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# WEST YORKSHIRE
# JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

**Meeting to be held in Civic Hall, Leeds, LS1 1UR on**
**Tuesday, 28th November, 2017 at 2.00 pm**

***(Pre-meeting for all Committee Members at 1:30 pm)***

## MEMBERSHIP

### Councillors

| | | |
|---|---|---|
| Councillor M Gibbons | - | Bradford Council |
| Councillor V Greenwood | - | Bradford Council |
| Councillor A Evans | - | Calderdale Council |
| Councillor S Baines | - | Calderdale Council |
| Councillor J Hughes | - | Kirklees Council |
| Councillor E Smaje | - | Kirklees Council |
| Councillor B Flynn | - | Leeds Council |
| Councillor H Hayden (Chair) | - | Leeds Council |
| Councillor Y Crewe | - | Wakefield Council |
| Councillor B Rhodes | - | Wakefield Council |

*Please note: Certain or all items on this agenda may be recorded*

**Principal Scrutiny Adviser:**
**Steven Courtney**
**Tel: (0113) 24 74707**

# A G E N D A

| Item No | Ward/Equal Opportunities | Item Not Open | | Page No |
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| 1 | | | **APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS**<br><br>To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded).<br><br>(*In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting.) | |
| 2 | | | **EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC**<br><br>1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report.<br><br>2 To consider whether or not to accept the officers recommendation in respect of the above information.<br><br>3 If so, to formally pass the following resolution:-<br><br>**RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:<br><br>**No exempt items have been identified on this agenda.** | |

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| 3 | | | **LATE ITEMS**<br><br>To identify items which have been admitted to the agenda by the Chair for consideration.<br><br>(The special circumstances shall be specified in the minutes.) | |
| 4 | | | **DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS**<br><br>To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct. | |
| 5 | | | **APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES**<br><br>To receive any apologies for absence and notification of substitutes. | |
| 6 | | | **MINUTES - 24 MARCH 2017**<br><br>To confirm as a correct record, the minutes of the meeting held on 24 March 2017. | 1 - 4 |
| 7 | | | **CORRESPONDENCE RECEIVED**<br><br>To receive and consider a report from Leeds City Council's Head of Governance and Scrutiny Support that presents a range of correspondence received in relation to the work of the West Yorkshire Joint Health Overview and Scrutiny Committee. | 5 - 78 |

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| 8 | | | **IMPROVING STOKE SERVICES**<br><br>To receive and consider a report from Leeds City Council's Head of Governance and Scrutiny Support that introduces a range of information to update members of the West Yorkshire Joint Health Overview and Scrutiny Committee on the specific programme area associated with Improving Stroke Services, as part of the wider West Yorkshire and Harrogate Sustainability and Transformation Plan. | 79 - 264 |
| 9 | | | **WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP - A PROGRESS UPDATE AND AN OUTLINE OF THE NEXT STEPS**<br><br>To receive and consider a report from Leeds City Council's Head of Governance and Scrutiny Support that introduces a general progress update on the West Yorkshire and Harrogate Health and Care Partnership and an outline of the next steps. | 265 - 286 |
| 10 | | | **CHAIRS UPDATE**<br><br>To receive and consider a report from Leeds City Council's Head of Governance and Scrutiny Support providing an opportunity for the Chair to give an update on any general matters in relation to the work of the Joint Committee not specifically included elsewhere on the agenda. | 287 - 288 |
| 11 | | | **WORK SCHEDULE**<br><br>To consider a report from Leeds City Council's Head of Governance and Scrutiny Support on the development of the West Yorkshire Joint Health Overview and Scrutiny Committee's work programme. | 289 - 308 |
| 12 | | | **DATE AND TIME OF NEXT MEETING**<br><br>To be confirmed. | |

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| | | | **THIRD PARTY RECORDING**<br><br>Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda.<br><br>Use of Recordings by Third Parties– code of practice<br><br>a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title.<br><br>b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete. | |

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**WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

**FRIDAY, 24TH MARCH, 2017**

**PRESENT:** Councillor P Gruen in the Chair

Councillors Yvonne Crewe,
Marilyn Greenwood, Vanda Greenwood,
Betty Rhodes, Joanne Sharp and
Liz Smaje

**Co-opted Member:** Dr J Beal (Healthwatch Leeds)

## 19 Late Items

There were no formal late items, but the following supplementary information was provided following publication of the agenda:

- Item 7 – Chair's Update – letter from West Yorkshire and Harrogate STP Programme Director (minute 23 refers).
- Item 8 – Access to NHS Dental Services – submissions from NHS 111 and Dental Care Direct (minute 24 refers).

## 20 Declaration of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interests made at the meeting.

In the interests of openness and transparency, Dr J Beal advised he had previously been involved in developing and implementation 'Out of Hours Dental Services' in Leeds, Birmingham and Bristol. Dr J Beal remained present for the meeting.

## 21 Apologies for Absence and Notification of Substitutes

The following apologies and notification of substitutes were noted at the meeting:

- Councillor M Gibbons (Bradford Council) with Councillor J Sharp attending as a substitute member
- Councillor S Baines (Calderdale Council)
- Councillor J Hughes (Kirklees Council)
- Councillor B Flynn (Leeds City Council) with Dr John Beal attending as a substitute member.

## 22 Minutes - 23 January 2017

**RESOLVED –**

(a) The draft minutes provided were agreed as an accurate record of the meeting held on 23 January 2017.

(b) That a formal update be requested and circulated to members of the Joint Committee in relation to the autism scoping exercise referred to in minute 13.

## 23 Chair's Update

The Joint Committee received a report from Leeds City Council's Head of Governance and Scrutiny Support, providing an opportunity for the Chair to provide an update on any actions or specific activity since the previous meeting, on any matters not presented elsewhere on the agenda.

The Chair provided an update following a recent meeting with senior officials overseeing the development of the West Yorkshire and Harrogate Sustainability and Transformation Plan. Reference was made to the subsequent letter from the Programme Director which commented on:

- Overall STP engagement
- The stroke workstream
- Standardisation of commissioning polices
- The cancer workstream

It was suggested that there may be some merit in holding a more detailed development session for the Joint Committee, to build a better and consistent understanding of the STP approach and to consider the level and timeliness of and scrutiny activity. Members accepted the suggestion and agreed to offer some additional places to other members of the constituent health overview and scrutiny committees.

**RESOLVED –** That officers work with the STP programme office to help design and deliver a development session, as outlined at the meeting.

## 24 Access to NHS Dental Services

The Joint Committee received a report from Leeds City Council's Head of Governance and Scrutiny Support introducing a range of information and inputs from various stakeholders regarding the inquiry into Access to NHS Dental Services in West Yorkshire.

The following representatives presented information to the Joint Committee and contributed to the subsequent discussion:

- Rory Deighton – Manager Kirklees Healthwatch
- Emma Wilson – Head of Co-Commissioning (Yorkshire and Humber) – NHSE

- Mike Edmondson – Secondary Care dental lead for Yorkshire and Humber – NHSE
- Roger Furniss – Local Dental Committee
- Alan McGlaughlin – Local Dental Committee
- Andrew Cooke – Head of Service Development and Innovation NHS111 – Yorkshire Ambulance Service NHS Trust
- Linda Wolstenholme – Support Services Manager – Dental Care Direct

There was a wide ranging discussion of the issues affecting access to NHS dental services across West Yorkshire. Some of the specific areas of discussion included:

- Health inequalities, community resilience and equity of access, particularly in more deprived communities.
- The balance between preventative work and treatment.
- The new (2006) Dental Contract.
- The independent review of NHS dentistry in 2008 and subsequent 2009 report of Professor Jimmy Steele.
- Available information for (prospective) patients, NHS Choices and a single/ central point of contact.
- Availability and effective use of financial and workforce resources.
- Accessing dentists as NHS and private patients.
- Emergency and urgent dental care provision and walk-in services.
- The level of dental related calls to NHS 111.
- Increasing complexity of some dental patients.
- Dental recall intervals for patients.

The Joint Committee subsequently tasked support officers with drafting a report and series of recommendations to reflect the main areas identified for improvement at the meeting.

It was noted that the report should be based on the evidence presented and discussed at the meeting, with specific consideration given to ensuring recommendations are directed to the most appropriate relevant organisations.

At the conclusion of the discussion, the Chair thanked all those present at the meeting for their attendance and contribution to the discussion.

**RESOLVED –** That, based on the evidence presented and discussed at the meeting, officers draft a report and recommendations to reflect the main areas identified for improvement, to be adopted by the Joint Committee and agreed at a future meeting.

**25 Work Programme**

The Joint Committee received a report from Leeds City Council's Head of Governance and Scrutiny Support on the development of the Joint Committee's future work programme.

The Principal Scrutiny Adviser addressed the meeting and advised that, as previously agreed, the Joint Committee's future work programme would be developed to reflect the nine work streams/ priority areas identified in the West Yorkshire and Harrogate STP; whilst also recognising the matters of Autism and STP Governance arrangements.

The report also identified work around the Urgent and Emergency Care Vanguard and the West Yorkshire Association of Acute Trusts (WYAAT) as considerations within the work programme.

Drawing reference to the development session agreed as part of the Chair's Update (minute 23 refers), it was reported that the future work programme remains undetermined.

**RESOLVED –** That, taking account of the outcome of the development session referred to in minute 23, officers continue to work towards developing a proposed future work programme for presentation, discussion and agreement at a future meeting of the Joint Committee.

**26 Date and Time of Next Meeting**

**RESOLVED –** That the date and time of the next meeting be agreed in consultation with the Chair of the Joint Committee.

The meeting closed at 12:55pm.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 0113 3788666

**Report of Head of Governance and Scrutiny Support**

**Report to the West Yorkshire Joint Health Overview and Scrutiny Committee**

**Date: 28 November 2017**

**Subject: Correspondence Received**

| | | |
|---|---|---|
| Are specific electoral Wards affected?<br>If relevant, name(s) of Ward(s): | ☐ Yes | ☒ No |
| Are there implications for equality and diversity and cohesion and integration? | ☐ Yes | ☒ No |
| Is the decision eligible for Call-In? | ☐ Yes | ☒ No |
| Does the report contain confidential or exempt information?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## Summary of main issues

1. The purpose of this report is to present a summary of various correspondence received in relation to the work of the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) and agree any specific scrutiny action or activity.

## Recommendation

2. Members are asked to consider the matters set out in this report and associated appendices; and to identify any specific scrutiny action / activity.

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## 1.0 Purpose

1.1 The purpose of this report is to present a summary of various correspondence received in relation to the work of the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) and agree any specific scrutiny action or activity.

## 2.0 Background information

2.1 In December 2015, the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) was established, drawing its membership from the five constituent West Yorkshire local authorities.

2.2 In November 2016, the JHOSC considered a report that set out the requirements for local NHS commissioning organisations to develop and submit place-based local Sustainability and Transformation Plans and presented the draft West Yorkshire and Harrogate Sustainability and Transformation Plan, for consideration.

2.3 As noted in the JHOSC's Terms of Reference, the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide for local NHS bodies to consult with the appropriate health scrutiny committee where there are any proposed substantial developments or variations in the provisions of the health service in the area(s) of a local authority.

2.4 It should be further noted that under the legislation officials from relevant NHS bodies are required to attend committee meetings; provide information about the planning, provisions and operation of health services; and must consult on any proposed substantial developments or variations in the provision of the health service.

2.5 With the lack of any nationally recognised definition of what constitutes a 'substantial' development or variation in the provision of the health service, it is recognised as good practice for NHS commissioners and providers to engage with the appropriate health scrutiny committees as early as possible to discuss any proposed service developments or variations in order to help define the necessary level of formal consultation.

## 3.0 Main issues

<u>Correspondence received from members of the public</u>

3.1 Members of the JHOSC will be aware of a range of correspondence received in September 2017, primarily from members of the public either affiliated or associated with local campaign groups *Calderdale and Kirklees 999 Call for the NHS* and *North Kirklees Support the NHS*.

3.2 Copies of the correspondence received have already been shared with members of the JHOSC. In summary, the correspondence received requested that the JHOSC:

a) Asks the Joint Clinical Commissioning Committee and the individual clinical commissioning groups to present all and any legal advice they have received about the lawfulness or otherwise of the JCCC's decision making and disputes resolution processes, as laid out in the Memorandum of Understanding.

b) Thoroughly scrutinise the clinical evidence base and the material resources required for the proposed centralisation/reconfiguration of West Yorkshire and Harrogate Hyper-Acute Stroke Services.

3.3 Further correspondence from *Calderdale and Kirklees 999 Call for the NHS* was received on 16 November 2017 and is appended to this report for consideration.

3.4 Representatives of *Calderdale and Kirklees 999 Call for the NHS* and *North Kirklees Support the NHS* are aware these details are due to be considered by the JHOSC and are likely to be in attendance at the meeting.

Responses received addressing the concerns raised

3.5 On receipt of the original correspondence, NHS officials supporting the West Yorkshire and Harrogate Sustainable and Transformation Partnership (WYH STP) were requested to address the specific concerns raised. Details of the NHS response have already been shared with members of the JHOSC and are also appended to this report.

Correspondence received from other sources

3.6 Members of the JHOSC are also be aware of correspondence received from the Chair of Calderdale's Health and Wellbeing Board, Councillor Tim Swift, following representations made at a recent meeting.

3.7 For completeness, details of the information received and associated response are also appended to this report.

3.8 It should be noted that in providing these details, any information directly associated with Improving Stroke Services are not repeated here/ appended to this report, as a separate, substantive item is included elsewhere on the agenda.

## 4.0 Recommendations

4.1 Members are asked to consider the matters set out in this report and associated appendices; and to identify any specific scrutiny action / activity.

## 5.0 Background documents[1]

5.1 None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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16 November 2017

Dear West Yorkshire and Harrogate Joint Health Overview Scrutiny Committee Councillors,

On 22 September 2017 we delivered a letter to Leeds Council Scrutiny Support, asking you to meet as a matter of urgency, in order to scrutinise the activities of the West Yorkshire and Harrogate Sustainability and Transformation Partnership Joint Clinical Commissioning Committee.

We have not received acknowledgement of the receipt of that letter, or a reply.

Our letter pointed out the urgent need for democratic scrutiny of the massive cuts and changes being imposed on the NHS and social care services. The change to regulations that enabled the creation of STP-wide joint clinical commissioning was carried out by a statutory instrument, meaning it escaped Parliamentary scrutiny by MPs and peers. This makes the work of the West Yorkshire and Harrogate Joint Health Overview Scrutiny Committee even more vital.

We are glad to hear that the West Yorkshire and Harrogate Joint Health Overview Scrutiny Committee is to meet on Tuesday, 28 November 2017 at 2:00pm at Leeds Civic Hall.

We hope that you will decide to scrutinise the whole West Yorkshire and Harrogate STP, not bits and bats of it as you currently seem to be doing. It amounts to a massive systemic change and needs to be scrutinised on that level.

In the weeks since we delivered our letter, many more issues have emerged that urgently need democratic scrutiny. These include significant cuts and changes to acute and elective hospital care and primary and community services.

Scrutiny of individual locality Sustainability and Transformation Plans cannot be a replacement for scrutiny of system-wide changes which involve multiple service providers. The locality 'fragments' need system-wide oversight.

In Airedale, Craven and Wharfedale a GP superpractice has resulted from the merger of 1/3 of the area's GPs with Modality - one of England's largest superpractices which now operates in six Sustainability and Transformation Partnership areas. https://calderdaleandkirklees999callforthenhs.wordpress.com/2017/10/02/publics-questions-about-gp-services-ignored-by-self-congratulatory-airedale-wharfedale-and-craven-nhs-commissioners/ In Sandwell and Birmingham, Modality (which is in partnership with the US health services company, Optum) is in line for Multispeciality Community Provider contract where it would manage a pooled budget for core primary care services as well as extended primary and community services - essentially an Accountable Care Organisation.

Airedale, Craven and Wharfedale CCG, Calderdale CCG, Leeds CCGs Partnership and Kirklees CCGs are all setting up Accountable Care Systems, which have not been consulted on. Other CCGs will be too. We note with dismay that on 14th November, Leeds Health Scrutiny Committee raised no objections to the proposal for an Accountable Care System for Leeds, when this was outlined by Nigel Gray from the 3 Leeds CCGs Partnership. It was the same story at Kirklees Health Scrutiny Committee on the same day, when they were presented with a similar proposal under the title of a local integrated health and social care system.

NHS Improvement is working out how to licence private companies as ACOs, so the original claim that ACOs are a Good Thing because they take the market out of the NHS is untenable - the whole of an area's health and social care services could be run by a private company. Like Modality.

NHS Property Services Ltd is imposing commercial rents on GP practices that will force them to fold - or to accept employment by an Accountable Care Organisation under NHS England's Accountable Care Contract, which 999 Call for the NHS is bringing to court on the grounds that it's unlawful. In Kirklees, NHS Property Services is demanding a huge and unaffordable rent hike from the Slawit GP Practice.

Cuts and changes are being introduced that, if allowed to proceed, will change the NHS into a version of Medicare - a rump service for those who cannot get private health insurance. At its 7th November meeting, the WYH STP Joint Clinical Commissioning Committee agreed to a proposal to cut £50m/year by 2020 by restricting access to elective care and so-called Procedures of Limited Clinical Value. Decisions about which patients receive elective treatments are to be based on economic values derived from a business concept, Right Care. This provides spending benchmarks for Clinical Commissioning Groups by comparing their performance on a number of indicators to other allegedly comparable Clinical Commissioning Groups. However, a recent Journal of Public Health article (Right Care, Wrong Answer) has shown that the Right Care data for breast, colorectal, and lung cancer are full of errors, leading the author to conclude that,

> "RightCare promises illusory savings based on an inappropriate fixed comparator group and faulty statistics…If RightCare is used to justify savings in NHS budgets, it is acting as a cover for cuts."

The area's NHS and social care system is under sustained pressure. There is a need for scrutiny of Health System Recovery Plans for organisations that are in special measures because they cannot meet harsh financial controls introduced as part of the STP. The Calderdale and Greater Huddersfield CCGs and CHFT Recovery Plan, presented to the October 2017 CCCG Governing Body meeting, mentions a new Aligned Incentives Contract between the 3 organisations. The Calderdale CCG Chief Financial Officer told the meeting that since they couldn't see how to make all the spending cuts imposed as a result of being in special measures, they were going to introduce a new form of contract with CHFT. Not a single Governing Body member questioned this. We asked and were told it was a local variation to the standard contract - which we understand to mean less than the National Tariff.

Such new contracts urgently need scrutiny. If areas are paying less than the National Tariff they will end up with a second class health service - not a National Health Service. After the meeting, we searched online for Aligned Incentives Contract and found it was introduced in Bolton and removes payment by results. In Portsmouth, where it has been introduced, instead of being paid for every treatment for every patient, the hospital gets one payment for the year and that has to cover everything that comes through the door. Raising the question of what happens if more comes through the door than the one-off payment can cover.

Changes outside West Yorkshire and Harrogate will affect our area. Cuts and changes to stroke services in South Yorkshire Bassetlaw and Derbyshire are so complex that the joint CCGS "Commissioners Working Together" across the Acute Hospital Vanguard in South Yorkshire, Bassetlaw, Derbyshire and Wakefield [https://smybndccgs.nhs.uk/about-us] have deferred a decision until they can work through the implications of the change.

South Yorkshire papers from the meeting of http://www.smybndccgs.nhs.uk/ Wednesday 18 October 2017, report that “Significant further work has been undertaken...”, but without any meetings since last March, we can’t see how you can have considered the implications for Pinderfields.

There is a need to scrutinise anecdotal evidence that services in Dewsbury Hospital (assured in documents as ‘safe and effective’) are not working in a safe and effective way. If this proves to be the case it would belie the centralisation rationale used in 2013 to change the service structure, and spotlight the need to scrutinise the centralisation of hyper-acute stroke services.

Many members of the public are gravely concerned about this unauthorised and secret STP reorganisation of their services, as are we. Consequently we urge you most strongly to investigate these changes and hold the members of WYHSTP JCCC and WYAAT to account, as well as Council officials in public health and adult health and social care, who are working with the CCGs to advance the STP/ Accountable Care Systems.

Best wishes

Jenny Shepherd

Chair, Calderdale and Kirklees 999 Call for the NHS

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West Yorkshire and Harrogate
Sustainability and
Transformation Partnership

**To:** Councillor Helen Hayden
Chair, Scrutiny Board (Adults and Health), Leeds City Council
Chair, West Yorkshire Joint Health Overview and Scrutiny Committee

Friday, 22 September 2017

Dear Cllr Hayden

**Calderdale and Kirklees 999 Call for the NHS Group - letter of response**

Thank you for your letter dated 15 September 2017 requesting information from West Yorkshire and Harrogate, Sustainability and Transformation Partnership.

Please find below a response to the letter you received from Calderdale and Kirklees 999 Call for the NHS group.

Apologies for the length of the letter and number of attachments, I felt it was important that you have all the information you may need now or in the future.

Please don't hesitate to contact me direct if you have any further questions.

**The legal standing of the West Yorkshire and Harrogate, Joint Committee of the 11 Clinical Commissioning Groups, the associated decision-making and broader governance arrangements**

- In agreeing to establish the West Yorkshire and Harrogate, Joint Committee of the 11 Clinical Commissioning Groups (CCGs) and delegate certain matters to it, each CCG has decided that there are benefits to be gained from the collaborative commissioning of some services at a WY&H level. More information about the Joint Committee of CCGs is available here.

- The legal basis for the Joint Committee is set out in a Memorandum of Understanding (MoU) for collaborative commissioning between CCGs across WY&H. The MoU has been agreed by each CCG and was signed by each CCG Accountable Officer in May 2017. The MOU was presented at the first meeting of the Joint Committee held in public on 4 July 2017. **A copy is attached.** The MoU sets out in the Background (A), the legal basis for the Joint Committee: *"Under section 14Z3(2A) of the NHS Act 2006, the Parties may establish a joint committee of the Parties to exercise the Parties' commissioning functions jointly".*

- The definitions and interpretation in the MoU (Section 1.1) defines Law at (a) as: "*Any applicable statute or proclamation or any delegated or subordinate legislation or regulation".*

Section 14Z3(2A) of the NHS Act 2006 was amended by the Legislative Reform (CCG) Order 2014. More information is available here. This states that: *"This order amends section 14Z3 so that, where two or more clinical commissioning groups are exercising their commissioning functions jointly, those functions may be exercised by a joint committee of the groups."*

**Decision making and broader governance**

The MOU sets out clearly the decision making and disputes resolution processes for the Joint Committee. To ensure that it met the needs of the CCGs and established appropriate statutory powers for the Joint Committee, the MOU was developed in close consultation with the legal firm DAC Beachcroft.

In summary:

- Each participating CCG has agreed to form a Joint Committee with the others.
- That Joint Committee can only take decisions on matters that are delegated to it by each CCG, and each CCG remains accountable for the delivery of its own functions, including those where it has delegated decision-making authority to the Joint Committee.
- The scope of the delegation is set by the work plan, which is approved by the members of each CCG. **A copy of the work plan is attached.** In this way, each CCG sets the parameters of what it delegates to the Joint Committee.
- If any CCG is not content for a decision on a matter to be taken in the Joint Committee, that matter will not be delegated to the Joint Committee.
- As noted, where the Joint Committee has delegated authority to take a decision, the CCGs remain accountable for that decision, and each CCG's statutory obligations (such as in respect of public involvement) continue to apply.
- The Principles of Collaboration set out at Section 3.1.2 of the MoU state that parties must "work proactively with service users and the public, actively seeking their engagement at all stages of the commissioning cycle". The Joint Committee will take account of public engagement in the same way that an individual CCG would.

**The specific matters and concerns raised in relation to specialist stroke services.**

- Jo Webster, Chief Officer, NHS Wakefield CCG and Senior Responsible Officer for the WY&H Stroke Programme attended the Joint Health Oversight Scrutiny Committee meeting in Leeds on 23 January 2017 to discuss stroke services across West Yorkshire and Harrogate. Dr Rana (specialist stroke consultant) and Jacqui Crossley from Yorkshire Ambulance Services also gave an overview on the patient pathway to expert care.

- As demand for stroke services continues to rise, a substantial amount of work has been undertaken both nationally and locally to improve outcomes for people who have suffered a stroke. With this in mind an overview was given on the first phase of planned engagement work.

- Healthwatch were commissioned to provide this independent piece of engagement, which took place this year in February and March. This involved asking people across the area their views on how West Yorkshire and Harrogate stroke services could be further improved to make sure they are 'fit for the future.'

- Jo sent a letter to Cllr Gruen as Chair of the Committee on the 27 June 2017 providing an update on engagement findings. Publicising the engagement findings was delayed due to pre-election protocols.

- Involving people who have experienced stroke, their families, carers and the public in conversations about stroke care is very important to us. Over 900 people completed the engagement survey and Healthwatch spoke to over 1,500, providing us with many comments. The report findings and all supporting information is available on our website here.

- Stroke services were also discussed at the WY&H Joint Committee of the 11 Clinical Commissioning Group's first meeting held in public on the 4 July 2017 A copy of the information from this meeting can be found here.

- Our focus over the coming months will be to take a closer look at clinical pathways and care model scenarios. This will be done with our area's leading clinicians and other health care professionals. This work will initially focus on hyper acute stroke and acute stroke services (hyper-acute refers to the first few hours and days after the stroke occurs.) Further work with stakeholders, public and patients will follow as appropriate. It is important to note that no decision has been made to close any stroke units. Work will also continue to take place to ensure we are maximising opportunities to further improve care and outcomes for our population along the whole of the stroke care pathway.

I wish to emphasise that the West Yorkshire and Harrogate STP senior leadership team intends to be fully open and transparent with the public about the work taking place across the area. We have published an engagement and consultation mapping report of work which has taken place across the area which is available here. We have also published engagement and consultation activity timelines for work coming up over the next few months at both WY&H and local place (please note this is subject to change). **A copy is attached.**

Working closely with local Overview and Scrutiny Committees (OSC) and JHOSC is an essential part of our STP. This can only help to ensure best practice, shared solutions to shared problems, and the delivery of specialised services across the area.

The STP leadership look forward to having further conversations around how best we move forward together over the coming months, and would welcome a convenient date to meet with you at your earliest convenience.

Best wishes

**Rob Webster**
**West Yorkshire and Harrogate STP Lead**
**CEO South West Yorkshire Partnership NHS FT**

Cc: Dr Andy Withers, Clinical Lead and Chair of the WY&H Stroke Task and Finish Group
Jo Webster, Senior Responsible Officer for WY&H STP Stroke Programme
All CCG Accountable Officers within WY&H
Marie Burnham, Independent Lay Chair, Joint Committee of CCGs
Tom Riordan, Chief Executive, Leeds City Council
Tony Cooke, Chief Officer, Health Partnerships, Leeds City Council

**Dated – 2nd May 2017**

# MEMORANDUM OF UNDERSTANDING
# FOR
# COLLABORATIVE COMMISSIONING
# BETWEEN
# CLINICAL COMMISSIONING GROUPS
# ACROSS
# WEST YORKSHIRE AND HARROGATE

**FINAL VERSION**

**CONTENTS**

**THIS AGREEMENT** is dated the 2nd day of May 2017

**BETWEEN**

(1) **NHS Airedale, Wharfedale and Craven Clinical Commissioning Group** whose principal office is at Millennium Business Park, Station Road, Steeton, West Yorkshire, BD20 6RB ("**Airedale, Wharfedale and Craven CCG**");

(2) **NHS Bradford City Clinical Commissioning Group** whose principal office is at Douglas Mill, Bowling Old Lane, Bradford, West Yorkshire, BD5 7JR ("**Bradford City CCG**");

(3) **NHS Bradford Districts Clinical Commissioning Group** whose principal office is at Douglas Mill, Bowling Old Lane, Bradford, West Yorkshire, BD5 7JR ("**Bradford Districts CCG**");

(4) **NHS Calderdale Clinical Commissioning Gr**oup whose principal office is at 5th Floor, F Mill, Dean Clough Mills, Halifax, West Yorkshire, HX3 5AX ("**Calderdale CCG**");

(5) **NHS Greater Huddersfield Clinical Commissioning Group** whose principal office is at Broad Lea House, Dyson Wood Way, Bradley, Huddersfield, West Yorkshire, HD2 1GZ ("**Greater Huddersfield CCG**");

(6) **NHS Harrogate and Rural District Clinical Commissioning Group** whose principal office is at 1 Grimbald Crag Court, St James Business Park, Knaresborough, North Yorkshire, HG5 8QB ("**Harrogate and Rural District CCG**");

(7) **NHS Leeds North Clinical Commissioning Group** whose principal office is at Leafield House, 107-109 King Lane, Leeds, West Yorkshire, LS17 5BP ("**Leeds North CCG**");

(8) **NHS Leeds South and East Clinical Commissioning Group** whose principal office is at 3200 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB ("**Leeds South and East CCG**");

(9) **NHS Leeds West Clinical Commissioning Group** whose principal office is at Suites 2-4, Wira House, Wira Business Park, Leeds, West Yorkshire, LS16 6EB ("**Leeds West CCG**");

(10) **NHS North Kirklees Clinical Commissioning Group** whose principal office is at 4th Floor, Empire House, Wakefield Old Road, Dewsbury, West Yorkshire, WF12 8DJ ("**North Kirklees CCG**"); and

(11) **NHS Wakefield Clinical Commissioning Group** whose principal office is at White Rose House, West Parade, Wakefield, West Yorkshire, WF1 1LT ("**Wakefield CCG**"),

each a "**Party**" and together the "**Parties**".

**BACKGROUND**

(A) The Parties wish to enter into an arrangement to collaboratively commission the delivery of healthcare services across the geographic area covered by the Parties. Under section 14Z3(2A) of the NHS Act 2006, the Parties may establish a joint committee of the Parties to exercise the Parties' commissioning functions jointly.

(B) Under 'Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21[1] published in December 2015, all health and care systems nationally must produce a Sustainability and Transformation Plan, setting out how they will accelerate its implementation of the Five Year Forward View up to 2021.

(C) This Agreement sets out a framework for collaborative decision-making by the Parties in accordance with section 14Z3 of the NHS Act 2006 through a joint committee of the Parties and will play a crucial role in underpinning Sustainability and Transformation Plans across the West Yorkshire and Harrogate geography.

**IT IS AGREED:**

1. **DEFINITIONS AND INTERPRETATION**

1.1 In this Agreement unless the context otherwise requires the following words and expressions shall have the following meanings:

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| **"Agreement"** | this agreement between the Parties comprising these terms and conditions, together with the Schedules; |
| **"Annual Contribution"** | the annual financial contribution of each Party (as set out in Schedule 6) to the Programme Management Budget and such other costs of the Collaborative as the Joint Committee may agree; |
| **"CCG Decisions"** | has the meaning set out in Clause 6.1.1; |
| **"Claim"** | any legal proceedings or claim including but not limited to:<br>(a) pre-action correspondence and claims for judicial review and any enforcement action brought by the Information Commissioner; and<br>(b) any referral of a dispute to the Secretary of State for Health in accordance with section 9(6) of the National Health Service Act 2006; |
| **"Clinical Chair"** | the GP chair of a Party; |
| **"Collaborative"** | the collaborative commissioning arrangements set out in this Agreement; |
| **"Commencement Date"** | 2 May 2017; |
| **"Commissioning Contract"** | any agreement with a Provider for any Services listed in the Workplan; |
| **"Commissioning Contract Variation Report"** | has the meaning set out in Clause 10.8; |
| **"Data Protection Legislation"** | the Data Protection Act 1998, the Data Protection Directive (95/46/EC), the General Data Protection Regulation (Regulations (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016) once in application, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Electronic Communications Data Protection Directive (2002/58/EC), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of |

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| | practice issued by the Information Commissioner; |
| **"Defaulting Party"** | a Party that commits a persistent or material breach of this Agreement; |
| **"Deputy"** | has the meaning in paragraph 2.12 of Schedule 3; |
| **"First MoU"** | the memorandum of understanding entered into by the Parties dated 14 June 2016 in respect of collaborative commissioning across West Yorkshire and Harrogate; |
| **"Exiting Party"** | has the meaning in Clause 15.1; |
| **"Expiry Date"** | 31 March 2019; |
| **"FOIA"** | the Freedom of Information Act 2000, as amended from time to time; |
| **"Functions"** | the commissioning functions of each of the Parties in arranging for the provision of the Services, and "commissioning functions" has the meaning set out in section 14Z3(7) of the NHS Act 2006; |
| **"Guidance"** | any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Parties and/or a Provider have a duty to have regard (and whether specifically mentioned in a relevant Commissioning Contract or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Provider by the Parties and/or any relevant Regulatory or Supervisory Body; |
| **"Holding"** | in relation to each of the Parties, the percentage by value attributable to it of the annual contract value of the relevant Commissioning Contract, calculated at the start of the relevant financial year; |
| **"Host Party"** | the Party which hosts the Programme Management Office from time to time, being NHS Wakefield CCG as at the Commencement Date; |
| **"Information Sharing Agreement"** | the information sharing agreement to be entered into between the Parties on or about the date of this Agreement; |
| **"Initial Term"** | the period beginning on the Commencement Date and ending on the Expiry Date; |
| **"Joint Committee"** | the joint committee established by the Parties for the purpose of the Collaborative; |
| **"Joint Committee Decisions"** | has the meaning set out in Clause 6.1.2; |
| **"Joint Committee Member"** | means the nominated representative of a Party who is a member of the Joint Committee, in accordance with the terms of reference set out in Schedule 3; |

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| **"Law"** | (a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation;<br><br>(b) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972;<br><br>(c) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales;<br><br>(d) Guidance;<br><br>(e) National Standards; and<br><br>(f) any applicable code,<br><br>in each case in force in England and Wales; |
| **"Lead Commissioner/Contractor"** | in relation to a particular service, the Party listed as the lead commissioner/contractor in Schedule 4 and/or the Workplan; |
| **"Lead Commissioner/Contractor Decisions"** | has the meaning set out in Clause 6.1.3; |
| **"National Standards"** | those standards applicable to the Provider under the Law and/or Guidance as amended from time to time; |
| **"Personal Data"** | has the meaning given to it in the Data Protection Legislation; |
| **"Programme Management Budget"** | the budget for the Programme Management Costs in each financial year, to be agreed by the Joint Committee in accordance with Clause 8.3.4; |
| **"Programme Management Office"** | the programme management office providing Programme Management Support to the Collaborative and the Joint Committee; |
| **"Programme Management Support"** | the programme management support provided to the Collaborative and the Joint Committee by the Programme Management Office as further detailed in Schedule 5; |
| **"Provider"** | a provider under any Commissioning Contract as may be set out in the Workplan; |
| **"Regulatory or Supervisory Body"** | any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party must comply or to which it must or should have regard, including:<br><br>(a) Care Quality Commission;<br><br>(b) NHS Improvement (the umbrella name for Monitor and the NHS Trust Development Authority);<br><br>(c) NHS England; |

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| | (d) the Department of Health;<br><br>(e) NICE; and<br><br>(f) HealthWatch England; |
| **"Services"** | the services described in the Workplan; |
| **"Service Users"** | any individual for whose benefit the Services are provided; |
| **"STP"** | the Sustainability and Transformation Plan for West Yorkshire; |
| **"Terminating Party"** | a Party exercising its rights to terminate this Agreement in accordance with Clauses 14.4 or 14.5; |
| **"Variation"** | an addition, deletion or amendment in the Clauses of or Schedules or Appendices to this Agreement, agreed to be made by the Parties in accordance with Clause 10 (Variations); and |
| **"Variation Report"** | has the meaning in Clause 10.3; |
| **"Working Day"** | any day other than Saturday, Sunday, a public or bank holiday in England and Wales; |
| **"Workplan"** | has the meaning set out in paragraph 2.1 of Schedule 4. |

1.2 References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

1.3 The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses are clauses in this Agreement.

1.4 References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference. References to Appendices are references to the appendices to this Agreement.

1.5 References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

1.6 Words importing the singular number only shall include the plural.

1.7 Where anything in this Agreement requires the mutual agreement of the Parties, then unless the context otherwise provides, such agreement must be in writing.

1.8 If there is any conflict between the terms of this Agreement and the terms of a Commissioning Contract in respect of a particular Service, the terms of the Commissioning Contract will prevail.

