West Midlands Clinical Senate
Stroke Service Reconfiguration Review for Birmingham, Solihull and the Black Country

REPORT

Contents

1. Foreword by Panel Chair – Dr Bill Gowans

Although there is no single definition of major NHS service change, it is generally understood to involve a significant shift in the way front line health services are delivered, usually involving a change in the geographical location where services are delivered and typically affect large numbers of patients.

The objective of service change is to achieve a fundamental improvement in the quality and sustainability of services in a way that gains support of patients, staff and the public. The assurance process must therefore be consistent and robust and avoid becoming a checklist of legal requirements.

Whilst NHS England lead and oversee the assurance process of NHS service changes, the responsibility for external clinical assurance was recently been transferred (1st April 2014) from the National Clinical Advisory Team to Clinical Senates.

It is in this context that the Sandwell and West Birmingham CCG, as the co-ordinating commissioner, approached the West Midlands Clinical Senate in April 2014, with a request to perform an external clinical review of the Birmingham, Solihull and Black Country Stroke Review.

This report is the outcome of the external clinical review which was undertaken by an Independent Clinical Advisory Team, on behalf of the West Midlands Clinical Senate, between July and September 2014

This report was approved and signed off by the West Midlands Clinical Senate Council on 17th September 2014. The West Midlands Clinical Council duly noted the submission (letter dated 4th September 2014) from Nick Harding Chair of the Stroke Programme Review and Chair of Sandwell and West Birmingham CCG. The Council agreed the submission will form an addendum to this report.

2. Clinical Senate Chair Summary and Recommendations – Dr David Hegarty

The West Midlands Clinical Senate was asked to provide clinical assurance of the Birmingham, Solihull and Black Country Stroke Services Reconfiguration programme as part of NHS England's assurance process. The assurance sought was in relation to the clinical model for the hyper-acute and acute phases of the proposed stroke pathway.

The Clinical Senate Review panel has concluded that the current position, robust evidence-based case for change and the proposed service model are clearly defined in the review. The methodology utilised by the Clinical Senate Review panel is described within the document and a panel of appropriate clinical and non-clinical experts were convened from both within and outside of the West Midlands.

The review panel is completely assured on the components of the clinical model as defined within the terms of reference. However, the Clinical Senate Review Panel also recognises risks from

interdependencies outside of the terms of reference of the review, and therefore beyond the remit of the Senate review panel. These risks are clearly defined within the report, alongside some key recommendations for consideration by the Stroke Services Reconfiguration panels. The assurance of the clinical model is based on the conclusion of the Clinical Senate review panel that the proposal seeks to embed best evidence based practice which will result in improved outcomes for patients.

3. Background

Stroke is a major health problem in the UK. It is a preventable and treatable disease that is the third biggest cause of death in the UK and the largest single cause of severe disability. Each year in England, approximately 110,000 people (Scarborough et al, 2009) have a first or recurrent stroke which costs the NHS over £2.8 billion. South Asians (Indians, Pakistanis and Bangladeshis) have a higher risk of stroke than the rest of the population. In the West Midlands, approximately 11,600 people will have a first or recurrent stroke each year. Most people survive a first stroke, but often have significant morbidity.

Stroke mortality rates in the UK have been falling steadily since the late 1960s. The development of stroke units, following the publication of the Stroke Unit Trialists Collaboration meta-analysis of stroke unit care and the further reorganisation of services following the advent of thrombolysis, has resulted in further significant improvements in mortality and morbidity from stroke (National Sentinel Audit for Stroke 2010; National Sentinel Stroke Clinical Audit, 2011).

Care for people with any form of stroke (ischaemic or haemorrhagic stroke) is prompt admission to a specialist stroke unit. This reflects the Department of Health “Act F.A.S.T” campaign to highlight the symptoms of stroke and the importance of obtaining emergency treatment. The Stroke Strategy for England (2007) specifies that stroke is a medical emergency: local networks need to plan to ensure that everyone who could benefit from urgent care is transferred to an acute stroke unit. The quality of the stroke unit is the single biggest factor that can improve a person’s outcomes following a stroke. Successful stroke units are built around a stroke-skilled multi-disciplinary team; Hyper-acute stroke services enable patients to have rapid access to the right skills and equipment and be treated 24/7 on a dedicated stroke unit, staffed by specialist teams.

Outcomes for stroke patients have improved in London since specialist care was centralised in eight hyper-acute stroke centres in 2010. NHS England is advocating the roll-out of the London model of stroke reconfiguration on a nationwide basis and aims to build on the “evidence-based model” and “develop a specific case for acute stroke service reconfigurations in two geographical locations by April 2015” (NHS England Business Plan 2014/15 – 16/2017). NHS England is also looking at flexible models in preparation for the national rollout, recognising that urban and rural areas require different stroke service configurations. Birmingham, Solihull and Black Country; Greater Manchester; Coventry and Warwickshire are among the areas already working towards a full reconfiguration of their stroke services.

4. Description of Current Service Model

The Stroke Transformation Programme has been established by Clinical Commissioning Group’s (CCG’s) in Birmingham, Solihull and the Black Country (BSBC) to assess the need to reconfigure hyper acute and acute services to improve clinical outcomes for patients. The Birmingham, Solihull and Black Country Stroke Sentinel National Audit Performance (SSNAP) shows that often providers are

unable to meet the national average performance levels and meet the high levels of performance attainment areas that have already implemented specialist stroke centres, such as London. The CCG's suggests that if the stroke services in BSBC implemented specialist stroke units, there would be significant improvements in key standards e.g. CT scanning, thrombolysis and access to a multidisciplinary team, which would significantly improve the quality of outcomes delivered to patients. Their vision for stroke services is to prioritise stroke, to adopt a clinically-driven and clinically-owned model of care; to ensure a uniformly high treatment standard for stroke patients, irrespective of where in the Birmingham, Solihull and Black Country area they suffered their stroke.

In 2010, the West Midlands Regional Quality Review Service led a review process in co-ordination with the West Midlands Cardiac and Stroke Networks. The purpose of the review was to assess compliance with the West Midlands Quality Review Service (West Midlands Quality Review Service) quality standards for acute stroke and Transient Ischaemic Attacks (TIA) and to train future reviewers.

The review process showed that there was significant variation in the quality of care that is provided across the region. The West Midlands Strategic Health Authority was concerned about the model / configuration for stroke services in the region. In January 2012 the NHS across the Midlands and East approved a clinically led comprehensive review of stroke across the region. This review identified options that would improve outcomes by improving mortality, reduce chances of long term disability and improve patient experience. The Midlands and East Stroke Review for the Birmingham, Solihull and Black Country area concluded that there are six hospital trusts, which deliver nine Hyper Acute Stroke Units (HASU). Hyper Acute Stroke Units provide specialist stroke care in the first 72 hours after the stroke. The regional review recognised that strong collaborative work and clear governance arrangements were required to take this work forward at a local level during 2013/14 and considered a range of options from three to six HASU sites, all of which required local appraisal. Since this time a public consultation took place in Sandwell and West Birmingham to configure stroke services at Sandwell General Hospital, resulting in 8 HASU sites across the area in March 2013. There are further plans to move to six sites. Heart of England Foundation Trust is moving HASU services from both the Solihull and Good Hope site to the Heartland location. This is estimated to be completed by the end of October 2014.

