of the full stroke and TIA pathways, from the patient and carer perspective as well as a strategic perspective; starting from primary and secondary prevention, through to pre-hospital, hyper-acute and acute care, rehabilitation and recovery in the community. This outline will ensure that the stroke service is designed to maximise positive long term patient outcomes and experiences; and will avoid un-intentional consequences of concentrating on and prioritising just the acute elements of the pathway.

8.5.2 The panel noted in the proposed pathway that all possible stroke cases including mimics attended by WMAS will be conveyed directly to the RWT. Those patients that ‘walk-in’ to Walsall exhibiting stroke symptoms, or are already an in-patient and exhibit stroke symptoms, will be seen by Walsall ED in the first instance, and then conveyed to RWT as appropriate.

8.5.3 **RECOMMENDATION 12:** Provide a clear description of the full stroke and TIA pathways, from primary and secondary prevention, through to pre-hospital, hyper-acute and acute care, rehabilitation and recovery in the community.

8.5.4 **RECOMMENDATION 13:** out of hours thrombolysis at New Cross Hospital in Wolverhampton needs to be reviewed and changed to ensure it is stroke consultant rather than ED led in terms of thrombolysis decision making.

8.5.5 **RECOMMENDATION 14:** there is a clear agreement and pathway for Computed Tomography Angiography (CTA) 9am-5pm for thrombectomy patients and full 24/7 when the service is commissioned.

8.5.6 **RECOMMENDATION 15:** all staff ratios – nursing, medical and therapist are at least at the standards set nationally for what is acceptable for stroke rehab and not adjusted allowing for potential workforce shortfall/recruitment.

8.6 **Early Supportive Discharge and Rehabilitation**

8.6.1 The panel was of the opinion that without robust pathways for rehabilitation and ESD there is likely to be delayed transfer of care where patients will be stranded in the wrong unit for the stage of their care as well as restricting the ability and efficiency of the HASU/ASU in Wolverhampton.

8.6.2 **RECOMMENDATION 16:** Rehabilitation and ESD should be available for Wolverhampton, Staffordshire and Walsall patients alike, and access should not be compromised by their usual place of residence.

8.6.3 **RECOMMENDATION 17:** Rehabilitation and ESD planning should be integrated with that of the acute stroke unit inpatient rehabilitation and
other community services, as a whole pathway approach to stroke patient care. This is essential to achieve best outcomes, best value and coherent planning.

8.6.4 KEY FINDING: Walsall Healthcare NHS Trust has an established and comprehensive ESD service. There is currently no community bed facility to support ESD and no community bed stock. Current arrangements are delivered through excess bed days being incurred at Walsall Manor Hospital.

8.6.5 The panel was of the opinion that contradicting inpatient rehabilitation models were presented during the course of the review, referred to as Phase 1 an inpatient facility at Ward 1 Walsall Manor Hospital and Phase 2 delivered through an independent care home in Walsall.

8.6.6 RECOMMENDATION 18: The panel was of the view that a comprehensive inpatient community rehabilitation facility can be established through Phase 1 and should negotiate and contract directly with WHT to provide an inpatient community rehabilitation service.

8.6.7 RECOMMENDATION 19: Commissioners and providers should refer to ‘Rehabilitation Commissioning Guidelines’ (NHS England 16-17) to guide the quality and specification of the service, which should be built in to the financial modelling.

8.6.8 RECOMMENDATION 20: Walsall CCG should provide a detailed clinical model of Phase 1 (inpatient community rehabilitation), revisiting terminology used to describe patients on the proposed pathway and clarifying the proposed model of care for all levels of patients, but in particular level 4 and 5 patients. Medical cover for Ward 1 (rehabilitation unit) will need to be explicitly identified as this is a clinically vulnerable area. The revised clinical model will need to be presented to the Clinical Senate for clinical assurance.

8.6.9 From the evidence presented the panel was of the view that Phase 2 for rehabilitation in Walsall was not sustainable, and that Walsall CCG should concentrate on making Phase 1 the long term sustainable solution.

8.6.10 RECOMMENDATION 21: Should Walsall CCG decide to progress to Phase 2 for the community rehabilitation, then the proposed clinical model will need to be taken back to the Clinical Senate for sign off.

8.6.11 The panel was of the view that Adult social care is a critical component of stroke care in the community, and supported social services in Walsall being fully integrated into the planning and delivery of stroke services.
8.6.12 RECOMMENDATION 22: An urgent dialogue is required with relevant local authorities’ social services to understand the support required and to achieve joint planning for the service.

8.6.13 RECOMMENDATION 23: Walsall CCG to develop plans about how patients and families will be engaged in decision making in the pathways. For example how mental capacity to consent to interventions will be assessed. Those not having the mental capacity to be able to make a decision about interventions will have a best interest decision made in accordance with the principles of the MCA 2005’.

8.7 Financial Impact

8.7.1 Though not within the remit of a senate to review financial impact, the panel was of the view that the proposed stroke reconfiguration should demonstrate how any proposed changes would be financially sustainable, and that all commissioners and providers are committed to investing where required to deliver the highest quality service. Guidance is available in the NHS England Stroke Tool Kit, finance section.

8.8 WMAS

8.8.1 The panel was of the view that further modelling may need to be undertaken to ensure an accurate picture of journey times, turnaround impact, and future activity.

8.8.2 RECOMMENDATION 24: The financial implications that a centralised stroke services at RWH will have on the ambulance service will need to be more fully understood. Walsall CCG should consider the cost involved for an additional ambulance resource and how this will be funded.

8.8.3 The panel agreed with WMAS (2017) regarding additional impacts in Walsall in the following areas:
   - Patients being conveyed by WMAS that are not identified as stroke to Walsall in the first instance
   - Patients walking into ED and then being identified as having stroke symptoms
   - Patients having a stroke on a ward or within outpatients clinics

8.8.4 RECOMMENDATION 25: Walsall CCG to develop a plan for the transfer by emergency ambulance of stroke patients from WHT to RWT. This plan should also include patients for whom it is not clinically appropriate for HASU intervention and therefore define what would be in the best interests of such patients.

8.8.5 KEY FINDING: The panel was particularly concerned with regards to the provision of the Patient Transport Service (PTS) for patients as the contract is still in negotiation. The Panel was not assured regarding the transfer of patients with medical interventions such as
Percutaneous endoscopic gastrostomy (PEG), Tracheostomies and need to be assured of what was in place to ensure safe transfer of such patients from Wolverhampton to Walsall.

8.8.6 RECOMMENDATION 26: Walsall CCG to develop a repatriation policy.

8.8.7 RECOMMENDATION 27: Walsall CCG should collaborate with the ambulance services to map out the stroke patient pathways; there is also a need to further understand and update travel and clinical activity modelling.

8.9 Public Transport

8.9.1 The panel was concerned that there was no information presented regarding how Walsall residents would travel to see their relatives at RWH using public transport, and the impact this would have on Walsall residents.

8.9.2 RECOMMENDATION 28: Walsall CCG to map out the availability of public transport and develop robust communication with Walsall residents promoting the need for stroke services in Wolverhampton and how to access public transportation links.