1.9 If there is any conflict between the Clauses of this Agreement and the provisions of any Schedule or Appendix to this Agreement, the Clauses of this Agreement will prevail.

## 2. DURATION OF THE AGREEMENT

2.1 This Agreement comes into effect on the Commencement Date and shall remain in force until the Expiry Date, subject to earlier termination in accordance with Clause 14 (Termination) and any extension agreed in accordance with Clause 2.2. The Parties agree that the First MoU is hereby terminated and this Agreement shall supersede it in accordance with Clause 24.

2.2 The Parties may agree in writing to extend the Initial Term any number of times but each time by a period of up to twelve (12) months. The Agreement shall expire automatically without notice at the end of the extended term (subject to earlier termination in accordance with Clause 14 (Termination)).

## 3. PRINCIPLES OF COLLABORATION

3.1 In performing their respective obligations under this Agreement, the Parties must:

3.1.1 adhere to the principles and objectives set out in Schedule 7;

3.1.2 work proactively with Service Users and the public, actively seeking their engagement at all stages of the commissioning cycle;

3.1.3 at all times act in good faith towards each other;

3.1.4 collaborate and co-operate to work towards ensuring that the commissioning ambitions and intentions of each of the Parties are met;

3.1.5 be ambitious for the populations the Parties serve and the staff the Parties employ;

3.1.6 undertake shared analysis of problems and issues as the basis of taking action;

3.1.7 act in a timely manner and recognise the time-critical nature of the Commissioning Contracts and respond accordingly to requests for support;

3.1.8 be accountable by taking on, managing and accounting to the other Parties for the performance of their respective roles and responsibilities set out in this Agreement;

3.1.9 learn from best practice of other commissioning organisations and seek to develop as a collaborative to achieve the full potential of the relationship;

3.1.10 share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

3.1.11 adopt a positive outlook and behave in a positive, proactive manner;

3.1.12 act in an inclusive manner with regards to collaboration;

3.1.13 adhere to statutory powers, requirements and best practice to ensure compliance with applicable Law, Guidance and standards

including those governing procurement, data protection and freedom of information;

3.1.14 work effectively with internal and external stakeholders;

3.1.15 work toward a reduction in health inequality and improvement in health and well-being;

3.1.16 focus on quality;

3.1.17 seek best value for money, productivity and effectiveness;

3.1.18 develop towards a level of commissioning that is equal to best international practice; and

3.1.19 promote innovation.

## 4. OBJECTIVES OF COLLABORATION

4.1 The Parties agree that, with effect from the Commencement Date, the main objective of the Collaborative is to develop and implement the Sustainability and Transformation Plan for the people of West Yorkshire and Harrogate and improve effective governance structures for place based commissioning through those arrangements to effect such Plan, in line with the principles and objectives set out in Schedule 7.

4.2 The Parties agree to seek to achieve the main objective of the Collaboration through:

4.2.1 planning for the provision of the Services to meet the health needs of the relevant local population on a place basis in accordance with the Parties' respective commissioning intentions and ambitions and all relevant Law and Guidance applicable to the Parties;

4.2.2 agreeing the extent of the Services, and procuring the Commissioning Contracts (where relevant);

4.2.3 where relevant, managing and maintaining the Commissioning Contracts, including in respect of quality standards, observance of service specifications, and monitoring of activity and finance, so as to obtain best performance, quality and value from the Services; and

4.2.4 where relevant, managing variations to the Commissioning Contracts in accordance with national policy, the needs of Service Users and clinical developments.

## 5. ROLES AND RESPONSIBILITIES

5.1 The Parties agree that where a Deputy assumes the role of its nominated Joint Committee Member for a meeting, all references in this Agreement to a Joint Committee Member that are relevant to the meeting will be read as referring to the Deputy.

5.2 Each Party must:

5.2.1 ensure its Joint Committee Members attend every meeting of the Joint Committee;

5.2.2 ensure its Joint Committee Members have considered all documentation and are prepared to discuss matters at meetings of the Joint Committee;

5.2.3 make all reasonable efforts to inform the Chair in advance if its Joint Committee Member or Deputy is unable to attend meetings of the Joint Committee;

5.2.4 ensure it engages with all other Parties in matters related to the Collaborative;

5.2.5 communicate openly and in a timely manner about concerns, issues or opportunities relating to this Agreement; and

5.2.6 respond promptly to all requests for, and promptly offer, information or proposals relevant to the operation of the Collaborative.

## 6. GOVERNANCE AND MONITORING ARRANGEMENTS

6.1 The Parties agree that, for matters relating to the Services, there are three different levels of decision-making:

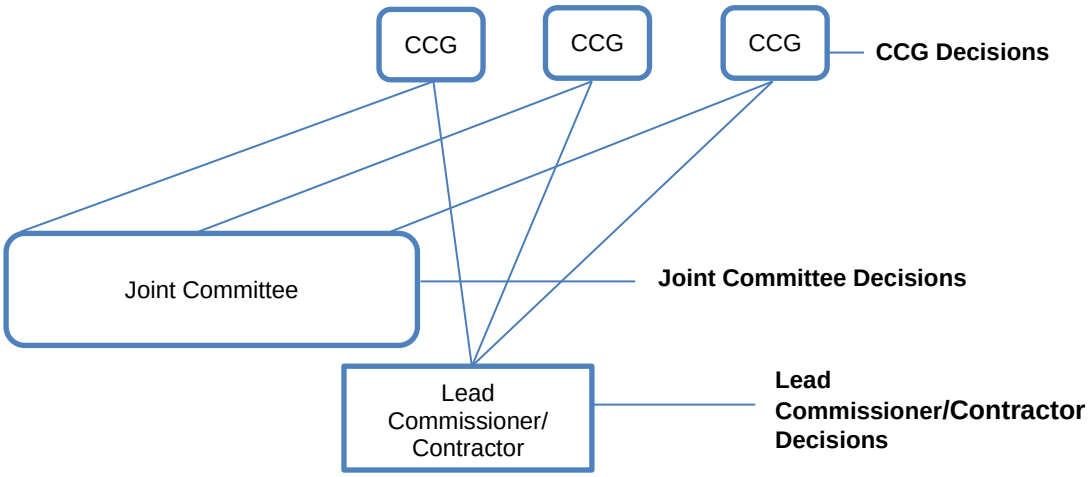
6.1.1 those decisions reserved to each Party ("**CCG Decisions**");

6.1.2 those decisions which are delegated by each Party to the Joint Committee ("**Joint Committee Decisions**"); and

6.1.3 those decisions which are delegated to the Lead Commissioner/Contractor by each Party, if relevant ("**Lead Commissioner/Contractor Decisions**").

6.2 Where, in relation to a particular Service, a Lead Commissioner/Contractor is not appointed, there will be no Lead Commissioner/Contractor Decisions.

6.3 The following diagram illustrates the levels of decision-making:




6.4 The Parties agree that matters that are not related to the Services ("**Non-Service Specific Matters**") shall be dealt with in accordance with Clause 6.9.3.

**CCG Decisions**

6.5 Each Party must ensure that the matters set out as CCG Decisions in Schedule 4 and/or the Workplan are reserved to each Party (or governing body or committee of each Party as appropriate).

6.6 The Parties agree that neither a Lead Commissioner/Contractor nor the Joint Committee has delegated authority to make CCG Decisions.

6.7 Each Party shall put in place mechanisms to ensure CCG Decisions are notified to:

6.7.1 the Lead Commissioner/Contractor (if relevant); or

6.7.2 the relevant Provider,

for action to be taken under the relevant Commissioning Contract, if appropriate.

6.8 Each Party shall report to the Joint Committee through its Joint Committee Member any CCG Decisions that affect the Collaborative.

**Joint Committee Decisions**

6.9 Each Party must:

6.9.1 appoint two representatives to represent it as Joint Committee Members;

6.9.2 provide the names and contact details of its nominated Joint Committee Members and Deputy in Schedule 1;

6.9.3 ensure that the matters set out as:

(a) Joint Committee Decisions in Schedule 4 and/or the Workplan; and

(b) the Non-Service Specific Matters set out in Schedule 2,

are delegated effectively and lawfully to the Joint Committee such that the Joint Committee has the appropriate authority to bind that Party in relation to Joint Committee Decisions and Non-Service Specific Matters;

6.9.4 ensure that the relevant Joint Committee Members are sufficiently appraised of the scope of the delegation by the relevant Party to the Joint Committee in relation to Joint Committee Decisions relating to the relevant Service and the Non-Service Specific Matters; and

6.9.5 ensure the relevant Joint Committee Members are able to give and receive notices and other communications that relate to the relevant Service.

6.10 Where a Party sends a Deputy to meetings of the Joint Committee in place of a Joint Committee Member in accordance with paragraph 1.7 of Schedule 3, the Parties shall ensure that the Deputy assumes the role of the Joint Committee Member for that meeting.

6.11 The Parties acknowledge and agree that:

6.11.1 the terms of reference of the Joint Committee will be as set out in Schedule 3; and

6.11.2 it is the Joint Committee that makes Joint Committee Decisions which bind the Parties and not the Joint Committee Members nominated by each Party.

6.12 The Parties agree that a Lead Commissioner/Contractor does not have delegated authority to make Joint Committee Decisions.

6.13 The Joint Committee shall implement reporting mechanisms to ensure that Joint Committee Decisions are notified to:

6.13.1 the Lead Commissioner/Contractor (if relevant); or

6.13.2 the Provider,

for action to be taken under the relevant Commissioning Contract, if relevant; and

6.13.3 each Party for onward dissemination to its members and governing body, as each Party deems appropriate.

**Lead Commissioner/Contractor Decisions**

6.14 Where the Parties have appointed a Lead Commissioner/Contractor for a Service, each Party must ensure that the matters set out as Lead Commissioner/Contractor Decisions Schedule 4 and/or the Workplan are delegated effectively and lawfully to the Lead Commissioner/Contractor.

6.15 Subject to Clause 6.14, the Parties acknowledge that where the Parties have appointed a Lead Commissioner/Contractor for a Service, the Lead Commissioner/Contractor is able to:

6.15.1 make Lead Commissioner/Contractor Decisions and such decisions will bind all of the Parties in relation to the Service; and

6.15.2 take action under the Commissioning Contracts in relation to Lead Commissioner/Contractor Decisions without reference to the Parties or the Joint Committee; and

6.15.3 implement Joint Committee Decisions as directed by the Joint Committee.

6.16 The Lead Commissioner/Contractor shall report to the Joint Committee in accordance with any reporting requirements as may be set out in the Workplan.

## 7. INSPECTION

The Parties shall co-operate with any investigation undertaken by any Regulatory or Supervisory Body in respect of any of the Services.

## 8. COLLABORATIVE COSTS AND RESOURCES

8.1 The Parties agree that payments due under Commissioning Contracts shall be made in accordance with the provisions of the relevant Commissioning Contract.

8.2 The Parties agree that the Host Party shall host the Programme Management Office which shall provide Programme Management Support to the Collaborative and the Joint Committee as set out in Schedule 5. Such hosting shall include the employment and/or engagement of staff.

8.3 The Parties agree that:

8.3.1 the Host Party shall manage the Programme Management Budget on behalf of the Parties;

8.3.2 each Party shall make an Annual Contribution to the Host Party in respect of the Programme Management Budget in accordance with this Clause 8 and Schedule 6;

8.3.3 the Programme Management Budget shall include (but not be limited to) costs which fall into the categories set out in Schedule 6;

8.3.4 the Joint Committee may agree that costs which do not fall within the categories set out in Schedule 6 will be shared between the Parties and may determine the proportions in which such costs shall be shared between the Parties; and

8.3.5 at least 30 days prior to the start of each financial year, the Joint Committee shall agree:

(a) the Programme Management Budget for the next financial year; and

(b) the proportions in which the Parties shall make Annual Contributions to the Programme Management Budget in the forthcoming financial year.

8.4 The provisions of Schedule 6 shall apply in relation to the management of the Programme Management Budget.

## 9. INDEMNITY

9.1 Nothing in this Agreement shall affect the liabilities of the Parties to the Service Users in respect of their Functions.

9.2 Each Party undertakes to indemnify each other Party against all actions, proceedings, costs, claims, demands, liabilities, losses and expenses, whether arising in tort (including negligence) or as a result of default or breach of this Agreement, to the extent that any loss or claim is due to the breach of contract, negligence, wilful default or fraud of the indemnifying Party (or its employees, agents or sub-contractors), except to the extent that the loss or claim is directly caused by or directly arises from the negligence, breach of this Agreement, or applicable Law by the indemnified Party or (or its employees, agents or sub-contractors).

9.3 Each Party further undertakes to indemnify the Lead Commissioner/Contractor against any liability, damages, costs, claims or proceedings arising out of or in connection with any act or omission (which is not recklessly negligence, fraudulent or involving criminal liability) committed or omitted by it during the course of performing its obligations under this Agreement, provided that the liability of each Party under such indemnity will be limited to the proportion of the total amount from time to time indemnified under this Clause 9.3 equal to that Party's Holding.

9.4 In the event that any Party (or Parties) receives a Claim against it which relates to a decision of the Joint Committee made on behalf of that Party (or Parties) (the "Receiving Party") in accordance with this Agreement, then the Receiving Party shall inform the Joint Committee as soon as reasonably

practicable. Notwithstanding that such Claims shall be responded to by the Receiving Party, each Party agrees (whether through the Joint Committee or otherwise) to assist and co-operate with the Receiving Party to enable the Receiving Party to respond to the Claim.

9.5 Each Party shall bear its own costs and expenses incurred in connection with responding to any Claims received by it which relate to decisions of the Joint Committee made on its behalf or otherwise.

9.6 Each Party shall ensure that it maintains appropriate insurance arrangements in respect of employer's liability, liability to third parties and all other potential liability under this Agreement.

## 10. VARIATIONS

10.1 If at any time during the term of this Agreement any Party requests in writing any Variation to this Agreement (which may include changes required as a result of a change in law), Clauses 10.3 to 10.7 shall apply.

10.2 If at any time during the term of this Agreement any Party requests in writing any variation to a Commissioning Contract, Clauses 10.8 to 10.10 shall apply.

**Variations to this Agreement**

10.3 The Party proposing the Variation shall provide a report in writing to the Joint Committee (the "**Variation Report**") setting out:

10.3.1 the Variation proposed;

10.3.2 the date upon which the Variation is to take effect;

10.3.3 a statement of the impact the Variation will have on, and any change required to, this Agreement;

10.3.4 a statement on the individual responsibilities of the Parties for any implementation of the Variation; and

10.3.5 details of any proposed staff and employment implications.

10.4 Following receipt by the Joint Committee of the Variation Report and allowing twenty (20) Working Days in which to consider the Variation Report, the Joint Committee shall meet to discuss the proposed Variation and acting reasonably and in good faith shall use reasonable endeavours to agree the Variation.

10.5 Where the Joint Committee is unable to agree on the terms of the Variation then any Party may refer the matter to dispute resolution under Clause 12 (Dispute Resolution).

10.6 All Variations made to this Agreement shall be agreed between the Parties. Such Variations to this Agreement are only to be effective if made in writing and signed by all the Parties.

10.7 Variations to this Agreement shall be appended to this Agreement at Schedule 8 (Variations).

**Variations to a Commissioning Contract**

10.8 The Party proposing any variation to a Commissioning Contract shall provide a report (the "**Commissioning Contract Variation Report**") in writing to the

Lead Commissioner/Contractor (if relevant) or the Joint Committee (if there is no Lead Commissioner/Contractor) setting out:

10.8.1 the variation proposed;

10.8.2 the date upon which the variation is to take effect; and

10.8.3 a statement on the individual responsibilities of the Parties for any implementation of the variation.

10.9 Following receipt by the Joint Committee or Lead Commissioner/Contractor (as relevant) of the Commissioning Contract Variation Report and allowing twenty (20) Working Days in which to consider the Commissioning Contract Variation Report, the Joint Committee shall meet to discuss the proposed variation.

10.10 Where the variation is agreed by the Joint Committee, the Lead Commissioner/Contractor (if relevant) or the Party proposing (if there is no Lead Commissioner/Contractor) the variation shall put the variation to the Provider in accordance with the relevant provisions of the Commissioning Contract.

## 11. NOTICES

11.1 Any notices to be given under the Agreement must be in writing and served on the Parties' first named Joint Committee Member in Schedule 1 either by hand, post, or e-mail to the address for that Joint Committee Member as set out in Schedule 1.

11.2 Notices:

11.2.1 by post will be effective upon the earlier of actual receipt, or five (5) Working Days after mailing;

11.2.2 by hand will be effective upon delivery;

11.2.3 by e-mail will be effective when sent in legible form subject to no automated response being received.

## 12. DISPUTE RESOLUTION

12.1 Where any dispute arises between the Parties including the Lead Commissioner/Contractor (if relevant) or where the Joint Committee cannot reach a decision in accordance with its terms of reference, the Parties must use their best endeavours to resolve that dispute on an informal basis at the next meeting of the Joint Committee.

12.2 Where any matter referred to dispute resolution is not resolved under Clause 12.1, any Party in dispute may refer the dispute to the Accountable Officers of the relevant Parties, who will cooperate in good faith to recommend a resolution to the dispute within ten (10) Working Days of the referral.

12.3 If the dispute is not resolved under Clauses 12.1 and 12.2, any Party in dispute may refer the dispute to NHS England and each Party will co-operate in good faith with NHS England to agree a resolution to the dispute within ten (10) Working Days of the referral.

12.4 Any referral to NHS England under Clause 12.3 shall be to Director of Commissioning, NHS England.

12.5 Where any dispute is not resolved under Clauses 12.1 to 12.4, any Party in dispute may refer the matter for mediation arranged by an independent third party and any agreement reached through mediation must be set out in writing and signed by the Parties in dispute.

## 13. JOINING THE COLLABORATIVE

13.1 A clinical commissioning group that wishes to join the Collaborative may do so, subject to:

13.1.1 that Party establishing the Joint Committee as a joint committee of the relevant Party and delegating the exercise of its Functions as set out in the Scheme of Delegation;

13.1.2 that Party agreeing to be bound by the terms of this Agreement and entering into a Memorandum of Adherence in the form set out in Schedule 9; and

13.1.3 the agreement of all the existing Parties.

13.2 The Parties agree that statutory successor bodies to any one or more of the Parties shall be deemed to be Parties to this Agreement and the agreement of the remaining Parties in accordance with Clause 14.1 is not required. For the avoidance of doubt, this includes an organisation formed as a result of the merger of two or more Parties.

## 14. TERMINATION

### Termination of this Agreement

14.1 The Parties may agree in writing at any time to terminate this Agreement from such date as may be agreed between the Parties.

### Termination of a Defaulting Party

14.2 The remaining Parties acting in agreement may, at any time terminate a Defaulting Party's participation in the Agreement by notice in writing to the Defaulting Party where such default is not capable of remedy or, where capable of remedy, has not been remedied within two (2) weeks of the Defaulting Party receiving notification of such default.

14.3 The Parties agree that a failure of a Party's Joint Committee Member or Deputy to attend three meetings (whether consecutive or otherwise) of the Joint Committee in any one financial year shall constitute a default which is not capable of remedy in accordance with Clause 14.2.

### Termination of a Party in relation to a Service

14.4 Where a Party terminates its participation in a Commissioning Contract, that Party's participation in matters relating to the relevant Service and that Party's inclusion in the Workplan in relation to the Service shall automatically terminate on the same date.

### Termination of a Party's participation in this Agreement

14.5 Any Party may terminate its participation in this Agreement by giving the other Parties notice in writing if that Party's fulfilment of its obligations hereunder would be in contravention of any guidance from any Secretary of

State, regulations or legislation issued or enacted after the Commencement Date.

14.6 Upon termination in accordance with Clauses 14.2, 14.4 or 14.5, this Agreement shall partially terminate as between the remaining Parties and the Defaulting Party or Terminating Party (as the case may be) only. For the avoidance of doubt, this Agreement shall continue in force as between the remaining Parties notwithstanding any partial termination in respect of any one or more Parties and the remaining Parties shall effect such amendments to this Agreement as may be necessary in accordance with Clause 10 (Variations).

## 15. CONSEQUENCES OF EXPIRY, TERMINATION OR PARTY LEAVING

15.1 In the event that this Agreement expires, is terminated (whether in full or in part) or a Party leaves the Collaborative (the "**Exiting Party**"), the Parties agree to co-operate to ensure an orderly wind down of their joint activities as set out in this Agreement and the following provisions shall (unless agreed otherwise by the Parties) have effect:

15.1.1 each Party shall ensure or procure the continued provision of the Services related to its Functions;

15.1.2 insofar as it is necessary, each Party shall use its reasonable endeavours to arrange and ensure the novation of any relevant contracts which are necessary to be novated from an Exiting Party to a remaining Party who shall accept such novation; and

15.1.3 reconciliation of the Programme Management Budget against actual expenditure shall be undertaken in accordance with Schedule 6.

15.2 The Parties shall at all times act in such a manner as not to adversely affect the delivery of the Services.

## 16. SURVIVAL

16.1 The provisions of this Agreement which are expressly stated to survive its termination or expiry or which are intended by their nature to survive termination or expiry shall continue in force (including but not limited to Clauses 7, 8, 9, 12, 15, 16, 17, 18, 19, 23, 28 and Schedule 6 together with those other Clauses, the survival of which is necessary for the interpretation or enforcement of this Agreement).

16.2 Termination or expiry of this Agreement does not affect any accrued rights or remedies under this Agreement or any other agreement between the Parties.

## 17. CONFIDENTIALITY

17.1 Except as required by law and specifically pursuant to Clause 19 (Freedom of Information), each Party agrees at all times during the continuance of this Agreement and after its termination or expiry to keep confidential any and all information, data and material of any nature which that Party may receive or obtain in connection with the operation of this Agreement or otherwise relating in any way to the business, operations and activities of another Party, its employees, agents and/or any other person with whom it has dealings. For

the avoidance of doubt this Clause shall not affect the rights of any workers under section 43 A-L of the Employment Rights Act 1996.

17.2 The Parties agree to provide or make available to each other sufficient information concerning their own operations and actions to enable the efficient operation of the Collaborative.

## 18. DATA PROTECTION

18.1 The Parties acknowledge their respective duties under the Data Protection Legislation and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.

18.2 The Parties may share information with each other which may comprise anonymised and pseudonymised data to support decision-making by the Collaborative, but will not include any patient identifiable data. The Parties shall comply with the terms of the separate Information Sharing Agreement.

## 19. FREEDOM OF INFORMATION

19.1 Each Party acknowledges that the other Parties are subject to the requirements of the FOIA and each Party shall assist and co-operate with the others (at their own expense) to enable the other Parties to comply with their information disclosure obligations.

19.2 Where a Party receives a "request for information" (as defined in the FOIA) in relation to information which it is holding on behalf of another Party, it shall (and shall procure that its sub-contractors shall):

19.2.1 transfer the request for information to the other Party as soon as practicable after receipt and in any event within two (2) Working Days of receiving the request for information;

19.2.2 provide the other Party with a copy of all information in its possession or power in the form that the other Party requires within five (5) Working Days (or such other period as may be agreed) of the other Party requesting that information; and

19.2.3 provide all necessary assistance as reasonably requested to enable the other Party to respond to the request for information within the time for compliance set out in section 10 of the FOIA.

19.3 Where a Party receives a request for information which relates to the Agreement, it shall inform the other Parties of the request for information as soon as practicable after receipt and in any event within two (2) Working Days of receiving the request for information.

19.4 If any Party determines that information must be disclosed pursuant to Clause 19.3, it shall notify the other Parties of that decision at least two (2) Working Days before disclosure.

19.5 Each Party shall be responsible for determining at its absolute discretion whether the relevant information is exempt from disclosure or is to be disclosed in response to a request for information.

19.6 Each Party acknowledges that the other Parties may be obliged under the FOIA to disclose information:

19.6.1 without consulting with the other Parties; or

19.6.2 following consultation with the other Parties and having taken their views into account.

19.7 Where the Programme Management Office or the Joint Committee receives a request for information in relation to this Agreement then the relevant affected Parties may agree that the response to such request for information shall be co-ordinated by the Programme Management Office on behalf of the Parties involved, such Parties to assist and co-operate with the Programme Management Office in this regard.

## 20. STATUS

20.1 The Parties acknowledge that they are all health service bodies for the purposes of section 9 of the NHS Act 2006. Accordingly, this Agreement shall be treated as an NHS Contract and shall not be legally enforceable.

20.2 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Parties or render any Party directly liable to any third party for the debts, liabilities or obligations of any other Party.

20.3 Save as specifically authorised under the terms of this Agreement, a Party shall not hold itself out as the agent of any other Party.

## 21. ASSIGNMENT AND SUB-CONTRACTING

This Agreement, and any right and conditions contained in it, may not be assigned or transferred by any Party without the prior written consent of the other Parties, except to any statutory successor to the relevant function.

## 22. THIRD PARTY RIGHTS

The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Parties to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

## 23. COMPLAINTS

23.1 Any complaints relating to a Party's Functions shall be dealt with in accordance with the statutory complaints procedure of that Party.

23.2 Insofar as any complaint may relate to the content of this Agreement such complaints shall be referred to the Joint Committee. The Parties shall co-operate as to the resolution of complaints.

23.3 In the event that a complaint arises about a Commissioning Contract, that complaint should be dealt with in accordance with the procedure set out in the relevant Commissioning Contract.

24. **ENTIRE AGREEMENT**

This Agreement constitutes the entire agreement and understanding of the Parties and supersedes any previous agreement between the Parties relating to the subject matter of this Agreement.

25. **SEVERABILITY**

If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

26. **WAIVER**

No failure or delay by a Party to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

27. **COSTS AND EXPENSES**

Each Party shall be responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

28. **GOVERNING LAW AND JURISDICTION**

This Agreement shall be governed by and construed in accordance with English Law and, subject to Clauses 12.1 (Dispute Resolution) and 20.1 (Status), the Parties irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

29. **FAIR DEALINGS**

The Parties recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of any of them and that if in the course of the performance of this Agreement, unfairness to any of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

30. **COUNTERPARTS**

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Parties shall constitute a full original of this Agreement for all purposes.

This Agreement is effective on the date stated at the beginning of it.

**IN WITNESS OF WHICH the Parties have signed this Agreement on the date shown below**

Signed by _____ _____

*(print name)* *(signature)*

for and on behalf of **NHS Airedale, Wharfedale and Craven Clinical Commissioning Group**

Date of signature _____

Signed by _____ _____

(print name) (signature)

for and on behalf of **NHS Bradford City Clinical Commissioning Group**

Date of signature _____

Signed by _____ _____

(print name) (signature)

for and on behalf of **NHS Bradford Districts Clinical Commissioning Group**

Date of signature _____

Signed by _____ _____

(print name) (signature)

for and on behalf of **NHS Calderdale Clinical Commissioning Group**

Date of signature _____

Signed by _____ _____

(print name) (signature)

for and on behalf of **NHS Greater Huddersfield Clinical Commissioning Group**

Date of signature _____

Signed by _____

(print name)

for and on behalf of **NHS Harrogate and Rural District Clinical Commissioning Group**

_____

(signature)

Date of signature _____

Signed by _____

(print name)

for and on behalf of **NHS Leeds North Clinical Commissioning Group**

_____

(signature)

Date of signature _____

Signed by _____

(print name)

for and on behalf of **NHS Leeds South and East Clinical Commissioning Group**

_____

(signature)

Date of signature _____

Signed by _____

(print name)

for and on behalf of **NHS Leeds West Clinical Commissioning Group**

_____

(signature)

Date of signature _____

Signed by _____

(print name)

for and on behalf of **NHS North Kirklees Clinical Commissioning Group**

_____

(signature)

Date of signature _____

Signed by _____

(print name)

for and on behalf of **NHS Wakefield Clinical Commissioning Group**

_____

(signature)

Date of signature _____

**SCHEDULE 1**

**JOINT COMMITTEE MEMBERS**

**1. Joint Committee Member details**

1.1. The table below sets out the names and contact details of each Party's nominated Joint Committee Members.

| Name of Party | Name of Joint Committee Members | Contact Details of Member | Name of Deputy | Contact Details of Deputy |
|---|---|---|---|---|
| Airedale, Wharfedale and Craven CCG | Helen Hirst | | Julie Lawreniuk | |
| | James Thomas | | None | |
| Bradford City CCG | Helen Hirst | | Julie Lawreniuk | |
| | Andy Withers | | None | |
| Bradford Districts CCG | Helen Hirst | | Julie Lawreniuk | |
| | Akram Khan | | None | |
| Calderdale CCG | Matt Walsh | | Neil Smurthwaite | |
| | Alan Brook | | None | |
| Greater Huddersfield CCG | Carol McKenna | | Ian Currell | |
| | Steve Ollerton | | Dr Jane Ford | |
| Harrogate and Rural District CCG | Amanda Bloor | | Dilani Gamble | |
| | Alistair Ingram | | None | |
| Leeds North CCG | Phil Corrigan | | Visseh Pejhan – Sykes | |
| | Jason Broch | | Manjit Purewal | |
| Leeds South and East CCG | Phil Corrigan | | Visseh Pejhan – Sykes | |
| | Alistair Walling | | | |

| Name of Party | Name of Joint Committee Members | Contact Details of Member | Name of Deputy | Contact Details of Deputy |
|---|---|---|---|---|
| Leeds West CCG | Phil Corrigan | | Visseh Pejhan – Sykes | |
| | Gordon Sinclair | | None | |
| North Kirklees CCG | Richard Parry | | None | n/a |
| | Dr David Kelly | | None | n/a |
| Wakefield CCG | Jo Webster | | None | n/a |
| | Philip Earnshaw | | None | n/a |

## SCHEDULE 2

## NON-SERVICE SPECIFIC MATTERS

1. The Parties agree that the matters below are Non-Service Specific Matters and shall be delegated to the Joint Committee in accordance with Clause 6.9.3:

    1.1. consideration, and agreeing or proposing resolutions to, disputes referred to the Joint Committee in accordance with Clause 12 (Dispute Resolution);

    1.2. consideration of, and agreeing resolutions to, any complaint relating to the content of this Agreement in accordance with Clause 23 (Complaints);

    1.3. agreeing the Programme Management Budget for each financial year and oversight of management of the Programme Management Budget by the Host Party;

    1.4. development and communication;

    1.5. engagement events; and

    1.6. engaging with the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common, other Provider Groups and the West Yorkshire and Harrogate STP System Leadership Executive Group as appropriate to further the STP objectives as set out in Schedule 7.

## SCHEDULE 3

## TERMS OF REFERENCE OF THE JOINT COMMITTEE

### 1. ROLE OF THE JOINT COMMITTEE

1.1. The overarching role of the Joint Committee is to take efficient and effective commissioning decisions on a place basis, where appropriate and in accordance with the delegation of authority from each Party, and, in doing so, to support the aims and objectives of the STP as set out in Schedule 7. The Joint Committee shall at all times act in accordance with all relevant Law and Guidance applicable to the Parties and relevant to the joint exercise of each Party's Functions.

### 2. TERMS OF REFERENCE OF THE JOINT COMMITTEE

**Frequency and notice of meetings**

2.1. Meetings shall be held monthly or other such frequency as agreed by the Parties.

2.2. Meetings may be held by telephone or video conference. Joint Committee Members may participate (and count towards quorum) in a face-to-face meeting via telephone or video-conference.

2.3. The Chair shall set the agenda and arrange for the circulation of any papers to be considered at least five Working Days prior to the meeting.

2.4. Meetings of the Joint Committee shall be open to the public save where the Joint Committee resolves to exclude members of the public from any meeting or part of a meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or there are special reasons as stated in the resolution and arising from the nature of the business of the proceedings.

2.5. The Chair may exclude any member of the public from a meeting of the Joint Committee if they are interfering with or preventing the proper or reasonable conduct of that meeting.

2.6. Members of the public or representatives of the press may not record proceedings in any manner whatsoever, other than writing, or make any oral report of the proceedings as they take place, without the prior written agreement of the Chair.

2.7. The right of attendance at meetings by members of the public as referred to in paragraph 2.4 does not give the right to such members of the public to ask questions or otherwise participate in that meeting, unless invited to do so by the Chair.

**Joint Committee Members and attendees**

2.8. The Joint Committee Members shall comprise:

2.8.1. two voting representatives appointed by each Party; and

2.8.2. three non-voting lay representatives (appointed by the Parties via an open application process) to comprise:

(a) one lay representative who is independent of any of the Parties (the "Independent Lay Representative"); and

(b) two lay representatives who are existing lay members of a Party's governing body (provided that the two lay representatives shall not be lay members of the same Party).

2.9. The Joint Committee shall invite a representative of NHS England to attend meetings and may invite other persons to attend meetings as it deems appropriate.

2.10. No such persons invited to attend meetings shall be able to vote on a matter.

**Quorum**

2.11. Meetings of the Joint Committee shall be quorate when at least 75% of the Joint Committee Members are present.

2.12. In circumstances where a Joint Committee Member who is not a lay representative is unable to attend a meeting, or they have a conflict of interest which required them to be excluded from a meeting, the nominating Party may send to a meeting of the Joint Committee a deputy (a "**Deputy**") to take the place of the Joint Committee Member. Where a Party sends a Deputy to take the place of the Joint Committee Member, the references in this paragraph 2 to Joint Committee Members shall be read as references to the Deputy. Parties must ensure that a Deputy attending a meeting of the Joint Committee has the necessary delegated authority.

**Voting**

2.13. The Joint Committee Members nominated by each Party (referred to in paragraph 2.8.1 above) shall have one vote between them, so that there is one vote per Party. The lay representative Joint Committee Members shall not vote on any matter.

2.14. The Joint Committee will make decisions by consensus of those Joint Committee Members present and voting at the meeting wherever possible. If a consensus decision cannot be reached then decisions of the Joint Committee will be made by 75% majority of those Joint Committee Members voting and present at the meeting.

2.15. The validity of any act of the Joint Committee shall not be affected by any defect in its constitution, by any vacancy among the Joint Committee Members or by any defect in the appointment of any of its Joint Committee Members.

**Chair**

2.16. The Independent Lay Representative shall be appointed Chair of the Joint Committee. The Joint Committee will appoint another of the Joint Committee Members to act as Deputy Chair.

**Administration**

2.17. The Programme Management Office shall provide administrative support and advice to the Joint Committee including but not limited to:

2.17.1. taking the minutes and keeping a record of matters arising and issues to be carried forward;

2.17.2. maintaining a register of interests for Joint Committee Members; and

2.17.3. advising the Joint Committee and attendees if relevant as appropriate on best practice, national guidance and other relevant documents.

**Duties**

2.18. The Joint Committee will:

2.18.1. make Joint Committee Decisions (as set out in Schedule 4 and/or the Workplan); and

2.18.2. undertake actions as set out in this Agreement.

**Relationship with the Parties**

2.19. Minutes of meetings of the Joint Committee shall be provided to the members and/or governing bodies of the Parties.

2.20. The Joint Committee shall produce, with the support of the Programme Management Office, an annual report of the work of the Joint Committee which shall be provided to the members and /or governing bodies of each Party.

**Special Meetings**

2.21. Special meetings of the Joint Committee on any matter may be called by any of the Parties acting through its Joint Committee Member by giving at least forty-eight (48) hours' notice by e-mail to the other Joint Committee Members in the following circumstances:

2.21.1. where that Party has concerns relating to the safety and welfare of Service Users under any Commissioning Contract(s);

2.21.2. in response to a quality, performance or financial query by any Regulatory or Supervisory Body;

2.21.3. to convene a meeting under Clause 12.1 (Dispute Resolution) of the Agreement; and/or

2.21.4. for the consideration of any matter which that Party considers of sufficient urgency and importance that its consideration cannot wait until the date of the next meeting.

**Conflicts of Interest**

2.22. Each Joint Committee Member must abide by all policies of the Party it represents in relation to conflicts of interest.

2.23. Where any Joint Committee Member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that Joint Committee Member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed. Where the Chair decides to exclude a Joint Committee Member, the relevant Party may send a Deputy to take the place of the conflicted Joint Committee Member in relation to that matter in accordance with paragraph 2.12.

**Review**

2.24. These terms of reference shall be reviewed by the Joint Committee at least annually and any consequential amendments approved by each Party's members.