4.1 Provider and Clinical Commissioning Groups:

The intended reconfiguration of services is in relation to the following provider Trusts

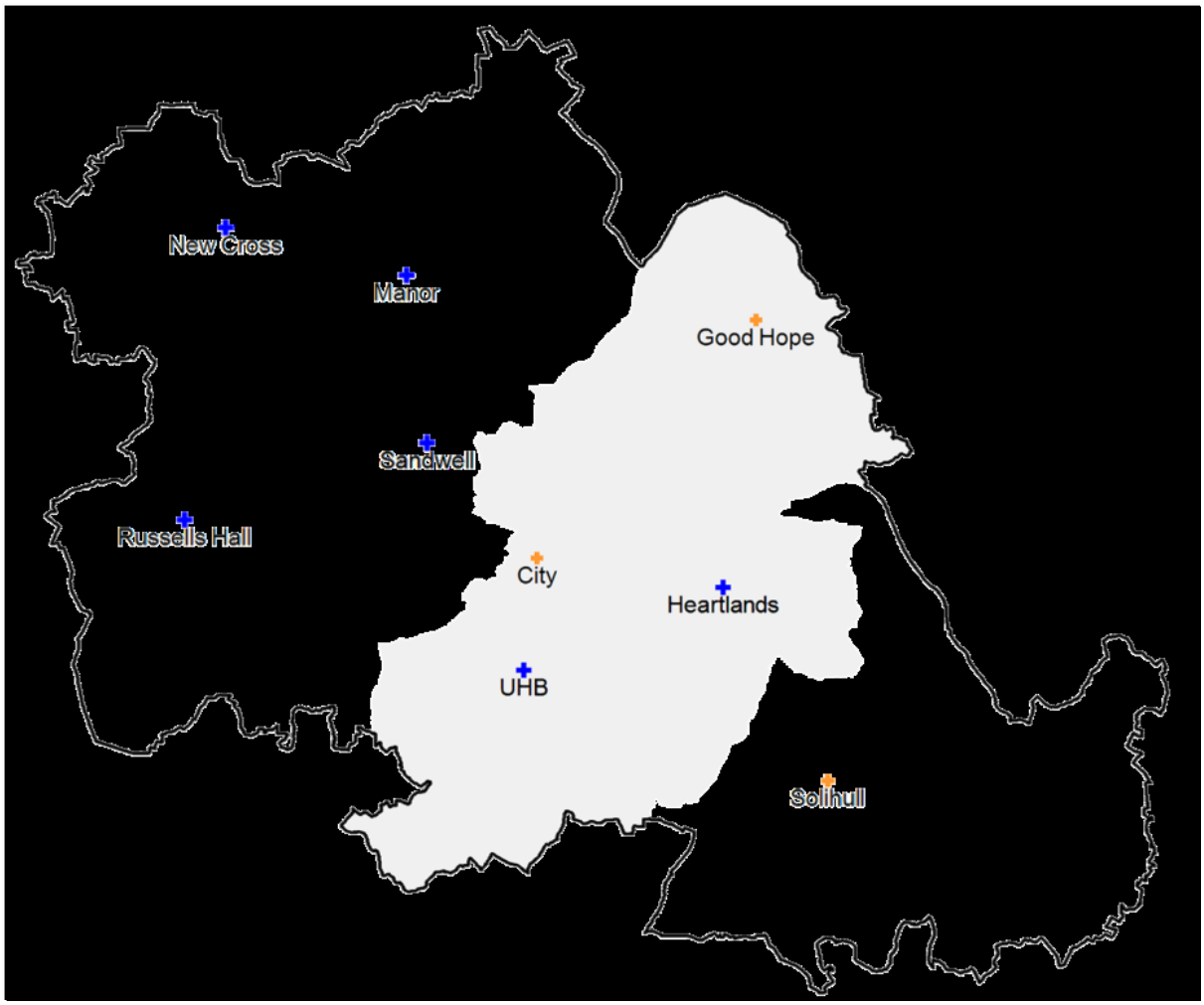
- Birmingham Community Healthcare NHS Trust
- Heart of England NHS Foundation Trust
- Royal Wolverhampton Hospitals NHS Trust
- Sandwell and West Birmingham NHS Trust
- The Dudley Group NHS Foundation Trust
- University Hospitals Birmingham NHS Trust
- Walsall Healthcare NHS Trust
- West Midlands Ambulance Trust

These are respectively commissioned by:

- Birmingham Cross City Clinical Commissioning Group
- Birmingham South Central Clinical Commissioning Group
- Dudley Clinical Commissioning Group

- Sandwell and West Birmingham Clinical Commissioning Group
- Solihull Clinical Commissioning Group
- Walsall Clinical Commissioning Group
- Wolverhampton Clinical Commissioning Group

4.2 Map of Provider Trusts



5. Scope of the Review

The scope of this review is to provide clinical assurance on the hyper-acute and acute phases of the proposed stroke pathway. This includes the pre-hospital phase, hyper-acute stroke services, acute stroke services and TIA services. The non hyper-acute phases of the proposed stroke pathway lie outside the scope of this review as defined in its Terms of Reference. This includes Prevention, In-patient and Community Rehabilitation, Long Term Care and End of Life Care.

Assurance was sought from the West Midlands Clinical Senate on the following:

- Whether the clinical case is made for reconfiguring stroke services to deliver specialist stroke centres providing Hyper-acute, acute stroke and TIA services

- Whether the preferred model of centralised hyper-acute stroke specialist centre delivering specialist centres that support Hyper-Acute and Acute Stroke care (0-7 days) with repatriation of non-local patients to inpatient stroke rehabilitation centres. Patients who are deemed local will receive the Acute Stroke Care and rehabilitation at the HASU site or off site where there are pre-agreed local pathways

- Do the proposed five site HASU configuration options constitute a safer and sustainable pattern of services that promote access? The Programme Board has identified two five site configurations that deliver the travel and clinical critical mass.

6. Methodology of Review

6.1 Terms of Reference

A request to the West Midlands Clinical Senate from Sandwell and West Birmingham CCG (Co-ordinating Commissioner) was received in April 2014. The request came at a time of transition when two of the functions namely, early advice and stage II assurance, was being transferred from the National Clinical Advisory Team (NCAT) to Clinical Senates. The West Midlands Clinical Senate sought permission from the Birmingham, Solihull and Black Country Medical Director to undertake the review in order to assure the Area Team that the Clinical Senate was fit for purpose and had the capability and capacity to undertake the clinical assurance for the Birmingham, Solihull and Black Country Stroke Review (see appendix 1). The Birmingham, Solihull and Black Country Stroke Review were formally adopted onto the Clinical Senate work programme by the Clinical Senate Council on Wednesday 9th July 2014.

The process to formulate the advice was led by Dr Bill Gowans, Clinical Senate Council Vice-Chair. Terms of reference for the Council's work were developed as per NHS England guidance (see appendix 2). This included the approach for formulating advice and the overall process through which advice and recommendations would be developed.

The terms of reference was shared and agreed with Sandwell and West Birmingham CCG, the Programme Director and Programme Board. This ensured that the advice which the Clinical Senate had been asked to provide, and the approach to formulating it, were transparent to all stakeholders. Any comments and feedback received were addressed.

6.2 Process

The Clinical Senate formulated advice between July and September 2014. 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 outside the West Midlands area (see table 1 and Appendix 3). A Confidentiality agreement and potential conflicts and associations were declared during the process. These are recorded in appendix 4.

Review dates were held on 8th July, 22nd July and 12th August 2014. The ICRT reviewed documentation provided by Sandwell and West Birmingham CCG. Presentations relevant to the review were made from key members of the Stroke Transformation Programme (see appendices 5, 6 and 7).

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. The panel's main observations and conclusions are presented as per Clinical Senate Review Process: Guidance Notes (June 2014).

6.3 Table 1 Independent Clinical Review Team

Chair	Position	Organisation
Dr Bill Gowans	Vice Chair of Shropshire Clinical Commissioning Group Vice Chair of West Midlands Clinical Senate	Shropshire Clinical Commissioning Group
Dr L Warburton	Consultant in Stroke Medicine	Cambridge University Hospitals NHS Foundation Trust
Dr N Baldwin	Consultant Stroke Physician	Wye Valley NHS Trust
Prof C Roffe	Consultant Stroke Physician	University Hospital of North Staffordshire NHS Trust
Prof G Venables	Consultant Neurologist	Sheffield Teaching Hospitals NHS Trust
Dr L Greasley	Emergency Department Consultant	Peterborough and Stamford Hospitals NHS Trust
Ms Diane Lloyd	Care Group Clinical Director	The Shrewsbury and Telford Hospital NHS Trust
Ms Lynn Scott	Service Director of Adult Social Care & Health	Milton Keynes Local Authority
Mr M Ward	Head of Clinical Practice	West Midlands Ambulance Trust
Dr A Whitehouse	Ass Dean, Head of Foundation Programmes and Head of School of Medicine	Health Education West Midlands
Dr R Smith	Deputy Postgraduate Dean	Health Education West Midlands
Dr H Carter	Consultant in Public Health	Public Health England
Mr N Phillips	Patient and Public Representative	On Behalf of the West Midlands SCN and Senate NHS England
Angela Knight Jackson (in attendance)	Clinical Senate Manager	West Midlands SCN and Senate NHS England

Victoria Millward (in attendance)	Quality Improvement Lead Manager	West Midlands SCN and Senate NHS England
Karen Edwards (in attendance)	Senate PA	West Midlands SCN and Senate NHS England
Alison Lake (in attendance)	Admin Support	West Midlands SCN and Senate NHS England

7. The Case for Change

The commissioners provided and presented a variety of information to support the case for change, from which the panel formed the following observations and views:

7.1 The Case for Change – the centralisation of hyper-acute and acute stroke services

The panel is of the view that a clear and compelling case for change was made, based on sound evidence presented to the panel on current performance, improvements seen in other regions by adopting a centralised hyper-acute stroke service, potential long term financial benefits and alignment with national NHS strategy. In particular:

- Nationally, stroke mortality and morbidity remains high.