8.10 Wider Engagement and Partners

8.10.1 The panel acknowledged that the Walsall CCG business case and stroke reconfiguration proposal are aligned with the vision of the Black Country STP.

8.10.2 The panel were cognisant of the fact that bordering/neighbouring health care economies are undergoing service reconfigurations; the impact of these changes may affect patient flows.

8.10.3 RECOMMENDATION 29: Analysis is undertaken by Walsall CCG to set the proposed changes within a broader health economy context.

8.11 Equality Impact Assessment

8.11.1 Health service reconfigurations may have unintended impacts on those members of the population who have protected characteristics or those who live in the most deprived areas. The panel was of the view that the Walsall CCG Quality Impact Assessment Document (Whatton 2017) provided evidence that ‘Protected Characteristics’ had been considered.

8.11.2 KEY FINDING: The panel was concerned that attention to potential impacts of the proposed stroke service reconfiguration upon deprived populations of Walsall had not been evidenced.
8.11.3 RECOMMENDATION 30: Walsall CCG to consider using the HEAT tool to provide a systematic way to assess potential impacts upon deprived populations of proposed health service reconfigurations.

8.11.4 RECOMMENDATION 31: Walsall CCG should continue to build on the Equality Impact Assessment through engagement with the people that will ultimately be affected – patients their families, carers and the wider public.
9. Conclusion

The panel have been through an iterative process over the duration of the three day review. The information which Walsall CCG provided at times was contradictory, especially with respect to ESD and Rehabilitation.

From the evidence provided over the three days including the various documents, presentations and interactive sessions with Walsall CCG the panel agree that reconfiguration of stroke services is the right thing to do, for the local health economy and that centralisation of suspected stroke admissions at RWT, with relevant changes to the rest of the pathway, has the potential to deliver real benefits to all stroke patients across Walsall.

The panel have a number of recommendations that they would like Walsall CCG to take account of as set out in this document.
10. References


NHS (2016) The NHS Right Care Commissioning for Value Packs for Cardiovascular Disease


RWT (2017) Current provision of Stroke services at Royal Wolverhampton Trust


Walsall CCG (2017) Stroke Services Business Case for Public Consultation (v1.9 SR/DW)

Walsall CCG (2017) Walsall Stroke Service Sustainability Review


WM Clinical Senate (2014) Stroke Service Reconfiguration Review for Birmingham, Solihull and the Black Country
11. **Glossary**

The following list is a glossary of terms used throughout the ICRP report:

- **A&E** – Accident and Emergency
- **AHP** – Allied Health Professionals
- **ASU** – Acute Stroke Unit
- **BCA** – Black Country Alliance
- **BPT** – Best Practice Tariff
- **CCG** – Clinical Commissioning Group
- **ED** – Emergency Department
- **ESD** – Early Supported Discharge
- **FAST** – Face, Arm, Speech Test
- **GP** – General Practitioner
- **HASU** – Hyper Acute Stroke Unit
- **HEE** – Health Education England
- **HEFT** – Heart of England Foundation Trust
- **ICRT** – Independent Clinical Review Team
- **NHS** – National Health Service
- **NICE** – The National Institute for Health and Care Excellence
- **RWT** – Royal Wolverhampton Trust
- **SNNAP** – The Sentinel Stroke National Audit Programme
- **STEMI** – ST-Elevation Myocardial Infarction
- **TIA** – Transient Ischaemic Attack
- **ToR** – Terms of Reference
- **WHT** – Walsall Healthcare Trust
- **WMAS** – West Midlands Ambulance Service
- **WMCS** – West Midlands Clinical Senate
12. Appendices

12.1 Appendix 1 – Terms of Reference

West Midlands Clinical Senate
NHS England Stage 2 Clinical Assurance
Walsall Stroke Review
Terms of Reference
West Midlands Clinical Senate

Walsall Stroke Review

Terms of Reference

First published: October 2017

Version 1

Prepared by

Angela Knight Jackson
Head of Clinical Senate
West Midlands Clinical Senate
TERMS OF REFERENCE

Terms of Reference for: Independent Clinical Review Panel

Topic: West Midlands Clinical Senate NHS England Stage 2 Review Walsall Stroke Services
Sponsoring Organisations: Walsall CCG
Clinical Senate: West Midlands Clinical Senate

NHS England (Regional or DCO team): West Midlands

Terms of Reference agreed by:

Prof. Adrian Williams, Clinical Senate Chair on behalf of the Clinical Senate

Date: 20/10/17

Prof. Simon Brake, Chief Officer Walsall CCG on behalf of the Sponsoring Organisations

Date: Received on 20/10/2017

Sense checked by NHS England: 19/10/17

NB: The following Terms of Reference have been developed using the document ‘Clinical Senate Review Process Guidance Notes’. This document should therefore be read in conjunction with the document ‘Clinical Senate Review Process Guidance Notes’.
# Independent Clinical Review Team Members

## Chair:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Adrian Williams</td>
<td>Professor of Neurology</td>
<td>University Hospitals Birmingham NHS Foundation Trust</td>
</tr>
</tbody>
</table>

## Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Suzanne Nicholl</td>
<td>Clinical Director of Therapy Services</td>
<td>Heart of England NHS Foundation Trust</td>
</tr>
<tr>
<td>Dr Jatt Khaira</td>
<td>Consultant Stroke/General Medicine</td>
<td>University Hospital Birmingham</td>
</tr>
<tr>
<td>Caroline Graham</td>
<td>Clinical Team Leader in Stroke &amp; Neurology &amp; SID</td>
<td>Good Hope Hospital</td>
</tr>
<tr>
<td>Carron Sintler</td>
<td>Consultant Physiotherapist for Stroke Services</td>
<td>Birmingham Community Health Care NHS Trust</td>
</tr>
<tr>
<td>Nighat Hussain</td>
<td>Programme Director – Integrated Urgent Care Transformation, Stroke Services, Urgent Care Model and RCRH Interventional Cardiology and Emergency Surgery</td>
<td>Sandwell and WB CCG</td>
</tr>
<tr>
<td>William Taylor</td>
<td>GP Principal Lordswood Medical Group</td>
<td>Lordswood House Group Medical Practice</td>
</tr>
<tr>
<td>Gill Cluckie</td>
<td>Stroke Nurse Consultant Neurosciences</td>
<td>St. George's Healthcare NHS Trust</td>
</tr>
<tr>
<td>Kamal Nathavitharana</td>
<td>Associate Postgraduate Dean</td>
<td>Health Education England</td>
</tr>
<tr>
<td>Helen Carter</td>
<td>Deputy Director - Healthcare Public Health &amp; Workforce</td>
<td>Public Health England</td>
</tr>
<tr>
<td>Rajan Paw</td>
<td>Consultant Emergency Physician</td>
<td>The Dudley Group NHS Foundation Trust</td>
</tr>
<tr>
<td>Name</td>
<td>Title/Role</td>
<td>Affiliation</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td>Malika Javid</td>
<td>Consultant Radiologist</td>
<td>University Hospitals Coventry and Warwickshire</td>
</tr>
<tr>
<td>Sarah Adderley</td>
<td>Head of Stroke Support (Central)</td>
<td>The Stroke Association</td>
</tr>
<tr>
<td>Ashok Sinha</td>
<td>Consultant Orthopaedic Surgeon</td>
<td>Royal Wolverhampton / Cannock Hospital</td>
</tr>
<tr>
<td>Linzie Bassett</td>
<td>Clinical Team Lead for Stroke and neuro therapies</td>
<td>Birmingham Heartlands and Solihull Hospitals</td>
</tr>
<tr>
<td>George Theodoulou</td>
<td>Consultant in Older Adult Mental Health</td>
<td>Worcestershire Health and Care NHS Trust</td>
</tr>
<tr>
<td>Dr Kamel Sharobeem</td>
<td>Consultant Stroke Physician Clinical Director for Admitted Care</td>
<td>Sandwell and West Birmingham Hospitals NHS Trust</td>
</tr>
<tr>
<td>Sissi Ispoglou</td>
<td>Consultant &amp; Service Lead – Stroke</td>
<td>Sandwell &amp; West Birmingham NHS Trust</td>
</tr>
<tr>
<td>Peter Fahy (Desktop Review)</td>
<td>Director of Adult Services</td>
<td>Coventry City Council</td>
</tr>
<tr>
<td>Rashid Sohail</td>
<td>Deputy Medical Director</td>
<td>East Midlands Ambulance Service</td>
</tr>
<tr>
<td>Keith Spurr</td>
<td>Patient Representative</td>
<td>N/A</td>
</tr>
<tr>
<td>Brendan Young</td>
<td>Patient Representative</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>In attendance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angela Knight Jackson</td>
<td>Head of Clinical Senate</td>
<td>West Midlands CN and Senate NHS England</td>
</tr>
<tr>
<td>Katy Wheeler</td>
<td>Clinical Senate Administrator</td>
<td>West Midlands CN and Senate NHS England</td>
</tr>
<tr>
<td>Janet Smith-Morrison</td>
<td>Quality Improvement Officer</td>
<td>West Midlands CN and Senate NHS England</td>
</tr>
</tbody>
</table>

All independent clinical review team members will sign a declaration of conflict of interest and confidentiality agreement (see appendix 1 and 2), and their names and affiliations will be published in the Clinical Senate Stage 2 report.
Aim of the Independent Clinical Review

To assess and confirm the clinical quality, safety and sustainability of the reconfiguration of Walsall Stroke Services.

Scope of the review

The scope of the review will not include the West Midlands Clinical Senate making any comment on any alternative models or options which have been considered. When reviewing the case for change and options appraisal the independent clinical review team (ICRT) should consider whether the preferred model delivers real benefits to patients. The panel should also identify any significant risks to patient care in these proposals.

The panel should consider benefits and risks in terms of:
- Clinical effectiveness
- Patient Safety and management of risks
- Patient experience, including access to services
- Patient reported outcomes

The clinical review panel is not expected to advise or make comment upon any issues of the NHS England assurance process that will be reviewed elsewhere (e.g. financial elements of risk in the proposals). However, if the panel felt that there was an overriding risk this should be highlighted in the panel report.

Questions to the Clinical Senate

Walsall CCG has asked the Clinical Senate to consider the following questions:

- Does the proposed clinical model consider the whole stroke and transient ischaemic attack patient pathways, and provide enhanced accessibility to specialist stroke resources with better patient outcomes?
- Does the proposed clinical model comply with clinical guidelines and national and international best practice; in particular NICE Guidelines and National Standards for Stroke (November 17)
- Is there evidence that the Walsall stroke reconfiguration programme has demonstrated a robust clinical engagement programme?
- Is there evidence that the Walsall stroke reconfiguration programme has listened to the consultation feedback to inform its service delivery model?

Questions that may help the panel in assessing the benefit and risk of the proposals include (but are not limited to):

- Is there evidence that the proposals will improve the quality, safety and sustainability of care? (e.g., sustainability of cover, clinical expertise)
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
• Will the proposals reflect further the delivery of the NHS Outcomes Framework?
• Do the proposals uphold and enhance the rights and pledges in the NHS Constitution?
• Will these proposals meet the current and future healthcare needs of their patients within the given timeframe of the planning framework (i.e. five years)?
• Is there an analysis of the clinical risks in the proposals, and is there an adequate plan to mitigate identified risks?
• Do the proposals demonstrate good alignment with the development of other health and care services, including national policy and planning guidance?
• Do the proposals support better integration of services from the patient perspective?
• Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
• Will the proposals help to reduce health inequalities?
• Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

The ICRT should assess the strength of the evidence base of the case for change and proposed models.

Timeline

The proposed timeline is subject to change. Changes to the timeline may originate from either the Sponsoring Organisation (SO) or Independent Clinical Review Team (ICRT). The ICRT may also take the decision to pause the review in order to gain more information and or expertise. All changes made to the timeline will be updated and circulated to both the SO, NHS England and ICRT by the Clinical Senate (CS).

<table>
<thead>
<tr>
<th>Week Beginning</th>
<th>Action</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>27th July</td>
<td>Sponsoring Organisation (SO) formally requests clinical review of senate as part of NHS England’s Stage 2 assurance</td>
<td>SO</td>
</tr>
<tr>
<td>27th July</td>
<td>Senate council member appoints Chair</td>
<td>CS</td>
</tr>
<tr>
<td>1st August – 7th September</td>
<td>Recruitment of Independent Clinical Review Team panel members.</td>
<td>CS</td>
</tr>
<tr>
<td>2nd October</td>
<td>Senate office and SO agree terms of reference (question, timeline and methodology)</td>
<td>CS</td>
</tr>
<tr>
<td>2nd October</td>
<td>Senate Office request documentation from the sponsoring organisation</td>
<td>CS</td>
</tr>
<tr>
<td>2nd October</td>
<td>Conflict of Interest and confidentiality guidance to</td>
<td>CS</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Notes</td>
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<td>--------------</td>
<td>-----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; October</td>
<td>NHS England Sense Check TOR</td>
<td>CS</td>
</tr>
<tr>
<td>16&lt;sup&gt;th&lt;/sup&gt; October</td>
<td>Documentation received from SO (Walsall CCG to send sample pack of evidence to WM CS by 23&lt;sup&gt;rd&lt;/sup&gt; October)</td>
<td>CS</td>
</tr>
<tr>
<td>16&lt;sup&gt;th&lt;/sup&gt; October</td>
<td>Documents and Clinical Senate process, governance and guidance dispatched to the independent clinical review team ((Walsall CCG to do by 23rd October)</td>
<td>CS</td>
</tr>
<tr>
<td>23&lt;sup&gt;rd&lt;/sup&gt; October</td>
<td>Independent Clinical Review Team reading</td>
<td>CS</td>
</tr>
<tr>
<td>30&lt;sup&gt;th&lt;/sup&gt; October</td>
<td>Independent Clinical Review Team meet Clinical review commences in line with TOR and methodology</td>
<td>CS</td>
</tr>
<tr>
<td>30&lt;sup&gt;th&lt;/sup&gt; October</td>
<td>Day 1 of Independent Clinical Review Team</td>
<td>CS</td>
</tr>
<tr>
<td>9&lt;sup&gt;th&lt;/sup&gt; November</td>
<td>Day 2 of Independent Clinical Review Team</td>
<td>CS</td>
</tr>
<tr>
<td>23&lt;sup&gt;rd&lt;/sup&gt; November</td>
<td>Day 3 of Independent Clinical Review Team</td>
<td>CS</td>
</tr>
<tr>
<td>27&lt;sup&gt;th&lt;/sup&gt; November</td>
<td>Clinical Senate team Report writing</td>
<td>CS</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; December</td>
<td>Draft Report to Independent Clinical Review Team for input and amendments</td>
<td>CS</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; December</td>
<td>Draft Report to SO for fact checking (5 day Turnaround)</td>
<td>CS</td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; January</td>
<td>Finalise report</td>
<td>CS</td>
</tr>
<tr>
<td>8&lt;sup&gt;th&lt;/sup&gt; January</td>
<td>Sign off by Clinical Senate Council</td>
<td>CS</td>
</tr>
<tr>
<td>15&lt;sup&gt;th&lt;/sup&gt; January</td>
<td>Formally submit final report to SO</td>
<td>CS</td>
</tr>
<tr>
<td>To be agreed with SO</td>
<td>Publish and disseminate as per terms of reference</td>
<td>CS</td>
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</tbody>
</table>
Methodology