## SCHEDULE 4

## SCOPE OF DECISION MAKING

### 1. INTRODUCTION

Each Party shall ensure that the matters noted as Joint Committee Decisions in this Schedule 4 and the matters set out in the Workplan in the Appendix are properly and lawfully delegated to the Joint Committee in accordance with the NHS Act 2006 and each Party's constitution and internal procedures.

### 2. MATTERS WITHIN THE SCOPE OF THIS AGREEMENT

**Workplan - general**

2.1 The Joint Committee will develop a workplan (the "**Workplan**") which will set out the proposed scope of the Joint Committee's work. The Workplan for 2017/18 effective from the Commencement Date and approved by the Parties is set out in the Appendix to this Schedule 4.

2.2 The Parties agree that the Workplan will be underpinned by a 'gateway' approach for the Services which are the subject of the Workplan, setting out the process and approvals for project initiation, case for change, options appraisal and final decision making.

**Workplan review – 2017/18**

2.3 The Parties shall review the Workplan for 2017/18 in the first six months following the Commencement Date and agree any potential new service areas which all of the Parties agree should be brought within the scope of the Workplan during the term of this Agreement ("Future Joint Committee Matters"), subject to certain conditions ("Gateway Conditions") being met.

2.4 Following such review, the Parties shall agree:

2.4.1 the Future Joint Committee Matters;

2.4.2 the Gateway Conditions;

2.4.3 the mechanism through which the Gateway Conditions will be assessed to have been met in order for any Future Joint Committee Matters to be brought within the scope of the Workplan. Such mechanism may include assessment and confirmation by each Party's governing body that the Gateway Conditions have been met in each such case; and

2.4.4 the reporting mechanisms as between the Joint Committee and each Party's governing body and members, and as between each Party's governing body and members, in respect of changes to the Workplan during the term of this Agreement, as appropriate.

2.5 The Parties shall document the matters set out in paragraph 2.4 in this Agreement and in the Joint Committee terms of reference in Schedule 3 by way of a variation to this Agreement in accordance with Clause 10 to be approved by each Party's members.

**CCG Decisions**

2.6 The Parties agree that the following matters are CCG Decisions which are reserved to each Party:

2.6.1 approval of the Workplan for 2017/18;

2.6.2 any other matter which is not set out in the Workplan and is not a Non-Service Specific Matter.

**Joint Committee Decisions**

2.7 The Parties have agreed that decisions in relation to the matters set out below shall be Joint Committee Decisions and shall be delegated to the Joint Committee accordingly:

2.7.1 matters set out in the Workplan; and

2.7.2 Non-Service Specific Matters set out in Schedule 2.

2.8 To avoid doubt, Joint Committee Decisions may be made by the Joint Committee without reference back to each Party.

**Lead Commissioner/Contractor Decisions**

2.9 The Parties may agree to delegate decisions in respect of a particular Service to a Lead Commissioner/Contractor in accordance with each Party's constitution and scheme of delegation and shall document any such matters in this Schedule 4 by way of a variation to this Agreement.

2.10 To avoid doubt, any Lead Commissioner/Contractor Decisions may be made by the Lead Commissioner without reference back to each Party or to the Joint Committee.

**APPENDIX**

**2017/18 WORKPLAN – Attached at Appendix B**

## SCHEDULE 5

## PROGRAMME MANAGEMENT SUPPORT

### SCOPE OF PROGRAMME MANAGEMENT SUPPORT

1.1 The Host Party shall provide Programme Management Support to the Collaborative and the Joint Committee, to include the following:

1.1.1 secretariat to the Joint Committee, including agendas papers and minutes;

1.1.2 oversight and support to the West Yorkshire and Harrogate collaborative programmes;

1.1.3 facilitation and co-ordination of West Yorkshire and Harrogate Sustainability and Transformation Plan activity;

1.1.4 partnership working with the 6 local place based planning units to ensure alignment and connectivity; and

1.1.5 support to the establishment of more formal governance and decision making structures to support the STP.

## SCHEDULE 6

## COSTS AND RESOURCES OF THE COLLABORATIVE

1.1. The Annual Contribution of each Party shall be determined by agreement of the Joint Committee in accordance with Clause 8.3.5.

1.2. The Host Party will issue an invoice to each Party for its respective Annual Contribution for the relevant financial year within 30 days of the beginning of that financial year. Each Party shall pay its Annual Contribution to the Host Party within 30 days of receipt of an invoice from the Host Party.

1.3. The Parties agree that the Annual Contributions may be used to reimburse the Host Party for costs associated with the Programme Management Support, including (but not limited to):

1.3.1. salary and travel costs of Programme Management Office staff; and

1.3.2. administration costs associated with the Collaborative and Programme Management Support, including:

1.3.2.1. office and meeting room hire;

1.3.2.2. IT support and telephony costs;

1.3.2.3. printing and stationery costs.

1.4. The Joint Committee may agree to expand or reduce the scope of the Programme Management Support provided by the Host Party subject to any additional costs incurred by the Host Party as a result of such expansion or reduction being apportioned between the Parties in such proportions as the Joint Committee may agree. In the case of a reduction in the scope of the Programme Management Support such additional costs shall include, but not be limited to, redundancy costs payable by the Host Party as a result of a reduction in the scope of Programme Management Support.

**Reporting to the Joint Committee**

1.5. The Host Party will provide a monthly written report to the Joint Committee setting out income and expenditure to date in respect of the Programme Management Budget, including identification of and provision of reasons for, any potential overspend or underspend against the Programme Management Budget, and any recommended actions for the Joint Committee to consider.

1.6. The Host Party will provide an annual written report to the Joint Committee setting out the final year-end position in respect of the Programme Management Budget, reconciling expenditure against budget and detailing any overspends or underspends and the reasons for such.

**Overspends and underspends during the term of the Agreement**

1.7. The Parties agree that any overspends against the Programme Management Budget in any financial year shall be shared between the Parties in the same proportions as the Annual Contributions to the Programme Management Budget in the relevant financial year unless otherwise agreed by the Joint Committee. The Host Party shall issue an invoice to each Party in respect of its share of the overspend within 30 days of the end of the relevant financial year to which the overspend relates. Each Party shall pay the Host Party its share of the overspend within 30 days of receipt of the invoice from the Host Party.

1.8. The Parties agree that any underspends against the Programme Management Budget in any financial year shall be shared between the Parties in the same proportions as the Annual Contributions to the Programme Management Budget in the relevant financial year unless otherwise agreed by the Joint Committee. Each Party shall issue an invoice to the Host Party for its share of the underspend within 30 days of the end of the relevant financial year to which the underspend relates. The Host Party shall pay each Party its share of the underspend within 30 days of receipt of the invoice from the relevant Party.

**Reconciliation of Programme Management Budget on expiry or early termination of the Agreement**

1.9. In the event that this Agreement expires or terminates (in whole) in accordance with its terms, the Host Party shall undertake a reconciliation of the Programme Management Budget as against actual expenditure and provide a written reconciliation report to each Party no later than 30 days following the expiry date or the date of termination (as relevant).

1.10. Such reconciliation shall set out the balance of any monies owing to each Party (in the event there has been an underspend as at the relevant date) or the balance of monies to be paid by each Party to the Host Party (in the event there has been an overspend as at the relevant date).

1.11. The Host Party shall issue an invoice to each Party, or each Party shall invoice the Host Party (as appropriate) and such invoices shall be paid within 30 days of receipt.

1.12. Where this Agreement terminates partially in respect of one or more Parties only, but not all of the Parties, then the Host Party shall provide the written reconciliation report referred to in paragraph 1.9 above to the Joint Committee setting out the balance of monies owed to or owed by (as the case may be) the Exiting Party (or Exiting Parties) for the Joint Committee's approval. Subject to such approval, the Host Party shall issue an invoice to the Exiting Party (or Exiting Parties) or the Exiting Party (or Exiting Parties) shall issue an invoice to the Host Party (as appropriate) and such invoice shall be paid within 30 days of receipt.

## SCHEDULE 7

## WEST YORKSHIRE SUSTAINABILITY AND TRANSFORMATION PLAN – PRINCIPLES AND OBJECTIVES

1.1. A link to the draft Sustainability and Transformation Plan as at October 2016 is attached below:

**http://www.southwestyorkshire.nhs.uk/wp-content/uploads/2016/10/Final-draft-submission-plan.pdf**

## SCHEDULE 8

## VARIATIONS

The Parties will insert agreed variations to this Agreement in this Schedule 8.

**SCHEDULE 9**

**MEMORANDUM OF ADHERENCE**

Dated _____

---

**MEMORANDUM OF ADHERENCE**

FOR THE

**COLLABORATIVE COMMISSIONING**

BETWEEN

**CLINICAL COMMISSIONING GROUPS ACROSS WEST YORKSHIRE AND HARROGATE**

---

**THIS MEMORANDUM** is dated is dated the day of 20{●}

**BETWEEN**

(1) [insert name of CCG] whose principal office is at [insert principal office address] ("**New Party"**) and

(2) The clinical commissioning groups named in the Schedule as the existing parties in the collaborative commissioning arrangements ("**Existing Parties"**).

**BACKGROUND**

(A) This memorandum is entered into under Clause [insert number] of a memorandum of understanding dated [insert date], made between Existing Parties setting out the terms for operating the collaborative commissioning as amended from time to time (the "**MOU"**).

(B) The New Party wishes to join the MOU.

**IT IS AGREED:**

1. **DEFINITIONS AND INTERPRETATION**

1.1 Words and expressions used in this memorandum shall, unless the context expressly requires otherwise, have the meaning given to them in the MOU. The **Effective Date** means the date of this memorandum.

2. **CONFIRMATION AND UNDERTAKING**

2.1 The New Party confirms that it has been supplied with a copy of the MOU. The New Party and each of the Existing Parties undertake with each other that, from the Effective Date, the New Party shall assume all of the rights and obligations under the MOU and shall observe, perform and be bound by the provisions of the MOU that contain obligations on the parties to the MOU as though the New Party was an original party to the MOU.

3. **COUNTERPARTS**

3.1 This memorandum may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

4. **GOVERNING LAW AND JURISDICTION**

4.1 The New Party and the Existing Parties acknowledge that they are all health service bodies for the purposes of section 9 of the NHS Act 2006. Accordingly, this memorandum shall be treated as an NHS Contract and shall not be legally enforceable.

4.2 This memorandum shall be governed by and construed in accordance with English Law and, subject to Clauses 4.1, the New Party and the Existing Parties irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this memorandum.

This document has been signed and takes effect on the date stated at the beginning of it.

**[INSERT NEW PARTY NAME]**

**AUTHORISED OFFICER** **Date**

**NHS HARROGATE AND RURAL DISTRICT**

**CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

**NHS WAKEFIELD**

**CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

**NHS LEEDS NORTH**

**CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

**NHS LEEDS SOUTH AND EAST**

**CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

**NHS LEEDS WEST**

**CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

**NHS BRADFORD CITY**

**CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

**NHS BRADFORD DISTRICTS**

**CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

**NHS NORTH KIRKLEES**

**CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

**NHS GREATER HUDDERSFIELD**

**CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

**NHS AIREDALE, WHARFEDALE AND**

**CRAVEN CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

**NHS CALDERDALE**

**CLINICAL COMMISSIONING GROUP**

**Authorised Officer** **Date**

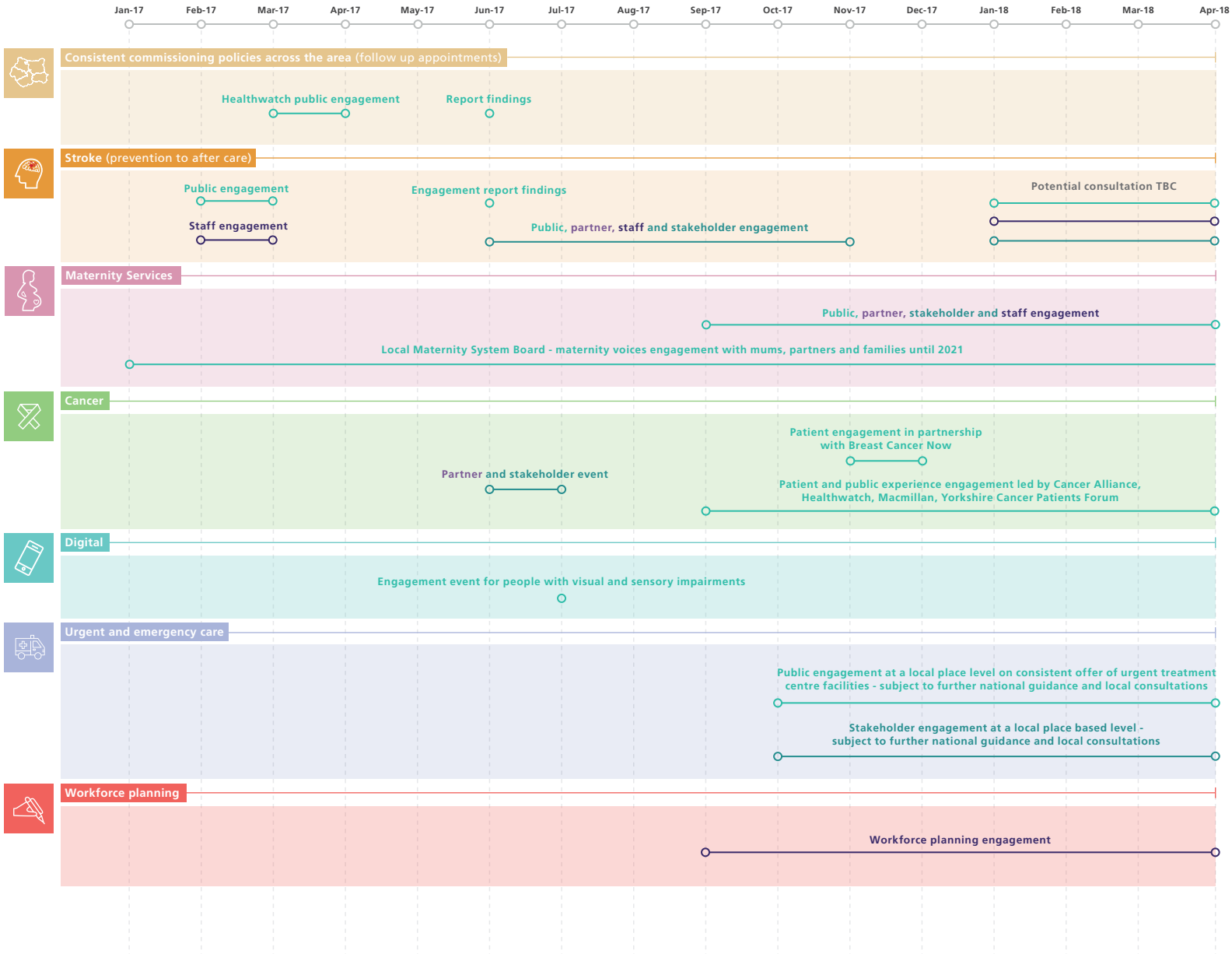
| HEALTHY FUTURES CCG JOINT COMMITTEE WORKPLAN 2017/18 | | | | | Agenda item 05/17 Appendix B | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2017 | | | | | | | | | 2018 | | |
| **TOPIC** | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March |
| **Committee administration** | | | | | | | | | | | | |
| Review and approve annual work plan and progress against work plan | | | | | | | ✓ | | | | | |
| Committee self assessment | | | | | | | ✓ | | | | | |
| Review committee terms of reference | | | | | | | | ✓ | | | | |
| Annual committee report to CCG Governing Bodies | | | | | | | | | | | | ✓ |
| **Mental Health Workstream** | | | | | | | | | | | | |
| West Yorkshire plan developed for provision of children young people inpatient units integrated with local pathways. Seeking to eliminate inappropriate placements. | 2017/18 Q1 | | | | | | | | | | | |
| West Yorkshire plan developed for low/medium secure services and associated pathways. | 2017/18 Q1 | | | | | | | | | | | |
| Bed management proposal developed to support reduction in out of area placements. | | | | 2017/18 Q2-Q4 | | | | | | | | |
| Proposal developed for standard approach to commissioning acute mental health services across West Yorkshire. | | | | 2017/18 Q2-Q4 | | | | | | | | |
| **Urgent & Emergency Care** | | | | | | | | | | | | |
| Agree future arrangements for NHS 111 and WY Urgent Care Services. | 2017/18 | | | | | | | | | | | |
| Agree business case for the Clinical Advice Service. | 2017/18 | | | | | | | | | | | |
| Uregnt emergency care technology workstream – Agree business case for direct booking licenses and acute trust telehealth. | 2017/18 | | | | | | | | | | | |
| Consider recommendations for reconfiguration of services, priority pathways and wider STP work | 2017/18 | | | | | | | | | | | |
| Agree significant improvements in the development of the clinical advice service which supports NHS 111, 999 and out-of-hours calls | 2017/18 | | | | | | | | | | | |
| Consider ongoing benefits realisation work & return on investment working with YHEC and the AHSN | 2017/18 | | | | | | | | | | | |
| **Stroke** | | | | | | | | | | | | |
| Agree Stage 2 NHSE Assurance – Outline Business Case sign off (subject to Stage 1 NHSE approval to proceed). Approval to proceed to Formal Consultation | | ✓ | | | | | | | | | | |
| Stage 3 Assurance – Formal Consultation completed (Subject to NHSE Stage 2 approval). | | | | | | ✓ | | | | | | |
| Consider outcome of consultation. Agree recommendations (Subject to NHSE Stage 1 and 2 approvals) | | | | | | | | | ✓ | | | |
| Stage 4 Assurance – Delivery Plan prepared and signed off | | | | | | | | | | | ✓ | |
| **Cancer** | | | | | | | | | | | | |
| Sign off Alliance Delivery Plan including 5 year diagnostic capacity building plan | ✓ | | | | | | | | | | | |
| Commit to local action plans to deliver Recovery Package & risk stratified post-treatment pathways by 2020 | 2017/18 | | | | | | | | | | | |
| Consider option appraisal for service model for strategic diagnostic growth. Where appropriate consider approval for public consultation. | 2017/18 | | | | | | | | | | | |
| Agree preferred model for service model for strategic diagnostic growth. | 2017/18 | | | | | | | | | | | |

| HEALTHY FUTURES CCG JOINT COMMITTEE WORKPLAN 2017/18 | | | | | Agenda item 05/17 Appendix B | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **2017** | | | | | | | | | **2018** | | |
| **TOPIC** | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March |
| Agree to pilot new strategic approaches to commissioning and provision of cancer care | 2017/18 | | | | | | | | | | | |
| **Clinical Thresholds** | | | | | | | | | | | | |
| Quarterly rolling process of development, agreement and implementation of commissioning policies. Covering: pre-surgery optimisation; clinical thresholds and procedures of low clinical value; eliminating unnecessary follow-ups; efficient prescribing. Proposed policies will have been considered through the clinical forum. | 2017/18 | | | | | | | | | | | |
| **Risk Management Framework** | | | | | | | | | | | | |
| Oversee the development and maintenance of assurance and risk management systems and processes | | | | | | | | | | | | |
| Maintain an up to date risk profile by reviewing all significant risks to the achievement of STP and CCGs' objectives through the development of an Assurance Framework | | | | | | | | | | | | |

# West Yorkshire and Harrogate Health and Care Partnership, engagement and consultation time-lines (please note these may be subject to change)

August 2017

West Yorkshire and Harrogate Health and Care Partnership




Public

Staff

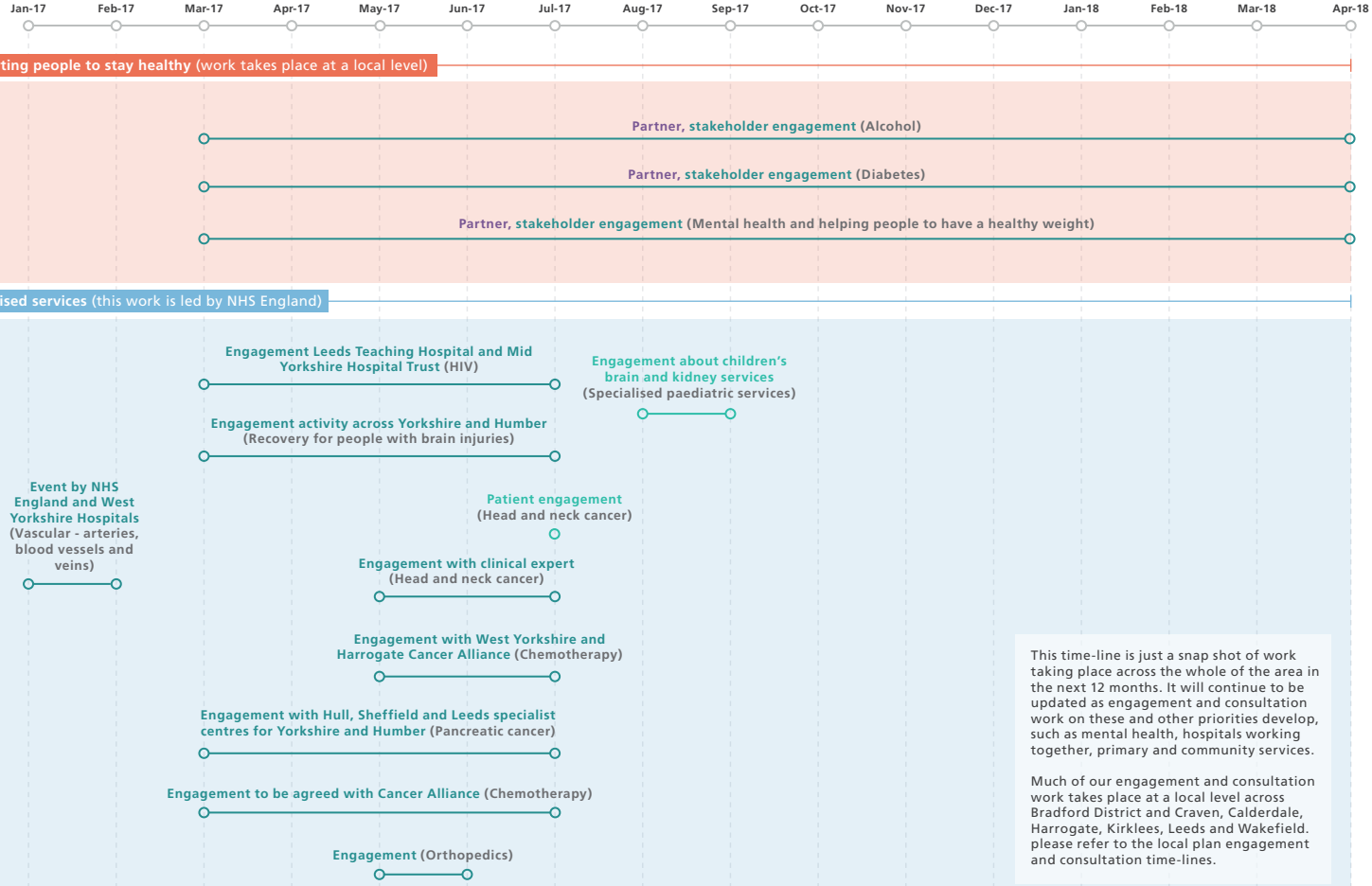
Stakeholders

Partners

# West Yorkshire and Harrogate Health and Care Partnership, engagement and consultation time-lines (please note these may be subject to change)

August 2017

West Yorkshire and Harrogate Health and Care Partnership




This time-line is just a snap shot of work taking place across the whole of the area in the next 12 months. It will continue to be updated as engagement and consultation work on these and other priorities develop, such as mental health, hospitals working together, primary and community services.

Much of our engagement and consultation work takes place at a local level across Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield. please refer to the local plan engagement and consultation time-lines.

Public

Staff

Stakeholders

Partners

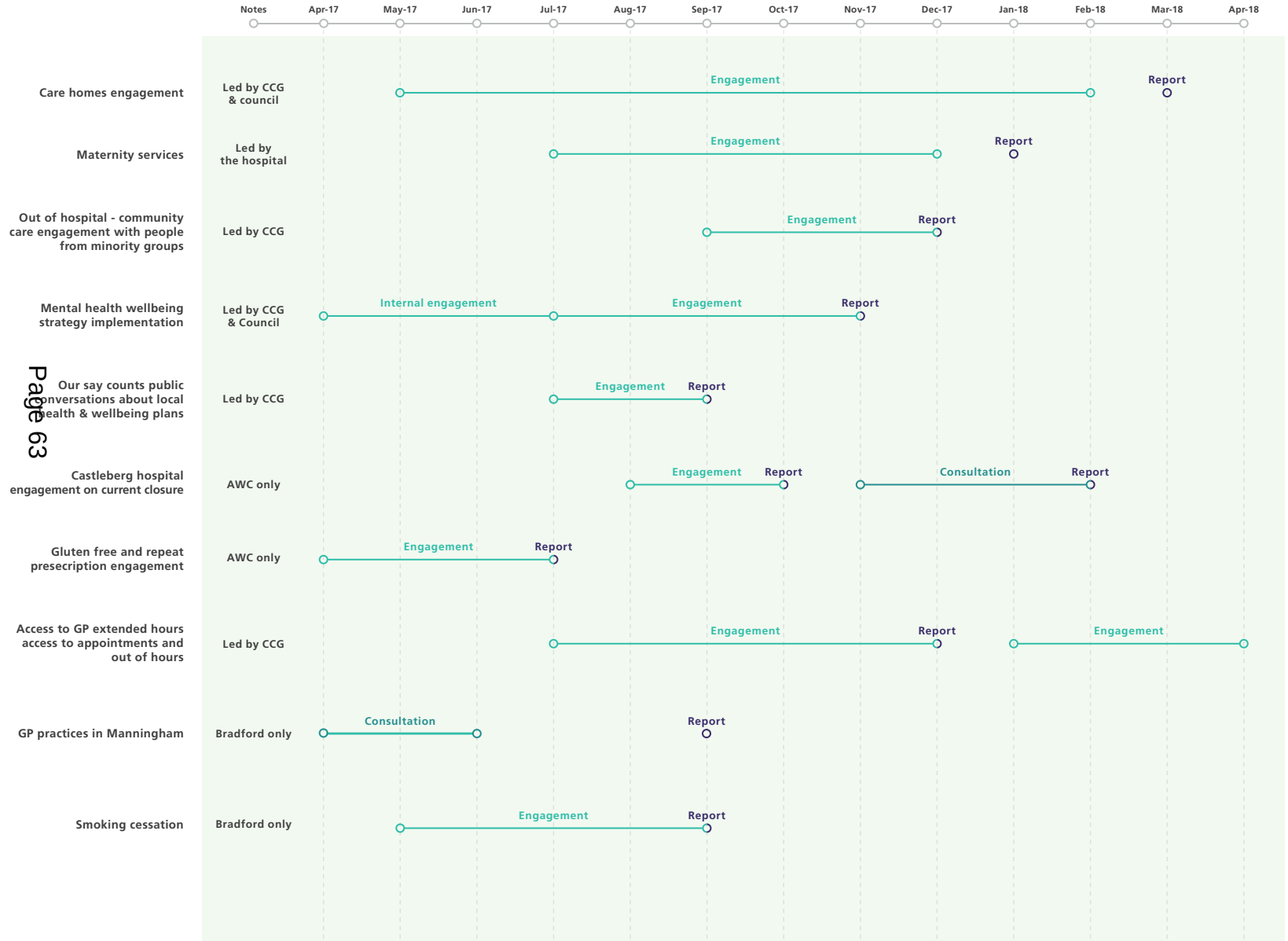
# Bradford City, Bradford Districts and Airdale, Wharfedale and Craven (AWC) Clinical Commissioning Group (CCG) local plan engagement and consultation

This time-line is just a snap shot of work taking place across the area of Bradford City, Bradford Districts and Airedale, Wharfedale and Craven from April 2017 to March 2018. It will continue to be updated as engagement and consultation work on these and other priorities develop.

West Yorkshire and Harrogate Health and Care Partnership

## August 2017

(please note these may be subject to change)




Mapping/ planning

Engagement

Report

Consultation

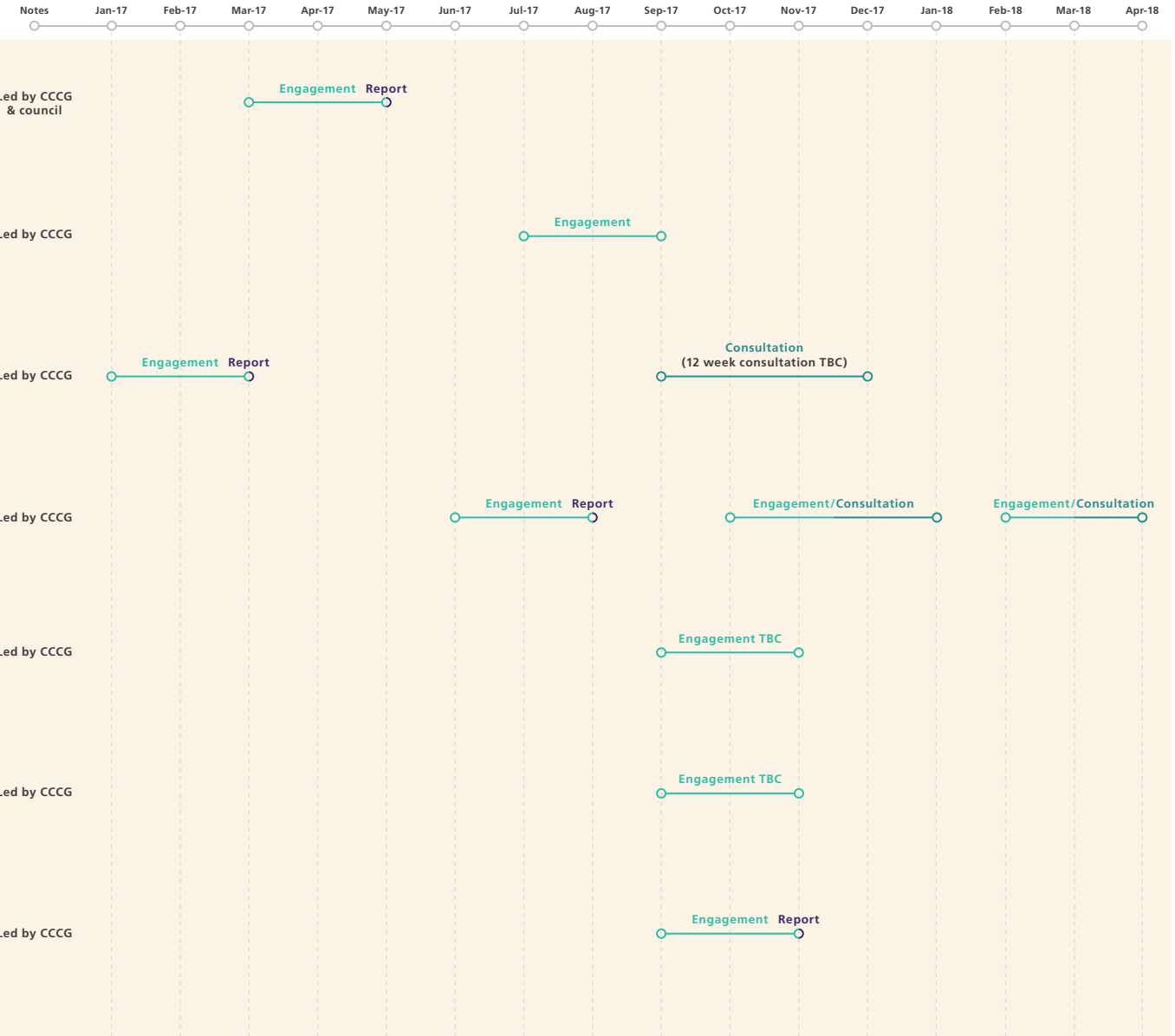
# Calderdale Clinical Commissioning Group (CCCG) local plan engagement and consultation

This time-line is just a snap shot of work taking place across the area of Calderdale from January 2017 to April 2018. It will continue to be updated as engagement and consultation work on these and other priorities develop.

West Yorkshire and Harrogate Health and Care Partnership

## August 2017

(please note these may be subject to change)




Mapping/ planning

Engagement

Report

Consultation

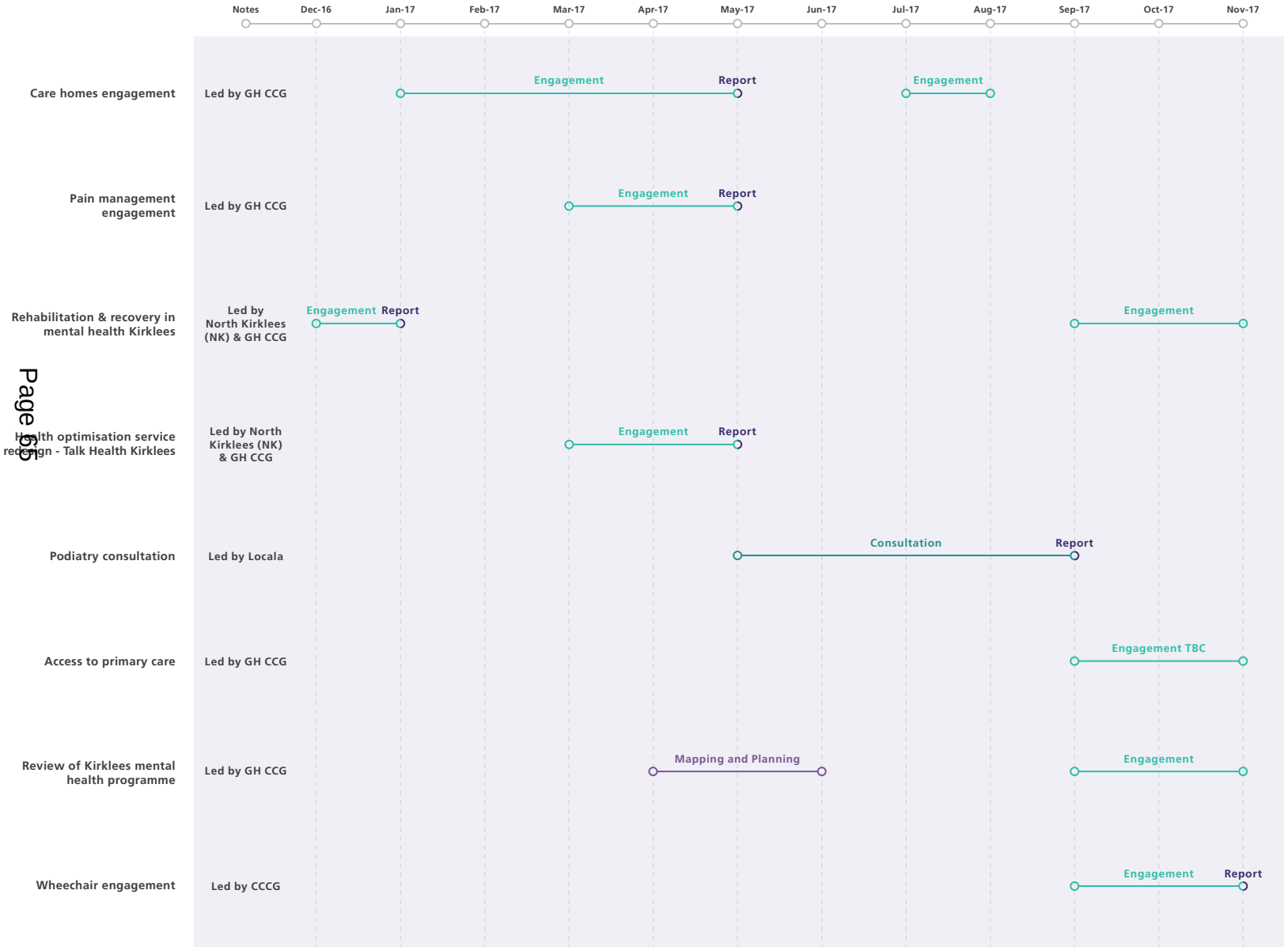
# Greater Huddersfield Clinical Commissioning Group (GH CCG) local plan engagement and consultation

This time-line is just a snap shot of work taking place across the area of Greater Huddersfield from December 2016 to November 2017. It will continue to be updated as engagement and consultation work on these and other priorities develop.