- The current service across BSBC, as evidenced by the Sentinel Stroke National Audit Programme (SSNAP) data, is under-performing with unacceptable variations between different services.

- Clinical and patient experience, as well as an emerging research evidence in the form of improved patient safety, outcomes and experience, supports the centralisation of acute stroke services in urban areas (London and Manchester models as cited by Morris, Hunter, Ramsey et al (2014); thrombolysis Wardlaw et al (2014); stroke unit trialists collaboration Emberson, Lees, Lyden et al (2014) and the Stroke Improvement National Audit Programme (SINAP)data)

- The workforce modelling presented to the panel, against a backdrop of the high probability of long term workforce challenges and constraints, describes and demonstrates the benefits to the sustainability and quality of services of consolidating the specialist workforce into a smaller number of hyper-acute and acute units. This is of particular relevance to trained stroke nurse staffing ratios where there is emerging evidence that these are sensitive to outcome data (Brabrand, Hallas and Knudsen 2014). Optimising the limited specialist workforce across the programme area will improve recruitment, retention, education and training.

- There is a clear narrative to suggest that short term investment in centralising services and reducing the number of HASU / Acute Stroke (ASU) units may reap longer term financial benefits for the health and care sectors through operational efficiencies, for the wider economy and society through increased productivity and reduced dependency and through improved patient outcomes as measured by Quality Adjusted Life Year (QALYS) (although a

recent BMJ paper (Bray et al 2013) suggests this will require full implementation of the model).

7.2 The Case for Change – alignment with local, regional and national strategic intentions

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

- National Stroke Strategy (2007) Department of Health.
- National Clinical Guideline for Stroke 3rd edition-prepared by the Intercollegiate Stroke Working Party (July 2008)
- 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)
- National Clinical Guidelines for Stroke (2012) Royal College of Physicians
- Quality Standards Programme: Stroke (2010) National Institute for Clinical Excellence
- Stroke Service Standards (2010) British Association of Stroke Physicians
- Quality and Outcomes Framework for 2012/13 (2011) NHS Employers
- The NHS Outcomes Framework 2012/13 (2011) Department of Health
- Department of Health (2012) A Public Health Outcomes Framework for England 2013-2016
- 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
- Putting patients First, Business Plan 2014 -2017 – NHS England 2014

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:

- Sandwell and West Birmingham CCG Stroke Services Reconfiguration Programme Brief
- Birmingham, Solihull and Black Country January 2014
- The inclusion of the stroke programme in the 2yr and 5yr plans of all the CCGs involved

8. Assessing Clinical Assurance for the Development, Delivery and Sustainability of the Clinical Model

Commissioners provided and presented a variety of information to the panel. From this information the panel formed the following observations and views:

8.1 The Development of the Clinical Model

The panel are of the view that there is a strong rationale and persuasive narrative to support and underpin the modelling assumptions used in the decision tree framework to determine and recommend the optimum model.

The rationale for the lower threshold of 600 and upper threshold of 1500 patients treated in each unit per annum is robust, although the panel recognised that these are based on estimated figures which may change according to multiple variables.

The panel were assured that the programme board were aware that there is an operational and workforce risk inherent in exceeding the agreed upper threshold of 1500 patients per unit and recognised that forward planning will be required to manage the predicted volumes above 1500 for every unit.

Access analysis is locally derived, thorough and persuasive in proposing a 95% achievement of a 45 minute travel time to determine the optimum HASU options.

The panel supports and assures the outcome of the process to determine the HASU / ASU configuration which concludes that 5 HASU / ASU / high risk TIA service units is the optimum configuration.

The panel also supports and assures the proposal to co-locate HASU and ASU services for the first 0-7 days of patient care following a stroke. The panel acknowledges that this differs from the London HASU-ASU split site 72 hour model and supports the view of the local patient and carer consultation that felt that a move at 72 hours was too soon.

The panel supports and assures the Midlands and East Service Specifications which are to be used to implement consistent and high quality stroke services in the new model. The panel recognises that the local CCAG has modified the service specifications to take account of local context and consensus.

The clinical model is supported by published evidence and guidelines including but not limited to, NICE (2008 and 2010), Royal College of Physicians (2008 and 2012), NHS Midlands and East (2010), the Alteplase guidelines (NICE 2012).

8.2 The Quality, Safety and Sustainability of Care Provided by the New Model

The panel are of the view that the proposals seek to embed best evidence based practice (as detailed above), suggesting that improved outcomes will be delivered.

However, the panel recognised that the impact from the currently evolving service change from 9 to 6 HASU's are unclear, which makes baseline assessment difficult since patient flows, operational delivery and workforce behaviour have all changed as a consequence.

Based on the evidence presented, the panel highlighted the risk to sustainability of the future service from a combination of predicted increase in patient volumes (exceeding the upper threshold set for modelling assumptions) and the expected workforce constraints.

Based on the evidence presented to the panel, there is an assumption that improvements in local services will occur as a result of centralisation. Since the reduction in the number of HASUs proposed is small, i.e. from 6 to 5 units, the operational, staffing and financial benefits gained will be limited and will not in themselves deliver a major improvement to stroke services in the programme area.

It is the view of the panel that major improvements in the quality, safety and sustainability of care will only result when, in combination with modest further centralisation of services, there is a robust and consistent implementation of the agreed service specifications, not only in the hyper-acute and acute phase, but also across the whole stroke pathway. It is the transformation and consistency of clinical practice and care within the context of a fully staffed centralised service that will have the biggest impact on quality.

The panel recognise the need to ensure that medical, nursing and therapy staffing levels will be in line with national guidance Intercollegiate Stroke Guideline (Royal College of Physicians, 2012). The provider returns presented to the panel indicate that investment will be required from all trusts hosting HASUs and ASUs to achieve this. This will require the full engagement and leadership of hospital chief executives and their senior clinicians. The panel relied on secondary evidence in regard to this, presented by Professor Rudd, and are unable to assure the successful delivery of this crucial component of the service at this stage.

The panel encourages triangulation with other quality assurance processes that determine the capacity and capability of providers (monitor, quality surveillance groups, CQC).

8.3 Improved integration of stroke services provided by the new model

The panel are of the view that co-location of HASU and ASU across all units does and will improve integration of acute stroke care and patient flow in the acute phase and, on that basis, can assure the proposed service standard of transfer from HASU to ASU at 3 days and discharge / repatriation at 7 days.

The processes employed by the programme itself are aimed at improving the integration of health services within the wider health and care system and with neighbouring services. The impacts on border services have been mapped in detail.

The service specifications adopted have the potential to improve integration of acute stroke services within the whole stroke pathway from prevention to end of life.

The panel were concerned that there was no evidence presented to it of improved integration between health and social care. Whilst the service specifications assume this, there is evidence that there are difficulties in engaging social care in the programme which strongly indicates a future risk of their lack of involvement in implementation and delivery.

The panel also concluded that the interdependencies and impacts with other medical specialties and radiology services have not yet been mapped. They felt that this would form a crucial and urgent next stage of the programme, particularly in regard to emergency and acute medicine, both in the units with HASU / ASU and those which may no longer be providing them as part of the new model. This is of particular relevance to the management of stroke mimics, many of whom will be elderly with multiple comorbidities and likely to be displaced from their local services.

8.4 A networked approach with co-operation and collaboration with other sites and organisations

The panel are of the view that there is good evidence of CCG commissioner networking but that this has yet to be translated into a comprehensive vision of a networked clinical regional stroke service.

Although there is evidence of an embryonic local clinical engagement through the Local Clinical Advisory Group (LCAG), the panel were concerned that commercial confidentiality and procurement processes are hindering the emergence of collaborative clinical leadership to lead the development of a networked service. The panel are therefore unable to assure this aspect of the programme and strongly recommend rapid progression beyond the constraints imposed by procurement to release the potential for the provider clinicians to develop networked clinical leadership.

The panel also recognised that a commissioning process involving 7 CCGs limited the ability to develop and deliver a joint vision for the whole stroke pathway. The delivery of consistent stroke services through the new model is largely dependent on the robust implementation of agreed service specifications and not on a full stroke strategy co-created by all stakeholders across the programme area.