The role of the independent clinical review team will be to examine documentary evidence, carry out site visits if necessary and decide recommendations. The independent clinical review team may decide to increase or decrease the number of days required for review and also the method by which panel members provide input into the review.

It is anticipated that the review will be over 3 days and will take place on the following dates:

- 30th October
- 9th November
- 23rd November

The independent clinical review team will need to consider the following bullet points 5-9:

Reporting

A draft report from the Independent Clinical Review Team will be made available to the sponsoring organisation for fact checking prior to publication. Any comments / corrections must be received within 5 working days.

The Independent Clinical Review Team will submit a draft report proportionate to a Stage 2 review (see as a guide Clinical Review Team Report Template appendix 3) to the Clinical Senate Council who will agree the report and be accountable for the advice contained in the final report. The council may wish to take a view or offer advice on any issues highlighted that should be taken into consideration in implementing change.

The Council will be asked to comment specifically on the:

- Comprehensiveness and applicability of the review
- Content and clarity of the review and its suitability to the population in question
- Interpretation of the evidence available to support its recommendations
- Likely impact on patient groups affected by the reconfiguration
- Likely impact / ability of the health service to implement the recommendations

The final report will be submitted to the sponsoring organisation by week commencing 15th January 2017 and the clinical advice will be considered as part of the NHS England’s Stage 2 Assurance process for service change proposals. The report is not expected to comment upon issues of the NHS England assurance process that will be reviewed elsewhere (e.g. patient engagement, GP support or the approach to consultation).

The review report will remain confidential until placed in the public domain at the conclusion of the review process with the agreement of the sponsoring organisation.
Communication and Media Handling

The Clinical Senate will ensure all communication activities, in whatever form, are conducted according to appropriate ethical, legal and professional standards, using professional guidance from in-house communications teams and or contracted external teams.

The Clinical Senate review will be published on the website of the Clinical Senate with the agreement of the Sponsoring Organisation. Council and assembly members will provide support to disseminate the review at a local level. The Clinical Senate may engage in various activities with the sponsoring organisation to increase public, patient and staff awareness of the review.

Resources

The West Midlands Clinical Senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

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

Accountability and Governance

The independent clinical review team is part of the West Midlands Clinical Senate accountability and governance structure.

The West Midlands 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.
Functions, Responsibilities and Roles

The Sponsoring Organisations

The Sponsoring Organisations will:

- Provide for the clinical review panel all relevant background and current information, identifying relevant best practice and guidance. 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 (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions).

- Respond within the agreed timescale to the draft report on matter of factual inaccuracy.

- Undertake not to attempt to unduly influence any members of the clinical review team during the review.

- Submit the final report to NHS England for inclusion in its Stage 2 formal service change assurance process.

The Clinical Senate Council and the Sponsoring Organisations

The Clinical Senate Council and the Sponsoring Organisations will:

- Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements

Clinical Senate council will:

- Appoint a clinical review team; this may be formed by members of the senate, external experts, or others with relevant expertise. It will appoint a chair or lead member

- Endorse the terms of reference, timetable and methodology for the review

- Endorse the review recommendations and report

- Provide suitable support to the team.

- Submit the final report to the sponsoring organisation
The Independent Clinical Review Team

The Independent Clinical Review Team will:

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template proportionate to Stage 2 review process and provide the sponsoring organisation with a draft report to check for factual inaccuracies
- 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
- keep accurate notes of meetings.

The Independent Clinical Review Team Members

The Independent Clinical Review Team members will undertake to:

- Commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology)
- contribute fully to the process and review report
- ensure that the report accurately represents the consensus of opinion of the clinical review team
- comply with a confidentiality agreement and not discuss the scope of the review nor 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.

NHS England

NHS England will:

- Sense check the TOR to ensure that the review will deliver the views that address DCO concerns raised during the assurance process
- Requests to change the TOR should be made through the commissioner of the review
Appendix 1

Declaration of Conflict of Interest

West Midlands Clinical Senate
Stage 2 Clinical Assurance Independent Clinical Review

Walsall Stroke Review

To be completed by all members of the clinical review team. Clinical Senate Council members should also consider if they have any conflicts in considering the review team’s report.

For advice on what items should and should not be declared on this form refer to the ‘Conflicts of Interest Policy’ issued by the West Midlands Clinical Senate. Further advice can also be obtained from the Clinical Senate Manager.

Name: __________________________________________________________

Position: _________________________________________________________

Please describe below any relationships, transactions, positions you hold or circumstances that you believe could contribute to a conflict of interest:

For completion

Type of Interest – Please supply details of where there is conflict in accordance with the following list:

A direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);

An indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision;

A direct non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract);

An indirect non-pecuniary interest: where an individual is closely related to, or in a relationship, including friendship with an individual.
A direct non-pecuniary benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual’s house);

An indirect non-pecuniary benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value but is a benefit to peers or colleagues (for example, a recommendation which results in an increase in revenue or status to their employing organisation or results in their organisation becoming the preferred provider).

An indirect non-pecuniary conflict: where the evidence of the senate may bring a member into direct or indirect conflict with their contracting or employing organisation, to the extent that it may impair the member’s ability to contribute in a free, fair and impartial manner to the deliberations of the senate council, in accordance with the needs of patients and populations.

Other – please specify

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Type of Interest</td>
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<tr>
<td>Details</td>
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<td>Action Taken</td>
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<tr>
<td>Action Taken By</td>
<td></td>
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<tr>
<td>Date of Declaration</td>
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</table>

I hereby certify that the information set forth above is true and complete to the best of my knowledge.