West Yorkshire and Harrogate Health and Care Partnership

## August 2017

(please note these may be subject to change)




Mapping/ planning

Engagement

Report

Consultation

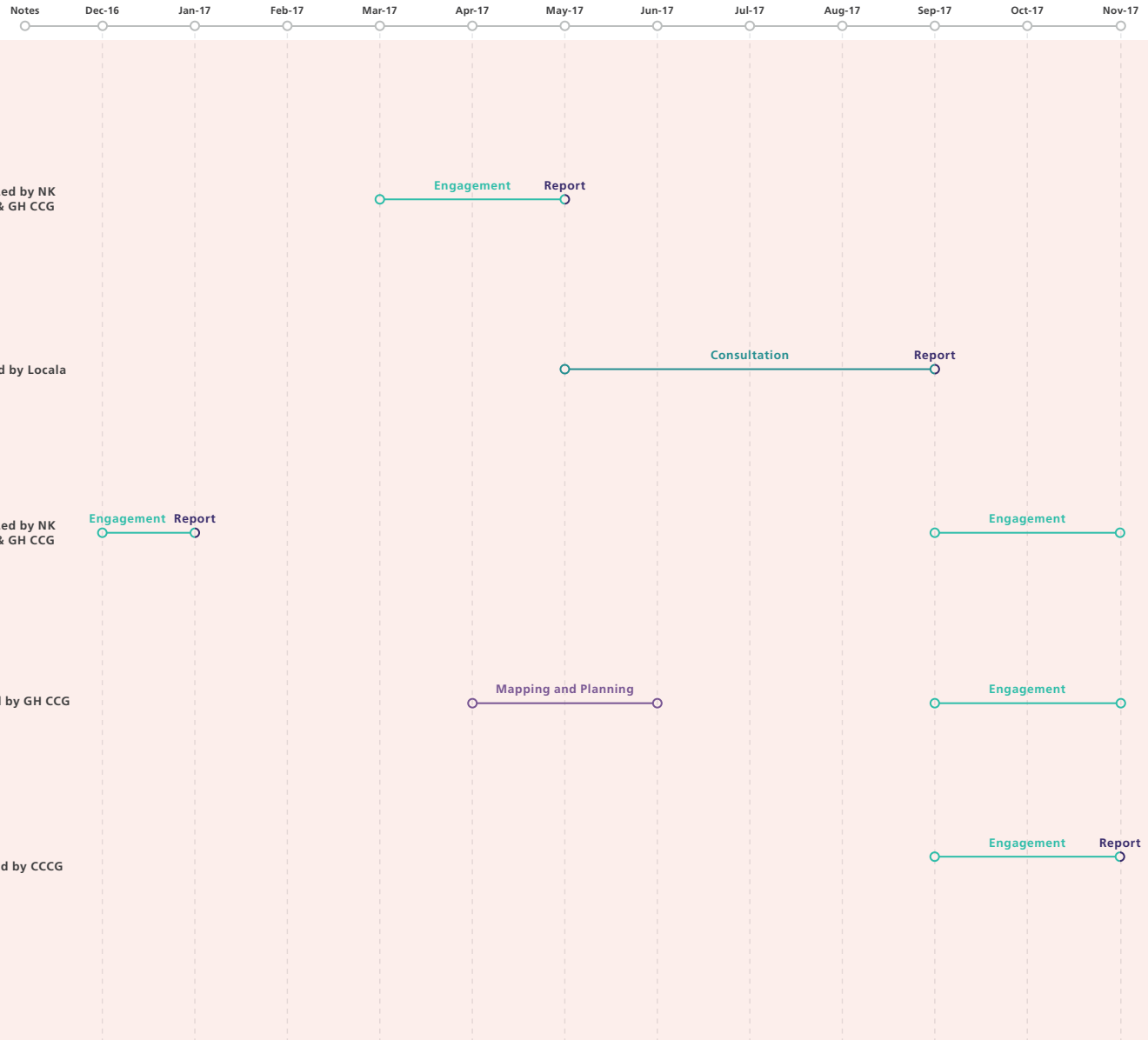
# North Kirklees Clinical Commissioning Group (NK CCG) - local plan engagement and consultation

This time-line is just a snap shot of work taking place across the area of North Kirklees from December 2016 to November 2017. It will continue to be updated as engagement and consultation work on these and other priorities develop.

West Yorkshire and Harrogate Health and Care Partnership

## August 2017

(please note these may be subject to change)






Mapping/ planning

Engagement

Report

Consultation

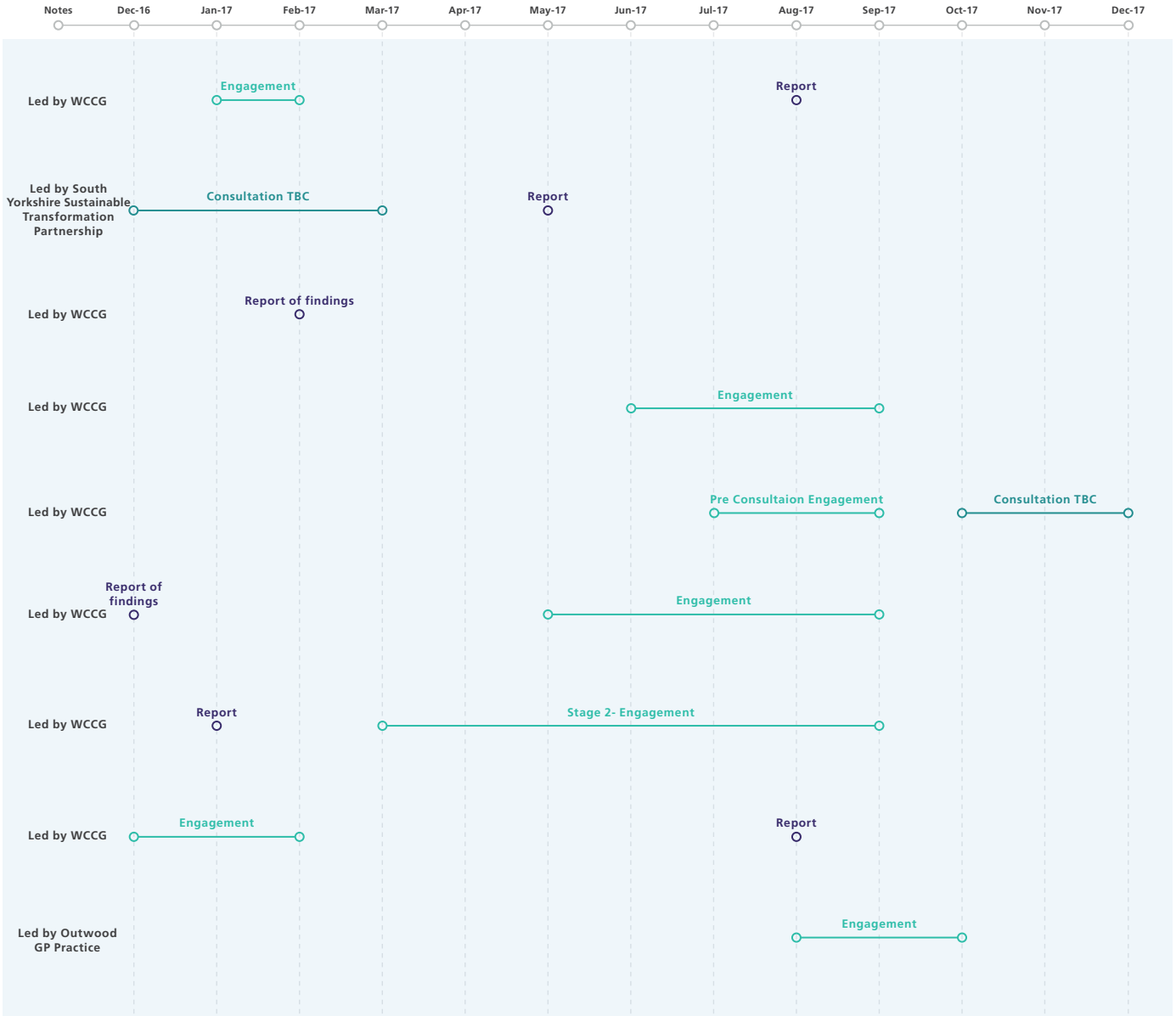
# Wakefield Clinical Commissioning Group (WK CCG) - local plan engagement and consultation

This time-line is just a snap shot of work taking place across the area of Wakefield from December 2016 to December 2017. It will continue to be updated as engagement and consultation work on these and other priorities develop.

West Yorkshire and Harrogate Health and Care Partnership

## August 2017

(please note these may be subject to change)




Mapping/ planning

Engagement

Report

Consultation

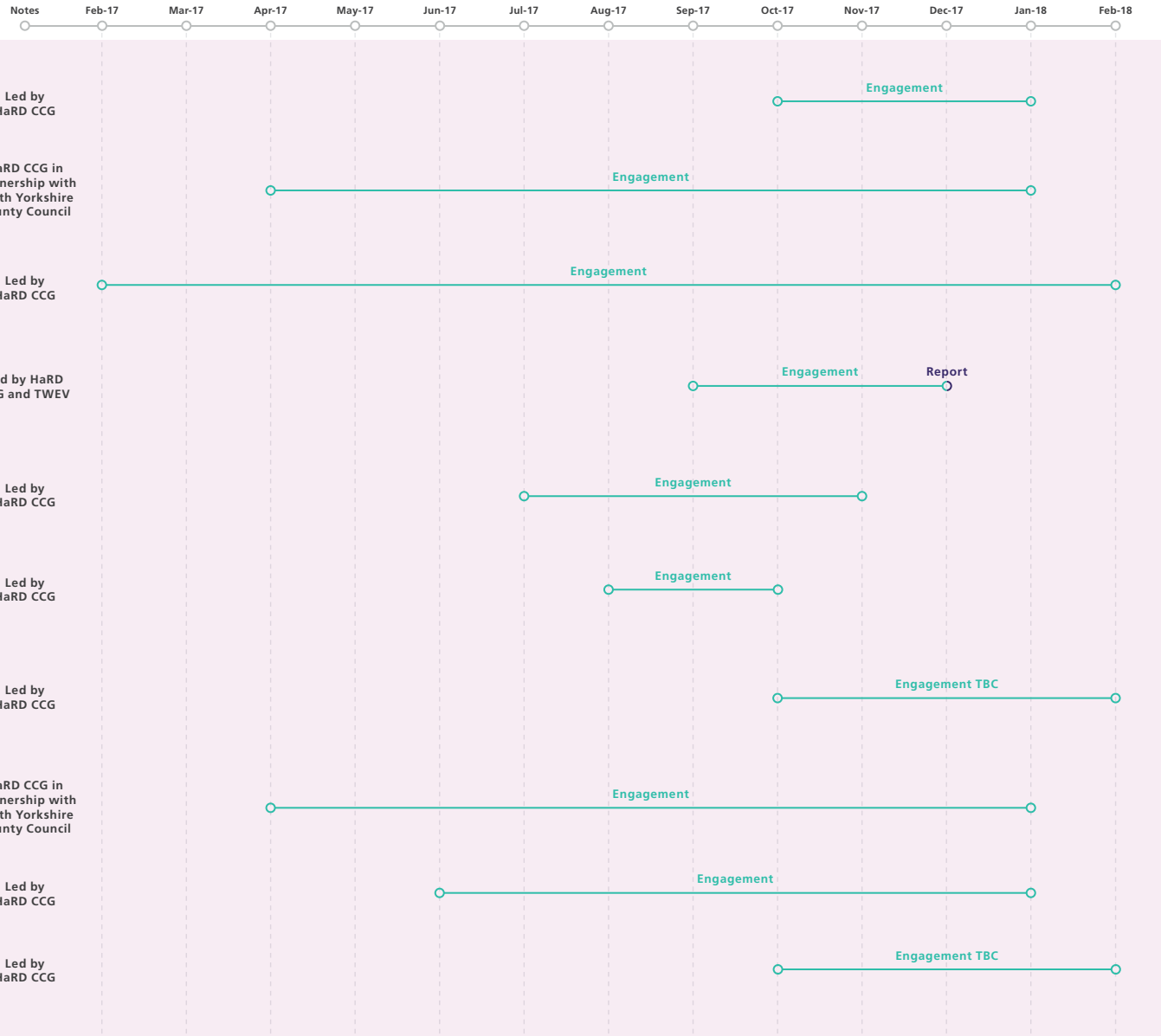
# Harrogate and Rural District Clinical Commissioning Group (HaRD CCG) local plan engagement and consultation

This time-line is just a snap shot of work taking place across the area of Harrogate and Rural District from April 2017 to January 2018. It will continue to be updated as engagement and consultation work on these and other priorities develop.

West Yorkshire and Harrogate Health and Care Partnership

## August 2017

(please note these may be subject to change)




Mapping/ planning

Engagement

Report

Consultation

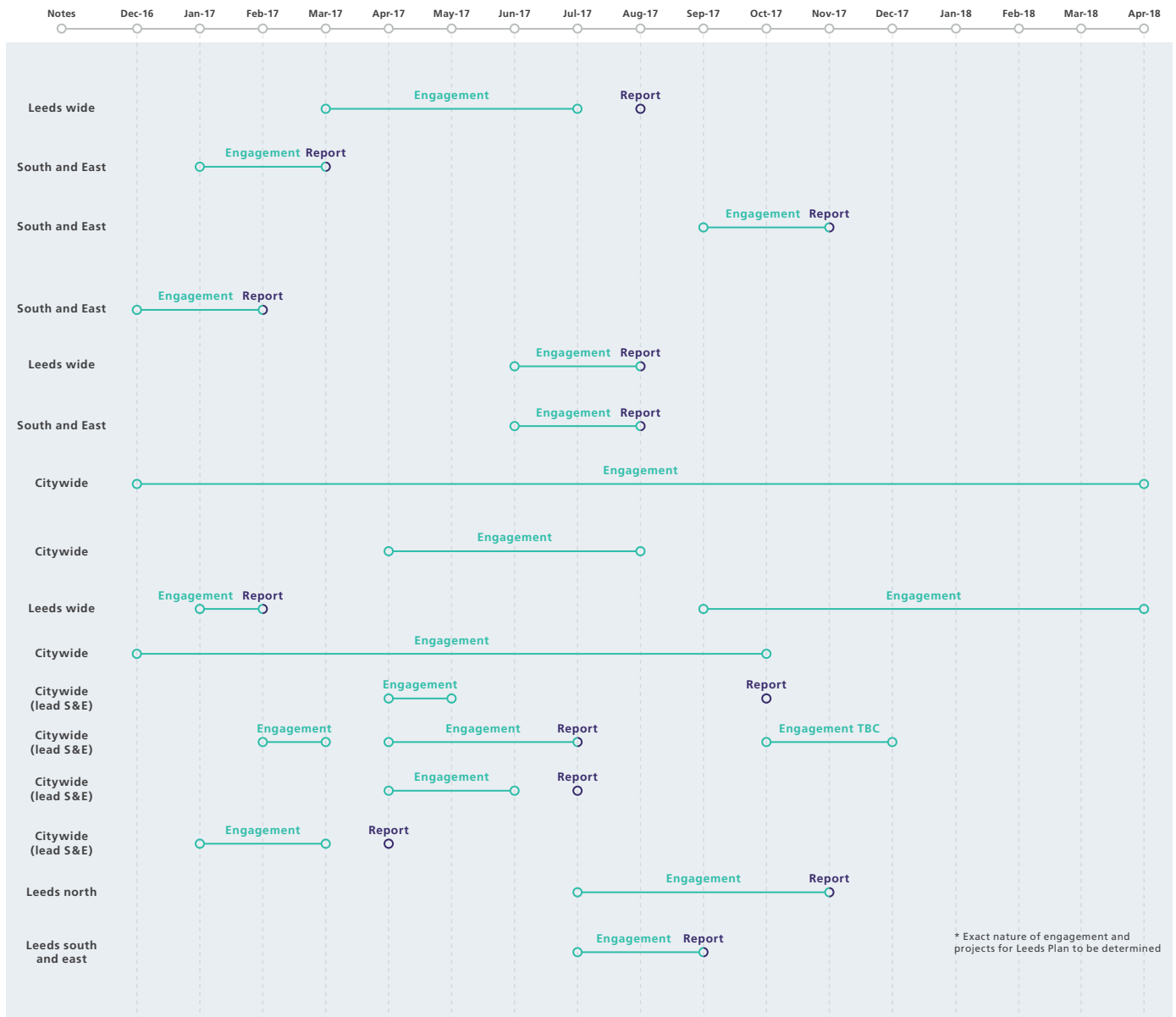
# Leeds Clinical Commissioning Groups (North, South & East and West CCG) - local plan engagement and consultation

This time-line is just a snap shot of work taking place across the area of Leeds from December 2016 to April 2018. It will continue to be updated as engagement and consultation work on these and other priorities develop.

West Yorkshire and Harrogate Health and Care Partnership

## August 2017

(please note these may be subject to change)




* Exact nature of engagement and projects for Leeds Plan to be determined

Mapping/ planning

Engagement

Report

Consultation

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Calderdale Council | everyone different everyone matters


Our Ref TS/CT
Your Ref
Please Contact: Councillor Tim Swift
Telephone 01422 393127
Email: Councillor.TSwift@calderdale.gov.uk
Date: 19 October 2017

**Leader's Office**
Town Hall
Halifax
HX1 1UJ


Cllr Helen Hayden
Chair West Yorkshire Joint Health Scrutiny Committee

Dear Councillor Hayden

**West Yorkshire Joint Health Scrutiny Committee**

At Calderdale Health and Wellbeing Board on 19 October a question, was asked by Colin Hutchinson, a Calderdale resident. I have attached the question.

I explained to the Health and Wellbeing Board that there is a proper separation between the Health and Wellbeing Board and scrutiny functions. I did say that I would write to you forwarding Mr Hutchinson's points.

I do agree with Mr Hutchinson that the West Yorkshire Joint Health Scrutiny Committee has a valuable role to play in scrutinising the work of the West Yorkshire and Harrogate STP.

I would be very grateful if you could let me know when the West Yorkshire Joint Health Scrutiny Committee plans to meet next and what you will be considering.

Yours sincerely

**Councillor Tim Swift**
Leader of the Council
Chair, Calderdale Health and Wellbeing Board

**Cc:** Steven Courtney, Principal Scrutiny Adviser, Leeds City Council

**Question to the Health and Well-being Board 19th October 2017**

The NHS locally and across England is in the throes of its largest reorganisation since its foundation.

The Health and Social Care Act of 2012 removed the Secretary of States responsibility for the provision of the NHS, and the ability of Parliament to hold him to account for the changes underway, which he maintains are the responsibility of locally appointed doctors.

It is only local government, through Health and Well-being Boards and Scrutiny Committees, that can try to ensure that decisions that affect our health and care services are in the best interest of the communities that elected them.

In July the Joint Health Scrutiny Committee of Calderdale and Kirklees decided to refer the Right Care, Right Time, Right Place proposals to the Secretary of State for Health, as they had not been provided with adequate evidence that the proposals would work in practice.

Since then, Calderdale and Huddersfield NHS Foundation Trust has published its Full Business Case, which is largely a discussion of whether the Trust can afford the Private Finance Initiatives that would be required.

There is very little detail of how Calderdale Royal would be modified to be able to accept the huge increase in patient numbers that will arise from the demolition of most of Huddersfield Royal. But those Calderdale Councillors and residents that expect to see a major investment in the facilities at the old Work-House should take on board that page 88 of the Full Business Case states “The Plan assumes minimal change of existing buildings at CRH and an appropriate level of derogation to ensure compliance with the necessary statutory requirements.” As far as I am aware, derogation means an exemption or relaxation from a rule of law: am I the only person to find this an alarming statement.

In the last fortnight, the Governing Bodies of both CCGs have voted their support for the Full Business Case. The planning process is rolling on, but the Joint Scrutiny Committee has no published plans to continue the valuable work that it has done so far. Does the Health and Well-being Board have any influence over their programme of work?

Important aspects of the NHS in Calderdale have been taken over by the West Yorkshire and Harrogate Sustainability and Transformation Partnership and are, as a result, even less transparent than before. This includes such vital concerns as work-force planning (which has been scandalously neglected over the past seven years and is the most serious threat to the continuation of the NHS), the centralisation of acute stroke services (for which the supporting evidence is nowhere near as strong as the zealots would have you believe: the results of the reconfiguration in Greater Manchester are underwhelming), and decisions on which treatments to restrict or ration.

Despite this, the West Yorkshire Joint Health Scrutiny Committee has not met since March.

Does the Health and Well-being Board find this acceptable, and if not, what is it going to do to at least make some show of democratic accountability?

Colin Hutchinson

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Leeds
CITY COUNCIL

**Councillor Helen Hayden**
Chair, Scrutiny Board (Adults and Health)
3rd Floor (East)
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LS1 1UR

Councillor Tim Swift
Leader of Council
Calderdale Council
Leader's Office
Town Hall
Halifax
HX1 1UJ

**Sent via e-mail only**

E-Mail address: Helen.hayden @leeds.gov.uk
Civic Hall tel: 0113 3950456
Our ref: HH/SMC

3 November 2017

Dear Councillor Swift,

**RE: West Yorkshire Joint Health Overview and Scrutiny Committee**

Many thanks for your recent letter, received on 23 October 2017.

Apologies for the slight delay in providing a formal reply; however work has been progressing to finalise arrangements for the next meeting of the West Yorkshire Joint Health and Overview and Scrutiny Committee (WYJHOSC). I am pleased to confirm this will be held on Tuesday, 28 November 2017 at 2:00pm, Leeds Civic Hall.

Quite separately, I recently received details from representatives from the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP); which presents an update around the Stroke Care Programme, including details of a report due to be considered by the West Yorkshire and Harrogate Joint Committee (of the 11 Clinical Commissioning Groups) at its meeting on 7 November 2017. I have enclosed a copy of these details for your information.

I have also enclosed a copy of a letter sent to all members of the WYJHOSC, which confirms the proposed meeting arrangements and includes details of the substantive matters likely to be considered. Confirmation of the agenda and associated reports will be published in advance of the meeting and will be available on the Leeds City Council website, in line with the statutory requirements. If helpful, I can ensure you receive formal notification of the meeting agenda on publication.

I trust these details are helpful; but should you have any queries or need any further information, please do not hesitate to contact me.

Yours sincerely

H Hayden

**Councillor Helen Hayden**
Chair, Scrutiny Board (Adults and Health),

Cc Councillor Rebecca Charlwood, Chair of Leeds Health and Wellbeing Board

Encl.

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All members of the West Yorkshire Joint Health Overview and Scrutiny Committee

**Councillor Helen Hayden**
Chair, Scrutiny Board (Adults and Health)
3rd Floor (East)
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**Sent via e-mail only**

E-Mail address: Helen.hayden @leeds.gov.uk
Civic Hall tel: 0113 3950456
Our ref: HH/SMC

3 November 2017

Dear Councillor,

**RE: West Yorkshire Joint Health Overview and Scrutiny Committee**

Please find attached a letter from the Jo Webster and Dr Andy Withers on behalf of the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP). This presents an update around the Stroke Care Programme, including details of a report due to be considered by the West Yorkshire and Harrogate Joint Committee (of the 11 Clinical Commissioning Groups) at its meeting on 7 November 2017.

Please note this meeting will be webcast live and will also be available to view online after the meeting. Further details can be provided if that would be helpful.

As you will be aware, recently there have been some concerns raised around the meeting frequency of the West Yorkshire Joint Health Overview and Scrutiny Committee (WYJHOSC); and its consideration of the priority areas set out in the West Yorkshire and Harrogate Sustainability and Transformation Plan – particularly in relation to Stroke Care. Most recently this included public representation made at the Calderdale Health and Wellbeing Board meeting on 19 October 2017.

The details provided by the WYHHCP are therefore both useful and timely; and I will share a copy of this letter and its attachments in response to the letter from Councillor Tim Swift, Leader of Calderdale Council and Chair of the Calderdale Health and Wellbeing Board.

While it is right and proper that the scrutiny function in individual local authorities agree arrangements to consider the specific placed based plans that contribute to the overall West Yorkshire and Harrogate Sustainability and Transformation Plan; it is important to establish some regularity to the scrutiny arrangements that will maintain an overview of the programme areas (including Stroke Care) being considered on a West Yorkshire and Harrogate footprint. As such, I plan to call a meeting of the WYJHOSC on **Tuesday, 28 November 2017 at 2:00pm (pre-meeting at 1:30pm)**, to be held at Leeds Civic Hall.

Cont./

I hope all relevant local authority areas will be represented at this meeting; and I should be grateful if you could confirm your availability to attend as soon as possible.

Currently, I envisage the substantive agenda items for this meeting being:

- An update on the West Yorkshire and Harrogate stroke task and finish group, including the outcome of the West Yorkshire and Harrogate Joint Committee due to be held on 7 November 2017.
- A general update on the development of the WYHHCP; the associated governance arrangements, programme areas and proposed next steps.
- A discussion on the future work programme for the WYJHOSC.

I trust the details set out in this letter and associated enclosures are helpful; but should you have any queries please contact Steven Courtney (Principal Scrutiny Adviser) in the first instance (Tel: 0113 3788666 Email: steven.courtney@leeds.gov.uk).

Yours sincerely

**Councillor Helen Hayden**
Chair, Scrutiny Board (Adults and Health),

cc Councillor Jim Clark, Chair, Scrutiny of Health Committee, North Yorkshire County Council
Councillor Tim Swift, Leader of Calderdale Council and Chair, Calderdale Health and Wellbeing Board
Councillor Rebecca Charlwood – Executive Board Member for Adults and Health and Chair, Leeds Health and Wellbeing Board
Tom Riordan, Chief Executive, Leeds City Council
Tony Cooke, Chief Officer Health Partnerships, Leeds City Council
Rob Webster, Lead Chief Executive West Yorkshire and Harrogate STP

Encl.

Report author: Steven Courtney
Tel: (0113) 3788666

**Report of Head of Governance and Scrutiny Support**

**Report to West Yorkshire Joint Health Overview and Scrutiny Committee**

**Date: 28 November 2017**

**Subject: Improving Stroke Services**

| | | |
|---|---|---|
| Are specific electoral Wards affected?<br>If relevant, name(s) of Ward(s): | ☐ Yes | ☒ No |
| Are there implications for equality and diversity and cohesion and integration? | ☐ Yes | ☒ No |
| Is the decision eligible for Call-In? | ☐ Yes | ☒ No |
| Does the report contain confidential or exempt information?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

**Purpose**

1. The purpose of this report is to introduce a range of information in order to update members of the West Yorkshire Joint Health Overview and Scrutiny Committee on the specific programme area associated with Improving Stroke Services, as part of the wider West Yorkshire and Harrogate Sustainability and Transformation Plan.

**Summary of main issues**

2. At its meeting in January 2017, the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) considered some specific information in relation to the 'Stroke' priority are with the West Yorkshire and Harrogate Sustainability and Transformation Plan (WYH STP).

3. At the meeting in January 2017, a range of general background and more detailed information was provided to the JHOSC, including:

   - Context of the national review of stroke services.
   - Emerging evidence on approaches to reduce strokes resulting in death and long-term conditions.
   - Projections for an increase in the number of patients having a stroke.
   - How hyper acute stroke and acute stroke care services could be improved across the West Yorkshire and Harrogate STP footprint.
   - Plans for public and patient engagement in relation to improvements across the whole clinical pathway for stroke care, commencing in February 2017.

- The potential impact of other stroke engagement and consultation work taking place in surrounding areas, including South Yorkshire and Bassetlaw and North Derbyshire.

4. Key drivers in relation to the review of stroke services were highlighted at the meeting and included increasing demand for services; levels of morbidity for those suffering a stroke; an ageing population with complex health and social care needs; and workforce sustainability.

Engagement activity

5. In June 2017, members of the JHOSC were advised of the outcome of the public engagement work undertaken by HealthWatch on behalf of the local Clinical Commissioning Groups.

6. As part of the information provided, it was reported that the engagement work had highlighted many findings including concern that a decision had already been made to reduce the number of hyper-acute stroke units (HASUs). However, the Senior Responsible Officer for the Stroke Programme highlighted that it was important to note that no decision had been made to reduce the number of units across West Yorkshire and Harrogate.

7. A summary of some of the comments received included:
   - Many people said that they would travel further if it meant they were able to receive the best treatment and to be treated by specialists; however, they wanted their rehabilitation to be available closer to home. Although some people were worried that if they had to travel further the extra journey time could negatively affect their health, and would make it more difficult for their family to visit them.
   - Those who had experienced a stroke described the excellent levels of care that they received in hospital, from being seen quickly, to accessing the most appropriate treatments and being kept informed throughout. They talked about staff being willing to help, whilst recognising that some were extremely busy. It was also felt that there should not be a difference in care during the week and at the weekend.
   - Many described how stroke can be a life changing event which can be difficult for the patient and their families to deal with. It was felt that there was a need to ensure that the patient and their family are provided with the appropriate levels of emotional support and advice.
   - The valuable role of voluntary and community organisations specialising in stroke support, particular on hospital wards, was recognised in the report.
   - Many felt that there was a need to raise awareness of the signs and symptoms of a stroke, and what to do if you think someone is having a stroke.

Update on Improving Stroke Care

8. An update on the overall progress of the West Yorkshire and Harrogate STP and the associated priority areas is included elsewhere on the agenda. However, an updated position which specifically focus on the improving stroke care programme area is attached at Appendix 1.

9. The update at Appendix 1 is also supported by the information presented to recent meetings of the West Yorkshire Joint Committee of Clinical Commissioning Groups (WYJCCG) on 4 July 2017 and 7 November 2017 – also attached to this report.

10. Appropriate NHS representatives have been invited to the meeting to discuss the details presented and address questions from members of the Joint Committee.

**Recommendations**

11. That the Joint Committee considers the details presented and agrees any specific scrutiny actions and/or future activity.

**Background documents[1]**

12. None.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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**APPENDIX 1**

## IMPROVING STROKE CARE – UPDATE

1. With regard to the work taking place to develop proposals to determine the 'optimal' service delivery models for our specialist stroke services (the care our patients receive in the first few hours and days after having a stroke) on the 7 November 2017 the Joint Committee of CCG's considered and approved the recommendations which were as follows:

    - Noted the progress to date in relation to developing proposals to determine the 'optimal' service delivery models particularly in relation to the 'scenario' modelling' exercise;
    - Noted the proposal to develop and implement a standardised care pathway and clinical standards for hyper acute and acute stroke services;
    - Noted the key risks and actions to mitigate risks related to our work; and
    - Noted the next steps and timelines summarised in the high level project plan.

2. This work is all about ensuring we make the most of our valuable skilled workforce, modern technology and equipment in order to maximise opportunities to deliver great services with good outcomes and quality for our population and ensure our specialist stroke services are 'fit for the future' and meet the 7 day hospital service standards for stroke.

3. As outlined in the November 2017 report we are also progressing the work to standardise the specialist stroke service care pathway and the feedback from the engagement work which took place in February and March 2017 is informing our work. Our clinicians and other health care professionals who attended a clinical workshop on the 16 November 2017 have already identified a number of areas they want to work collaboratively on over the next few months and we will be working with our engagement leads to ensure our population have opportunity to be engaged and involved in this work.

4. Our work to date has also highlighted the importance of taking a 'whole system' and whole care pathway to further improving stroke care and outcomes (reflecting our agreed vision for stroke care) across West Yorkshire and Harrogate and the engagement work also highlighted the importance of further improving awareness of the signs and symptoms of Stroke. In view of this Joint Committee members also considered and supported a proposal to request each West Yorkshire and Harrogate CCG to:

    - Agree an aspiration to detect and treat 89% of patients with Atrial Fibrillation(Atrial Fibrillation causes a fast and erratic heartbeat which is a major factor of stroke.) and
    - Work collaboratively with the Yorkshire and Humber Academic Health Science Network on implementing a targeted and phased approach to working with their local practices.

5. This work is about detecting and treating people who are at risk of stroke so that around 9 in 10 people with atrial fibrillation are managed by GPs with the best local treatments. This work could result in over 190 stroke being prevented in the next 3 years, improving both the health and quality gap and contributing to a reduction in health and well-being gap.

6. The Yorkshire and Humber Academic Health Science Network (AHSN) has an evidence based programme of support which can help us deliver this ambition. It is already being delivered in some of our primary care practices but this is an opportunity to scale the programme for maximum impact. This work is about building on existing work in order to avoid duplication and creating improvement capacity that stays within CCG's and practices to make the work sustainable over the longer term.

7. This is the first time any STP has attempted to address Atrial Fibrillation at scale in this way and the AHSN have already started discussions with our CCG's to progress this work at the very earliest opportunity.

**West Yorkshire and Harrogate STP – Core Team**
**20 November 2017**

# West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

| **Summary report** | | | |
|---|---|---|---|
| Date of meeting: 7 November 2017 | Agenda item: 26/2017 | | |
| Report title: | **Improving Stroke Outcomes** | | |
| Joint Committee sponsor: | Jo Webster, Senior Responsible Officer for West Yorkshire and Harrogate and Accountable Chief Officer for Wakefield CCG | | |
| Clinical Lead: | Dr Andy Withers, Chair of West Yorkshire and Harrogate Clinical Forum and Clinical Chair, Bradford Districts CCG | | |
| Author: | Linda Driver, West Yorkshire and Harrogate Stroke Services Project Lead | | |
| Presenter: | Dr Andy Withers<br>Jo Webster | | |
| **Purpose of report**: (why is this being brought to the Committee?) | | | |
| Decision | ✓ | Comment | ✓ |
| Assurance | ✓ | | |

**Executive summary**

Stroke is the third single cause of death in the UK and has a devastating impact on people's lives, their families and carers. In view of this, lots of work has taken place nationally and across West Yorkshire and Harrogate to improve the quality of care and outcomes for people who have had a stroke. This work includes preventing stroke happening in the first place, improving specialist care (the care you receive in the first hours and days after having a stroke), maximising the use of technology and improving after care by ensuring appropriate levels of support are available.

As an agreed West Yorkshire and Harrogate STP priority work stream two stroke reports were presented to the Joint Committee of Clinical Commissioning Groups (CCG) on the 4 July 2017 which provided members and other key stakeholders with:

- An overview of the engagement work that had taken place across West Yorkshire and Harrogate to seek the views of our population, our staff and key stakeholders on stroke services; and
- A summary of the key findings, conclusions and recommendations outlined in the Hyper Acute and Acute Stroke Strategic Case for Change and a high level overview of the key actions and timelines associated with the project.

From an assurance perspective the Joint Committee agreed that regular progress reports should be presented to the committee for their consideration, comment and approval as appropriate.
This report is being presented to provide the Joint Committee, our population and other key stakeholders with a update on the work currently underway to develop

proposals to determine the 'optimal' service delivery models for our specialist stroke services (the care our patients receive in the first few hours and days after having a stroke.)

This work is all about ensuring we make the most of our valuable skilled workforce, modern technology and equipment in order to maximise opportunities to deliver great services with good outcomes and quality for our population and ensure our specialist stroke services are 'fit for the future' and meet the 7 day hospital service standards for stroke. This report will provide an update on:

- Progress in relation to the first phase of our 'scenario modelling' exercise and proposed next steps;
- Work taking place to inform the development and implementation of standardised care pathways and clinical standards across all existing specialist stroke services;
- A proposal to set an STP aspiration to detect and treat 89% of patients with Atrial Fibrillation (Atrial Fibrillation causes a fast and erratic heartbeat which is a major factor of stroke) for consideration and approval by each of the 11 CCGs in West Yorkshire and Harrogate;
- Key risks and actions to mitigate the risks associated with our work; and
- The proposed next steps and timelines outlined in the high level action plan (Table 1 at the end of this report refers.)

It is important to note that our work to date has been subject to review by NHS England as part of the Stage 1 Assurance process and regular progress reports are being submitted to them as part of the Stage 2 Assurance process.

Our work is being informed by the Engagement work which took place during February and March 2017. We are also continuing to incorporate feedback from Yorkshire and Humber Clinical Senate and other key stakeholders into our action plans e.g. West Yorkshire and Harrogate STP Clinical Forum, West Yorkshire Association of Acute Trust (WYAAT) Committee in Common, WYAAT Medical Directors Forum and Yorkshire Ambulance Service.

Ongoing conversations and engagement will continue, to ensure the public, patient voice informs the development of our proposals. It is also important to note that no decision at this stage of our review process has been made to reduce the number of units across West Yorkshire and Harrogate.