8.5 Engagement, leadership & responsibility of clinicians, patients and carers in the programme

The panel were assured that there is evidence of good engagement with the 7 CCGs involved in the programme as evidenced by the Memorandum of Understanding which they have all signed and through the programme vision, aims and objectives being incorporated into all of their 2yr and 5yr plans.

There is also evidence of good clinical leadership at programme board and CCG level.

The panel felt that there was limited wider public and patient engagement in the programme up to this point, but recognised that this was in advance of a public consultation exercise.

The panel noted that the majority of Health and Wellbeing Boards, Health Overview and Scrutiny Committees and Healthwatch boards had received and approved a pre-engagement presentation from the programme board. This engagement process will require continuous attention to secure resilient support from these important stakeholders.

The panel also recognised that there had been good engagement with providers through the options appraisal process led by Professor Rudd and the full engagement of West Midlands Ambulance Service (WMAS) travel time analysis and the wider programme development.

Although there is some evidence of more recent engagement of provider clinicians through the Local Clinical Advisory Group, this has not yet developed to the point where clear network clinical

leadership is demonstrated. The panel were strongly of the view that this would become a critical component of the successful delivery of the new model.

8.6 Patient Access and Transport

The panel found good evidence of a robust modelling process to assess the impact of travel times during the acute phase of the stroke pathway. It also felt that the subsequent adoption of a 95% admitted to a HASU within 45 minutes as a criterion for determining the optimal service configuration had struck a clinically sensible balance between a potential increase in travel times and clinical benefits.

There has not yet been an appraisal or analysis of carer and relatives access and travel times in regard to the new model. The panel recognised the importance of being able to reassure carers and relatives that their needs are being taken into account and that this would affect patient experience, patient flow and potentially even outcomes.

The panel also recognised that the transport and access issues in regard to the non-acute phases of the pathway have not yet been examined.

8.7 Health and Equality Impact Assessments

The panel found good evidence that thorough health impact and health inequalities assessments have been completed and the consequences of service re-configuration have been considered (Health Impact Assessment (HIA), Equality Impact Assessment (EQIA), Health Needs Assessment (HNA) and travel times)

8.8 Workforce and Training Analysis

The panel noted that a workforce gap analysis is being developed, based on provider workforce position and national guidelines (British Association of Stroke Physician BASP guidelines) and recognised that further work needs to be undertaken to address the expected shortfall.

Further data provided by Health Education England (HEE) in regard to recruitment rates: *Recruitment across the UK to training programmes in the medical specialties of Geriatric Medicine and Acute Internal Medicine (AIM), which produce doctors ready to become consultants in these specialties, and which are central to acute and hyper-acute stroke services, are poor. In 2013, the national recruitment process produced fillrates of 56% in AIM and 75% in Geriatric Medicine (JRCPTB figures). There may in future be insufficient suitable trained consultants to supply the necessary workforce to stroke units across the country in general and in the programme area in particular.*

The panel felt that there was considerable optimism bias in regard to the management of projected local and national workforce limitations across all professional groupings.

The panel were of the view that a long term local multi-disciplinary training and development programme would be required to address the projected workforce gap. This would include an assessment of skills mix and the use of novel posts. The panel were not presented with evidence to suggest this is being planned.

The workforce risk would also be partially mitigated through the successful implementation of a 5 HASU model and by avoiding the contingency of retaining 6 units (or reversion back to six as a result of increasing volumes).

8.9 Monitoring progress and delivery through robust metrics and outcomes

The panel recognised that some work was being undertaken in developing agreed metrics to monitor progress and delivery but noted that poor data capture and quality were hampering this process.

The panel were presented with evidence of a large variation in the quality and quantity of data provided by the provider trusts who may host HASUs and ASUs.

The panel strongly suggests giving a high priority to improving data capture and quality to establish accurate base lines.

The panel is reassured that metrics will be agreed and consistent across the programme area for the whole stroke pathway even though the commissioning and delivery of the non-acute components will be locally determined.

8.10 Clinical risk analysis, risk mitigation and optimism bias

The panel were presented with good evidence of a programme risk assessment in the form of a programme risk register. The panel were not shown an equivalent clinical risk register and therefore made an assessment of clinical risk based on the programme risk register.

The panel felt that there was some optimism bias in the following areas of identified risk:

- 'That the reconfiguration would only be partially implemented.' The BMJ review of reconfiguration of stroke services strongly suggests that partial implementation results in no overall improvement in mortality, so full implementation becomes all the more vital.
- 'That the workforce is insufficient to provide future stroke services.' As detailed elsewhere, the panel has a high level of concern about this risk that is not reflected in the current risk scoring on the register.
- 'That the reduction in HASUs could adversely affect other core services for sites that lose a HASU service.' The panel feel that this risk has not been adequately mapped and that the degree of mitigation indicated in the risk register is optimistic. In addition, the impact on other clinical specialties in hospitals hosting a HASU / ASU unit has not yet been mapped.
- 'That there has been a lack of uptake from Social Care partners in engaging in this process.' On the basis of evidence presented to the panel, it is their view that this risk remains high and has not been sufficiently mitigated.
- 'That non-HASU service specifications may not be fully utilised and implemented by CCG commissioners.' Despite the fact that all CCGs have signed an MOU, the panel feel that the critical inter-dependencies across the whole pathway which require the service specifications to be fully implemented, means that this risk remains high.

In addition, the panel identified two further risks which do not appear on the risk register and which may therefore be subject to optimism bias:

- Stroke mimics – the programme may have underestimated the impacts that stroke mimics may have on other medical services, especially when the HASU / ASU units start to handle larger volumes of patients as predicted in the modelling.
- Transition management has not been not detailed. For example, planning the progression to meeting full service specifications, the impact of loss of HASU on one provider and a rapid increase of service provision on the remaining five sites.

8.11 Contingency Planning

The panel were informed that the contingency plan had not been fully worked up because it was not of the highest priority at this stage of the programme. However, a contingency plan in which the number of HASUs remains at 6, had been identified. The panel understand that the contingency plan would still require the full implementation of agreed service specifications across the 6 HASU / ASU sites and the non-acute components of the stroke pathway.

The panel expressed concern regarding the contingency proposal in regard to the workforce implications inherent in maintaining 6 HASU / ASU sites and the loss of benefit in consolidating an already scarce specialist workforce onto 5 sites.

The panel recognised that a robust programme clinical network, led or jointly led by provider clinicians, could support the development of a more flexible contingency plan.

8.12 The Department of Health's 4 Tests for Service Change

In preparation for consultation, the panel assessed the programme against the four tests for service change:

1. Strong public and patient engagement.
The panel recommend that this be strengthened but anticipate that the consultation phase of the programme will demonstrate this.

2. Consistency with current and prospective need for patient choice.
The panel felt that this needs more carefully defining and articulating, recognising that the emergency components of the stroke pathway lie outside the requirement for patient choice, with the exception that every patient must be made aware of their right to refuse treatment. The non-acute components of the pathway must comply with this test.

3. A clear evidence base.
The panel was assured that this is demonstrated.

4. Support for proposals from clinical commissioners.
The panel was assured that this is demonstrated.

9. Limitations of the Review

Although the scope of this review is confined to the hyper-acute and acute phases of the pathway, it was the opinion of the panel that this imposed a significant limitation on their ability to fully assure all aspects of the hyper-acute phases because of the critical interdependencies between the different components of the entire stroke pathway and the uncertainty surrounding the impact that these inter-dependencies are likely to have on the hyper-acute and acute components.

The model describes a high risk TIA service co-located with each HASU / ASU centre. Although the panel were able to clinically assure the 'standalone' service specifications of the TIA service, there was little available detail concerning the clinical, workforce and operational inter-relationships and implications between the provision of the TIA service and the HASU / ASU units. The panel were

therefore unable to assess the potential provider and patient impacts of the different operational issues related to TIA services which may result in workforce implications beyond those already highlighted in this report (particularly in regard to cardiology and radiology service implications).

Due to commercial confidentiality and sensitivities, the panel was unable to make site visits or interview provider clinicians and relied on secondary evidence to make an assessment of provider capacity and clinical leadership and engagement. It was the panel's view that this imposed a further important limitation on the assurance process in terms of project delivery and clinical sustainability and resilience.

The independent clinical review by the representatives of the West Midlands clinical senate was time limited and without an existing and established framework due to this being a new process. This imposed some limitations on the ability to explore and assure all aspects of the clinical model.