Signature: __________________________________________

Name: ________________________________________________

Date: ________________________________________________
Appendix 2

Confidentiality Agreement
West Midlands Clinical Senate Independent Clinical Review Team
Walsall Stroke Review

I (name)

hereby agree that during the course of my work (as detailed below) with the West Midlands Clinical Senate I am likely to obtain knowledge of confidential information with regard to the business and financial affairs of an NHS body, or other provider, its staff, clients, customers and suppliers, details of which are not in the public domain ('confidential information') and accordingly I hereby undertake to and covenant that:

I shall not use the confidential information other than in connection with my work; and

I shall not at any time (save as required by law) disclose or divulge to any person other than to officers or employees of West Midlands clinical senate, other NHS organisations, staff, clients, customers and suppliers whose province it is to know the same any confidential information and I shall use my best endeavours to prevent the publication or disclosure of any confidential information by any other person.

The restrictions set out above shall cease to apply to information or knowledge that comes into the public domain otherwise than by reason of my default of this Agreement.

The ‘Work’ (clinical review) is: Walsall Stroke Review

Signed __________________________ Date: ______________

Name (caps) __________________________
Appendix 3

West Midlands Clinical Senate Independent Clinical Review Team Report Template

West Midlands Clinical Senate
Walsall Stroke Review

[senate email]@nhs.net

Date of publication to sponsoring organisation:

CHAIR’S FOREWORD (Independent Clinical Review Team)

Statement from Clinical Senate Chair

SUMMARY & KEY RECOMMENDATIONS

BACKGROUND

- [CLINICAL AREA]
- [Description of current service model]
- [Case for change]
- [Review methodology]
- Details of approach taken, review team members, documents used, sites visited, interviewees]
- [Scope and limitations of review]
- [Recommendations]

CONCLUSIONS AND ADVICE

[References]

This should include advice against the test of ‘a clear clinical evidence base’ for the proposals and the other checks defined in the terms of reference agreed at the outset of the review.

Has the proposal been founded on robust clinical evidence? What evidence has been used and how has it been applied to local circumstances?

Has the available evidence been marshalled effectively and applied to the specifics of the proposed scheme?
GLOSSARY OF TERMS

APPENDICES:

Terms of Reference
Independent Clinical Review Team Members biographies and any declarations of interest
Background-

(NB this should be a summary and is not intended to be the set of evidence or information provided)
12.2 Appendix 2 – ICRT Panel Members’ Biographies

<table>
<thead>
<tr>
<th>Name</th>
<th>Adrian Williams</th>
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<tbody>
<tr>
<td>Adrian Williams</td>
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</table>

Adrian Williams graduated from University College Hospital, London and, after training in General Medicine there, took up a lectureship at The Cardiothoracic Institute, Brompton Hospital, investigating the pulmonary changes associated with chronic liver disease.

In 1975 Dr Williams was recruited to Harvard Medical School, Boston where his interest in sleep began with the investigation of Sudden Infant Death Syndrome (S.I.D.S.) and publication of a definitive study implicating obstructive sleep apnoea (OSA) as one cause of this syndrome.

An invitation to the University of California at Los Angeles in 1977 to take up a post as Chest Physician allowed this early interest in OSA in infants to extend into adult patients with the very first reports of OSA causing hypertension, and of oximetry as a natural diagnostic tool. In 1985 Dr Williams became tenured Professor of Medicine at UCLA and co-director of the UCLA Sleep Laboratory. As Sleep Medicine gelled as a specialty, Dr Williams was one of the first to take the Board exams in 1989 to become an accredited polysomnographer and later member of the American Academy of Sleep Medicine.

In 1994 Dr Williams returned to London where he established the Sleep Disorders Centre at St. Thomas’ Hospital.

He has published extensively on Sleep Disorders including more than 100 peer reviewed original scientific papers and more than 80 other published papers including chapters and books.

Dr Williams is a Diplomat of the American Board of Sleep Medicine, a founding member of The British Sleep Foundation, the Sleep Medicine Section of the Royal Society of Medicine as well as the RLS UK Group, and was recently appointed Professor of Sleep Medicine, King’s College London.

Dr Williams is Professor of Clinical Neurology at the Regional Centre for Neurology at the Queen Elizabeth Hospital Birmingham. He is also a senior advisor to the Parkinson’s Society and Chair of the West Midlands Clinical Senate.
<table>
<thead>
<tr>
<th>Name</th>
<th>Mr Ashok K Sinha</th>
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<tbody>
<tr>
<td></td>
<td>Ashok is a Consultant Orthopaedic Surgeon based at Cannock Hospital and employed by Royal Wolverhampton Hospital. He has been an Orthopaedic Consultant for over 15 years. He was last employed at Mid Staffs Hospital NHS Trust, Stafford since 2008. He was in a management post as Clinical Director of Planned Care there during the period of recovery from the Mid Staffs experience and gained valuable experience as a Clinical Manager. Ashok is involved with teaching and training and is an examiner for the FRCS) Trauma and Orth) exit exams.</td>
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<table>
<thead>
<tr>
<th>Name</th>
<th>Brendan Young</th>
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<td></td>
<td>Brendan has had a career in the Healthcare Industry, Consultancy &amp; Coaching. He has extensive experience of partnership working with NHS Clinicians, Commissioner &amp; Provider organisations to improve Quality outcomes and safety for patients. Having held many voluntary roles providing patient/carer perspectives on NHS Organisations for nearly 10 years, he has led many successful Co-Production initiatives. His post-graduate qualifications and wide experience of input to Organisational Development &amp; Change within the NHS helps him understand culture, values and staff motivations supporting innovation and improvement. He is a Chartered member of CIPD. Brendan engages extensively with patients, carers/supporters and Healthcare Professionals and Managers at all levels and this helps provide patient voice and insight to a number of NHS bodies on which he serves in a voluntary basis, having given up fulltime employment. He is a patient representative on the West Midlands Clinical Senate Council and the West Midlands AHSN AF Advisory Group and serves on the Worcestershire Stroke Strategy Forum. He has extensive experience of Stroke Services Improvement and has worked with the NHS across the stroke pathway from Stroke Prevention, Hyper/Acute Stroke Services &amp; Stroke Recovery. He has participated in a number of Stroke Service Re-Configurations. He is a qualified Wellbeing Coach with expertise in Positive Psychology and runs a Positive Stroke Group for Recoverers &amp; Supporters gaining first-hand access to stroke patient experiences.</td>
</tr>
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</table>
Name | Caroline Graham
---|---
Caroline is a clinical team leader and works in Good Hope hospital in Sutton Coldfield. She leads the stroke & neurology therapy teams on the acute stroke unit, ESD and neuro-out-patient services. Caroline is also a clinical specialist physiotherapist specialising in spasticity management. She leads the stroke spasticity clinic, is a physiotherapy injector and independent prescriber and skilled in the use of functional electrical stimulation.

Caroline has over 20 years of experience working in stroke and neurology. She has been a lead physiotherapist on an acute and rehabilitation stroke wards and has worked in neuro-out-patients for many years. She is passionate about stroke & neurology services; she chaired West Midlands Association of Chartered Physiotherapists interested in Neurology (ACPIN) for 7 years and was committed to promoting and developing specialist neuro-physiotherapist skills and services in the region.