All documentation discussed at the Joint Committee meetings and further information on the work that has taken place to date can be accessed via the following link http://www.wyhpartnership.co.uk/about/our-priorities

**Recommendations and next steps**

The Joint Committee is asked to:

- Note the progress to date in relation to developing proposals to determine the 'optimal' service delivery models particularly in relation to the 'scenario' modelling' exercise;
- Note the proposal to develop and implement a standardised care pathway

and clinical standards for hyper acute and acute stroke services;

- Consider and support the proposal to request each West Yorkshire and Harrogate CCG to:
  - agree an aspiration to detect and treat 89% of patients with Atrial Fibrillation; and
  - work collaboratively with the Yorkshire and Humber Academic Health Science Network on implementing a targeted and phased approach to working with their local practices;
- Note the key risks and actions to mitigate risks related to our work; and
- Note and comment on the next steps and timelines summarised in the high level project plan.

**Delivering outcomes:** describe how the report supports the delivery of STP outcomes (Health and wellbeing, care and quality, finance and efficiency)

We want to make sure our services are 'fit for the future' and we make the most of the skills of our valuable workforce and technology in order to maximise opportunities to improve services, quality and outcomes for local people. For example, further reducing variation and any unnecessary delays along the whole of the stroke care pathway and making more effective use of our resources.

This is in line with our strategic vision for stroke and strategic vision and priorities set out in the public summary of the West Yorkshire and Harrogate Draft STP published November 2016. This described the approach we would be adopting across our health and care economy and the work that would take place with key partners to identify opportunities to address the triple aims of improving health and wellbeing, care and quality, and finance and efficiency.

For example from a health and well-being perspective we will be working with each of our six local places in Bradford including Airedale Wharfedale and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds and Wakefield to reduce the number of people who die from stroke as well as reducing the number of strokes that occur.

One of the ways we will do this is by further improving the way we detect and treat Atrial Fibrillation (Atrial Fibrillation causes a fast and erratic heartbeat which is a major factor of stroke.) This report will include a proposal to set an STP aspiration to detect and treat 89% of patients with Atrial Fibrillation for consideration and approval by each of the 11 CCGs in West Yorkshire and Harrogate.

The Yorkshire and Humber Academic Health Science Network (Y&H AHSN) have estimated this could result in over 190 strokes being prevented in the next 3 years contributing to a reduction in both the health and well-being gap and the care and quality gap for the population of West Yorkshire and Harrogate.

Y&H AHSN have indicated this level of prevention could save over £2.5m which will contribute to our collective finance and efficiency gap. Although this work may have an impact on local prescribing costs the AHSN have confirmed they will work directly with each CCG to work through the practical aspects of implementation.

| | |
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| Other examples of how we intend to address the care and quality gap include:<br><br>• Increasing the proportion of stroke patients assessed by a stroke specialist consultant physician and nurse trained in stroke management within 24 hours;<br>• Increasing the proportion of patients scanned within 12 hours; and<br>• Delivery of the new 7-day standards specific to hyper acute stroke, which sets out an ambition that anyone who needs urgent or emergency hospital care will have access to the same level of assessment and review, tests and consultant-led support whatever day of the week. | |
| **Impact assessment** (please provide a brief description, or refer to the main body of the report) | |
| Clinical outcomes: | These are as described above and outlined in the report. They are also outlined in the Strategic Case for Change.<br><br>A Strategic Case for Change Public Summary and easy read version is also available and can be accessed via the following link http://www.wyhpartnership.co.uk/about/our-priorities |
| Public involvement: | Our approach was outlined in the Engagement Report findings presented to the Joint Committee members, the people of West Yorkshire and Harrogate and other key stakeholders on the 4 July 2017 (Agenda item 3 and Agenda item 4 referred.)<br><br>The outcome of the Engagement work that took place in February and March 2017 is informing our work.<br><br>The Engagement Report, Strategic Case for Change, Strategic Case for Change public summary and easy read version are also available at http://www.wyhpartnership.co.uk/about/our-priorities |
| Finance: | We want to make sure our services are 'fit for the future' and we make the most of the skills of our valuable workforce and technology whilst maximising opportunities to improve services quality and outcomes for local people e.g. further reducing variation and any unnecessary delays along the whole of the stroke care pathway and making more effective use of our resources.<br><br>The first phase of our work to understand the current costs of our specialist stroke services has now been completed and is informing further discussions between commissioners and providers of these services. The outcome of this work will be reflected in the Outline Business Case.<br><br>Finance will be an integral component of the work that will take place to ensure we are able to satisfy Joint |

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| | Committee members, NHS England and other key stakeholders about the broader tests that will be applied to our work related to clinical outcome and risk, public acceptability and finance. |
| Risk: | A risk register is in place. It is a standing agenda item subject to review at each meeting by core members of the Stroke Task and Finish Group.<br><br>As a West Yorkshire and Harrogate STP priority work stream, risks and actions to mitigate risks are subject to review by the West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups. The two risks which currently have a risk score of 12 are included in this report.<br><br>The risk register is also shared with Urgent Emergency Care Network Programme Board. |
| Conflicts of interest: | These are recorded. |

# West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

## 7 November 2017

### West Yorkshire and Harrogate – Improving Stroke Outcomes Report

**1 Working together across West Yorkshire and Harrogate to further improve the quality of stroke care and outcomes for our population**

1.1 Although considerable progress has been made both nationally and across West Yorkshire and Harrogate to further improve quality and stroke outcomes, variation continues to exist and as a result further improving quality and stroke outcomes for our population remains a key priority within the STP.

1.2 In view of this a Strategic Case for Change was developed which recommended that we begin work to develop proposals to determine the 'optimal' service delivery models and pathways for our specialist stroke services (the care our patients receive in the first few hours and days after having a stroke.) This is all about making the most of our valuable staff skills, latest technology and equipment in order to maximise opportunities to deliver great services with good quality and outcomes for our population that meet the 7 day hospital standards for stroke and ensure our specialist stroke services are 'fit for the future'.

1.3 The Strategic Case for Change also highlighted the importance of ensuring that work continues to take place to improve care and outcomes for our population across the whole care stroke pathway. The Case for Change document can be accessed at http://www.wyhpartnership.co.uk/about/our-priorities

1.4 As an agreed STP priority work stream which supports the delivery of STP outcomes it was agreed that from an assurance perspective regular progress reports will be submitted to the Joint Committee for their consideration, comment and approval as appropriate.

This report provides the Joint Committee, our population and other key stakeholders with an update on the following:

- Progress in relation to the first phase of our 'scenario modelling' exercise and proposed next steps;
- Work taking place to inform the development and implementation of standardised care pathways and clinical standards across all existing specialist stroke services;
- A proposal to set an STP aspiration to detect and treat 89% of patients with Atrial Fibrillation (Atrial Fibrillation causes a fast and erratic

heartbeat which is a major factor of stroke) for consideration and approval by each of the 11 CCGs in West Yorkshire and Harrogate;

- Key risks and actions to mitigate the risks associated with our work; and
- The proposed next steps and timelines outlined in the high level action plan (Table 1 at the end of this report refers.)

## 2. Improving quality and outcomes in our specialist stroke services – 'scenario modelling' update

2.1 The Strategic Case for Change highlighted there is strong evidence that outcomes following stroke are better if people are treated in specialised centres, even if this increases travelling time following the event, and this is likely to be the case in West Yorkshire & Harrogate. It also highlighted that stroke outcomes are likely to be better if people are treated in specialised centres that ideally achieve a minimum number of strokes per annum and do not exceed a maximum number of strokes. Ongoing rehabilitation should, however, be provided at locations closer to where people live and they should be transferred to these as soon as possible after initial treatment.

2.2 The main focus of the work carried out by the Stroke Task and Finish Group during Quarter 2 2017/18 has involved agreeing the methodology, information requirements and assumptions we will use to carry out a 'scenario modelling' exercise to inform the development of our future proposals.

2.3 Our work is being informed by the Engagement work which took place during February and March 2017.

We have worked collaboratively with Yorkshire Ambulance Services who have access to the skills and expertise to carry out travel time analysis and with our Trust clinical and managerial colleagues to review their activity profile and address any queries.

We have liaised with NHS England (NHSE) to gain an improved understanding of the activity assumptions related to the NHSE Thrombectomy (clot retrieval) developments and we have liaised with South Yorkshire and Bassetlaw and Humber Coast and Vale colleagues by way of further 'sense check' in relation to the approach to the 'scenario modelling' exercise.

We have also had further discussions with the Clinical Senate Chair to seek their views and expertise on clinical evidence to inform our 'scenario modelling' work.

2.4 The first phase of the 'scenario modelling' work indicates there is only limited opportunity to 'rebalance' activity flows for patients who had the same travel time to more than one specialist Hyper Acute Stroke service.

2.5 The next phase of the 'scenario modelling' exercise is underway. The pathway work, evidence related to minimum and maximum stroke numbers

and clinical standards e.g. the Stroke Sentinel National Audit Programme, 7 day hospital standards for stroke and the outcome of our earlier engagement work will inform our work. The modelling outputs should be available before the end of December 2017 to inform our next steps. Ongoing conversations and engagement will continue to ensure the public and patient voice will inform the development of our proposals.

2.6 In addition to the 'scenario modelling' the first phase of our work to understand the current costs of our specialist stroke services has now been completed and is informing further discussions between commissioners and providers of these services. The outcome of this work will be reflected in the Outline Business Case.

## 3. Developing standardised care pathways – specialist stroke services

3.1 It is important to note that the 'scenario modelling' is only one element of the work taking place to inform the development of 'optimal' service delivery proposals.

3.2 Work has commenced to review existing specialist stroke pathways which has highlighted further work is required to develop and implement standardised pathways across West Yorkshire and Harrogate and to implement standard operating procedures and a service specification. In view of this a clinical pathway workshop has been scheduled for the 16 November 2017 which will include clinical and managerial representatives from each of our respective Trusts and representatives from Yorkshire Ambulance Services.

3.3 The workshop will be led by the WYAAT Medical Director who is providing Medical Director Leadership and support to the work of the Stroke Task and Finish Group. The objective of the workshop will be to agree a standardised hyper acute and acute care pathway that we can work collectively to implement across West Yorkshire and Harrogate as soon as possible across each of our existing specialist stroke services.

This work is all about further reducing variation across our specialist stroke services and ensuring our specialist stroke services meet the relevant clinical standards. For example delivery of the new 7-day standards specific to hyper acute stroke, sets out an ambition that anyone who needs urgent or emergency hospital care will have access to the same level of assessment and review, tests and consultant-led support whatever day of the week.

3.4 We intend to build upon the key outputs from the clinical summit that took place in May 2017 which highlighted there were opportunities to standardise pathways, maximise the use of technology and ensure we are fully utilising the valuable skills and resources of our workforce. We also want to harness the learning from improvements to care pathways that have already occurred within our Trusts and reflect on the work taking place nationally and across the wider Yorkshire and Humber area to standardise stroke pathways e.g. the Stroke Association Right Care pathway work.

3.5 The outputs from this work will further inform our 'scenario modelling' work as it will provide an improved understanding of patient flows across the care pathway and between services. It will also inform the scope of the work and key actions that a workforce sub group and technology sub group will progress and further conversations and engagement with our staff, the people of West Yorkshire and Harrogate and other key stakeholders.

## 4. Atrial Fibrillation – prevention and treatment at scale

4.1 The Strategic Case for Change presented to the Joint Committee on the 4 July 2017 highlighted the importance of taking a 'whole system' and 'whole pathway approach' to further improving stroke care and outcomes (reflecting our agreed vision for stroke care) across West Yorkshire and Harrogate.

4.2 The Stroke Task and Finish Group members, our Clinical Forum members and Clinical Senate colleagues have also highlighted the importance of maintaining a continued focus on the detection and treatment of Atrial Fibrillation (which causes a fast and erratic heartbeat which is a major factor of stroke.) Our engagement work also highlighted the importance of further improving awareness of the signs and symptoms of stroke.

4.3 Joint Committee members will be aware that commissioners as part of the West Yorkshire and Harrogate Health Futures Programme already have an agreed Atrial Fibrillation (AF) Strategy which describes our collective ambition to reduce the number of strokes across our footprint by increasing the diagnosis and treatment of AF.

4.4 This work has remained a key priority and the success of this programme (which is the result of all the hard work that has taken place in each of our local place based areas) has meant that we didn't see an increase in strokes in line with population prevalence estimates, which is an achievement for our STP Partnership (Appendix A: Impact on stroke graph also refers.)

4.5 As an ambitious Partnership we recognise however there is still much more work that we can and should do. Over the past couple of months we have been exploring with our clinical colleagues how we can build on this and go 'further faster'.

4.6 Our clinicians are supportive of this approach and the STP Clinical Forum has recommended that we continue to work with the Yorkshire and Humber Academic Health Science Network (Y&H AHSN) to set an aspiration to detect and treat 89% of patients with AF across the West Yorkshire and Harrogate STP footprint. This could result in over 190 strokes being prevented in the next 3 years, improving both the care and quality gap and contributing to a reduction in the health and well-being gap.

4.7 This work could also contribute to reducing our collective finance and efficiency gap. For example, the Y&H AHSN have indicated this level of prevention could save over £2.5m. Although this work may have an impact

on local CCG prescribing costs, the AHSN have confirmed they will work directly with each CCG to work through the practical aspects of implementation and estimated impacts on CCG prescribing budgets.

4.8 The Y&H AHSN has an evidence based programme of support which can help us to deliver this ambition. This programme is already being delivered in some of our primary care practices but this is an opportunity to scale the programme for maximum impact. It will draw upon improvement science methods and has a clear indication of return on investment, with a structured approach to monitoring and evaluating impacts. This work is also about alignment to any existing local work in order to avoid duplication and creating improvement capacity that stays within CCGs and practices to make the work sustainable over the long term.

4.9 As a Partnership we have always been very clear that primacy is at place and our place based plans are key to delivering our priorities and ambitions. If we receive support from each of the 11 CCGs to adopt this approach we will be ahead of the national target regarding AF which is expected next year. This would be the first time any STP has attempted to address AF at scale in this way.

## 5 Risks

5.1 The risk register for the stroke project is reviewed and updated by the Stroke Task and Finish Group at every meeting and reported to the Urgent and Emergency Care Steering Group and Joint Committee in line with the agreed governance arrangements.

5.2 It is important to note the accountability and responsibility for addressing and mitigating any operational risks that are included on the Stroke Project risk register e.g. risks related to workforce pressures, remains with the Hospital and Lead Commissioner of the relevant stroke service.

5.3 The purpose of including these risks on the project risk register is to ensure a shared understanding of the risks that some of our services are experiencing, the actions that are being taken locally to address them and to ensure the impacts of these actions are reflected in our project plans, 'scenario modelling' work and care pathway developments. For example one of our Trusts experienced operational workforce pressures during September 2017 (these are now resolved.)

As one of the key drivers for change is to ensure our specialist stroke services are 'fit for the future' it is also important that we work collectively across the West Yorkshire and Harrogate STP to develop robust 'optimal' service delivery model proposals as soon as possible.

5.4 Joint Committee members are asked to note there are currently two risks on the Stroke risk register with a score of 12. Both relate to workforce and the score reflects the ongoing workforce challenges in some of our specialist stroke services. The two risks are as follows:

- Risk 5 (impact score 4, probability score 3, total score 12) - There is a risk that providers may not be able to implement the latest stroke guidelines due to lack of available and appropriately skilled workforce able to deliver new models of care resulting in continued variance in stroke outcomes across the West Yorkshire & Harrogate footprint; and

- Risk 6 (impact score 4, probability score 3, total score 12) - There is a risk existing hyper acute stroke services across West Yorkshire and Harrogate may experience operational resilience issues due to inability to recruit and retain appropriately skilled workforce during the transformation period, resulting in emergency commissioning arrangements being implemented in advance of new models of care being approved and implemented.

Actions to mitigate the above risks include the following:

- As part of the risk register review clinical representatives who are core members of the Stroke Task and Finish Group provide alert of any operational workforce pressures to ensure the impacts of local actions are reflected in our project plans, 'scenario modelling' work and care pathway developments as appropriate;
- Operational workforce pressures are addressed via existing contractual routes with the Lead commissioner and provider of services working collaboratively with local stakeholders and other providers across the West Yorkshire and Harrogate footprint to resolve pressures;
- Workforce is one of the key drivers in our Strategic Case for Change and therefore the work currently underway is key to ensuring we are supporting and making the most of our valuable staff and are able to retain and recruit the skilled workforce now and in the future;
- New national stroke guidelines are circulated to all members of the Task and Finish Group and the implications of implementing new guidelines is informing the development of 'optimal' service delivery proposals e.g. our care pathway, service specification and 'scenario modelling' work;
- We are working collaboratively with the West Yorkshire and Harrogate STP Workforce and Local Workforce Action Board (LWAB) Leads to ensure STP, LWAB and Stroke Project developments are aligned;
- We are working collaboratively with NHSE England to ensure Thrombectomy service, care pathway and workforce developments are aligned in order to avoid duplication; and
- The clinical pathway workshop outputs related to workforce will inform the work of the stroke workforce sub group.

## 6 Next steps and timelines

6.1 Providing the best stroke services possible across West Yorkshire and Harrogate to further improve quality and stroke outcomes is a priority for us all and something we are committed to achieving.

6.2 In line with our Stroke Communication, Engagement and Equality Strategy we will be having more conversations with our staff, partners, public, communities and stakeholders as we develop proposals to inform the next phase of our work.

6.3 In addition to the proposal on prevention and treatment of AF at scale and development of 'optimal' service delivery proposals for specialist stroke services, we will also be progressing work to establish the current position in relation to services patients access following a stroke e.g. early supported discharge services and community rehabilitation services.

This next phase of work is in line with the Engagement work which took place during February and March 2017.

6.4 For ease of reference Table 1 (Appendix B) provides a high level overview of the key actions and timelines associated with this project.

Members are asked to note the table reflects revised timelines for areas where there has been slippage e.g. stroke pathway developments, 'scenario modelling' exercise and may be subject to further change depending on the outcome of the 'scenario modelling' exercise and discussions with key stakeholders.

## 7 Recommendations

7.1 The Joint Committee is asked to:

- Note the progress to date in relation to developing proposals to determine the 'optimal' service delivery models particularly in relation to the 'scenario' modelling' exercise;
- Note the proposal to develop and implement a standardised care pathway and clinical standards for hyper acute and acute stroke services;
- Consider and support the proposal to request each West Yorkshire and Harrogate CCG to:
  - agree an aspiration to detect and treat 89% of patients with Atrial Fibrillation; and
  - work collaboratively with the Yorkshire and Humber Academic Health Science Network on implementing a targeted and phased approach to working with their local practices;
- Note the key risks and actions to mitigate risks related to our work; and
- Note and comment on the next steps and timelines summarised in the high level project plan.

Linda Driver
West Yorkshire and Harrogate Stroke Services Project Lead
31 October 2017


Appendix A - Impact on Stroke
No Growth in AF strokes since OCT 2014
Healthy Futures strategy work
Data based on SUS activity with primary diagnosis ICD-10 codes between I61, I63 and I64

**APPENDIX B**

## Table 1 – High level Project Plan

### NB: Timelines may be subject to further change - section 6.4 of the report refers)

| | Q 1<br>Apr–Jun 2017 | Q2<br>July – Sept 2017 | Q3<br>Oct – Dec 2017 | Q 4<br>Jan – Mar 2018 | Q1<br>Apr - Jun 2018 |
|---|---|---|---|---|---|
| Equality Impact Assessment (EIA) - the EIA will be subject to ongoing review and update | | | | | |
| Engagement - targeted further engagement to gain the views of protected groups and capture patient stories (phase 1 communication and engagement plan) | | Target date July/Aug 2017 | | **To be scheduled following completion of 'scenario' modelling exercise** | |
| Phase 2 Communication and Engagement - action plan refresh (subject to ongoing review and update) | | | | | |
| Review existing stroke pathways and highlight opportunities to standardise across the West Yorkshire and Harrogate and where appropriate across the wider Yorkshire and Humber | | Target date August 2017 | **Clinical Pathway workshop scheduled 16/11/17** | **Standard Care Pathways developed** | |
| Making more effective use of technology - review and identify options to 'pilot' (subject to appropriate governance)<br>NB: Pending outcome of standardised pathway work | | August 2017 | | | |
| Development of clinical model proposal to inform the next phase of work (quality and outcomes, workforce, travel , activity including mimics and costs analysis) | | Aug/Sept 2017 | **End of Dec 2017/ Jan 2018** | | |

| | | | | | |
|---|---|---|---|---|---|
| Impact of NHS England Mechanical Thrombectomy service developments are understood and inform clinical model proposals | | | **NHSE Clinical Advisory Group Thrombectomy meeting 20 Nov 2017** | **NHSE roll out timelines to be confirmed** | |
| Establish baseline position for post-acute stroke service pathways e.g. Early Supported Discharge, Community rehabilitation | | | **End of Dec 2017** | | |
| Continued dialogue with South Yorkshire and Bassetlaw, Humber Coast and Vale | | | | | |
| Discussions with each local place based areas to agree next steps (Prevention, Atrial Fibrillation and Hypertension) | | July/Aug 2017 | **AF Proposal to Clinical Forum**<br><br>**5/9/17 & 3/11/17**<br><br>**AF proposal to Joint Committee Meeting 7/11/17** | | |
| Decision – Joint Committee<br>- On readiness to consult | | | Original target date November 2017 Joint Committee meeting | **March 2018 Joint Committee Meeting (in public)** | |
| Stage 2 Assurance - NHS England | | | Oct/Nov 2017<br><br>**Stage 2 Pre- meeting with NHSE end of Dec 2017** | **Stage 2 Meeting with NHSE Jan 2018** | |
| Consultation (As appropriate) | | | | | **To Be confirmed** |

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# West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

| **Summary report** | | | |
|---|---|---|---|
| Date of meeting: **4 July 2017** | Agenda item: 04/17 | | |
| Report title: | **Improving Stroke Outcomes** | | |
| Joint Committee sponsor: | Jo Webster, Senior Responsible Officer for West Yorkshire and Harrogate and Accountable Chief Officer for Wakefield CCG | | |
| Clinical Lead: | Dr Andy Withers, Chair of West Yorkshire and Harrogate Clinical Forum and Clinical Chair, Bradford Districts CCG | | |
| Author: | Linda Driver, West Yorkshire and Harrogate Stroke Services Project Lead | | |
| Presenter: | Dr Andy Withers<br>Jo Webster | | |
| **Purpose of report**: (why is this being brought to the Committee?) | | | |
| Decision | | Comment | ✓ |
| Assurance | ✓ | | |

**Executive summary**

Stroke is the third single cause of death in the UK and has a devastating impact on people's lives, their families and carers. In view of this, work has taken place nationally and across West Yorkshire and Harrogate to improve the quality of care and outcomes for people who have had a stroke. This work includes preventing stroke happening in the first place, improving specialist care (the care you receive in the first hours and days after having a stroke), maximising the use of technology and improving after care by ensuring appropriate levels of support are available.

Although considerable progress has been made across West Yorkshire and Harrogate, variation continues to exist and as a result further improving quality and stroke outcomes for our population was included as a key priority within the West Yorkshire and Harrogate draft Sustainability and Transformation Plan (STP) published in November 2016.

There are challenges for the health and social care system and most importantly for stroke survivors, their families and carers. We are committed to ensuring our services can meet future demands and deal with these challenges in line with our agreed shared vision across West Yorkshire and Harrogate:

> *To reduce the incidence of stroke and avoidable deaths due to stroke, across the West Yorkshire health economy, minimising the long term effects and improving the quality of life for survivors. This will be achieved by providing consistently high quality care that is responsive to individual needs and*

*through encouraging healthier lifestyles and reducing inequalities in risk factors of stroke.*

Establishing what service users, their families and carers and members of the public feel and experience about stroke care is very important to us. With this in mind we commissioned an independent piece of work led by Healthwatch.

Healthwatch led the initiation of a robust engagement framework which took place during February and March 2017. Over 900 people completed our engagement survey and we directly connected with over 1,500 people, providing us with many comments, all of which are very important to us and will inform our future work.

In recognition that many of our staff are or could be future users of healthcare and have witnessed first-hand the experience of service users, we felt it important to seek their views as part of this process. Regional and local media were kept informed and Health and Well-Being Boards, Governing Bodies, MP's, Joint Health Overview and Scrutiny Committee and the Regional Lay member Assurance group were also updated on the engagement work and asked to encourage people to have their say. You can read the full report at http://bit.ly/2sjcLfa.

Stroke is a life changing event and evidence shows the care that people receive in the first few hours can make a difference to how well they recover. This includes having specialist scans to assess the nature of the stroke and if appropriate receive clot-busting drugs (thrombolysis) delivered by specialist staff working in sustainable and resilient hyper acute and acute stroke units.

We have an ageing population and the number of people who suffer a stroke is expected to increase. We strongly believe that if we are to continue to improve quality of life, with the resources we have available we must change the way in which we deliver stroke services. We want to ensure we are making the most of our valuable skilled workforce, modern technology and equipment in order to maximise opportunities to deliver great services with good outcomes and quality for our population.

In view of this, our doctors, nurses and other health care representatives have been working together to progress this work. For example, they have built upon the work to further improve stroke quality and outcomes that has taken place previously across West Yorkshire and Harrogate and wider Yorkshire and Humber region. They have reviewed the current position of our specialist stroke services and considered the engagement findings. They have also looked at the latest available literature evidence and work taking place in other areas to improve stroke outcomes.

A Strategic Case for Change has been developed which concludes there is strong evidence that outcomes following stroke are better if people are treated in specialised centres, even if this increases travelling time following the event, and this is likely to be the case in West Yorkshire and Harrogate. Ongoing rehabilitation should, however, be provided at locations closer to where people live and they should be transferred to these as soon as possible after initial treatment. The Strategic Case for Change is attached for reference in Appendix A. A Public Summary and easy read version have also been developed and all of these

documents can be accessed at http://bit.ly/2sjcLfa.

The Case for Change highlights the importance of taking a 'whole system' and 'whole pathway approach' to further improving stroke care and outcomes (reflecting our agreed vision for stroke care.) This approach is in line with work taking place elsewhere e.g. Manchester and our literature review findings.

It states that as a result of the work we have done to date, we believe the information outlined in the Strategic Case for Change demonstrates that if we are to further improve the quality of our specialist stroke services, outcomes and experience for our patients further work is required to ensure that our services are resilient and 'fit for the future'.

The Strategic Case for Change recommends that we begin work to develop our proposals to determine the 'optimal' service delivery models and pathways that need to be in place across West Yorkshire and Harrogate (which is all about making the most of staff skills, latest technology and ensuring our services meet the latest standards of care to improve quality and stroke outcomes for people now and in the future.) This should be set in the context of ensuring that we are maximising the opportunities to further improve care and outcomes for our population along the 'whole stroke care pathway'.

It is important to note that our work to date has been subject to review by NHS England as part of the Stage 1 Assurance process and regular progress reports are being submitted as part of the Stage 2 Assurance process. We have also shared the Strategic Case for Change with the Yorkshire and Humber Clinical Senate and we are incorporating their feedback into our action plans.

As an agreed West Yorkshire and Harrogate STP priority work stream, this report is being presented to the West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups in order that from an assurance perspective, members can review progress of the work that has taken place to date.

It will provide Joint Committee members, the people of West Yorkshire and Harrogate and other key stakeholders with an overview of the engagement work that has taken place across West Yorkshire and Harrogate to seek the views of our population, our staff and other key stakeholders.

The report will outline the approach we have adopted to develop the Strategic Case for Change and summarise the key findings, conclusions and recommendations.

Finally from an assurance perspective this report will outline the proposed next steps and timelines.

**Recommendations and next steps**

West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Group members are asked to:

- Note the progress to date;
- Note the Engagement Report and Strategic Case for Change; and
- Note and comment on the next steps and timelines.

**Delivering outcomes:** describe how the report supports the delivery of STP outcomes (Health and wellbeing, care and quality, finance and efficiency)

We want to make sure our services are 'fit for the future' and we make the most of the skills of our valuable workforce and technology in order to maximise opportunities to improve services, quality and outcomes for local people. For example, further reducing variation and any unnecessary delays along the whole of the stroke care pathway and making more effective use of our resources.

We will be working with our local place based areas to ensure prevention strategies continue to focus on reducing the incidence of stroke and avoidable deaths due to stroke through encouraging healthier lifestyles and reducing inequalities in risk factors of stroke.

This is in line with our strategic vision for stroke and strategic vision and priorities set out in the public summary of the West Yorkshire and Harrogate Draft STP published November 2016. This described the approach we would be adopting across our health and care economy and the work that would take place with key partners to identify opportunities to address the triple aims of improving health and wellbeing, care and quality, and finance and efficiency.

For example from a health and well-being perspective we will be working with each of our six local places in Bradford District and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds and Wakefield to reduce the number of people who die from stroke as well as reducing the number of strokes that occur. One of the ways we will do this is by further improving the way we detect and treat Atrial Fibrillation (Atrial Fibrillation causes a fast and erratic heartbeat which is a major factor of stroke.)

Examples of how we intend to address the care and quality gap include:

- Increasing the proportion of stroke patients assessed by a stroke specialist consultant physician and nurse trained in stroke management within 24 hours;
- Increasing the proportion of patients scanned within 12 hours; and
- Delivery of the new 7-day standards specific to hyper acute stroke, which sets out an ambition that anyone who needs urgent or emergency hospital care will have access to the same level of assessment and review, tests and consultant-led support whatever day of the week.

**Impact assessment** (please provide a brief description, or refer to the main body of the report)

| | |
|---|---|
| Clinical outcomes: | These are as described above and outlined in the report. The Strategic Case for Change (Appendix A also refers.)<br><br>A Strategic Case for Change Public Summary and easy read version is available for access at http://bit.ly/2sjcLfa. |
| Public involvement: | Our approach to engagement and the Engagement Report findings are included for reference by Joint Committee members, the people of West Yorkshire and Harrogate and other key stakeholders (Agenda item 3 and Agenda item 4, 4 July 2017 Joint Committee meeting refer) |

| | |
|---|---|
| | The Engagement Report and Strategic Case for Change are available at http://bit.ly/2sjcLfa.<br><br>A Strategic Case for Change Public Summary and easy read version are also be available. |
| Finance: | We want to make sure our services are 'fit for the future' and we make the most of the skills of our valuable workforce and technology whilst maximising opportunities to improve services quality and outcomes for local people e.g. further reducing variation and any unnecessary delays along the whole of the stroke care pathway and making more effective use of our resources.<br>Work is currently taking place to ensure there is a shared understanding of current hyper acute and acute costs between Commissioners and providers of these services.<br><br>Finance will be an integral component of the work that will take place to ensure we are able to satisfy Joint Committee members, NHS England and other key stakeholders about the broader tests that will be applied to our work related to clinical outcome and risk, public acceptability and finance. |
| Risk: | A risk register is in place. It is a standing agenda item subject to review at each meeting by core members of the Stroke Task and Finish Group.<br><br>As a West Yorkshire and Harrogate STP priority work stream, risks and actions to mitigate risks are subject to review by the West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups. The two risks which currently have a risk score of 12 are included in this report.<br><br>The risk register is also shared with Urgent Emergency Care Network Programme Board. |
| Conflicts of interest: | These are recorded. |

# West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups

## 4 July 2017

### West Yorkshire and Harrogate – Improving Stroke Outcomes Report

**1 Working together across West Yorkshire and Harrogate to further improve the quality of stroke care and outcomes for our population**

1.1 Stroke is the third single cause of death in the UK and has a devastating impact on people's lives, their families and carers. In view of this, work has taken place nationally and across West Yorkshire and Harrogate to further improve the quality of care and outcomes for people who have had a stroke. This work includes preventing stroke happening in the first place, further improving specialist care (the care you receive in the first hours and days after having a stroke), making the most of new technology and improving after care.

1.2 Although considerable progress has been made across West Yorkshire and Harrogate, variation continues to exist and as a result further improving stroke outcomes for our population was included as a key priority within the West Yorkshire and Harrogate draft Sustainability and Transformation Plan (STP) published in November 2016.

1.3 The ambitions of the West Yorkshire and Harrogate STP are focused around achieving improved outcomes to address the health and well-being gap, the care and quality gap and ensure we utilise our resources effectively. The draft plan highlighted the importance of ensuring our stroke work focuses on the 'whole stroke pathway' with stroke prevention, community rehabilitation and after care support delivered in local places to meet the needs of specific populations, locally planned with a consistent approach determined by clinicians and stakeholders across West Yorkshire and Harrogate to further reduce variation and improve stroke outcomes.

1.4 With regard to hyper acute and acute stroke care it was agreed that a West Yorkshire and Harrogate wide approach would be required to achieve the best outcomes, share best practice, further reduce variation and achieve better outcomes for people overall.

1.5 From a health and well-being perspective we will be working with each of our six local places in Bradford District and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds and Wakefield to reduce the number of people who die from stroke as well as reducing the number of strokes that occur. One of the ways we will do this is by further improving the way we detect and treat Atrial Fibrillation (Atrial Fibrillation causes a fast and erratic heartbeat which is a major factor of stroke.)

1.6 Examples of how we intend to address the care and quality gap include increasing the proportion of stroke patients assessed by a stroke specialist consultant physician and nurse trained in stroke management within 24 hours and increase the proportion of patients scanned within 12 hours.

1.7 As an agreed West Yorkshire and Harrogate STP priority work stream this report is being presented to the West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups in order that from an assurance perspective members can review progress of the work that has taken place to date.

1.8 It will provide Committee members, the people of West Yorkshire and Harrogate and other key stakeholders with an overview of the engagement work that has taken place across West Yorkshire and Harrogate to seek the views of our population, our staff and other key stakeholders.

1.9 It will outline the approach we have adopted to develop the Strategic Case for Change (Appendix A refers) and summarise the key findings, conclusion and recommendations. Finally from an assurance perspective this report will outline the proposed next steps and timelines.

## 2 Background - West Yorkshire and Harrogate

2.1 In 2015/16 there were approximately 3,600 stroke admissions into West Yorkshire Hospitals. The majority of strokes (74% of all strokes) occurred in the 65+ age group with the greatest concentration in the 75+ population (52% of all strokes). Although the numbers of people having a stroke are expected to increase in the coming years the good news is that the number of deaths related to stroke continues to decline.

2.2 Across West Yorkshire and Harrogate we have an agreed shared vision for stroke which is as follows:

> *To reduce the incidence of stroke and avoidable deaths due to stroke, across the West Yorkshire health economy, minimising the long term effects and improving the quality of life for survivors. This will be achieved by providing consistently high quality care that is responsive to individual needs and through encouraging healthier lifestyles and reducing inequalities in risk factors of stroke.*

2.3 In line with our agreed vision, prior to the publication of the National Stroke Strategy, Hospitals within West Yorkshire and Harrogate with multiple hospital sites for admitting strokes had consolidated their hyper-acute stroke provision (which provides care up to the first 72 hours after a stroke) onto a single site. This significantly reduced the number of hospital sites admitting acute strokes. There are currently five hyper acute stroke units within West Yorkshire based at:

- Bradford Teaching Hospitals NHS Foundation Trust – Bradford Royal Infirmary;

- Calderdale & Huddersfield NHS Foundation Trust – Calderdale Royal Hospital;
- Harrogate and District NHS Foundation Trust;
- Leeds Teaching Hospitals NHS Trust – Leeds General Infirmary; and
- Mid Yorkshire Hospitals NHS Trusts – Pinderfields Hospital.

2.4 Other examples of work that has taken place across West Yorkshire and Harrogate to improve stroke outcomes are as follows:

- The Yorkshire and Humber Strategic Clinical Network for Cardiovascular Disease (CVD) delivered an extensive programme of work to facilitate improvements in services;
- Our Hospitals have participated in the Sentinel Stroke National Audit Programme (SSNAP). This aims to improve the quality of stroke care by auditing stroke services against evidence based standards to identify and support implementation of improvements; and
- Our GP's and Nurses have been working to further improve the way we detect and treat Atrial Fibrillation.

2.5 There are challenges for the health and social care system and most importantly for stroke survivors, their families and carers. This alongside an ageing population, with complex health and social care needs, means we have to change if we want to continue to further improve people's quality of life with the resources we have available.