10. Conclusions and Recommendations

From the evidence presented, the panel are able to fully assure the case for change and the clinical model for the proposed hyper-acute and acute stroke services. This includes full assurance of the patient volume thresholds and travel time analysis used to develop the optimum configuration of services across the programme area. The panel is therefore able to fully assure the conclusion that 5 HASU / ASU sites provide the optimum configuration. The panel fully assures the decision to co-locate HASU and ASU services for 0-7 days of admission. The panel fully assures the Midlands and East Service Specifications adopted, with some local amendment, by the programme. This includes assurance of the high risk TIA service specifications, although detail around service delivery of this service integrated with the HASU / ASU sites was not available.

The panel made a number of recommendations based on areas of concern. In summary, these are:

- Review the rationale and assumptions for the upper patient volume threshold of 1500, assuming that the predicted activity levels are reached and the threshold is consistently breached in all units.
- Ensure that commissioners and providers remain totally committed to implementing the whole stroke pathway using the agreed service specifications to provide consistency of delivery.
- Resolve the limitations imposed by commercial confidentiality and procurement rules to enable the creation of a clinically led networked service which will be crucial to the success of the programme.
- Develop further strategies to improve and assure provider capacity and capability.
- Ensure social care engagement throughout the programme.
- Map the impact of the proposed model on other medical specialties.
- Gain a more detailed understanding of the impact of stroke mimics on the consolidated service and its clinical adjacencies.
- Create a local workforce development programme, with support from HEE, to mitigate the high risk of a long term workforce gap.

- Improve data capture and quality to establish reliable baselines and monitoring processes.
- Ensure robust transition planning.

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12. Glossary of Terms

ASU – Acute Stroke Unit
BASP – British Association of Stroke Physicians
BMJ – British Medical Journal
BSBC – Birmingham, Solihull and the Black Country
CCG – Clinical Commissioning Group
EQIA – Equality Impact Assessment
HASU – Hyper Acute Stroke Unit
HEE – Health Education England
HIA – Health Impact Assessment
HNA – Health Needs Assessment
ICRT – Independent Clinical Review Team
LCAG – Local Clinical Advisory Group
PLOS – Public Library of Science
QALY – Quality Adjusted Life Year
SINAP – Stroke Improvement National Audit Programme
SSNAP – Sentinel Stroke National Audit Programme
SWB – Sandwell and West Birmingham
TIA – Transient Ischaemic Attack
WMAS – West Midlands Ambulance Service
WMQRS – West Midlands Quality Review Service

13. Appendices

Appendix 1 Letter to Birmingham, Solihull and Black Country Area Team Medical Director

West Midlands Strategic Clinical Network & Senate
St Chad's Court
213 Hagley Road
Edgbaston
Birmingham, B16 9RG
Email: karen.edwards14@nhs.net
Telephone: 0113 825 3257

Dr Kiran Patel
Area Team Medical Director for Birmingham, Black Country and Solihull
NHS England
St Chad's Court, 213 Hagley Road
Edgbaston, Birmingham
B16 9RG

Thursday 10th April 2014

Dear Dr Patel

West Midlands Clinical Senate Proposed Stroke Review Panel Process

Please find below the West Midlands Clinical Senate Proposed Stroke Review Panel Process.

From the 1st April 2014 Clinical Senates are required to review a service change proposal against the appropriate key test (clinical evidence base) and the best practice checks that relate to clinical quality, alongside any bespoke requirements for an individual proposal. This is a new function for senates and some lead in time is required for the development of national core products as well as refresh and recruitment of members to the Clinical Senate which is consistent with emerging national guidance. All senates are expected to be fully operational across England by September 2014. Those Clinical Senates that are required to undertake an independent clinical review before the national suite of core products are fully available must come to a pragmatic solution with the Area Team Medical Director in discussion with the Clinical Senate Chair, to ensure that the assurance process to be used is fit for purpose.

Birmingham, Solihull and Black Country Stroke Review
In 2010, the West Midlands Regional Quality Review Service led a review process in co-ordination with the West Midlands Cardiac and Stroke Networks to assess compliance with the WMQRS (West Midlands Quality Review Service) quality standards for acute stroke and Transient Ischaemic Attacks (TIA) and to train future reviewers. The review process showed that there was significant variation in the quality of care that is provided across the region and in January 2012 the NHS across the Midlands and East approved a clinically led comprehensive review of stroke across the region, to identify options that would improve outcomes by improving mortality, reduce chances of long term disability and improve patient experience. An important aspect of the review was examining the pathway which relates to hyper acute stroke units. The evidence suggests that there is a minimum

specification that all hyper acute stroke units should achieve if they are to provide optimal care to patients.

Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) is leading the Birmingham and Black Country Stroke Reconfiguration Programme. SWB CCG has overall responsibility for the delivery of the programme and hosts the Stroke CCG Programme Board to provide the strategic steer for the programme. The decision on the future placement of hyperacute and acute stroke centres sits with the respective CCG Governing Bodies; the programme board's role is to advise and recommend the preferred model for hyper acute stroke units. The lead commissioner for the Birmingham, Solihull and Black Country Stroke Review has now approached the West Midlands Clinical Senate to provide Clinical assurance and sign off of the stroke model and future stroke service configuration proposals for the stroke programme in the Birmingham, Solihull and Black Country.

The purpose of this paper is to give confidence to the Birmingham Solihull and Black Country Medical Director that the West Midlands Clinical Senate is sufficiently developed to provide clinical assurance to undertake this review.

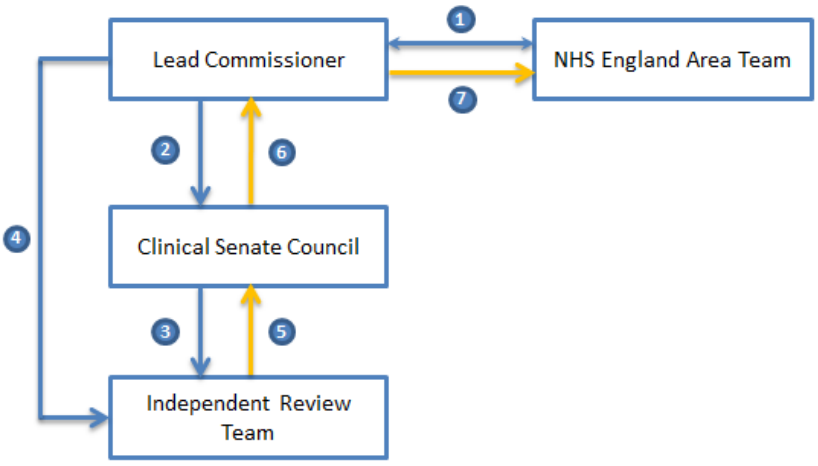
Clinical Senate Process
The following process will be informed by the Effective Service Change Tool Kit V8.4 (awaiting publication) and Clinical Senates role in service change (Barton 2014).

- The level of assurance required for the Stroke review will be agreed by NHS England and the lead commissioner SWB CCG
- The terms of reference for the review will be agreed with the Clinical Senate Chair and the lead commissioner
- SWB CCG will provide documentary evidence to NHS England against the key tests and a proportionate range of the best practice tests
- The Clinical Senate will provide independent advice against the clinical key test and an appropriate selection of best practice checks
- The Clinical Senate will convene a review panel of independent clinical experts, and appoint a Chair from the Senate Council. Establishing a tailor-made independent clinical review teams will enable any potential conflicts of interest to be managed
- The role of the review team will be to examine documentary evidence, carry out site visits if necessary and decide recommendations
- A formal report containing clinical senate advice will be returned to SWB CCG who will share it with NHS England as part of their assurance evidence
- The Clinical Senate (through its Council) will be responsible for the review being carried out (see Figure 1overleaf)
- The Clinical Senate report will be placed in the public domain at the conclusion of the NHS England assurance process

Figure 1 Clinical Review Process

The Independent Clinical Review Process: a worked example

1. NHS England agrees level of assurance required with lead commissioner (at stage 1 of NHS England assurance process)
2. Lead commissioner requests clinical senate advice as part of assurance process. Clinical senate and lead commissioner agree terms of reference for independent clinical review
3. Clinical senate establishes independent review team and appoints chair of review
4. Lead commissioner provides key documents to independent review team and supports other review requirements
5. Review undertaken and draft report sent to Clinical Senate Council
6. Clinical Senate Council agrees final report and returns to lead commissioner
7. Report submitted by lead commissioner as part of NHS England's assurance process.