Name | Carron Sintler
---|---
Carron qualified as a physiotherapist in 1995 after training at Coventry University, returning there in 2004 to complete her MSc in Physiotherapy. She has experience of working across various rehabilitation services, both in hospital and community settings, and specialised in stroke early in her career. Her current post as consultant physiotherapist allows her the benefit of working across the whole stroke pathway, from acute admission to long term follow up. Clinically, her interests include early and continued rehabilitation, spasticity management, patient and carer involvement, and AHP role in stroke prevention. Long term, she intends to continue in the field of stroke.

Name | Dr Georgios S Theodoulou
---|---
George has worked as a substantive consultant psychiatrist since 2008; working in community, inpatient and acute hospital liaison settings. He completed his psychiatric training in the West Midlands gaining specialist registration in old age and general psychiatry. He is currently section 12(2) approved, a MHA Approved Clinician, a Deprivation of Liberty Safeguards mental health assessor, an Honorary Senior Lecturer at the University of Worcester and sits on the Midlands and East of England Section 12(2)/Approved Clinician approval panel.

George has also been the clinical director for older adult mental health services in Worcestershire Health and Care NHS Trust (2013-2016). He has considerable clinical experience in applying the Mental Health Act and the Mental Capacity Act as well as dealing with the interface of the two Acts. He regularly carries out Mental Health Act assessments, DoLS assessments and mental capacity assessments for the Court of Protection. He also lectures and teaches widely on all aspects of psychiatric practice.
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<th>Name</th>
<th>Gill Cluckie</th>
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<tbody>
<tr>
<td>Gill completed her nurse training at Glasgow University followed by an MSc at King’s College London. She completed her PhD in 2014 which investigated patient, carers and clinicians views on communication about thrombolysis treatment. She has worked in stroke care since 2000. Her current role encompasses the whole patient pathway including thrombectomy, hyper-acute care, inpatient care, research, outpatient stroke clinics and community stroke prevention group. She is the principle investigator for a number of clinical research trials. Gill is the stroke care group lead for St. George’s Hospital. She is a nurse advisor to the London stroke clinical leadership group and leads the London wide stroke nursing competencies project. She is a member of the Intercollegiate Stroke Working Party at the Royal College of Physicians. She is an honorary lecturer at University College London.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Helen Carter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen is a Birmingham University Medical graduate who started working in the field of Public Health in 2001. She has worked for many different organisations during this time including Health Authorities, Primary Care Trusts, and Strategic Health Authority on a wide range of projects and programs. Helen joined Public Health England when it was formed in 2013. Her portfolio is currently very diverse and includes being the PHE Children and Young People Executive Team sponsor and the Vice chair of the West Midlands Clinical Senate.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Jattinder Khaira</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jattinder trained at Cambridge and Oxford Universities and received postgraduate training in the West Midlands. After training as a GP he returned to hospital medicine specialising in stroke medicine. Interests in the clinical aspects of stroke care.</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Dr Kamal Nathavitharana</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Kamal is Associate Postgraduate Dean, Quality, Research and Innovation, Health Education England - West Midlands. He is a Consultant Paediatrician and Gastroenterologist, Honorary Associate Professor at Warwick Medical School and Honorary Senior Lecturer at the Birmingham Medical School.</td>
</tr>
<tr>
<td></td>
<td>Kamal is a strong advocate for paediatrics and is a published researcher in mucosal immunology and medical education. He is a passionate enthusiast for education and training, leading the development of the online generic induction through a multi-professional partnership across the West Midlands region.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Kamel Sharobeem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dr Kamel Sharobeem has been a consultant stroke physician at Sandwell and West Birmingham Hospitals (SWBH) NHS Trust since April 2005. He developed the stroke &amp; TIA pathways and introduced the thrombolysis service. He undertook a complete service redesign and reconfiguration that was fully implemented on the Sandwell site in March 2013.</td>
</tr>
<tr>
<td></td>
<td>He is currently the Clinical Director for Admitted Care at SWBH and participates in the TIA, hyper-acute and stroke rehabilitation services locally. He has a particular interest in cardioembolic stroke due to atrial fibrillation and cryptogenic stroke in young patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Keith Spurr</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Keith is a retired HR Professional and an accredited Trade Union Representative. From retirement, he is;</td>
</tr>
<tr>
<td></td>
<td>1) The Service Champion for South Lincolnshire, Diabetes UK. He has organised 3 Diabetes Education Event in Stamford and Spalding Lincolnshire and established a Peer group for people with diabetes based</td>
</tr>
<tr>
<td></td>
<td>2) Patient Representative of the East Midlands Clinical Senate reviewing STP proposals from NHS Trusts before the Consultation phase.</td>
</tr>
<tr>
<td></td>
<td>3) National Patient Participation Voice for NHS England,</td>
</tr>
<tr>
<td></td>
<td>4) Volunteer for Healthwatch Lincolnshire</td>
</tr>
<tr>
<td></td>
<td>5) Secretary to a PPG for Lakeside Healthcare Stamford.</td>
</tr>
<tr>
<td>Name</td>
<td>Linzie Bassett</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td><strong>Linzie is an HCPC registered Physiotherapist who qualified in 1988 from Queen Elizabeth School of Physiotherapy Birmingham. She has always had a strong interest in treating neurological conditions and was awarded a Fellowship by the CSP in 2007 for her contribution to neuro-physiotherapy and development of ACPIN.</strong></td>
<td></td>
</tr>
<tr>
<td>Linzie is currently working for Heart Of England Foundation Trust where her leadership skills have enabled her to work as a Therapy Clinical team lead for a group of Physiotherapists, Occupational Therapists, dietitians and speech and language therapists within Stroke and Neuro. Her clinical skills include the assessment and treatment of a complex caseload of neurological patients. She has a keen interest in service development and patient experience.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Malika Javid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consultant Musculoskeletal Radiologist at University Hospitals Coventry and Warwickshire NHS Trust (UHCW NHS Trust) - since December 2005. Qualifications: MBBS, MRCP, FRCR. Currently AudiUGovernance/Discrepancy Lead for the Radiology Dept.</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Nighat Hussain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nighat is an experienced director and works as a transformation programme lead within the West Midlands Integrated Urgent Care (IUC) Team. She support the West Midlands Urgent and Emergency Care Development forum and transformation programme for IUC. She has led on the programme management of a complex regional stroke programme within Birmingham, Solihull and Black country conurbation. Nighat has worked closely with Professor Tony Rudd (National Clinical Director for Stroke) to develop the NHS (2016) stroke services: Configuration Decision Support Guide. Nighat has over 19 years of experience working in hospital, commissioning and programme management settings. Nighat has extensive knowledge and experience in service re-design in both an acute hospital and commissioning environment. She is extremely passionate about service transformation and has extensive knowledge of operational including programme and project management, especially within modernisation and clinical pathways.</strong></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Peter Fahy</th>
</tr>
</thead>
</table>
Peter Fahy is the Director of Adult Services for Coventry City Council, a role he took up in October 2015. He has been in local government since 1997 and social care since 2003 in which has managed a range of service areas including Adults Safeguarding, Housing, Provider Services and Commissioning across children’s and adult’s services.