2.6 We want to make sure our services are 'fit for the future' and make the most of the skills of our valuable workforce and new technology whilst maximising opportunities to improve quality and outcomes for local people. We also want to ensure that care across the whole stroke pathway is working effectively to meet the current and future needs of our population in line with our agreed vision.

## 3 What are the people of West Yorkshire and Harrogate telling us about stroke services?

3.1 Establishing what service users, their families and carers and members of the public feel and experience about stroke care is very important to us. With this in mind we commissioned an independent piece of work led by Healthwatch.

3.2 On the 23 January 2017, members of the West Yorkshire and Harrogate Stroke Task and Finish Group and a Healthwatch representative attended the Joint Health Overview and Scrutiny Committee (JHOSC) to discuss and gain their views on the approach to engagement we intended to adopt across West Yorkshire and Harrogate. On the 24 January 2017, we also attended the Regional Lay Member Assurance Group to share our proposed approach and to seek their views to inform our next steps.

3.3 Healthwatch led the initiation of a robust engagement framework which took place during February and March 2017 and was informed by the Equality

Impact Assessment (EIA). Over 900 people completed our engagement survey and we directly connected with over 1,500 people, providing us with many comments, all of which are very important to us and will inform our future work.

3.4 In recognition that many of our staff are or could be future users of healthcare and have witnessed first-hand the experience of service users, we felt it important to seek their views as part of this process. Regional and local media were kept informed and Health and Well-Being Boards, Governing Bodies, MP's, Joint Health Overview and Scrutiny Committee and the Regional Lay Member Reference Group were also updated on the engagement work and asked to encourage people to have their say.

3.5 This work is in line with our Stroke Communications, Engagement and Equality Strategy. The key findings from the engagement work have been captured in the Healthwatch Stroke Services Engagement Report which sets out the findings from this important piece of work. You can read the full report at http://bit.ly/2sjcLfa.

3.6 A snap shot of some of the comments we received include:

- Many people said that they would travel further if it meant they were able to receive the best treatment and to be treated by specialists; however, they wanted their rehabilitation to be available closer to home. Although some people were worried that if they had to travel further the extra journey time could negatively affect their health, and would make it more difficult for their family to visit them;

- Those who had experienced a stroke described the excellent levels of care that they received in hospital, from being seen quickly, to accessing the most appropriate treatments and being kept informed throughout. They talked about staff being willing to help, whilst recognising that some were extremely busy. It was also felt that there should not be a difference in care during the week and at the weekend;

- Many described how stroke can be a life changing event which can be difficult for the patient and their families to deal with. It was felt that there was a need to ensure that the patient and their family are provided with the appropriate levels of emotional support and advice;

- The valuable role of voluntary and community organisations specialising in stroke support, particularly on hospital wards, was recognised in the report; and

- Many felt that there was a need to raise awareness of the signs and symptoms of a stroke, and what to do if you think someone is having a stroke.

3.7 The engagement work also highlighted concerns that a decision had already been made to reduce the number of hyper-acute stroke units. **It is therefore important to note that no decision at this stage of our review process**

**has been made to reduce the number of units across West Yorkshire and Harrogate.**

## 4 Strategic Case for Change - why do we need to change?

4.1 Stroke is a life changing event and evidence shows the care that people receive in the first few hours can make a difference to how well they recover. This includes having specialist scans to assess the nature of the stroke and if appropriate receive clot-busting drugs (thrombolysis) delivered by specialist staff working in sustainable and resilient hyper acute and acute stroke units.

4.2 We have an ageing population and the number of people who suffer a stroke is also expected to increase. We therefore believe that if we are to continue to improve people's quality of life, with the resources we have available, we must change the way in which we deliver stroke services to ensure we are making the most of our valuable skilled workforce, modern technology and equipment in order to maximise opportunities to further improve stroke outcomes and quality for our population.

4.3 *The NHS 5 Year Forward View* published in October 2014, sets out a clear direction for the NHS, showing why change is needed and what it will look like. It states that, for some services, there is a compelling case for greater concentration of care. It also highlights the strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur.

4.4 In view of this, doctors, nurses, medical directors and other health professionals across West Yorkshire and Harrogate have been working with partners such as Yorkshire Ambulance Service, West Yorkshire Association of Acute Trusts, Clinical Commissioners and other key stakeholders to review the current position of our specialist stroke services. Our work to date has made reference to the growing number of examples across the United Kingdom (UK) where commissioners (who are responsible for ensuring services are in place to meet the health needs of our population), and Hospital providers are working together to improve access to specialist stroke inpatient care, where patients are taken to specialist units rather than the nearest hospital.

4.5 This focus is being driven from a national level and originates from the concentration of specialist stroke services that occurred in 2010 across two metropolitan areas of England (Greater Manchester and London) and from supporting international research. This suggests that specialist centres can improve the provision of evidence based care e.g. by improving access to specialist care and thrombolysis (clot-busting drugs), the latter of which, when undertaken more frequently, can lead to better outcomes.

4.6 Our specialist stroke services will also need to deliver the new 7 day standards, which sets out an ambition that anyone who needs urgent or emergency hospital care will have access to the same level of assessment and review, tests and consultant-led support whatever day of the week.

4.7 This work has informed the development of a Strategic Case for Change and Section 5 and Section 6 below provide an overview of the key findings, conclusions and recommendation outlined within it. The Strategic Case for Change is attached for reference in Appendix A. A Public Summary and easy read version have also been developed and all of these documents can be accessed at http://bit.ly/2sjcLfa.

## 5 What is the Strategic Case for Change telling us?

5.1 Our doctors and other health care professionals across West Yorkshire and Harrogate have built on the work that has taken place previously with the Strategic Clinical Network, the Yorkshire and Humber Clinical Senate, our consultants, doctors and other health care professionals across West Yorkshire and Harrogate and the wider Yorkshire and Humber Region. The recurring key themes, from all the work that has taken place to date, which have informed the Strategic Case for Change, are as follows:

- We need a more consistent approach to prevention across West Yorkshire and Harrogate so that people receive information and advice to make informed decisions about their health – this will help reduce stroke incidents for some people;

- Depending on where you live, some people have better experiences and access to specialist services than others;

- Further work is needed to reduce differences in the services people receive, so that no matter where people live and what time of day they are admitted to hospital, they are able to receive high quality stroke services;

- By looking at the way we deliver care after a stroke, we can maximise the opportunities to further improve quality of life for people whilst also reducing a person's chance of living with a disability afterwards;

- We have five hyper acute stroke units in West Yorkshire and Harrogate. In view of the need to meet new standards (including specialist early supported discharge every day and access to new technology), further work is needed to ensure all our services are 'fit for the future', can achieve the quality standards, maintain great outcomes and be sustainable;

- We want to ensure we make the most of the skills of our valuable workforce and retain and recruit the skilled workforce we need to maximise opportunities to further improve quality and outcomes for our population;

- There is strong evidence that outcomes following stroke are better if people are treated in specialised centres, even if this increases travelling time following the event, and this is likely to be the case in West Yorkshire and Harrogate;

- We know that most people with a suspected stroke arrive at hospital by ambulance and we need to work closely with our ambulance staff who

provide assessment and treatment as they convey people to the right hospital for their medical needs;

- Ongoing specialist care should be provided at locations closer to where people live, and people should be transferred to these as soon as possible after initial treatment;

- We need to ensure care and support following a stroke is the best it can be in hospital and in the community, this includes access to speech and language therapy, physiotherapy, occupational therapy, psychology and social care;

- We also need to look more closely at the support given by voluntary and community organisations that provide support to those who have had a stroke and their carers; and

- Adopting a 'whole pathway' approach to the provision of stroke services is crucial to further improving the quality of services and maximising clinical outcomes for our population.

## 6 Strategic Case for Change – conclusions and recommendations

### *Conclusion*

6.1 There is strong evidence that outcomes following stroke are better if people are treated in specialised centres, even if this increases travelling time following the event, and this is likely to be the case in West Yorkshire & Harrogate. Ongoing rehabilitation should, however, be provided at locations closer to where people live and they should be transferred to these as soon as possible after initial treatment.

6.2 The importance of taking a 'whole system' and 'whole pathway approach' to improving stroke care has also been highlighted through discussions with our local clinicians and other key stakeholders (reflecting our agreed vision for stroke care.) This approach is in line with work taking place elsewhere e.g. Manchester and our literature review findings.

6.3 Across West Yorkshire and Harrogate, significant work has already taken place in our Hospitals and our Ambulance Service to improve the quality of care and outcomes for stroke. Work has also taken place across our local areas to further reduce the risk of stroke through the implementation of a range of initiatives e.g. Atrial Fibrillation and Hypertension pathway developments and implementation of prevention strategies.

6.4 The outcome of our work, to date, suggests that in order to further improve quality and stroke outcomes for our patients further work is now required to determine the 'optimal' service delivery models across the West Yorkshire and Harrogate footprint so that our services are 'fit for the future' (which is all about making the most of our workforce skills, latest technology and ensuring our services meet the latest standards of care for people now and in the future.)

6.5 Our work to date has been supported by the Strategic Clinical Network, which included consultants and doctors and other clinical and non-clinical stakeholders across West Yorkshire and Harrogate.

6.6 The recommendations made are in line with new models of care described in the NHS 5 Year Forward View, work taking place in other areas such as Manchester and London, and our strategic vision and priorities set out in the public summary of the West Yorkshire and Harrogate Draft Sustainability and Transformation Plan published November 2016.

***Strategic Case for Change recommendations***

6.7 As a result of the work we have done to date, we believe the information outlined in the Strategic Case for Change demonstrates that if we are to further improve the quality of our specialist stroke services, outcomes and experience for our patients further work is required to ensure that our services are resilient and 'fit for the future'.

6.8 In view of this, it recommends that we begin work to develop our proposals to determine the 'optimal' service delivery models and pathways that need to be in place across West Yorkshire and Harrogate. This should be set in the context of ensuring that we are maximising the opportunities to further improve care and outcomes for our population along the whole stroke care pathway.

***Strategic Case for Change – assurance, support from clinical commissioners and other key stakeholders***

6.9 A range of mechanisms have been in place to ensure there have been appropriate levels of engagement and involvement with our health care professionals and other key stakeholders. For example Stroke Task and Finish Group members, Clinical Commissioning Group clinical and executive leads, Clinical Forum members, West Yorkshire Association of Acute Trust Medical Directors and executive leads have all informed the development of the Strategic Case for Change, conclusions and recommendations prior to its approval.

6.10 NHS England reviewed the Strategic Case for Change as part of the Stage 1 NHS Assurance process and they receive monthly updates as part of the Stage 2 Assurance process.

6.11 Yorkshire and Humber Clinical Senate members were also asked to review the Case for Change and as requested have provided feedback on areas we should focus on to inform our next steps.

6.12 In addition to the above we have had further discussions with our clinicians and other health care professionals who are currently working in our hyper acute and acute stroke services and Yorkshire Ambulance Services. It is important to note our clinicians and other health care professionals who attended the first provider clinical workshop have identified a number of areas which could be implemented at the earliest opportunity (subject to approval through the appropriate governance routes)

6.13 These include:

- Reviewing and implementing more standardised stroke care pathways across West Yorkshire and Harrogate; and
- 'Piloting' more effective use of technology between our hospitals and the Yorkshire Ambulance service to provide earlier assessments for our patients.

6.14 Their clinical expertise has also informed the next steps summarised in Section 8 of this briefing.

## 7 Risks

7.1 The risk register for the stroke project is reviewed and updated by the Stroke Task and Finish Group at every meeting and reported to the Urgent and Emergency Care Steering Group and Joint Committee in line with the agreed governance arrangements.

7.2 Joint Committee members are asked to note that there are currently two risks on the risk register with a score of 12, these are as follows:

- Risk 5 (impact score 4, probability score 3, total score 12) - There is a risk that providers may not be able to implement the latest stroke guidelines due to lack of available and appropriately skilled workforce able to deliver new models of care resulting in continued variance in stroke outcomes across the West Yorkshire & Harrogate footprint; and

- Risk 6 (impact score 4, probability score 3, total score 12) - There is a risk existing hyper acute stroke services across the West Yorkshire and Harrogate may experience operational resilience issues due to inability to recruit and retain appropriately skilled workforce during the transformation period, resulting in emergency commissioning arrangements being implemented in advance of new models of care being approved and implemented.

7.3 Workforce is one of the key drivers for change. Actions to ensure we are supporting and making the most of our valuable staff and are able to retain and recruit the skilled workforce we need are therefore key to mitigating the risks outlined above.

7.4 As part of the risk register review clinical representatives who are core members of the Stroke Task and Finish Group also provide early alert of any workforce pressures that may need to be addressed via other contractual routes in advance of the development of 'optimal' service delivery models.

## 8 Next steps and timelines

8.1 Providing the best stroke services possible across West Yorkshire and Harrogate to further improve quality and stroke outcomes is a priority for us all and something we are committed to achieving.

8.2 In line with our Stroke Communication, Engagement and Equality Strategy over the next few months we will be having more conversations with our staff, partners, public, communities and stakeholders as we develop options to inform the next phase of our work. This work will include the following:

- Further targeted work to gain the views of our protected groups referenced in the Equality Impact Assessment (EIA) as being more likely to be impacted by any proposed changes and ensure patient stories are captured as part of this work.

8.3 Other work will include the following:

- A review of existing stroke pathways to identify opportunities to further improve pathways with a view to adopting a more consistent approach across West Yorkshire and Harrogate and where possible Yorkshire and Humber Region;

- A review of how technology is currently being used by our clinicians and other health care professionals to support existing services and care pathway/s and to identify opportunities to further maximise the use of technology e.g. to assist with providing earlier assessment and treatment for our patients;

- Development of clinical model options to inform the next phase of our work;

- Working with NHS England Specialised Services colleagues to ensure the impact of mechanical thrombectomy service developments (clot retrieval procedure) informs the development of our options: and

- Continued dialogue with colleagues in South Yorkshire and Bassetlaw, Humber Coast and Vale and wider Yorkshire and Humber region to ensure the impact of developments across the wider Yorkshire and Humber Region remain aligned and impacts of any proposed options are understood e.g. to understand the impact of cross boundary flow of patients.

8.4 As outlined previously it is important that work also continues to take place to maximise the opportunities to prevent stroke and improve outcomes and quality for our population across the whole of the stroke care pathway. In order to do this we intend to:

- Commence further discussion with our clinicians, other health care professionals, public health and other key stakeholders in each of our six local place based areas at the very earliest opportunity in Q2 2017/18 to establish whether the prevention, Atrial Fibrillation and Hypertension interventions are delivering the intended benefits to our population in line with previous projections: and

- Ensure there is a shared understanding of the position across West Yorkshire and Harrogate in relation to timely access and availability of

early supported discharge (ESD), community rehabilitation, end of life, longer term care and voluntary care sector provision.

8.5 It is our intention to expand the core membership of the Stroke Task and Finish Group to include a patient representative. Discussions have commenced with the Regional Lay Member Assurance Group and communication and engagement colleagues to define the role and responsibilities with a view to a patient representative joining the Stroke Task and Finish Group at the very earliest opportunity.

8.6 As part of the NHS England Assurance process, monthly progress reports are submitted to NHS England and further discussion will take place with them during October/November 2017/18 as part of the Stage 2 NHS England Assurance process to discuss progress and next steps.

8.7 It is envisaged the next progress report to the Joint Committee will be presented at the November 2017/18 meeting with a view to requesting Joint Committee members to make a decision on the readiness to consult.

8.8 For ease of reference Table 1 provides a high level overview of the key actions and timelines associated with this project.

**Table 1**

| | **Quarter 1** | **Quarter 2** | **Quarter 3** | **Quarter 4** |
|---|---|---|---|---|
| | **Apr – Jun 2017** | **Jul – Sep 2017** | **Oct – Dec 2017** | **Jan – Mar 2018** |
| Equality Impact Assessment (EIA) - the EIA will be subject to ongoing review and update | | | | |
| Engagement - targeted further engagement to gain the views of protected groups and capture patient stories (phase 1 communication and engagement plan) | | July/Aug 2017 | | |
| Phase 2 Communication and Engagement - action plan refresh (subject to ongoing review and update) | | | | |
| Review existing stroke pathways and highlight opportunities to standardise across the West Yorkshire and Harrogate and where appropriate across the wider Yorkshire and Humber region | | August 2017 | | |
| Making more effective use of technology - review and identify options to 'pilot' (subject to appropriate governance) | | August 2017 | | |
| Development of clinical model options to inform the next phase of work (quality and outcomes, workforce, travel , activity including MIMICs and costs analysis) | | Aug/Sept 2017 | | |

| | Quarter 1<br>Apr – Jun 2017 | Quarter 2<br>Jul – Sep 2017 | Quarter 3<br>Oct – Dec 2017 | Quarter 4<br>Jan – Mar 2018 |
|---|---|---|---|---|
| Impact of NHS England Mechanical Thrombectomy service developments are understood and inform clinical model options | | | | |
| Continued dialogue with South Yorkshire and Bassetlaw, Humber Coast and Vale | | | | |
| Discussions with each local place based areas to agree next steps (Prevention, Atrial Fibrillation and Hypertension) | | July/Aug 2017 | | |
| Discussions with local placed based areas to understand current position of early supported discharge, community rehabilitation, end of life care and voluntary care sector provision | | | | |
| Decision – Joint Committee<br>- On readiness to consult | | | November 2017 meeting | |
| Stage 2 Assurance – NHS England | | | Oct/Nov 2017 | |
| Consultation (As appropriate) | | | | To Be Confirmed |

## 9 Recommendations

9.1 West Yorkshire and Harrogate Joint Committee of CCG's members are asked to:

- Note the progress to date;
- Note the Engagement Report and Strategic Case for Change; and
- Note and comment on the next steps and timelines.

**Linda Driver**
**West Yorkshire and Harrogate Stroke Services Project Lead**
**19 June 2017**

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# West Yorkshire Healthy Futures Stroke/Hyper Acute Stroke and Acute Stroke Strategic Case for Change

## Final V6.0

## 1 March 2017

**Version Control**

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## DOCUMENT HISTORY

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## VERSION DETAILS

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| 1.0 | | | Strategic Case for Change developed which builds upon the following:<br>- Healthy Futures Programme Hyper Acute Stroke Current | |

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|---|---|---|---|---|
| | | | State Assessment V1.0 Final (February 2015)<br>- Healthy Futures Hyper Acute Stroke Services Review: Options Appraisal Final (July 2015)<br>- Yorkshire and Humber Strategic Clinical Network Hyper Acute Stroke Service 'Blueprint' recommendations for West Yorkshire V1.1 (June 2016) | |
| 2.0 | 24 Jan 2017 | Linda Driver Project Lead | Strategic Case for Change updated to reflect key points of discussion by Stroke/HAS Task & Finish Group members. | |
| 3.0 | 30 Jan 2017 | Linda Driver Project Lead | Strategic Case for Change updated to reflect feedback from Stroke/HAS Task and Finish Group members and WYAAT provider representatives. | |
| 4.0 | 16 Feb 2017 | Linda Driver Project Lead | Strategic Case for Change updated to reflect feedback from Healthy Futures Clinical Forum Members meeting (7 February 2017.) HF Clinical Forum members required specific reference to 7 day standards. | |
| 5.0 | 23 Feb 2017 | Linda Driver Project Lead | Strategic Case for Change updated to reflect feedback from Stroke/HAS Task and Finish Group members (23 February 2017) and to reflect comments received following circulation to Urgent and Emergency Care Network members (15 February 2017.) | |
| 6.0 | 28 Feb 2017 | Linda Driver Project Lead | Strategic Case updated to reflect further feedback from WYAAT, final review with clinical Chair of Stroke/HAS Task and Finish Group and final format. | |
| 6.0 | May 2017 | Linda Driver Project Lead | Strategic Case reflects feedback from Clinical Senate Working Party. | |

**DISTRIBUTION LIST**

| Name | Title | Email |
|---|---|---|
| The names and contact details of the West Yorkshire Healthy Futures Stroke/HAS Task & Finish Group members is embedded for reference. | West Yorkshire Healthy Futures Stroke/HAS Task & Finish Group |  West Yorkshire Healthy Futures Strol |
| The draft Strategic Case for Change has been circulated to the following stakeholders for onward cascade and comment. | - Clinical Forum Members<br>- Health Futures Collaborative Forum Members<br>- West Yorkshire Association of Acute Trust Medical Director's Forum and Chief Officer's Forum<br>- Yorkshire Ambulance Service Chief Officer Forum | |
| The Strategic Case for Change will be circulated to NHS England as part of the Stage 1 Assurance process following approval by Healthy Futures Collaborative Forum (7 March 2017) | - NHS England | |
| The Strategic Case for Change will be circulated to Yorkshire & Humber Clinical Senate members following approval by Healthy Futures Collaborative Forum (7 March 2017) | - Yorkshire and Humber Clinical Senate members | |

**Contents**

## 1. Executive Summary

### 1.1 The Yorkshire and Humber and West Yorkshire and Harrogate context

Nationally and locally lots of work has taken place to improve outcomes for people who have had a stroke. Although the numbers of people having a stroke are expected to increase in the coming years the good news is that the number of deaths related to stroke continues to decline.

In 2015/16 there were approximately 3,600 stroke admissions into West Yorkshire Hospitals (based on Stroke Sentinel National Audit Programme data[1]). Previous analysis (2013) showed the majority of strokes (74% of all strokes) occurred in the 65+ age group with the greatest concentration in the 75+ population (52% of all strokes).

Progress in improving stroke care over the past 10 – 15 years has increased the demand for the provision of specialist hyper acute stroke services. This has led to some of our hyper acute stroke services experiencing difficulty in recruiting and retaining the skilled workforce needed to meet these demands. We want to make sure our services are 'fit for the future' and we make the most of new technology and the skills of our valuable workforce whilst maximising opportunities to improve quality and outcomes for local people.

There are challenges for the health and social care system and most importantly for stroke survivors, their families and carers. This alongside an ageing population, with complex health and social care needs, means we have to change if we want to continue to further improve people's quality of life with the resources we have available.

In view of this, health professionals and key stakeholders across West Yorkshire and Harrogate have been considering how we can further improve our hyper acute stroke and acute stroke care services so they are 'fit for the future' whilst maximising the opportunity to increase quality and outcomes for people. We also want to ensure that care across the whole stroke pathway is working effectively to meet the current and future needs of our population in line with our agreed vision to:

*Reduce the incidence of stroke and avoidable deaths due to stroke, across the West Yorkshire health economy, minimising the long term effects and improving the quality of life for survivors. This will be achieved by providing consistently high quality care that is responsive to individual needs and through encouraging healthier lifestyles and reducing inequalities in risk factors of stroke.*

Improving stroke outcomes for our population has therefore been included as a key priority within the West Yorkshire and Harrogate draft Sustainability and Transformation Plan (STP)[2].

### 1.2 Why change?

Stroke is a life changing event and evidence shows the care that people receive in the first few hours can make a difference to how well they recover. This includes having specialist scans to assess the nature of the stroke and if appropriate receive clot-busting drugs

[1] https://www.strokeaudit.org/

[2] West Yorkshire and Harrogate. Sustainability and Transformation Plan draft proposals, October 2016.

(thrombolysis) delivered by specialist staff working in sustainable and resilient hyper acute stroke units.

We have an ageing population and the number of people who suffer a stroke is also expected to increase. We therefore believe that if we are to continue to improve people's quality of life, with the resources we have available, we must change the way in which we deliver stroke services to ensure we are making the most of our valuable skilled workforce, modern technology and equipment in order to maximise opportunities to further improve stroke outcomes and quality for our population.

The *NHS 5 Year Forward View*[3] published in October 2014 sets out a clear direction for the NHS, showing why change is needed and what it will look like. It states that, for some services, there is a compelling case for greater concentration of care highlighting there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur.

Our work to date has made reference to the growing number of examples across the UK where commissioners and providers are working collaboratively to improve access to specialist stroke inpatient care where patients are taken to specialist units rather than the nearest hospital.

This focus is being driven from a national level and stems from the concentration of specialist stroke services that occurred in 2010 across two metropolitan areas of England (Greater Manchester and London) and from supporting international research that suggests that specialist centres can improve the provision of evidence based care e.g. by improving access to specialist care and thrombolysis, the latter of which, when undertaken more frequently, can lead to better outcomes[4].

Another key driver for change is set out in *The Government's mandate to NHS England for 2016-17*[5] which sets an objective that anyone who needs urgent or emergency hospital care will have access to the same level of consultant assessment and review, diagnostic tests and consultant-led interventions, whatever the day of the week. Alongside this *The 2017-19 NHS Shared Planning Guidance*[6] states there is an ambition for 5 urgent network specialist services to meet these standards by November 2017 and Hyper Acute Stroke (specialist care for acute stroke patients) is one of these 5 specialist services.

From a West Yorkshire and Harrogate perspective work has taken place with the Strategic Clinical Network, our consultants, doctors and other health care professionals, as part of the wider Yorkshire and Humber Region, and this work has informed our Strategic Case for Change and recommendations.

In particular:

[3] NHS England (2014) Five Year Forward View. Available from https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (accessed 3 Nov 2016)

[4] Hunter R, Davie C, Rudd A, Thompson A, Walker H, Thompson N, et al. Impact on Clinical and Cost Outcomes of a Centralized Approach to Acute Stroke Care in London: A Comparative Effectiveness before and after model. Plos One.8,8.

[5] The Government's mandate to NHS England for 2016-17, Department of Health, January 2016, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/494485/NHSE_mandate_16-17_22_Jan.pdf

[6] NHS Operational Planning and Contracting Guidance 2017 – 2019, NHS England and NHS Improvement, September 2016, https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

- ***Case for Change Stroke Prevention (2014)[7],*** which identified opportunities, key enablers and benefits of adopting a unified approach to prevention across West Yorkshire and Harrogate footprint (improving quality and outcomes, improving performance against key metrics, reducing risks and costs);
- ***The Healthy Futures Programme Hyper Acute Stroke Services Review: Current State Assessment V1.0 Final (25 February 2015***)[8] which identified a significant number of opportunities, that when implemented, have the potential to improve sustainability and resilience;
- ***Healthy Futures Hyper Acute Stroke Services Review: Options Appraisal Final (7 July 2015)[9];*** and
- ***The Hyper Acute Stroke Services Yorkshire and Humber 'Blueprint' for Yorkshire and Humber Clinical Commissioning Groups Version 1.1*****. published in June 2016**[10]

During Q3 2016/17 a 'desk top review' was carried out by the Stroke/Hyper Acute Stroke Task and Finish Group to build on upon the work done previously to determine whether there were any significant changes to the assumptions and recommendations outlined in the 'Blueprint'. The recurring key themes, from all the work that has taken place to date, which have informed the Strategic Case for Change are as follows:

- Depending on where you live, some people may have better experiences and access to services than others;
- By changing the way we deliver care after stroke, we can maximise the opportunities to further improve outcomes and quality for our patients whilst also reducing our patients' chances of living with a disability afterwards;
- Although some Trusts have improved their performance against some of the Stroke Sentinel National Audit Programme (SSNAP)[11] metrics, variation in the quality of our specialist hyper acute services and pathways continues to exist. Further work is therefore required to reduce this variation and ensure that, no matter where our patients live and what time of day they are admitted, our patients have access to consistently high quality services and pathways;
- We currently have 5 hyper acute stroke units in West Yorkshire and Harrogate. In view of the requirements to meet new quality standards e.g. *National Clinical Guideline for stroke, Fifth Edition 2016*[12], 7 day standards[13] (including early supported discharge at weekends), improved access to imaging and Intra Arterial Thrombectomy (IAT) technology[14] developments, further work is needed to determine the optimal service delivery models to ensure our services are 'fit for the future' and delivering improved outcomes for our patients;

[7] West and South Yorkshire and Bassetlaw Commissioning Support Unit (2014). Healthy Futures Programme:Case for Change Stroke Prevention.

[8] Healthy Futures Stroke Programme. Hyper-Acute Stroke Services Review: Current State Assessment V1.0 Final, 25 February 2015.

[9] Healthy Futures Stroke Programme. Hyper-Acute Stroke Services Review: Options Appraisal, Version: Final for approval, 7 July 2015.

[10] Yorkshire and Humber Strategic Clinical Networks. Hyper Acute Stroke Services, Yorkshire and Humber 'Blueprint' for Yorkshire and Humber Clinical Commissioning Groups V1.1, June 2016.

[11] Royal College of Physicians Sentinel Stroke National Audit Programme. 2016, https://www.strokeaudit.org/results.aspx

[12] Royal College of Physicians. Intercollegiate Stroke Working Party. National clinical guideline for stroke. Fifth Edition, 2016.

[13] NHS England (2016) Business Plan 2016/17. Available from https://www.england.nhs.uk/wp-content/uploads/2016/03/bus-plan-16.pdf (accessed 14 November 2016)

[14] Royal College of Physicians. Intercollegiate Stroke Working Party. National clinical guideline for stroke. Fifth Edition, 2016 Section 3.5, p41

- Progress in improving stroke care over the past 10 – 15 years has increased the demand for the provision of specialist hyper acute stroke services. This has led to some of our hyper acute stroke services experiencing difficulty in recruiting and retaining the skilled workforce needed to meet these demands and deliver services in line with the required quality standards. In view of the projected demographic growth increase of 12.7%[15] by 2020 we want to determine how we can make the most of the skills of our valuable workforce whilst maximising opportunities to further improve the quality of services and outcomes for local people;
- Across the Yorkshire and Humber footprint a number of hyper acute services have experienced resilience issues which have required emergency commissioning and provider arrangements to be put in place. We want to determine the optimal service delivery models that will further improve the resilience of our specialist hyper acute and acute stroke services so they are fit for the future and we minimise the risks of our services experiencing resilience issues;
- Evidence from elsewhere shows that the outcomes following hyper-acute stroke are better if people are treated in specialised centres that achieve a minimum number of strokes per annum and do not exceed a maximum number of strokes, even if this increases travelling time following the event; this is likely to be the case in West Yorkshire & Harrogate
- We know that most people with a suspected stroke arrive at hospital by ambulance and we need to work closely with our ambulance staff who provide assessment and treatment as they convey people to the right hospital for their medical needs;
- Ongoing rehabilitation should be provided at locations closer to where people live, and they should be transferred to these as soon as possible after initial treatment;
- In line with the Strategic Clinical Network 'Blueprint' recommendations further modelling is required to review patient flows across the West Yorkshire and Harrogate footprint to ensure we are optimising the resilience of our stroke model set in the context of the Urgent and Emergency Care Network Programme and wider Yorkshire and Humber developments e.g. cross boundary flows from Working Together Programme developments; and
- Adopting a whole pathway approach to the provision of stroke services is crucial to further improving the quality of services and maximising clinical outcomes for our population e.g. we need to ensure repatriation from our specialist hyper acute stroke services into our acute stroke or community rehabilitation services are working effectively so that we avoid delays along the care pathway and we ensure inter-dependencies between our specialist hyper acute and acute stroke services are understood. We also need to continue to work with our place based colleagues to ensure that, across the West Yorkshire and Harrogate footprint, we maintain a focus on the implementation of place based prevention strategies, hypertension and atrial fibrillation pathway developments, post-acute rehabilitation, end of life and voluntary sector care.

### 1.3 Conclusions, recommendations and next steps

#### 1.3.1 Conclusion

There is strong evidence that outcomes following stroke are better if people are treated in specialised centres, even if this increases travelling time following the event, and this is likely

[15] Healthy Futures Stroke Programme. Hyper-Acute Stroke Services Review: Current State Assessment V1.0 Final, 25 February 2015, Section 6.3.1, p40

to be the case in West Yorkshire & Harrogate. Ongoing rehabilitation should, however, be provided at locations closer to where people live, and they should be transferred to these as soon as possible after initial treatment.

The importance of taking a 'whole system' and 'whole pathway approach' to improving stroke care has also been highlighted through discussions with our local clinicians and other key stakeholders (reflecting our agreed vision for stroke care) and is in line with work taking place elsewhere e.g. Manchester and our literature review findings.

Across West Yorkshire and Harrogate, significant work has already taken place in our Hospitals and our Ambulance Service to improve the quality of care and outcomes for stroke. Work has also taken place across our place based footprints to further reduce the risk of stroke through the implementation of a range of initiatives e.g. atrial fibrillation and hypertension pathway developments and implementation of prevention strategies.

The outcome of our work, to date, suggests that in order to further improve quality and stroke outcomes for our patients further work is now required to determine the optimal service delivery models across the West Yorkshire and Harrogate footprint so that our services are 'fit for the future'.

Our work to date has been supported by the Strategic Clinical Network, which included consultants and doctors and other clinical and non-clinical stakeholders across the West Yorkshire and Harrogate STP footprint.

The recommendations made are in line with new models of care described in the *NHS 5 Year Forward View*. Work taking place in other areas such as Manchester and London, and our strategic vision and priorities set out in the public summary of the *West Yorkshire and Harrogate Draft Sustainability and Transformation PlanP*[16] published November 2016.

### 1.3.2 Recommendations

As a result of the work we have done to date, we believe the information outlined in this Strategic Case for Change demonstrates that if we are to further improve the quality of our specialist stroke services, outcomes and experience for our patients further work is required to ensure that our services are resilient and 'fit for the future'.

In view of this we recommend that we begin the work to develop our proposals to determine the optimal service delivery models and pathways that need to be in place across the West Yorkshire and Harrogate footprint set in the context of ensuring that we are maximising the opportunities to further improve care and outcomes for our population along the whole stroke care pathway.

### 1.3.3 Next steps

The Strategic Case for Change (V6.0) reflects comments from the following stakeholders:

- West Yorkshire Healthy Futures Stroke/HAS Task and Finish (T&F) Group members (includes Trust and Ambulance service clinical representatives and CCG commissioner clinical chair and Chief Officer representatives);
- West Yorkshire Association of Acute Trust (WYAAT) colleagues (including Medical Directors and Chief Officers);

[16] West Yorkshire and Harrogate. Draft Sustainability and Transformation Plan Public Summary, November 2016.

- Urgent and Emergency Care Network colleagues (representation includes clinical and non clinical representatives from acute, non acute and primary care providers, commissioners, Healthwatch and Local Authorities);
- Healthy Futures Clinical Forum members (includes CCG and Acute and Ambulance Provider clinical representatives); and
- Healthy Futures Collaborative Forum (11 CCG's and NHS England.)

Subject to the approval of the Healthy Futures Collaborative Forum (HFCF) on 7 March 2017 the Strategic Case for Change will be submitted to NHS England as part of the Stage 1 NHS England Assurance process[17].

The Clinical Senate will also be asked to review the Strategic Case for Change to determine whether they support our recommendations to commence further work to develop proposals to determine the optimal service delivery models for the population of West Yorkshire and Harrogate. Subject to the outcome of our discussions with NHS England we will also be seeking the Clinical Senate's views on the key areas that we should focus on in order to strengthen our discussions with key stakeholders to inform the development of our proposals.

Subject to approval of the Strategic Case for Change we will produce a public summary/easy read version at the earliest opportunity and this will be avaialable on the website.

We have developed a communications and engagement toolkit to inform discussion with our staff, Overview and Scrutiny Committees, Health and Well Being Boards, Governing Boards, Voluntary Sector, MPs, Media and other key stakeholders. On the 1 February 2017 we began a 6 week period of engagement with our population across the West Yorkshire and Harrogate STP footprint (led by Healthwatch) to gain their views on stroke care (prevention, primary care, 72hrs and rehabilitation through to after care). A mid point engagement review meeting is also scheduled.

A post engagement report will be prepared for consideration by key stakeholders and will inform the development of the next phase of our work (subject to NHS England approval to proceed to the Stage 2 Assurance process.)

Both the work that has taken place to date and the literature review highlight the importance of ensuring the whole stroke pathway is working effectively (from pre-hospital to long-term management) in order to support timely repatriation from specialist hyper acute stroke services to acute stroke or community stroke services, avoid delays along the whole care pathway and to maximise the opportunities to prevent stroke and improve outcomes and quality for our population.

In view of this, further discussions with the Yorkshire and Humber Academic Health Science Network (AHSN)[18], the Primary and Community Care STP work stream lead, Public Health, place based stroke leads and other key stakeholders will take place to determine the current position in relation to these important elements of the care pathway to inform the next phase of our work particularly in relation to the following:

17 NHS England, Effective Service Change: A support and guidance toolkit v.2 2016. Publications Gateway Reference 00814

18 http://www.yhahsn.org.uk/

- Gaining an improved understanding of the current position in relation to place based prevention work;
- Establishing whether the atrial fibrillation and hypertension interventions are delivering the intended benefits in line with projections; and
- Timely access and availability of early supported discharge (ESD), community rehabilitation, end of life, longer term care and voluntary care sector provision .