Summary

This paper represents the suggested approach as agreed by the national task and finish group 2014. It is recommended that the West Midlands Clinical Senate is fit for purpose and has the capability and capacity to undertake the clinical assurance for the Birmingham, Solihull and Black Country Stroke Review.

The West Midlands Clinical Senate is requesting permission from the Birmingham, Solihull and Black Country Medical Director to undertake this review.

References

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Effective service change: a support and guidance toolkit, unpublished.

Yours sincerely

Dr David Hegarty
West Midlands Clinical Senate Chair

c.c. Anna Morton, Associate Director of the West Midlands SCN/Senate

Appendix 2 Birmingham, Solihull and Black Country Stroke Review West Midlands Clinical Senate

Terms of Reference

NHS England

West Midlands Clinical Senate

Stroke Service Reconfiguration

Terms of Reference

THE NHS CONSTITUTION
the NHS belongs to us all

West Midlands Clinical Senate

Stroke Service Reconfiguration Terms of Reference

First published: June 2014

Prepared by

Angela Knight Jackson
Clinical Senate Manager

Victoria Millward
Quality Improvement Lead Manager

TERMS OF REFERENCE

Independent Clinical Review Panel
Birmingham, Solihull and Black Country
Stroke Services Reconfiguration

Sponsoring Organisation: Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG)

Clinical Senate: West Midlands

NHS England (regional or area team):
Birmingham, Black Country and Solihull Area Team, NHS England

Terms of reference agreed by:
Name DR DAVID HEGARTY on behalf Clinical Senate
Name DR NICK HARDING on behalf of sponsoring organisation
Date: 20.6.14

1. Clinical Review Team Members

Chair:

Name	Position	Organisation
Dr Bill Gowans	Vice Chair of Shropshire Clinical Commissioning Group Vice Chair of West Midlands Clinical Senate Council	Shropshire Clinical Commissioning Group

Members:

Name	Position	Organisation
Dr L Warburton	Consultant in Stroke Medicine	Cambridge University Hospitals NHS Foundation Trust
Dr N Baldwin	Consultant Stroke Physician	Wye Valley NHS Trust
Prof C Roffe	Consultant Stroke Physician	University Hospital of North Staffordshire NHS Trust
Prof G Venables	Consultant Neurologist	Sheffield Teaching Hospitals NHS Trust
Dr L Greasley	Emergency Department Consultant	Peterborough and Stamford Hospitals NHS Trust

Ms Diane Lloyd	Care Group Clinical Director	The Shrewsbury and Telford Hospital NHS Trust
Ms Lynn Scott	Service Director of Adult Social Care & Health	Milton Keynes Local Authority
Mr M Ward	Head of Clinical Practice	West Midlands Ambulance Trust
Dr A Whitehouse	Ass Dean, Head of Foundation Programmes and Head of School of Medicine	Health Education West Midlands
Dr R Smith	Deputy Postgraduate Dean	Health Education West Midlands
Dr H Carter	Consultant in Public Health	Public Health England
Mr N Phillips	Patient and Public Representative	On Behalf of the West Midlands SCN and Senate NHS England
(representative)	(n/a)	West Midlands Academic Health Science Network (unable to recruit)
(representative)	(n/a) GP	General Practice (unable to recruit)
Angela Knight Jackson (in attendance)	Clinical Senate Manager	West Midlands SCN and Senate NHS England
Victoria Millward (in attendance)	Quality Improvement Lead Manager	West Midlands SCN and Senate NHS England
Karen Edwards (in attendance)	Senate PA	West Midlands SCN and Senate NHS England
Alison Lake (in attendance)	Admin Support	West Midlands SCN and Senate NHS England

N.B; The team will not include any individuals that will be, or have been, involved in any other part of the NHS England assurance process for this service change. All 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 review report.

Aims and Objectives of the Clinical Review

2.1 Aim

To provide clinical assurance of the Birmingham, Solihull and Black Country Stroke Services Reconfiguration Programme as part of NHS England's assurance process.

2.2 Objectives

The independent clinical review team will:

- Assess the strength of the clinical case for change
- Check alignment with clinical guidelines and best practice
- Ensure a full range of options have been and that potential risks are identified and mitigated
- Assess alignment between the proposed change and strategic commissioning intentions
- The review will identify key areas where there is no need to repeat work which has been undertaken, ensure independent and impartial input to the Board and meet the formal requirements within the framework to which the Clinical Senate must adhere.
- Scope of the review
- The Independent Clinical Review Team will assess the clinical case for change for the proposed future stroke model and future hyper-acute stroke configuration proposal (SWB CCG), in order to provide clinical assurance and sign off from the West Midlands Clinical Senate.

2. Timeline

Week Beginning	Action	Organisation
09.06.14	Agree terms of reference Request for stroke documentation from the sponsoring organisation COI, Confidentiality guidance to Clinical Review Team	SWB CCG & CS CS CS
16.6.14	CS receives stroke documentation	SWB CCG
23.6.14	Stroke documents & CS process, governance and guidance dispatched to clinical review team	CS
30.6 14	Clinical review team reading	
07.7.14	08.7.14 Clinical Review Team Meeting	CS
21.7.14	22.7.14 Clinical Review Team Meeting	CS
11.8.14	12.8.14 Clinical Review Team Meeting	CS
18.8.14 & 25.8.14	Clinical Review Team – report writing	CS
01.9.14	Draft report to sponsoring organisation for fact checking	CS
08.9.14	Report to Clinical Senate Council	CS
15.9.14	17.9.14 Clinical Senate Council meeting - for formal endorsement of advice	CS
29.9.14	Submit final report to sponsoring organisation	CS

13.10.14	Publish and disseminate as per terms of reference	CS

3. Methodology

The role of the review team will be to examine documentary evidence, carry out site visits if necessary and decide recommendations. The West Midlands Clinical Senate acknowledges that the sponsoring organisation has undertaken an external expert review as part of the Stroke Services Reconfiguration programme and the report will be made available.

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

8th July 2014
22nd July 2014
12th August 2014

The clinical review team will need to consider the following;

- Is there robust evidence underpinning both the clinical case for change and the proposed clinical model? Documentation should include the case for change, proposed clinical models and relevant activity information.
- Has relevant available evidence been effectively marshalled and applied to the specifics of the proposed scheme?
- Is there alignment with other national, regional and local intentions?
- Is there evidence of clinical overstatement or optimism bias in the proposals?

4. Reporting

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

The Clinical Review Team will submit a draft report (see Independent 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 sponsoring organisation by 30th September 2014, and the clinical advice will be considered as part of the NHS England's Birmingham, Solihull and Black Country Area Team 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

5. Communication and Media Handling

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

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

7. Accountability and Governance

The 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.

8. Functions, Responsibilities and Roles

8.1. The sponsoring organisation 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 formal service change assurance process.

8.2 Clinical Senate Council and the sponsoring organisation 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

8.3 Clinical review team will

- undertake its review in line with the methodology agreed in the terms of reference
- follow the report template 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.

8.4 Clinical review team members will undertake to

- commit fully to the review and attend all briefings, meetings, interviews, 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.

Appendix 1 (within ToR)

Declaration of Conflict of Interest

West Midlands Clinical Senate Independent Clinical Review Team
Birmingham, Solihull and Black Country Stroke Services Reconfiguration Programme

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 in categories a-f.

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

Name	
Type of Interest	
Details	
Action Taken	
Action Taken By	
Date of Declaration	

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

Signature:

Name:

Date:

Appendix 2 (within ToR)

Confidentiality Agreement

West Midlands Clinical Senate Independent Clinical Review Team
Birmingham, Solihull and Black Country Stroke Services Reconfiguration

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:
Birmingham, Solihull and Black Country Stroke Services Reconfiguration Programme

Signed _____ Date: _____

Name (caps) _____

Appendix 3 (within ToR)

West Midlands Clinical Senate Independent Clinical Review Team Report Template

Birmingham, Solihull and Black Country Stroke Services Reconfiguration Clinical Senate

[senate email]@nhs.net

Date of publication to sponsoring organisation:

CHAIR'S FOREWORD (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

Appendix 3 ICRT Panel Member Biographies

MEMBER BIOGRAPHY / PROFILE

Name	Dr Bill Gowans (MRCP MRCGP) Vice Chair of the Shropshire Clinical Commissioning Group Vice Chair of the West Midlands Clinical Senate Chair of the Independent Clinical Review Team

BRIEF INTRODUCTION

I am Vice Chair of the Shropshire Clinical Commissioning Group responsible for clinical strategic and whole system planning, workforce education and training and primary care. I have been a full time GP in Shrewsbury for 24 years but I have now reduced to 2 clinical sessions due to my CCG workload. I have a background in medical education as a trainer, course organiser and faculty member of Scaling the Heights. People and their attitudes, behaviours and relationships are what shape good clinical care and health organisations.