External to the City Council Peter is national policy lead for ADASS (Association of Directors of Adult Social Services) for Physical and Sensory Impairment and West Midlands lead Use of Resources.
<table>
<thead>
<tr>
<th>Name</th>
<th>Rajan Paw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rajan has been an ED consultant at Dudley Group for the last twelve years. He has spent six of those years as a medical service head and two years as the lead for urgent care. He is a member of the RCEM service redesign group and has extensive experience in pathway design and configuration.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Rashid Sohail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rashid has a background in healthcare in the UK NHS. He qualified &amp; trained in UK. He has a broad experience of healthcare but for the past 15yrs this has been predominantly emergency medicine and he has been a consultant for 14 years &amp; senior manager for past 6 years.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>His interests include clinical education, particularly legal aspects of medicine. He is an experienced trainer &amp; appraiser of undergraduate &amp; postgraduate doctors in training. Emergency &amp; Advanced Nurse Practitioner trainer. Prehospital trainer of trauma skills to fire crews.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Sarah Adderley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah has worked for the Stroke Association for 2½ years, having worked in management for over 10yrs previously.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>She initially joined as Deputy Head of Operations and most recently gained the position of Head of Stroke Support for the Central region.</td>
</tr>
<tr>
<td></td>
<td>Having graduated in 2001 (BSc Human Psychology), Sarah spent six years working within the recruitment industry before moving to a Specialist College for young people with disabilities.</td>
</tr>
<tr>
<td></td>
<td>She is currently responsible for the delivery of commissioned services across our region and must ensure that we are supporting stroke survivors and their carers via a person centred approach to achieve a life after stroke.</td>
</tr>
</tbody>
</table>
### Dr Sissi Ispoglou

Sissi qualified in Thessalonica, Greece, 1994  
- MBA – Health exec, Keele, 2011.  
- Stroke Physician in SWBH since 2012 (Service Lead 2017).  
- **Special interests:**  
  - Small vessel disease, Intracerebral haemorrhage,  
  - Process Mapping & Lean in Healthcare systems

### Suzanne Nicholl

Suzanne is a Physiotherapist by profession and is currently the Clinical Director of Therapy Services at Heart of England Foundation Trust. She has worked in the West Midlands for 23 years across community and acute sectors, and endeavours to eliminate the impact of professional boundaries within therapy and the health economy. She is passionate about enabling staff to deliver quality through clinical and system improvement and innovation.

### Will Taylor

Will is one of the founder members of Our Health Partnership, a large GP super partnership that sits across Birmingham and Shropshire.

He has also been a GP Partner at Lordswood Medical Centre in Birmingham for 11 years.

Will also works for BXC CCG as a Contracting Lead.
## 12.3 Appendix 3 – Declaration of Interest

<table>
<thead>
<tr>
<th>Name</th>
<th>Mr Ashok K Sinha</th>
</tr>
</thead>
<tbody>
<tr>
<td>No direct conflict of interest. Employed by Wolverhampton Hospital and based at Cannock Hospital.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Malika Javid</th>
</tr>
</thead>
<tbody>
<tr>
<td>It may or may not be relevant but I have 1400 shares in MEDICA (Radiology Reporting Company) as part of my ISA. I do not work for the company (or any outsourcing reporting company).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Sarah Adderley</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are a provider of services across this area.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Sissi Ispoglou</th>
</tr>
</thead>
<tbody>
<tr>
<td>My partner, Dr Ken Fotherby is one of the Stroke Consultants at New Cross Hospital, Wolverhampton.</td>
<td></td>
</tr>
</tbody>
</table>
12.4 Appendix 4 – Agendas – Day 1, 2, 3

**DAY 1**

Independent Clinical Review Panel  
Stage II Clinical Assurance of Walsall Stroke Services Review  
Monday 30th October 2017, 9:00 until 16:30  
Venue – Copthorne Hotel, Paradise Circus, Birmingham, B3 3HJ

**AGENDA**

<table>
<thead>
<tr>
<th>Item</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| 09:00 | Arrival with Refreshments  
Panel Pre-meet Adrian Williams & Clinical Senate Team |
| 09:30 | 1 Session 1:  
Introduction and Review of Documentation Submitted  
Introductions  
Housekeeping  
Declaration of Interest  
Review ToR  
Overview of the documentation  
Additional questions posed by the programme board |
| 11:00 | Refreshments |
| 11:15 | 2 Panel Discussion – Key Lines of Enquiry  
Explore and clarify specific issues  
Formulate questions for Commissioners |
| 12:45 | Lunch and Refreshments |
| 13:30 | 3 Session 2:  
Presentation from Sponsoring Organisation  
Commissioners presentation of the Clinical Case for Change and preferred Clinical Model |
| 14:30 | 4 Panel Questions to Commissioning Organisation |
| 15:15 | Refreshments |
| 15:30 | 5 Panel Deliberations  
Assess, Agree and Capture |
| 16:15 | 6 ICRT Chair - Debrief with Sponsoring Organisation  
Debrief |
| 16:30 | 7 END |
# DAY 2

**Independent Clinical Review Panel**

**Stage II Clinical Assurance of Walsall Stroke Services Review**

**Thursday 9th November 2017, 9:00 until 16:30**

**Venue – Site Visit – Walsall and Wolverhampton**

## AGENDA

<table>
<thead>
<tr>
<th>Timing</th>
<th>Item</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:25</td>
<td>Train will depart from Birmingham New Street</td>
<td></td>
</tr>
<tr>
<td>9:20</td>
<td>Train will arrive at Walsall Train Station</td>
<td></td>
</tr>
<tr>
<td>9:20</td>
<td>Minibus will be at Walsall Train Station and drive to Walsall Hospital</td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Arrival and refreshments</td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>Welcome and Introduction</td>
<td>Chair</td>
</tr>
<tr>
<td>10.10</td>
<td>Declaration of Interest</td>
<td>All</td>
</tr>
<tr>
<td>10.15</td>
<td>Review of Day 1 – 30th October</td>
<td>All</td>
</tr>
<tr>
<td>10:30</td>
<td>Welcome from the Chair</td>
<td></td>
</tr>
<tr>
<td>10.40</td>
<td>Meeting with Medical Director</td>
<td></td>
</tr>
<tr>
<td>11.00</td>
<td>Tour of Walsall</td>
<td>Programme Team Leads accompanied by a Directorate Manager to lead the tour</td>
</tr>
<tr>
<td>12.40</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>1.20</td>
<td>Minibus will arrive and drive to (Wolverhampton?)</td>
<td></td>
</tr>
<tr>
<td>2.05</td>
<td>Welcome and Introduction</td>
<td>Chair</td>
</tr>
<tr>
<td>2.15</td>
<td>Tour of Wolverhampton</td>
<td>Programme Team Leads accompanied by a Directorate Manager to lead the tour</td>
</tr>
<tr>
<td>4.00</td>
<td>Panel Discussion</td>
<td>All</td>
</tr>
<tr>
<td>4.45</td>
<td>CLOSE</td>
<td></td>
</tr>
<tr>
<td>4:45</td>
<td>Minibus will take you to Walsall Train Station</td>
<td></td>
</tr>
<tr>
<td>5:08</td>
<td>Train departs from Walsall Train Station</td>
<td></td>
</tr>
<tr>
<td>5:55</td>
<td>Train arrives at Birmingham New Street</td>
<td></td>
</tr>
</tbody>
</table>
**DAY 3**