It is our intention to expand the core membership of the T&F Group to include a member of the Patient and Involvement Regional Lay member Reference Group, a public health representative and a community services representative.

Subject to NHS England approval to proceed to Stage 2 Assurance process, work will commence on the next phase of the project plan which will include, modelling and discussion with key stakeholders in the following areas:

- Workforce e.g. in hours and out of hours, inter-dependencies between specialist and acute stroke care;
- Business Intelligence e.g. travel times, impact of cross boundary flows and 7 day standards;
- Finance (validation of CCG and Provider costs and financial modelling approach, assumptions and principles);
- Further Equality Impact Analysis (which includes Joint Strategic Needs Analysis across each of the place based footprints) to further inform our communication and engagement activities;
- Communications and engagement e.g. review of engagement outputs, Equality Impact Assessment update and review, preparatory work for the pre-consultation engagement (subject to approval to proceed) and ongoing dialogue with key stakeholders, e.g. our population, our staff and STP partners; and
- Further discussion with NHS England specialised commissioners regarding Intra-Arterial Thrombectomy developments e.g. timelines, capacity and demand assumptions, impact on pathways and repatriation policies.

## 2. Background and context

### 2.1 National Context

Stroke is the third leading single cause of death in the United Kingdom[19] and has a devastating impact on the lives of people, their families and carers. Although the incidence of stroke is declining, stroke survivorship is creating significant challenges to the health and social care system, the society – and most importantly – stroke survivors, their families and carers.

The *National Stroke Strategy* published by the Department of Health in 2007[20] provided a national quality framework to secure improvements across the stroke pathway over a period of 10 years. The document's main recommendations were to provide hyper acute stroke units for rapid patient access and then transfer to dedicated stroke units for rehabilitation once patients are stabilised.

More recently the *National clinical guidelines for stroke (Fifth Edition 2016)* have been published which provide the most comprehensive and up to date document on how stroke care should be provided covering the whole pathway from pre-hospital to longer term management. The recommendations contained within this document will further inform our recommendations for transforming stroke care across the West Yorkshire and Harrogate STP footprint.

The *NHS 5 Year Forward View* published in October 2014 sets out a clear direction for the NHS, showing why change is needed and what it will look like. It states that for some services there is a compelling case for greater concentration of care highlighting there is a strong relationship between the number of patients and the quality of care derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. For example, consolidating 32 stroke units to 8 specialist ones in London achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

*The Government's mandate to NHS England for 2016-17 also* sets an objective that anyone who needs urgent or emergency hospital care will have access to the same level of consultant assessment and review, diagnostic tests and consultant-led interventions, whatever the day of the week. This objective will be delivered through the implementation of four priority clinical standards (Standard 2,5,6 and 8) selected from 10 identified by the NHS Services, Seven Days a Week Forum in 2013[21]. Alongside this *The 2017-19 NHS Shared Planning Guidance* states there is an ambition for 5 urgent network specialist services to meet these standards by November 2017 and Hyper Acute Stroke (specialist care for acute stroke patients) is one of these 5 specialist services.

[19] NHS England. Stroke Services: Configuration Decision Support Guide. Available from http://emsenate.nhs.uk/downloads/documents/End_of_Life/Stroke/Stroke_Services_Configuration_Support_Guide.pdf

[20] Department of Health, National Stroke Strategy. 2007, London.

[21] NHS Services, Seven Days a Week Forum, Summary of Initial Findings, December 2013, https://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf

## 2.2 West Yorkshire and Harrogate and Yorkshire and the Humber context

In West Yorkshire our agreed shared vision for stroke is as follows:

*To reduce the incidence of stroke and avoidable deaths due to stroke, across the West Yorkshire health economy, minimising the long term effects and improving the quality of life for survivors. This will be achieved by providing consistently high quality care that is responsive to individual needs and through encouraging healthier lifestyles and reducing inequalities in risk factors of stroke.*

In 2015/16 there were approximately 3,600 stroke admissions into West Yorkshire Hospitals (based on Stroke Sentinel National Audit Programme data). Previous analysis (2013) showed the majority of strokes (74% of all strokes) occurred in the 65+ age group with the greatest concentration in the 75+ population (52% of all strokes) and the estimated cost of admissions into hospital was approximately £15m. This does not take into consideration social care costs or the broader societal impact.

Across West Yorkshire considerable work has taken place to improve outcomes for stroke. For example prior to the publication of the National Stroke Strategy, Trusts within West Yorkshire and Harrogate with multiple admitting hospitals consolidated their Hyper-Acute Stroke Unit provision onto a single site significantly reducing the number of hospital sites admitting acute strokes. There are currently five Hyper Acute Stroke units within West Yorkshire based at:

- Bradford Teaching Hospitals NHS Foundation Trust – Bradford Royal Infirmary;
- Calderdale & Huddersfield NHS Foundation Trust – Calderdale Royal Hospital;
- Harrogate and District NHS Foundation Trust;
- Leeds Teaching Hospitals NHS Trust – Leeds General Infirmary; and
- Mid Yorkshire Hospitals NHS Trusts – Pinderfields Hospital.

Other examples of work that has taken place to improve stroke outcomes for patients are as follows:

- *The Yorkshire and Humber Strategic Clinical Network for Cardiovascular Disease (CVD)* [22] delivered an extensive programme of work that aimed to influence both what and how services are commissioned, facilitate improvements in performance, and address unwarranted variation in services;
- Provider participation in the *Sentinel Stroke National Audit Programme (SSNAP).* This aims to improve the quality of stroke care by auditing stroke services against evidence based standards, providing the ability to benchmark services, monitor progress against a background of change, support clinicians in identifying where improvements are needed, and empower patients to ask searching questions;
- The rollout and application of the GRASP–AF (atrial fibrillation) tool across West Yorkshire to help primary care clinicians to assess the risk of AF-related stroke and to encourage effective management; and

[22] http://www.yhscn.nhs.uk/index.php

- The implementation of local CCG initiatives. These include campaigns across primary care to increase the prescribing of anti-coagulants, risk profiling and care management through direct enhanced services, the delivery of 'hot clinics' that enable direct primary care access to stroke consultants, and the delivery of specialist clinics which review patients on AF Registers.

## 3. Strategic fit and support from clinical commissioners and key stakeholders

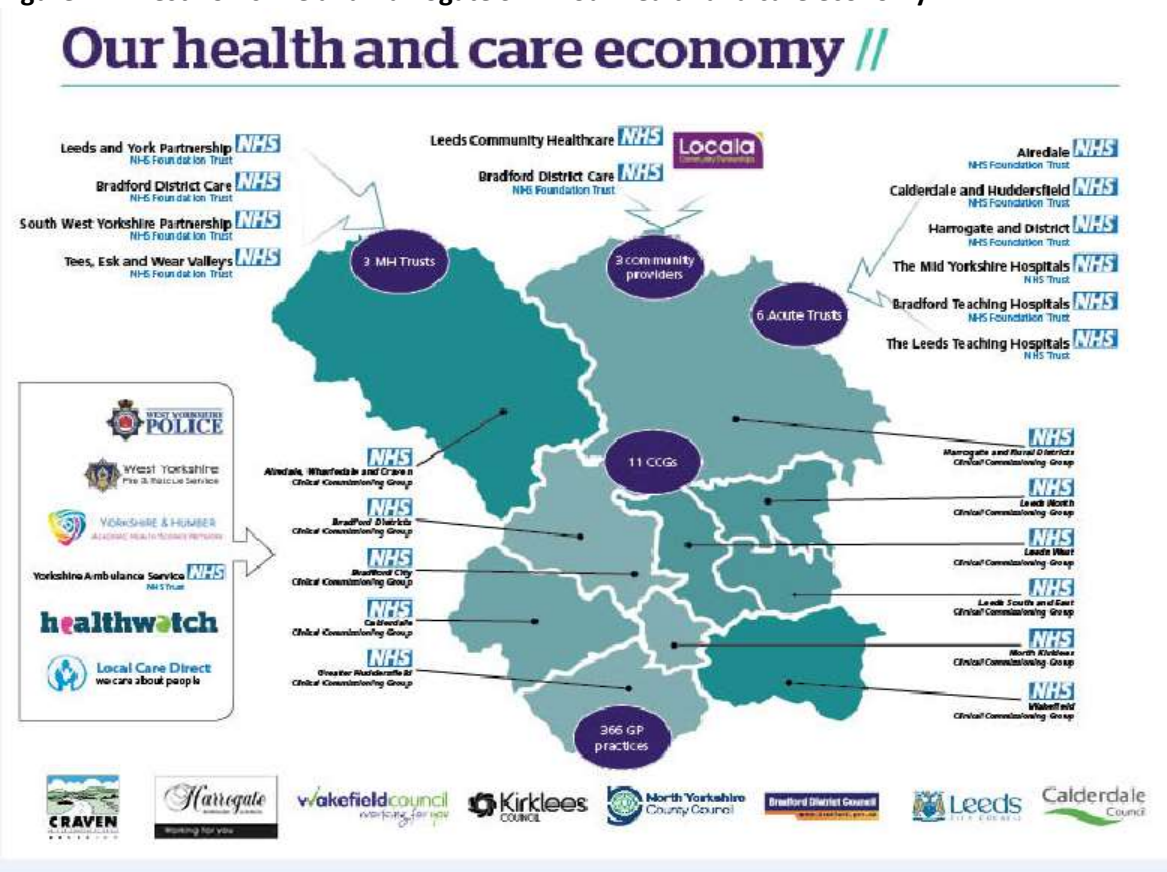
This Strategic Case for Change brings together all of the activities and key deliverables from work that has taken place to date which are core element of the Stage 1 NHS England Assurance process set in the context of the development of the draft West Yorkshire and Harrogate STP.

### 3.1 Strategic fit with West Yorkshire and Harrogate Sustainability Transformation Plan (STP) and local place based plans

In order to progress West Yorkshire and Harrogate wide service transformation key stakeholders across the West Yorkshire and Harrogate STP footprint have been working hard to establish a shared vision for transformed health and care delivery for West Yorkshire and Harrogate, focused on tackling all three gaps in the Five Year Forward View.

Figure 1 below provides an overview of our health and care economy and the key partners who are working collaboratively to identify opportunities to address the triple aims of improving health and wellbeing, care and quality, and finance and efficiency.

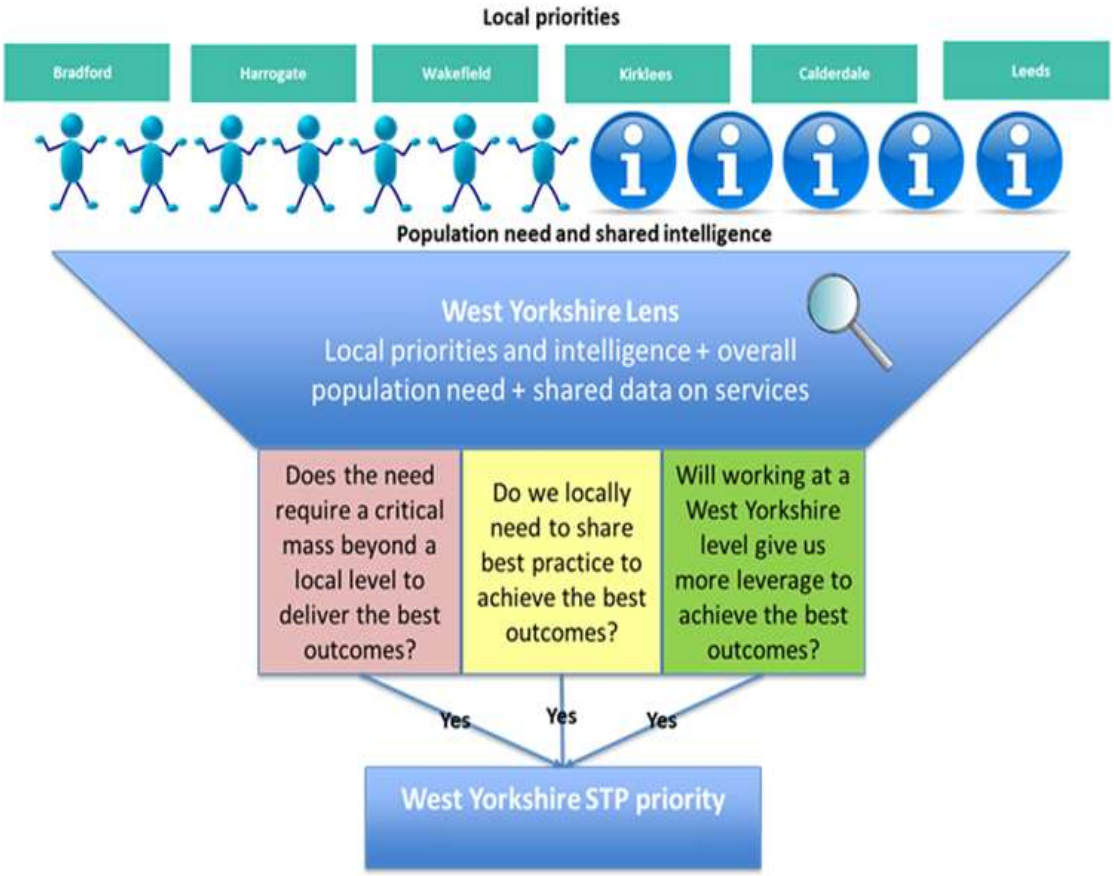
**Figure 1 – West Yorkshire and Harrogate STP – our health and care economy**



Our health and care economy serves a population of 2.6m people, with a total allocation of £4.7bn across health by 2021 and 113,000 health and social care staff. There are 650 care homes, 319 Domicilliary care providers, 10 Hospices, 8 large independent sector providers and thousands of Voluntary and Community Sector organisations within the footprint.

West Yorkshire and Harrogate STP stakeholders have set out how they will work together to determine which areas of work need to be progressed at a West Yorkshire level in order to deliver their shared vision. The diagram below (Figure 2) provides an overview of the approach that has been adopted for the West Yorkshire and Harrogate STP which recognises the importance of the work that is taking place at place based STP levels and the STP 'lens' that will be applied to determine what work requires a West Yorkshire and Harrogate STP approach.

**Figure 2 – West Yorkshire and Harrogate STP – our approach**



In view of the challenges currently facing specialist Hyper Acute Stroke and Acute Stroke services across the West Yorkshire and Harrogate STP footprint, key stakeholders agreed this work requires a West Yorkshire and Harrogate wide approach to further improve quality and outcomes for our population. Improving stroke outcomes is thefore included as a key strategic priority area within the West Yorkshire and Harrogate STP.

In line with our agreed vision to reduce the incidence of stroke and avoidable deaths due to stroke, encourage healthier lifestyles, reduce inequalities in risk factors of stroke, minimise the long term effects and improve the quality of life for survivors a number of high level metrics/indicators have been developed to measure progress towards addressing the 3 gaps described within the West Yorkshire draft STP. These include the following:

**Care and quality gap**

- Stroke Sentinel National Audit Performance (SSNAP) data

↓ Reduce median time between clock start and thrombolysis

↑ Increase proportion of stroke patients assessed by a stroke specialist consultant physician and nurse trained in stroke management within 24 hours of clock start

↑ Increase proportion of patients given swallow screen within 24 hours of clock start

↑ Increase proportion of patients scanned within 12 hours

(Increase from 'Blueprint' SSNAP performance data Oct – Dec 2015)

- Medical and Therapy workforce (SSNAP) and other Health Education England workforce metrics e.g. recruitment and retention

The 7 day hospital standards specific to hyper acute stroke services (as described in the *Urgent Network Specialist Services and 7 day hospital services baseline position November 2016*[23]*)* are as follows:

- Standard 2: Time to first consultant review;
- Standard 5: Access to diagnostics;
- Standard 6: Consultant-directed interventions; and
- Standard 8: Ongoing review.

There is an expectation for hyper acute stroke specialist services to meet these standards and associated metrics by November 2017.

**Health and wellbeing gap**

- Place based STP metrics

↓ Under 75 mortality rate from stroke

↓ Reduce hypertension QOF prevalence all ages national / West Yorkshire / CCG

↓ Reduce premature mortality from stroke

[23] Urgent Network Specialist Services and 7 day hospital services baseline position November 2016

↓ Reduce incidence of stroke (e.g. anticoagulant treatment – for every 25 patients with AF receiving an anticoagulant, we can avoid one stroke every 18 months)

↑ Identification and treatment of AF with OACs

(*Information source: West Yorkshire Population Health Characteristics by CCG*)

In order to take the work forward it was agreed a West Yorkshire Healthy Futures Stroke/HAS Task and Finish (T&F) Project Group should be set up to progress this work.

### 3.2 Support from clinical commissioners and key stakeholders

The governance arrangements for the T&F Group are outlined in Figure 3 and provide an overview of the relationships between key stakeholders across the wider STP footprint e.g. our Health and Well Being Boards, our Clinical Forum (which has clinical representatives from each Provider including Yorkshire Ambulance Service, NHS England and Clinical Commissioning Group's) and our Provider Forums which include the WYAAT Chief Officers and WYAAT Medical Director forums.

In line with the Strategic Clinical Network and Clinical Senate 'Blueprint' recommendations, the Project is part of the Urgent and Emergency Care Network (UECN) Transformation Programme. The Healthy Futures Collaborative Forum is a decision making group that will recommend the project deliverables that can progress to the next phase for approval by Accountable Organisations.

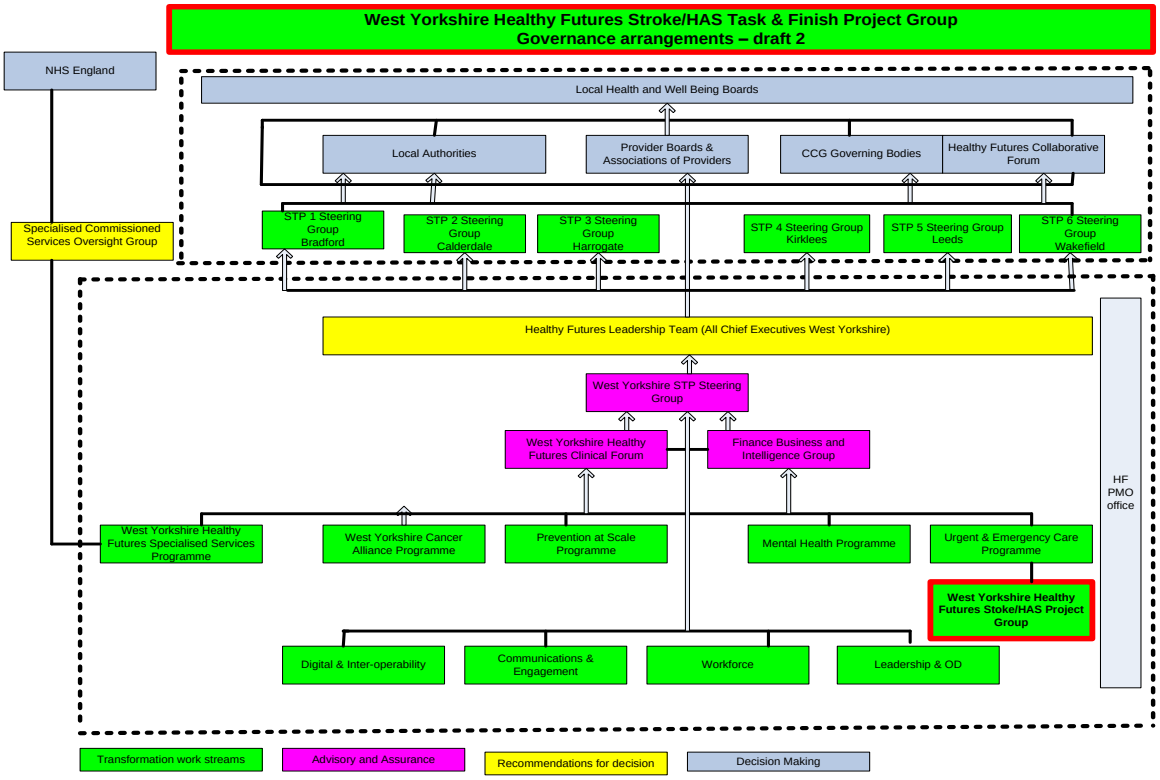
The Project has adopted a project management approach using the Healthy Futures Programme Management Office (PMO) project documentation. As the project is part of the UECN Transformation Programme, key outputs are shared with the UECN Steering Group to ensure inter-dependencies are managed. Mechanisms are are also in place to ensure that there is regular dialogue with the leads of other key work streams within the West Yorkshire STP e.g. primary and community care, workforce and digital interoperability to avoid duplication and maximise opportunities.

These arrangements have enabled us to have a continuous dialogue with our clinical and non-clinical colleagues across the West Yorkshire and Harrogate STP footprint in relation to developing an agreed clinical narrative which has informed our clinical case for change and the recommendations outlined in this Strategic Case for Change.

For example the content of the Project Initiation Document (PID) and the clinical narrative contained within this document and the communication and engagement toolkit products were shared for comment with Healthy Futures Collaborative Forum, Clinical Forum, WYAAT Chief Officers and Medical Director's Forum and Yorkshire Ambulance Service Clinical and non-Clinical Leads, and their feedback informed the content.

There have also been regular updates to Healthy Futures Clinical Forum and feedback from these meetings has informed the work of the Stroke/HAS T&F Group. The governance arrangements for the Stroke/HAS T&F Group are outlined in Figure 3 below.

**Figure 3– Governance arrangements for the T&F Group**




The T&F Group is chaired by Dr Andy Withers of NHS Bradford District CCG who was involved in previous Healthy Futures Stroke Programme work. The Sponsor for this work is Jo Webster, Chief Officer, NHS Wakefield CCG and Healthy Futures Collaborative Forum Lead Officer for this project.

Membership of this group includes a clinical representative from each of the acute trusts, and a West Yorkshire Association of Acute Trust (WYAAT) representative who liaises directly with wider WYAAT members to ensure there is an ongoing two way dialogue between the work of this group and wider stakeholders (clinical and non-clinical) in each of the provider organisations within the West Yorkshire and Harrogate STP footprint.

As we know that most people with a suspected stroke arrive at hospital by ambulance, a Yorkshire Ambulance representative is a core member of the group so that we can ensure we are working closely with our ambulance staff who provide assessment and treatment to patients as they convey them to the right hospital for their medical needs.

In view of workforce being one of the key drivers for change, a Health Education England representative is a core member of the group. The communications and engagement Lead for the STP is also a core member and has provided expertise in relation to the development of the communication and engagement plan, the toolkit and co-ordinating communication and engagement activities with Healthwatch, the Lay member group and the regional and place based Leads.

In order to ensure impacts and inter-dependencies associated with stroke transformation across the wider Yorkshire and Humber footprint are understood and are informing our

work, clinical and non-clinical representatives from the South Yorkshire, Bassetlaw and North Derbyshire (Working Together Programme), the Humber Coast and Vale footprint and NHS England are also members of the T&F Group (in line with the Clinical Senate recommendations). The Clinical Representative from the Working Together Programme is also the Clinical Network Lead for Stroke and provides further expertise into the work of the group, particularly in relation to cross boundary flow implications and Intra-Arterial Thrombectomy developments.

## 4. Approach

A structured approach has been adopted in developing our Strategic Case for Change which brings together a range of both quantative and qualitive methodologies to develop a clear understanding of provision across the West Yorkshire and Harrogate STP footprint and to identify the potential opportunities to further improve outcomes, quality and safety of stroke services for our population that are 'fit for the future'.

From an assurance perspective we are adopting the best practice approach to service transformation outlined in the *Department of Health Effective Service Change: A Support and Guidance Guide* in order to ensure our service transformation recommendations comply with the four key tests throughout the engagement, pre-consultation, consultation and post consultation phases and best practice checks. The four key tests are as follows:

- Strong public and patient engagement;
- Consistency with current and prospective need for patient choice;
- Clear evidence base; and
- Support for proposals from clinical commissioners.

### 4.1 Clear clinical evidence base

We have adopted an evidence based approach throughout the whole process and Section 6 of this document summarises the latest literature review conducted during Q3 2016/17. It provides reference to the most up to date and comprehensive clinical evidence available on how stroke care should be provided covering the whole pathway from pre-hospital to long-term management. It is important to note this builds upon the extensive literature review conducted as part of the *Current State Assessment Section 7 page 74* (Appendix B refers.)

The information included in this Strategic Case for Change also summarises and makes reference to the significant analysis (including scenario modelling and assumptions), literature reviews, risk assessments and options appraisals that were carried out as part of the Healthy Futures Programme.

This previous analysis has informed the work that has taken place across the wider Yorkshire and Humber sub regional footprints and the recommendations outlined in the Strategic Clinical Network 'Blueprint' recommendations which were reviewed and agreed with the Clinical Senate. As outlined in the Executive Summary the key documents are as follows:

- ***The Healthy Futures Programme Hyper Acute Stroke Services Review: Current State Assessment V1.0 Final (25 February 2015***) which identified a significant number of

opportunities, that when implemented, have the potential to improve sustainability and resilience;

- ***Healthy Futures Hyper Acute Stroke Services Review: Options Appraisal Final (7 July 2015);***
- ***The Hyper Acute Stroke Services Yorkshire and Humber 'Blueprint' for Yorkshire and Humber Clinical Commissioning Groups Version 1.1. was published in June 2016;*** and
- ***Case for Change Stroke Prevention (2014),*** which identified opportunities, key enablers and benefits (improving quality, reducing risks and costs and improving performance against key metrics) of adopting a unified approach to prevention across West Yorkshire and Harrogate footprint.

For ease of reference the key findings are summarised in Section 5 and provide further evidence against the four key tests and best practice checks.

In order to avoid duplication key stakeholders, e.g. Healthy Futures Collaborative Forum, Clinical Forum, WYAAT Forums and Yorkshire Ambulance Service representatives, asked the T&F Group to build upon all the work that has taken place to date.

In line with this agreed mandate, during Q3 2016/17 the T&F Group carried out a 'desk top review' to determine whether there were any significant changes to the assumptions and recommendations outlined in the 'Blueprint' assumptions and recommendations. During Q3 2016/17 the group has:

- Worked collaboratively with members of the Urgent and Emergency Care Network, Healthy Futures Collaborative Forum, Clinical Forum, WYAAT Forums and Yorkshire Ambulance Service colleagues to ensure they views and comments informed the development of the Project Initiation Document and have provided ongoing input into the work of the group and development of the draft Strategic Case for Change through regular briefings and ongoing dialogue;
- Built upon the work carried out previously by the Healthy Futures Programme which informed the *Strategic Clinical Network Hyper Acute Stroke 'Blueprint'* recommendations;
- Conducted a Literature review to consider more recent guidance e.g. *National Clinical Guidelines for Stroke: Fifth Edition 2016*;
- Considered the impact of new technologies e.g. Intra Arterial Thrombectomy - Mechanical Clot Retrieval developments;
- Worked collaboratively with members of the Working Together Programme (South Yorkshire and Bassetlaw) and Humber Coast and Vale colleagues to share and learn from developments and evidence from elsewhere and ensure impact of inter-dependencies and cross boundary flow impacts across the wider Yorkshire and Humber footprint are understood in line with Clinical Senate recommendations;
- Participated in a visit to the Greater Manchester Stroke Operational Delivery Network to meet with Clinicians, Therapists, Early Supported Discharge team representatives and key stakeholders to inform our future developments;
- Liaised with place based colleagues to encourage continued focus on reducing the risk factors associated with stroke and to identify opportunities to 'level up' and where possible 'scale up' further improvements at place; and
- Conducted a 'desk top review' looking at Access, Workforce and Quality and gained further insights from Acute Provider Clinical representatives on the current position in

relation to these dimensions to identify if there are any further factors that may affect the development of a Strategic Case for Change for the West Yorkshire and Harrogate footprint.

The outcome of the 'desk top review' is summarised in Section 5 of this document and has also informed the content of this Strategic Case for Change.

### 4.2 National best practice and learning from others

#### 4.2.1 Working Together Programme and Humber Coast and Vale

In addition to reviewing the latest available evidence available as part of the literature review, colleagues from the Working Together Programme and Humber Coast and Vale (who are core members of the T&F Group) have been sharing their knowledge and expertise to inform the content of Strategic Case for Change and West Yorkshire and Harrogate STP colleagues would like to formally acknowledge their valuable contribution to this work.

#### 4.2.2 Greater Manchester Stroke Operational Delivery Network

On the 6 January 2017 a representative from the T&F Group joined members of the Working Together Programme to visit the Greater Manchester Stroke Operational Delivery Network. Their Clinical Leads, Manager and Co-ordinator, Therapists, Director of Finance and other key stakeholders provided an overview of the progress they had made to date, key challenges, opportunities and key learning points. For example:

- **Whole pathway –** Colleagues emphasised the importance of focusing on the whole pathway particularly Community Rehabilitation services and Early Supportive Discharge as variation in this area can cause delays along the care pathway for some patients;
- **Modelling activity and cost assumption** – importance of getting shared ownership of the data inputs and modelling assumptions from the outset particularly in relation to direct admissions to non hyper acute stroke units;
- **Ambulance Services** - Early engagement with Ambulance Services is key;
- **SSNAP data quality improvement** – This has been a significant focus for the Network who have been working collaboratively with Units to further improve the quality of data and dissemination of reports to inform continuous service improvement;
- **Repatriation policies** – Importance of having shared agreements and shared ownership to avoid delays; and
- **The Network** – Colleagues summarised the roles, responsibilities and benefits of a Network e.g. supporting audits, sharing with others locally and nationally.

The Greater Manchester Stroke Operational Delivery Network published their *Annual Report July 2015 – July 2016 October 2016.*[24] It summarises the key impact of their new stroke pathway which we feel reflects the opportunites to further improve quality and stroke outcomes across the West Yorkshire and Harrogate footprint so that:

- More people than before will be treated on a specialist stroke unit;

[24] Greater Manchester Stroke Operational Delivery Network. Annual Report, July 2015 – July 2016.

- The majority of patients with suspected stroke will go straight to the right hospital for their medical needs by ambulance as paramedics are very good at taking people to the right hospital for their medical needs;
- The average length of stay in hospital for stroke will be reduced;
- The number of patients dying from a stroke will decrease; and
- Our Patients and carers will have an improved experience of care;

Manchester colleagues have agreed to share a number of products with both the Working Together Programme and West Yorkshire and Harrogate Stroke/HAS T&F Group which will be enable us to avoid duplication and benefit from the transformational changes they have been making to improve the quality and outcome of their stroke services e.g. service specifications, SSNAP data quality improvement methodologies, Network dashboard developments, tariff methodology and repatriation policies.

Subject to approval to proceed to the Stage 2 NHS England Assurance Gateway we intend to invite Manchester colleagues to attend a Clinical Summit to inform the development of proposals. We would like to formally acknowledge their valuable contribution to our work.

### 4.2.3 Yorkshire and Humber Academic Health Science Network (AHSN)

The Yorkshire and Humber Academic Health Science Network (AHSN) have advised us that they are making progress in their programme of *Stroke Prevention in atrial fibrillation*[25] in two areas in the West Yorkshire and Harrogate area with a view to preventing strokes over the next 18 months.

During Q3 2016/17 the T&F Group have raised awareness of the AHSN work with place based colleagues. We are in discussion with both the AHSN and the Primary and Community STP workstream leads to inform discussions with our place based Stroke Leads to further maximise the opportunities to realise the benefits of the stroke prevention programme for our local population.

It is particularly important that there is continued focus on this work in each of our place based footprints in view of the importance of achieving progress in relation to the *Stroke Prevention Case for Change* trajectories that were developed as part of the Healthy Futures Stroke Programme and their potential impact on our growth trajectories (Section 5.4 Figure 4 refers.)

### 4.2.4 West Yorkshire and Harrogate transformation developments

In addition to learning from elsewhere we know through discussion with our colleagues across the West Yorkshire and Harrogate STP footprint there are local transformation examples that will further inform our work. For example:

- Our clinical leads have highlighted a range of areas where stroke pathway improvements have been made e.g. Yorkshire Ambulance Service have worked with provider Trust colleagues to implement a number of changes to care pathways to improve access to specialist hyper acute care.

[25] Academic Health Science Network. Stroke Prevention in atrial fibrillation. Available from: http://www.yhahsn.org.uk/service/population-health-service/atrial-fibrillation/

We are continuing to liaise with key stakeholders across the West Yorkshire and Harrogate footprint to gain an improved understanding of the transformation work that has taken place across the stroke pathway to identify opportunities to learn, share and 'scale up at pace' where possible.

### 4.3 Communication and engagement – our population, our staff and other key stakeholders

Fundamental to improving stroke outcomes is engagement with our population, our staff and other key stakeholders across the West Yorkshire and Harrogate footprint and collecting and incorporating their feedback into our work.

A communications and engagement plan for the West Yorkshire Healthy Futures Stoke/HAS Project has been developed . It describes the range of activities and approaches that will span the life cycle of the project and is also referenced in the West Yorkshire and Harrogate draft STP Communication and Engagement plan. The Executive Summary (Section 1.3.3), Section 5.5.5, and Section 7.3 of this document provides and overview of work that has taken place to date and actions we will be taking as part of our next steps.

### 4.4 Equality Impact Assessment (EIA)

To ensure compliance with the *Equality Act 2010*[26], all strategies or policies, proposals for a new service or pathway or changes to an existing service or pathway, should be assessed for their relevance to equality, diversity and inclusion for patients, the public and for staff. A Integrated Quality Impact Assessment (which includes the EIA) has been developed and will be subject to ongoing review throughout the life cycle of our transformation project as it is key to informing our communication and engagement and project plan activities e.g. ensuring we are reaching our protected groups.

### 4.5 Risk

The Risk Register and mitigating actions is subject to ongoing review and update by the T&F Group throughout the life cycle of the transformation project and is also considered by the Urgent and Emergency Care Network.

A summary of the risks associated with the project are as follows and provide further context to this Strategic Case for Change and the recommendations outlined within it. The risks are as follows:

1. Key deliverables may not be delivered within planned timelines due to lack of project resources to progress key tasks, resulting in delay to implementing improved access to high quality, safe, sustainable & resilient stroke services for the population covered by the West Yorkshire and Harrogate STP footprint (Risk score 12);
2. Transformational changes cannot be implemented (subject to outcome of consultation with key stakeholders) due to lack of available & appropriately skilled

[26] http://www.legislation.gov.uk/ukpga/2010/15/contents

workforce to deliver care across the whole stroke care pathway resulting in continued variance in stroke outcomes across the West Yorkshire and Harrogate STP footprint (Risk score 9);

3. Transformational changes cannot be implemented (subject to consultation with key stakeholders) due to lack of provider engagement, resulting in delay in implementing, safe, sustainable resilient stroke services for the population covered by the West Yorkshire and Harrogate STP footprint (Risk score 9);
4. Incidence of stroke & avoidable deaths from stroke is not reduced due to insufficient focus at commissioner/public health/primary care provider level on implementing place based STP initiatives (prevention, atrial fibrillation, hypertension) resulting in increased demand for acute services and variance in West Yorkshire and Harrogate STP outcomes v national (Risk score 9);
5. Providers may not be able to implement the latest stroke guidelines due to lack of available and appropriately skilled workforce able to deliver new models of care resulting in continued variance in stroke outcomes across the West Yorkshire & Harrogate footprint (Risk score 9);
6. Existing Hyper Acute Stroke services across the West Yorkshire and Harrogate footprint may experience operational resilience issues due to inability to recruit and retain appropriately skilled workforce during the transformation transition period resulting in emergency commissioning arrangements being implemented in advance of new models of care being approved and implemented (Risk score 12);
7. Implementing new model of care may not be cost neutral as envisaged resulting in additional cost pressures across the West Yorkshire and Harrogate footprint and potential delay to implementing improved access to high quality, safe, sustainable & resilient stroke services for the population covered by the West Yorkshire & Harrogate footprint (Risk score 9); and
8. West Yorkshire and Harrogate Providers may experience further operational resilience issues due cross boundary flow impacts from the Working Together footprint resulting in further impacts on their workforce, potential impact on SSNAP performance and patient flow across the wider hospital (Risk score 9.)