MEMBER BIOGRAPHY / PROFILE

Name	Dr R Neil Baldwin Consultant Physician in Stroke Medicine

BRIEF INTRODUCTION

I qualified from the University of Nottingham in 1981. Junior medical posts in Nottingham and Liverpool and a period of research in Oxford. I was appointed as a Consultant Physician in Gloucester in 1990. I developed an interest in Stroke Medicine and the use of Care pathways. In 2011 I was appointed as Consultant in Stroke Medicine and Clinical Lead in North Bristol NHS Trust. In 2013 I moved to Hereford County Hospital as a Consultant in Stroke Medicine.

Expertise:-

I am a Specialist in Hyper acute stroke (including i.v. and i.a. Thrombolysis) Post-Acute stroke care and Rehabilitation.
I ran Clinics for TIA Stroke prevention, Rehabilitation and Spasticity and Botulinum Toxin therapy. I have a particular interest in cardio-embolic stroke due to atrial fibrillation and patent foramen ovale. As well as Stroke in young patients.

Research interest are in clinical stroke including:-

• Hyper-acute stroke pathway design

• Assessment & Management of Dysphagia

Posts held:-

1. Secretary British Association of Stroke Physicians 2008-2012
2. Member Stroke Intercollegiate working party 2004- present
3. I was the clinical lead for the NHS Institute for Innovation and improvement acute stroke project 2006-7.
4. Chair AGWSS Stroke Network 2006-9
5. South west Regional Stroke Sub-speciality lead 2004 – 2013.
6. Hon Senior Lecturer at the University of Bristol and coordinator of the Basic Clinical skills Course.
7. Stroke sub-speciality advisor for revalidation royal College of Physicians (London)
8. BASP peer review member
9. Member of the West Midlands Quality Review team

MEMBER BIOGRAPHY / PROFILE

Name	Dr Helen Carter FFPH MPH MB ChB Consultant in Public Health (Healthcare)

BRIEF INTRODUCTION

Helen is a graduate from Birmingham University Medical School and spent a short while in clinical medicine, primarily emergency medicine and General Practice, before moving into Public Health in 2001. She has worked in a variety of Public Health settings at local, regional and national level including Centre for Infections as part of her health protection training. More recently she worked at the West Midlands Strategic Health Authority and was the lead for emergency planning during the pandemic and Olympics. She joined the West Midlands centre for Public Health England on April 2013. Her current role includes providing commissioning support to NHS England and is the West Midlands PHE children and young people executive sponsor.

MEMBER BIOGRAPHY / PROFILE

Name	Dr Lorraine Greasley Consultant in Emergency Medicine

BRIEF INTRODUCTION

Dr Lorraine Greasley is a consultant in Emergency Medicine who graduated from the University of London in 1996 and gained her FCEM and consultant appointment in Emergency Medicine in 2007. She is a regular serving member of the Royal Army Medical Corps and has held her commission since 1993. She has served in Bosnia, NI, Iraq and Afghanistan on Operations and was awarded the Queens Gallantry Medal for her actions in Bosnia. She has worked as a consultant at both Peterborough District and City hospitals. She now is working in the Emergency Department at the John Radcliff in Oxford.

MEMBER BIOGRAPHY / PROFILE

Name	Ms Diane Lloyd Care Group Clinical Director

BRIEF INTRODUCTION

Dianne Lloyd qualified as an Occupational Therapist in 1985 from Liverpool College of Occupational Therapy and spent the first three years of her career working in the St Helen's and Knowsley Health Authority area. Dianne moved to the Robert Jones and Agnes Hunt Orthopaedic and District Hospital in Oswestry, Shropshire, following her marriage in 1988. Dianne spent over 9 years at the Orthopaedic Hospital.

In 1997, Dianne joined the Shrewsbury and Telford Hospital NHS Trust and is currently the Therapy Care Group Clinical Director covering the professions of Dietetics, Occupational Therapy, Physiotherapy, Speech & Language Therapy. In a previous role, Dianne also managed Radiology and Pathology.

MEMBER BIOGRAPHY / PROFILE

Name	Mr Norman Phillips Patient Representative

BRIEF INTRODUCTION

In 2003 Norman Phillips was assistant head of design technology in a large comprehensive school until He had a stroke at the age of 55 which left him with hemiplegia of the left side. Since then he has have been actively involved in the world of stroke, representing the views of stroke survivors in the planning of services. During the last eleven years he has been a member of the West Midlands Stroke Research Network, Coventry & Warwickshire Cardiac and Stroke Network working towards improving care and

treatment for people suffering a stroke. He also as given talks in many universities to student nurses, physiotherapists training to work with stroke survivors and as also participated practical terms in different aspects of stroke research. He as attended the UK Stroke Forum to be aware of progress in the world of stroke to enable him to spread the ideas through different stroke groups and professionals that he meets. Norman has a wide knowledge of living with the effects of a stroke and the problems it causes.

MEMBER BIOGRAPHY / PROFILE

Name	Professor Christine Roffe Consultant Stroke Physician
BRIEF INTRODUCTION Christine Roffe is a stroke physician at the University Hospital of North Staffordshire (UHNS) and Professor of Stroke Medicine at Keele University. She is the Clinical Lead for the West Midlands Stroke Clinical Research Network and the Hyper acute Stroke Research Centre at UHNS. As member and chair of the Service Development Group of the British Association of Stroke Physicians she has been involved in the development of stroke service standards, the definition of a specialist stroke physician, a workforce review, and the development of standards for intra-arterial therapies for stroke. She has acted as an external advisor in the Yorkshire and Humber Stroke Service review. She has published widely on the topic of post stroke hypoxia and is the principal investigator of the Stroke Oxygen Study, a large multicentre study investigating the effect of oxygen supplementation on outcome after acute stroke.	

MEMBER BIOGRAPHY / PROFILE

Name	Ms Lyn Scott Service Director of Adult Social Care
BRIEF INTRODUCTION Born and brought up in Glasgow, Scotland, Lyn attended Stirling University from 1971- 1974 where she obtained a BA in Sociology and Economics. After another period of study, she obtained a Social work qualification and in 1976, Lyn joined Middlesex Probation Service as a Probation Officer. She undertook variety of roles with the Probation Service over the next 12 years. In 1989 she joined the mental health service in Buckinghamshire, initially as a social worker and then as a team manager. In 1997 she piloted the integration of health and social care in mental health as an operational manager, and eventually was promoted to Head of	

Integrated Services in the Aylesbury Vale locality.

Lyn joined Milton Keynes Council and Milton Keynes Pct, in 2004, as Head of Joint Mental Health Services and oversaw a whole system redesign in Adult Services. Lyn was appointed as interim Head of Adult Social Care in 2008 and then as Assistant Director (then Service Director) of Adult Social Care, for Milton Keynes Council in 2009. She is currently responsible for Mental Health , Learning Disability, Older peoples' and Physical Disability services, Intermediate Care services and in addition, Sheltered Housing, Telecare/ Telehealth and Community Alarm services.

MEMBER BIOGRAPHY / PROFILE

Name	Dr Russell Smith Deputy Postgraduate Dean for Health Education West Midlands

BRIEF INTRODUCTION

Russell Smith is Deputy Postgraduate Dean for Health Education West Midlands with previous roles as Associate Dean (Quality) and Cardiology Training Committee chairman. He is responsible for all aspects of postgraduate medical education and training having lead on the development of the quality framework and involvement of lay advisors in the process. He works closely with the GMC on education and training issues and is particularly involved in responding to patient safety concerns. His role is multi-professional having developed the first combined Quality Management reviews. He also works as the national Quality Lead for cardiology training for the Royal College of Physicians. Clinically, he is a cardiologist at University Hospital Birmingham with expertise in Pacing and Device Management. Prior to 2009, he was a physician and cardiologist at Good Hope Hospital and their Clinical Director of Medicine. He continues to teach medical undergraduates and also advanced life support to the multidisciplinary team. He is an examiner for the Royal College of Physicians and a faculty member of regional and national cardiology simulation programmes. His recent research interests involve device management of heart failure. Russell is married to Elizabeth, a consultant elderly care physician who is also a Foundation Programme Director and Royal College of Physicians examiner. In his little spare time Russell enjoys keeping up with their 3 adult children and trying to tame their allotment.