Independent Clinical Review Panel

Stage II Clinical Assurance of Walsall Stroke Services Review

Thursday 23rd November 2017, 9:00 until 16:30

Venue – Copthorne Hotel, Paradise Circus, Birmingham, B3 3HJ (GPS post code: B1 2DT)

**AGENDA**

<table>
<thead>
<tr>
<th>Item</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:10</td>
<td>Arrival with Refreshments Panel Pre-meet</td>
</tr>
<tr>
<td>09:45</td>
<td>1 Introduction by the Chair</td>
</tr>
<tr>
<td>09:55</td>
<td>2 Panel Discussion – Review of Day Two Scope of Terms of Reference Key Lines of Enquiry Further Documentation Submitted</td>
</tr>
<tr>
<td>10:30</td>
<td>3 Panel Discussion – Key Lines of Enquiry</td>
</tr>
<tr>
<td>11:00</td>
<td>Refreshments</td>
</tr>
<tr>
<td>11:15</td>
<td>4 Programme Board Follow up Q&amp;A (sponsoring organisation)</td>
</tr>
<tr>
<td>12:30</td>
<td>5 Lunch &amp; Refreshments</td>
</tr>
<tr>
<td>1:15</td>
<td>6 Panel Deliberations</td>
</tr>
<tr>
<td>3:00</td>
<td>7 ICRT Chair, Vice Chair, Clinical Senate Team Debrief with Sponsoring Organisation Teleconferencing Details Dial In 0800 915 1950 or 0203 463 9697 Participant passcode: 47598189 then #</td>
</tr>
<tr>
<td>3:30</td>
<td>END</td>
</tr>
</tbody>
</table>
### 12.5 Appendix 5 – List of Evidences

#### 12.5.1 Day 1

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Stroke Service Sustainability Review</strong> – June 2017, <em>Walsall Healthcare NHS Trust</em></td>
</tr>
<tr>
<td>2</td>
<td><strong>Stroke Services current position</strong> – October 2017, <em>Royal Wolverhampton Hospitals NHS Trust</em></td>
</tr>
<tr>
<td>3</td>
<td><strong>Walsall Stroke Services – Business Case for Public Consultation</strong>, June 2017 <em>NHS Walsall CCG</em></td>
</tr>
<tr>
<td>4</td>
<td><strong>Changes to Estate Facilities and Workforce</strong> Oct 2017, <em>Royal Wolverhampton Hospitals NHS Trust</em></td>
</tr>
<tr>
<td>5</td>
<td><strong>Stroke Rehabilitation</strong> – Proposed Pathway/Models of Care, <em>Walsall Healthcare NHS Trust</em></td>
</tr>
<tr>
<td>6</td>
<td><strong>Pathway</strong> - Patient arrives independently at Walsall ED</td>
</tr>
<tr>
<td>7</td>
<td><strong>Pathway</strong> - Patient picked up by WMAS</td>
</tr>
<tr>
<td>8</td>
<td><strong>Existing</strong> WHT RWHT and proposed merged stroke pathways</td>
</tr>
<tr>
<td>9</td>
<td><strong>Quality Impact Assessment</strong> for re-configured Stroke Services in Walsall.</td>
</tr>
<tr>
<td>10</td>
<td><strong>Updated</strong> Risk Register – RHT</td>
</tr>
<tr>
<td>11</td>
<td><strong>RWT Acute and WHT Community Stroke Services</strong>: End-to-End Process Model</td>
</tr>
<tr>
<td>12</td>
<td><strong>WMAS</strong> Mapping Review – <em>October 2017</em></td>
</tr>
<tr>
<td>13</td>
<td><strong>Walsall Council</strong> travel time analysis using TRACC software – <em>October 2017</em></td>
</tr>
<tr>
<td>14</td>
<td><strong>Letter</strong> - Prof Adrian Williams to Prof Simon Brake – July 27th 2017</td>
</tr>
</tbody>
</table>
### 12.5.2 Day 2

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1</td>
<td><strong>Stroke Service Sustainability Review</strong> – June 2017, <em>Walsall Healthcare NHS Trust</em></td>
</tr>
<tr>
<td>Appendix 2</td>
<td><strong>Stroke Services current position</strong> – October 2017, <em>Royal Wolverhampton Hospitals NHS Trust</em></td>
</tr>
<tr>
<td>Appendix 3</td>
<td><strong>Walsall Stroke Services – Business Case for Public Consultation</strong>, June 2017 <em>NHS Walsall CCG</em></td>
</tr>
<tr>
<td>Appendix 4</td>
<td><strong>Changes to Estate Facilities and Workforce</strong> Oct 2017, <em>Royal Wolverhampton Hospitals NHS Trust</em></td>
</tr>
<tr>
<td>Appendix 5</td>
<td><strong>Stroke Rehabilitation</strong> – Proposed Pathway/Models of Care, <em>Walsall Healthcare NHS Trust</em></td>
</tr>
<tr>
<td>Appendix 6</td>
<td><strong>Pathway</strong> - Patient arrives independently at Walsall ED</td>
</tr>
<tr>
<td>Appendix 7</td>
<td><strong>Pathway</strong> - Patient picked up by WMAS</td>
</tr>
<tr>
<td>Appendix 8</td>
<td><strong>Existing</strong> WHT RWT and proposed merged stroke pathways</td>
</tr>
<tr>
<td>Appendix 9</td>
<td><strong>Quality Impact Assessment</strong> for re-configured Stroke Services in Walsall.</td>
</tr>
<tr>
<td>Appendix 10</td>
<td><strong>Updated</strong> Risk Register - RWT</td>
</tr>
<tr>
<td>Appendix 11</td>
<td><strong>RWT Acute and WHT Community Stroke Services</strong>: End-to-End Process Model</td>
</tr>
<tr>
<td>Appendix 12</td>
<td><strong>WMAS Mapping Review</strong> – <em>October 2017</em></td>
</tr>
<tr>
<td>Appendix 13</td>
<td><strong>Walsall Council</strong> travel time analysis using TRACC software – <em>October 2017</em></td>
</tr>
<tr>
<td>Appendix 14</td>
<td><strong>Letter</strong> - Prof Adrian Williams to Prof Simon Brake – July 27th 2017</td>
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### 12.5.3 Day 3

<table>
<thead>
<tr>
<th>Number</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Slide pack with additional responses as requested</td>
</tr>
<tr>
<td>2</td>
<td>WHT - The ESD pathway and pathway evidence for L4 and L5. This is an interim arrangement until Sept 2018, the long term arrangement is proposed for Holly bank.</td>
</tr>
<tr>
<td>3</td>
<td>WMAS Doc</td>
</tr>
<tr>
<td>4</td>
<td>RWHT Impact Doc</td>
</tr>
</tbody>
</table>