MEMBER BIOGRAPHY / PROFILE

Name	Professor Graham Venables Consultant Neurologist

BRIEF INTRODUCTION

Professor Graham Venables is a consultant neurologist with a special interest in stroke care and prevention and a clinician in the Sheffield Teaching Hospitals Hyper acute Stroke Service. He is Honorary Professor of Vascular Neurology at the University of Sheffield, Clinical lead for the South Yorkshire Stroke network and Clinical Director of the Yorkshire and the Humberside Strategic Clinical Networks. He is a past President of the Association of British Neurologists and the Joint Neurosciences Council and a Fellow of the European Stroke Organisation.

MEMBER BIOGRAPHY / PROFILE

Name	Dr Liz Warburton Consultant in Stroke Medicine

BRIEF INTRODUCTION

Dr Liz Warburton has been a stroke physician in Cambridge since 1998. She participates in the TIA, hyper acute and stroke rehabilitation services locally and runs specialist clinics for patients with aphasia and intracerebral haemorrhage. As clinical lead for the Anglia stroke network she set up the Eastern regional telemedicine service for stroke thrombolysis. In 2008 she was part of the expert review panel for the 'stroke for London' reorganisation. Currently she is a NICE senior fellow working on optimisation of stroke care within rural communities. She is the lead for stroke within the newly formed Eastern Academic Health Service Network (AHSN) and the lead for the Cambridge Hyperactive Stroke Research Centre (HSRC).

MEMBER BIOGRAPHY / PROFILE

Name	Mr Matthew Ward Head of Clinical Practice

BRIEF INTRODUCTION

Matthew Ward has worked for West Midlands Ambulance Service for 18 years and is the Head of Clinical Practice and is a representative of the National Ambulance Lead Paramedic Group. Matthew has had responsibility for Mental Health, Alternative Pathways, Cardiac and Stroke Management and Clinical Lead for 111 implementation.

Matthew was the Head of Cardiac and Stroke Management from 2009 to 2014 during which he worked collaboratively with the Acute Trusts providers and the Cardiac Networks has developed new clinical guidelines, policies and procedures for the Trust and region to ensure there are robust and consistent clinical pathway throughout the West Midlands for both Stroke and Acute Coronary Syndromes.

Matthew chaired the Midlands and East Stroke Review for Operational and Clinical modelling working with the project team from Midlands and East Strategic Health Authority and has also been the pre-hospital lead for a number of independent clinical review panels for Stroke services.

Matthew is also a Director and Advance Paramedic Practitioner with the West Midlands CARE Team and a clinical educator with the British Association of Immediate Care Specialists (BASICS).

MEMBER BIOGRAPHY / PROFILE

Name	Dr Andrew Whitehouse (MA, MB, BCh, FRCP) Head of Postgraduate School of medicine and Foundation Programmes Health Education West Midlands

BRIEF INTRODUCTION

Having trained at Cambridge and Guys, and after pre-consultant work in London, Zululand and Exeter, AW worked for 26 years until 2009 as a physician specialising in respiratory, geriatric, acute and general medicine at the George Eliot Hospital, Nuneaton. Throughout this time he worked on the acute general medical admissions rota, and led the local movement towards clear, evidence based clinical guidelines and their application as learning and standard setting tools. He chaired the Medical Staff committee, and the Drug and Therapeutics committee, and was postgraduate Clinical Tutor. Since 1998 he has also worked in various Associate Postgraduate Dean jobs in the West Midlands Deanery, during which time he developed

interests in curriculum design, assessment and programme evaluation. He led the West Midlands development of TAB, the 360 team assessment tool now mandatory for all UK Foundation doctors, and has published over 25 papers in medical education research. He represented the National Association of Clinical Tutors (NACTUK) as travelling fellow to N. Carolina in 1997, and is now NACTUK's deputy chair.

Appendix 4 Day 1 ICRT Agenda & Evidences Presented and Considered

NHS England

West Midlands Clinical Senate

DAY 1

Independent Clinical Review Panel
Stroke Service Reconfiguration – Birmingham, Black Country and Solihull

Tuesday 8th July 2014, 10.00 am until 4.30 pm

Venue – The International Convention Centre,
Symphony Hall, Broad Street, Birmingham, B1 2EA

AGENDA

Item			Purpose
10.00	1	Arrival with Refreshments and Panel Pre-meet	
10.30	2	Declaration of Interest	
10.40	3	Session 1: Introduction and review of information submitted	Overview of documentation and programme
12.30	4	Lunch	
1.30	5	Session 2: Desk Top Review Continues	Explore specific questions to be asked to commissioner
2.45	6	Refreshment Break	
3.00	7	Session 3: Presentation by Dr Nick Harding – Chair of Sandwell and West Birmingham Clinical Commissioning Group, followed by a Question and Answer Session Ms Nighat Hussain (in attendance)	Overview of programme question and answer session
4.00	8	Session 4: Deliberations and Next Steps	Identify gaps in unanswered questions Set agenda for day 2
4.30	9	End	

Appendix 5 Day 2 ICRT agenda & Evidences Presented and Considered

West Midlands Clinical Senate

DAY 2

Independent Clinical Review Panel
Stroke Service Reconfiguration – Birmingham, Black Country and Solihull

Tuesday 22nd July 2014, 10.00 am until 4.30 pm

Venue: The International Convention Centre, Broad Street, Birmingham, B1 2EA

AGENDA

Timing	Item		Purpose
9.30	1	Arrival, Refreshments, Panel Pre-Meet	
10.00	2	Review of Day 1 – 8th July 2014	
10.25	3	Declaration of Interest	
10.30	4	Introduction: Dr Andy Williams, Chief Accountable Officer at Sandwell and West Birmingham CCG	Presentation of context
10.40		Case for Change: Professor Tony Rudd	Clinical rationale for change
10.50		Questions	
11.00		Programme Governance: Dr Andy Williams, Chief Accountable Officer at Sandwell and West Birmingham CCG	Present assessments and governance
11.10		Questions	Quality impact assessment and programme governance
11.20		Decision Framework: Dr Andy Williams, Chief Accountable Officer at Sandwell and West Birmingham CCG	Understand the decision making process: Clinical safety Financial principles Contract award process
11.30		Questions	
11.40	5	Session 3: Travel and Activity Analysis: Steven Wyatt and Stacey Croft. Midland and Lancashire Central Midlands Clinical Support Unit	Explore the issues of access, modelling baseline, catchment populations
12.00		Questions	
12.30	6	Lunch	
1.15	7	Session 4: Provider Submission Update: Professor Tony Rudd	Overview and methodology of the ICRP (the Stroke Programme Board) for distilling the provider submissions
2.45		Questions (with refreshments being made available)	

3.45	8	Session 3: Deliberations and Next Steps	Explanation of: Each provider submission SSNAP data Outline mortality data on the SHMI Explore ICRT options post presentations Identify areas where assurance has been evidenced Identify any gaps Plan day 3
		Ms Nighat Hussain (in attendance)	
4.30	9	End	

Appendix 6 Day 3 ICRT Agenda & Evidences Presented and Considered

West Midlands Clinical Senate

PROGRAMME - DAY 3

Independent Clinical Review Panel
Stroke Service Reconfiguration – Birmingham, Black Country and Solihull

Tuesday 12th August 2014, 10.00 am until 4.30 pm

Venue: The International Convention Centre, Broad Street, Birmingham, B1 2EA

AGENDA

Timing	Item		Purpose
9.30	1	Arrival, Refreshments, Panel Pre-Meet	
10.00	2	Welcome Panel Members and Introduction of Observer	
10.05	3	Review of Day 2 – 22nd July 2014	
10.25	4	Declaration of Interest	
10.30	5	Risk Register – Assumptions and Mitigations – Ms Nighat Hussain	Explore clinical risks, assumptions and mitigations
11.30	6	Health Education England Perspective	Explore workforce perspective
12.00	7	REPORT	Identify areas of assurance Identify areas where there are gaps Populate report headings
12.45	8	Lunch	
1.30	9	REPORT - CONTINUATION	Populate report headings
3.30	10	Summary and Conclusions	
4.00	11	Next Steps in Review Process	Presentation of report timeline and Clinical Senate sign off.
4.30	12	CLOSE	

Appendix 7- Declaration of Interest

Matthew Ward was the chair for the modelling group for the development of the Birmingham, Solihull and Black Country Stroke proposals and also previously chaired the Midlands and East Stroke Review Modelling Group.

No other declaration of interest were declared by the ICRT

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