## 5. Overview of key findings

As outlined in the Executive Summary, significant work has taken place across West Yorkshire and Harrogate and the wider Yorkshire and Humber footprint to review the current position with a view to identifying opportunities to further improve stroke outcomes and quality of care for our population. This section of the Strategic Case for Change summarises the key findings of this work which has informed our case for change and recommendations.

### 5.1 The Healthy Futures Programme Hyper Acute Stroke Services Review: Current state Assessment V1.0 Final (February 2015)

During 2013/14 the three sub-regions of Yorkshire and the Humber identified the need to undertake an assurance review to ascertain the resilience of their hyper-acute stroke services and to identify opportunities to further improve stroke care and outcomes to meet the needs of people from prevention, primary and community services and stroke after care.

For West Yorkshire and Harrogate, the review was undertaken as a part of the "Healthy Futures" programme and the key findings were included in the *The Healthy Futures Programme Hyper Acute Stroke Services Review: Current State Assessment V1.0 Final (February 2015),*. This included a scenario modelling exercises which looked at the potential impact on capacity and quality e.g. beds, workforce, costs and performance in relation to key quality measures.

The first stage of the review involved a two stepped approach:

1. Developing a baseline of hyper-acute stroke provision across West Yorkshire and Harrogate taking a snapshot of the current quality and performance of these services to identify gaps in service resilience; and
2. Testing elements of the sub-regional system to ensure that it is resilient for the future through a desk top scenario modelling exercise which looked at the impact on capacity e.g. beds, workforce and costs.

As the *Current State Assessment* was carried out at a sub-regional level, focus was placed on 'system resilience'. 'System resilience' is a collective term dependent on the resilience of the individual providers that make up the system. For the purposes of the *Current State Assessment Review* 'resilience' was therefore defined as:

***'The ability to provide high quality and sustainable hyper-acute stroke services to patients'***

Individual reports were developed for each of the hyper acute stroke service providers within West Yorkshire and Harrogate. Each report analysed the main stages of the hyper-acute stroke pathway and the supporting workforce. Each stage included an assessment against the relevant SAF standards and SSNAP performance indicators. Where deemed useful for the reader, contextual information was also provided. The reports were structured as follows:

1. Provider Overview
2. Workforce
3. Pre-hospital and Admission
4. Acute Assessments
5. Scanning
6. Thrombolysis & Other Acute Treatments
7. Patient Involvement
8. Stroke Pathway Contextual Information
9. Summary of Observations

The review highlighted the following:

- **Demographic changes up to 2020 –**The number of strokes admitted into hospital is projected to increase by 12.7%;
- **Importance of improved conditions management** – atrial fibrillation and hypertension interventions have the potential to offset a significant number of the projected increase in strokes caused by demographic changes. The net result is an increase of 5.6% in the number of strokes admitted into hospital;

- **Variation** - All providers evidenced areas for improvement to a greater or lesser extent but it was noted further action was required to further improve the quality of hyper-acute stroke care provided to patients. Considerable variation in the quality of hyper-acute stroke services across the West Yorkshire and Harrogate footprint when comparing providers and there was also variation in quality across the hyper-acute pathway when looking at individual providers;
- **Sustainability and resilience –** The report indicated further work was required to ensure stroke services across the West Yorkshire and Harrogate footprint were sustainable and resilient.

The review also highlighted a significant number of opportunities to further improve resilience grouped under two headings:

- **Reducing stroke admissions** e.g. through continued focus on Primary prevention and Health and Well Being; and
- **Improving quality and sustainability**.

### 5.2 Healthy Futures Hyper Acute Stroke Services Review Options Appraisal (7th July 2015)

Through extensive engagement with commissioners and providers the opportunities outlined above were explored further and the outputs were included in the *Healthy Futures Hyper Acute Stroke Services Review Options Appraisal (7th July 2015).* The key recommendations were as follows:

- **Hyper Acute Services Contingency Planning –** developing a framework for contingency planning to be adopted by all providers to minimise the risks of disruption, keep patients as safe as possible and reduce the impact on quality of care if any service was at risk of failure;
- **Develop repatriation protocol –** develop a single protocol signed up to by all providers across West Yorkshire; and
- **Hypertension Dashboard –** develop guidance for primary care on the diagnosis and management of patients with hypertension.

### 5.3 The Hyper Acute Stroke Services Yorkshire and Humber 'Blueprint' for Yorkshire and Humber Clinical Commissioning Groups

In November 2015 the 23 CCGs across the wider Yorkshire and Humber Region asked the Strategic Clinical Network and Clinical Senate to provide a high level overview of the three sub regional networks intentions regarding Hyper Acute Stroke services, to provide assurance that there is a single coherent view of the direction of travel and cross boundary impacts.

*The Hyper Acute Stroke Services Yorkshire and Humber 'Blueprint' for Yorkshire and Humber Clinical Commissioning Groups Version 1.1.* was published in June 2016. The 'Blueprint' highlighted a number of key drivers which indicated further work was required to further improve stoke outcomes for the population of the West Yorkshire and Harrogate STP footprint. In summary these were as follows:

- **Performance**: *Stroke Sentinel Audit National Audit Programme (SSNAP)* performance in Y&H Region remains disappointing with key metrics not being met e.g. the drivers

for change are quality, access and workforce but the resulting system must be financially sustainable;

- **Urgent and Emergency Care Mandate**: Stroke is one of five services expected to deliver *7 days service standards*. This will be challenging as the whole system is not working 7 days. Genuine whole pathway 24 hour services are required including early supported discharge at weekends;
- **Growth**: The confirmed strokes within Yorkshire and Humber (Y&H) is currently 9014 expected to rise to 9915 by 2020;
- **Outcomes:** The 'Blueprint' stated there is growing evidence, based on the London model that a Hyper Acute Stroke Unit that sees less than the minimum number of confirmed strokes per annum provides worse outcomes in terms of morbidity, and may be associated with poorer outcomes;
- **Workforce**: Workforce is a major consideration and needs to cover diagnostic and therapy staff as well as medical and nursing. Further work is therefore required to ensure we maximise the skills and resources of our valuable workforce .
- **Number of Units**: The number of units should be determined by workforce, geography (travel time) and long term financial viability, with the key drivers for change being quality, access and workforce;
- **Hyper Acute Stroke and Acute Stroke**: Consideration of whether Acute Stroke Services should be co-located with Hyper Acute Stroke services is required;
- **Activity Levels**: The 'Blueprint' describes a lower and upper threshold of confirmed strokes per annum (in line with national guidance);
- **Sustainability and Transformation Planning (STP)**: Transformation of Hyper Acute Stroke services needs to reflect the ambitions of the UECN in the context of STPs.

From a West Yorkshire and Harrogate STP footprint perspective the HAS 'Blueprint' recommends the following:

- Further reconfiguration within West Yorkshire is considered within the Urgent and Emergency Care Network Programme of work to optimise the resilience of the stroke service model.

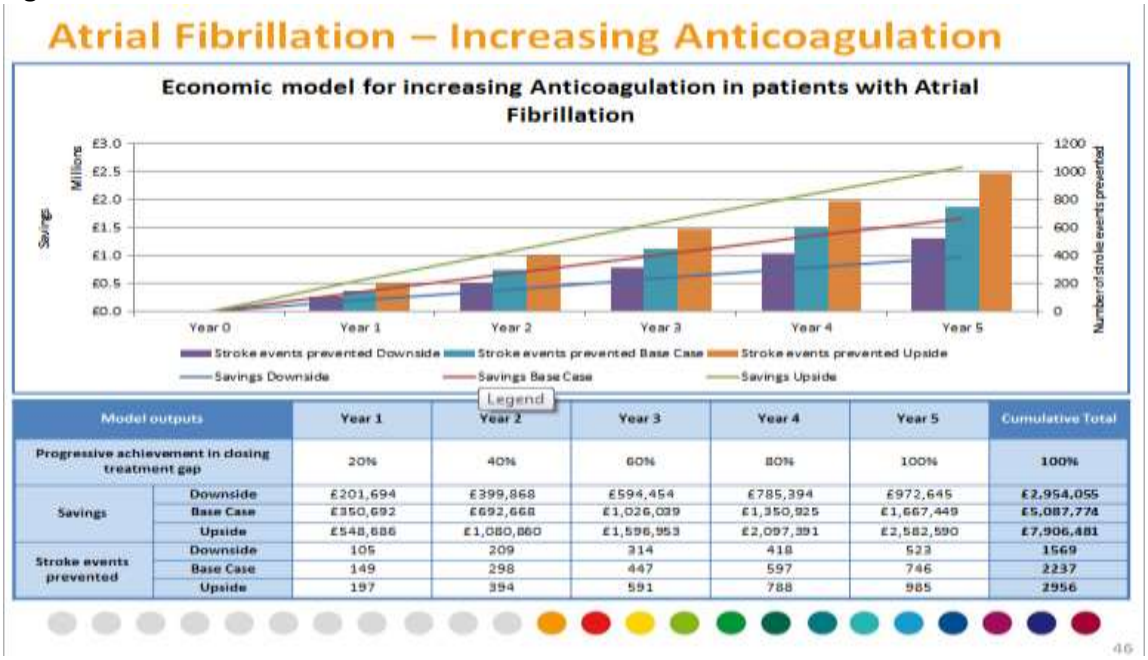
### 5.4 Case for Change Stroke Prevention

In line with the agreed West Yorkshire and Harrogate vision outlined in Section 1.1 of this document the Health Futures Programme also developed a *Case for Change for Stroke Prevention* This proposed a unified approach across West Yorkshire which would include:

- Development and implementation of a strategy for the initiation and management of anticoagulation for known patients with atrial fibrillation (prescribing, management and monitoring);
- A single voice with Health and Well Being Boards in relation to the stroke prevention agenda and influencing population level interventions; and
- Improved management of patients with hypertension in primary care e.g. increasing public awareness, increasing self-care, providing support and guidance to primary care and maximising technology enablers.

The Case for Change also included economic modelling for increasing anti-coagulation in patients with atrial fibrillation and the progressive achievement in closing treatment gaps, stroke events prevented and potential impact on costs (Figure 4 below refers.)

**Figure 4**




| Model outputs | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Cumulative Total |
|---|---|---|---|---|---|---|---|
| Progressive achievement in closing treatment gap | | 20% | 40% | 60% | 80% | 100% | 100% |
| Savings | Downside | £201,694 | £399,868 | £594,454 | £785,394 | £972,645 | £2,954,055 |
| | Base Case | £350,692 | £692,668 | £1,026,039 | £1,350,925 | £1,667,449 | £5,087,774 |
| | Upside | £548,686 | £1,080,860 | £1,596,953 | £2,097,391 | £2,582,590 | £7,906,481 |
| Stroke events prevented | Downside | 105 | 209 | 314 | 418 | 523 | 1569 |
| | Base Case | 149 | 298 | 447 | 597 | 746 | 2237 |
| | Upside | 197 | 394 | 591 | 788 | 985 | 2956 |

## 5.5 Q3 2016/17 'desk top review', provider position and technology developments - overview of key findings

As outlined previously during Q3 2016/17 a 'desk top review' was carried to determine whether there were any significant changes to the assumptions and recommendations outlined in the 'Blueprint' assumptions and recommendations. The key findings are included in this section of our Strategic Case for Change and have informed our recommendations.

### 5.5.1 Provider position – A provider perspective

Provider clinical colleagues presented an overview of services across each of their respective organisations. Following discussion it was noted that comparable issues were highlighted, these being:

- **Workforce: Medical staffing** - Consultant recruitment remains a concern with a number of Trusts reporting vacancies, difficulty recruiting to Consultant posts, difficulty filling rotas and ensuring skills and resource are aligned e.g. to deliver thrombolysis. Trusts also reported a wide range of network and telemedicine arrangements in place to support 'out of hours' services;
- **Workforce: Nursing –** Two out of five Trusts reported nursing vacancies. All Provider clinical leads highlighted the impact wider changes to nursing roles and responsibilities were having on the capacity of their Hyper Acute Service nurse workforce e.g. development of more generic nursing roles and facilitating timely discharge of medical outliers to support improved throughput across their Trusts. Trusts also highlighted the introduction of new pathways intended to further improve earlier assessment.

Direct admission to the Hyper Acute Service has further changed the way their stroke nurses work, with nurses spending more time on the front end of the pathway;

- **Workforce: Therapists** – a number of Trusts reported Speech Therapy vacancies and variable access to psychological therapy. Occupational Therapy and Physiotherapy access was also reported to be under establishment in some Trusts;
- **Workforce recruitment other key points to note**: Colleagues highlighted concerns in relation to their ability to attract new workforce into the West Yorkshire and Harrogate footprint. Colleagues noted recruitment is often resulting in transfers of workforce between existing Trusts within the footprint. A number of Trusts also reported the impact of training staff who subsequently transfer to other posts. Provider colleagues have also highlighted the importance of understanding inter-dependencies between Hyper Acute Stroke and Acute Stroke Units from a workforce recruitment, retention and resilience perspective. Opportunities to develop new roles and 'train up' staff so they can step up to fill new roles that become vacant was also highlighted training Band 5 nurses ready to step up to Band 6 roles as these become available;
- **Pathways:** Clinical leads highlighted the importance of ensuring Health and Social Care repatriation pathways, policies and procedures are in place to ensure pathways are working effectively to avoid delays. Early Supported Discharge (ESD) processes were reported to be variable and Clinical colleagues highlighted the importance of ensuring patients are able to access appropriate local health, social and voluntary care services at the appropriate time in order to reduce discharge delays;
- **Demand pressures:** Trusts reported continued demand pressures both 'in hours' and 'out of hours.' The importance of understanding the impact of other changes to acute hospital and community services on existing and future stroke workforce and improving efficiency, throughput and outcomes was also highlighted e.g. changes to the roles of Early Supported Discharge Teams and Vanguard developments;
- **SSNAP performance:** All Trusts confirmed the data quality of information submitted and reported via SSNAP had improved however some Trusts have identified further work is taking place to further improve SSNAP data quality. Some Trusts reported they were continuing to improve performance against some of the SSNAP metrics/indicators but highlighted that sustaining improvement is a significant challenge; and
- **Sustainability and Resilience:** In summary clinical colleagues agreed that from a provider perspective in view of the requirement to meet new quality standards e.g. *National clinical guidelines for stroke (Fifth Edition 2016)* and *7 day standards*, improve access to specialist skills, imaging and new technology and ongoing workforce challenges, further work is required to maximise opportunities to further improve quality and outcomes for patients, make more effective use of our skilled workforce and technology and equipment and ensure our services are resilient and 'fit for the future'.

### 5.5.2 Stroke – Activity levels

As part of the 'desk top review' the latest data (to July 2016) for the West Yorkshire and Harrogate stroke units was obtained from the SSNAP information. On an ongoing basis this programme captures a comprehensive picture of stroke services across England, Wales and Northern Ireland.

The table below (Figure 5) shows the number of strokes recorded through the SSNAP programme for the 3 years 2013/14 to 2015/16, with a pro rata estimate for the current financial year based on the first 4 months of the year.

**Please note the data in Figure 5 for 2013/14 is incomplete.**

**Figure 5 - SSNAP Stroke numbers summary – July 2016**

| | *13/14* | *14/15* | *15/16* | *4 months Apr - Jul 16* | *Estimated FY 16/17 (i.e. 4m * 3)* |
|---|---|---|---|---|---|
| Airedale NHS Foundation Trust | 337 | 302 | - | - | - |
| Bradford Teaching Hospitals | 356 | 466 | 787 | 245 | 735 |
| Calderdale and Huddersfield | 407 | 479 | 569 | 231 | 693 |
| Harrogate and District NHS | 304 | 343 | 354 | 110 | 330 |
| Leeds Teaching Hospitals NHS | 952 | 987 | 1,022 | 318 | 954 |
| Mid Yorkshire Hospitals NHS | 534 | 822 | 901 | 297 | 891 |
| **West Yorkshire Total** | **2,890** | **3,399** | **3,633** | **1,201** | **3,603** |

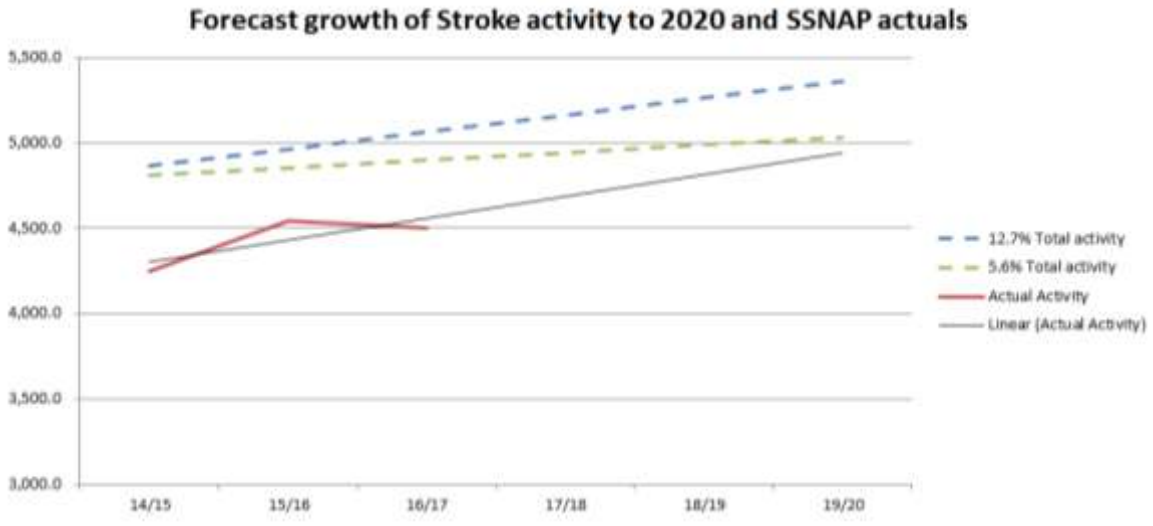
**Notes: Table includes proxy figure for LTHT who submitted one quarter of data in 2013/14.**
**Proxy value calculated by applying 2014/15 - 2015/16 growth of 3.5% to derive 2013/14 total.**
**Bradford figure incorporates Airedale patients from 2015/16 onwards.**

The *Current State Assessment* document modelled various scenarios (based on 2013/14 baseline of 4,855 strokes including mimics). This indicated demographic changes alone would drive activity and cost growth of 12.7%.

Improved conditions management (primarily relating to atrial fibrillation and hypertension interventions) were predicted to mitigate this growth to a rate of 5.6%. Modelling assumptions also included a stable stroke mimic rate of 25%.

Applying these assumptions to the latest SSNAP data and comparing a linear trend based on the actuals to the scenario modelling results from the *Current State Assessment* document shows actual growth in stroke volumes in line with the upper estimates of the generated scenarios – see the below graph (Figure 6 refers.)

**Figure 6**



### 5.5.3 Workforce

The *Current State Assessment* document scenario modelled the workforce surplus or deficit for key staff groups. Current SSNAP data illustrates the actual size of the stroke workforce across the West Yorkshire area (Figure 7 below refers.)

**Figure 7 - Current Stroke Workforce – SSNAP Organisational Audit July 2016**

| | ANHST | BTHT | CHFT | HDFT | LTHT | MYHT | West Yorks Total |
|---|---|---|---|---|---|---|---|
| Number of consultant stroke physicians 2016 | 2 | 4 | 5 | 4 | 9 | 6 | 30 |
| Total number of Programmed Activities 2016 | 21 | 31 | 50 | 23 | 51 | 44.5 | 220.0 |
| Number of Direct Clinical Care Programmed Activities 2016 | 18 | 25 | 42 | 21 | 44 | 35.5 | 184.5 |
| Junior Doctor (FY/Core/ST1/ST2) Programmed Activities 2016 | 14 | 20 | 7 | 10 | 35 | 35 | 121.0 |
| Junior Doctor (ST3/Registrar grade or above) Programmed Activities | 0 | 0 | 1 | 0 | 8 | 7 | 16.0 |

Comparing these numbers with the 2014 data included on page 24 of the *Current State Assessment* document shows the size of the workforce has changed as outlined in Figure 8 below.

**Figure 8 - Net change in workforce between 2014 and 2016**

| | ANHST | BTHT | CHFT | HDFT | LTHT | MYHT | West Yorks Total |
|---|---|---|---|---|---|---|---|
| Net change in number of consultant stroke physicians 2014-16 | 0 | 1 | 1 | 0 | 2 | -2 | 2 |
| Net change in total number of Programmed Activities | 0 | 6 | 6 | 0 | 3 | 9.5 | 24.5 |
| Net change in total number of DCC Programmed Activities | 1 | 6 | 4 | 0 | 2 | 6.9 | 19.4 |
| Net change in Junior Doctor (FY/Core/ST1/ST2) Programmed Activities | -6 | 0 | 3 | 0 | 1 | 10 | 8.0 |
| Net change in Junior Doctor (ST3/Reg grade +) Programmed Activities | 0 | 0 | -1 | 0 | 0 | 3 | 2.0 |

Whilst there have been slight increases in reported workforce numbers, there is little indication that the current configuration of workforce is more sustainable than when the current state assessment document was produced in February 2015. Note – CHFT data subject to further validation.

T&F members have agreed that further work will be required as part of the next phase of work to gain a more comprehensive view on workforce to inform our future proposals

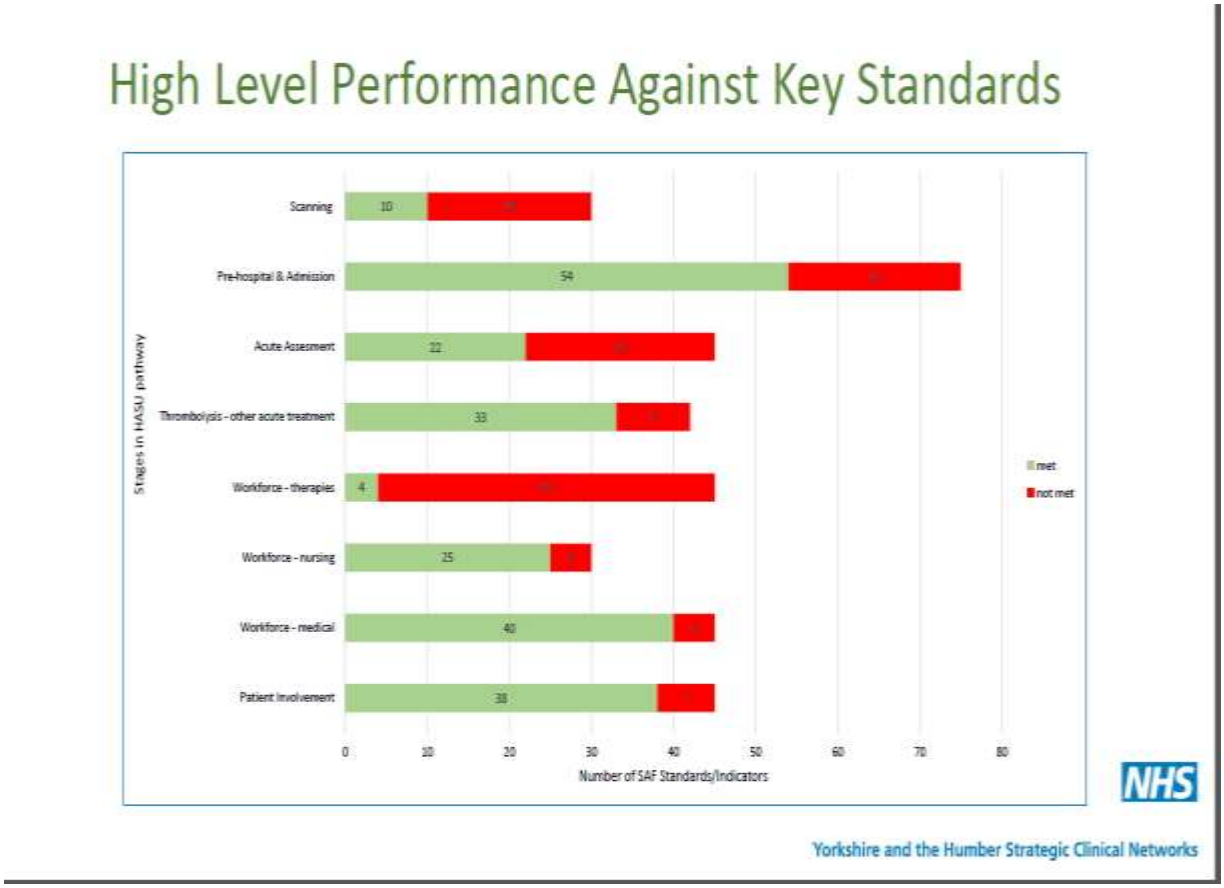
(subject to NHS England approval to proceed to next stage) for example, there was agreement that going forward information on the 'in hours' and 'out of hours' workforce position needs to be captured.

### 5.5.4 Quality – Stroke Sentinel National Audit Programme (SSNAP) analysis

Both the Strategic Clinical Network Hyper Acute Stroke Blueprint and the Current State Assessment highlighted variation in performance against a range of SSNAP metrics for example:

- Proportion of patients directly admitted to stroke unit within 4 hours;
- Proportion of patients scanned within 12 hours; and
- Thrombolysis within 1 hour;

**Figure 9 - High level performance against key standards at Strategic Clinical Network Launch Event April 2016.**




(Information source: Yorkshire and Humber Strategic Clinical Network 'Blueprint' launch event - SSNAP data Oct – Dec 2015)

T&F Clinical colleagues agreed for the purposes of the 'desk top review' the SSNAP measures should also be used to inform discussions regarding the quality of services. The following tables (Figure 10, 11 and 12 provide an overview of performance against key indicators).

**Figure 10**

# Key indicators – Nov 2014

| Acute Organisational Audit November 2014 Performance Table | Total stroke unit beds | Overall band | D1* | D2 | D3 | D4 | D5 | D6 |
|---|---|---|---|---|---|---|---|---|
| **Yorkshire and the Humber SCN** | | | | | | | | |
| Airedale NHS Foundation Trust | 21 | C | C | D | D | C | B | B |
| Bradford Teaching Hospitals NHS Foundation Trust | 13 | C | A | E | D | B | C | B |
| Calderdale and Huddersfield NHS Foundation Trust | 55 | C | A | D | D | A | D | C |
| Harrogate and District NHS Foundation Trust | 15 | C | A | B | D | B | C | B |
| Leeds Teaching Hospitals NHS Trust | 41 | D | A | B | B | E | E | E |
| Mid Yorkshire Hospitals NHS Trust | 63 | D | D | B | D | B | E | A |

*16 sites that do not treat during the first 72-hours after stroke have been allocated the Domain 1 score of the site where their patients are treated during this initial phase - please see the summary report for more details

| Key |
|---|
| D1 Acute care |
| D2 Specialist roles |
| D3 Interdisciplinary services |
| D4 TIA/ Neurovascular clinic |
| D5 Quality improvement, training and research |
| D6 Planning & access to specialist support |

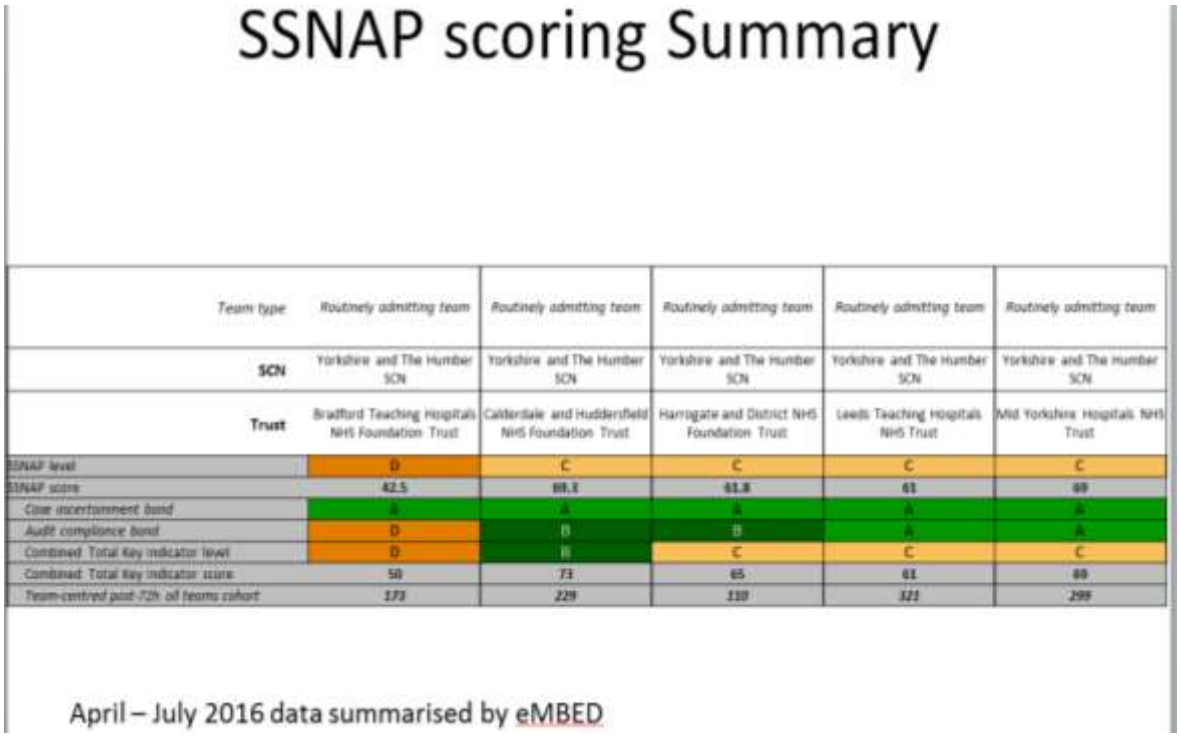
**Figure 11**

# Key indicators – July 2016

| Key indicator | | Airedale NHS Foundation Trust | Bradford Teaching Hospitals NHS Foundation Trust | Calderdale and Huddersfield NHS Foundation Trust | Harrogate and District NHS Foundation Trust | Leeds Teaching Hospitals NHS Trust | Mid Yorkshire Hospitals NHS Trust |
|---|---|---|---|---|---|---|---|
| *Staffing/Workforce* | National results* | | | | | | |
| 1. Establishment of band 6 and band 7 nurses per 10 SU beds | 51% (90/178) of sites meet KI | No | No | No | Yes | No | Yes |
| 2. Presence of a clinical psychologist (qualified) | 6% (10/178) of sites meet KI | No | No | No | Yes | No | No |
| *7-day working* | | | | | | | |
| 3. Stroke consultant led ward rounds** | 72% (112/156) of sites meet KI | Yes | Yes | Yes | Yes | Yes | Yes |
| 4. Nurses on duty at 10am weekends*** | 20% (31/156) of sites meet KI | Yes | Yes | No | Yes | No | Yes |
| 5. At least two types of therapy available 7 days a week | 31% (55/178) of sites meet KI | No | No | Yes | Yes | No | No |
| *Access to specialist treatment and support* | | | | | | | |
| 6. Patients can access intra-arterial (thrombectomy) treatment | 67% (105/156) of sites meet KI | No | No | No | No | Yes | No |
| 7. IPC used as first line prevention of venous thromboembolism | 80% (143/178) of sites meet KI | Yes | Yes | Yes | Yes | Yes | Yes |
| 8. Access to a specialist (stroke/neurological specific) Early Supported Discharge (ESD) team | 81% (145/178) of sites meet KI | Yes | No | Yes | Yes | No | Yes |
| 9. Timescale to see, investigate and initiate treatment for both high risk and low risk patients | 73% (130/178) of sites meet KI | No | No | Yes | Yes | No | No |
| *Patient and carer engagement* | | | | | | | |
| 10. Formal survey undertaken seeking patient/carer views on stroke services | 61% (108/178) of sites meet KI | Yes | No | No | No | Yes | No |
| Total number of key indicators achieved (Maximum = 10) | 1: 2% (3/178) 2: 2% (4/178) 3: 12% (21/178) 4: 13% (24/178) 5: 19% (33/178) 6: 21% (37/178) 7: 15% (27/178) 8: 11% (19/178) 9: 4% (8/178) 10: 1% (2/178) | 5 | 3 | 5 | 8 | 4 | 5 |

(Information supplied by EmBED)

**Figure 12**



SSNAP scoring Summary

| Team type | Routinely admitting team | Routinely admitting team | Routinely admitting team | Routinely admitting team | Routinely admitting team |
|---|---|---|---|---|---|
| SCN | Yorkshire and The Humber SCN | Yorkshire and The Humber SCN | Yorkshire and The Humber SCN | Yorkshire and The Humber SCN | Yorkshire and The Humber SCN |
| Trust | Bradford Teaching Hospitals NHS Foundation Trust | Calderdale and Huddersfield NHS Foundation Trust | Harrogate and District NHS Foundation Trust | Leeds Teaching Hospitals NHS Trust | Mid Yorkshire Hospitals NHS Trust |
| SSNAP level | D | C | C | C | C |
| SSNAP score | 42.5 | 69.1 | 61.8 | 61 | 69 |
| Case ascertainment band | A | A | A | A | A |
| Audit compliance band | D | B | B | A | A |
| Combined Total Key Indicator level | D | B | C | C | C |
| Combined Total Key Indicator score | 50 | 73 | 65 | 61 | 69 |
| Team-centred post-72h all teams cohort | 173 | 229 | 110 | 321 | 299 |

April – July 2016 data summarised by eMBED

T&F clinical members noted the quality of SSNAP data submitted by Trusts as part of the SSNAP had improved during the period covered by the *Current State Assessment* and *'Blueprint'* and agreed the information presented in the above graphs reflected their understanding of the current position for each of their respective organisations.

It was agreed Clinical Colleagues would submit Trust specific MIMIC information to inform future modelling. It was also agreed that further work will be required to capture and validate further quality, activity, cost and workforce information to inform our next steps.

### 5.5.5 Quality – Patient experience

The 'desk top review' highlighted that further work is required to capture patient experience to inform a wider view on quality to inform our future proposals.

Reference to patient satisfaction is included within our Integrated Quality Impact Assessment (which also includes the Equality Impact Assessment) and this is informing our communication and engagement activities. Information about patient experience will also be captured as part of the engagement phase which commenced with staff (mid-January 2017) and our population across the West Yorkshire and Harrogate STP footprint (1 February 2017 for a period of 6 weeks). These outputs will inform our proposals (subject to approval to proceed to Stage 2 Assurance process.)

A review of previous patient information collated as part of the Communication and Engagement Toolkit also includes reference to the engagement work that has already taken place, for example in Airedale, Wharfedale and Craven (AWC) and Bradford in 2015. That

engagement exercise identified five key themes in relation to people's concerns and ideas for improvement.

These were as follows:

- Discharge and aftercare focused on both physical and mental health support;
- Travel and parking costs with people having to travel further distances to see their loved ones;
- Treatment and outcomes for patients;
- Staffing; and
- Communication;

As a result of this feedback a patient information leaflet for ambulance staff to give to family and friends was produced highlighting what would happen to their relative and where they would be taken along with maps and telephone numbers. Visiting times to hyper acute stroke units were 'flexed' for people who travel across AWC; a community stroke rehabilitation service was commissioned in AWC (Bradford already had this) and providers established a joint focus group with patients and carers.

Further information will be captured as part of the post engagement, pre-consultation, consultation and post consultation phases (as appropriate) and mechanisms will be put in place to capture and evaluate any changes to services or care pathways from a patient perspective.

Members also considered preliminary transfer time analysis and agreed that further work is required to look at the complete pathway e.g. Ambulance call to the patient's door and Hospital door to needle time data.

### 5.5.6 Total Activity and Costs - Secondary Uses Service (SUS) data summary

The latest Secondary Uses Service (SUS) data was obtained from eMBED. This has captured costs and volumes for all primary spells based on the ICD-10 codes I61, I63 and I64. This data is showing an average annual growth in volumes over the last 3 years of 2.4%, along with commensurate annual average cost growth of 4.8%.

**Figure 13 SUS Volume – 2013/14 to 2016/17**

| 13/14 Totals | 14/15 Totals | 15/16 Totals | 16/17 Totals (Annualised) | Grand Total |
|---|---|---|---|---|
| 3,654 | 3,598 | 3,862 | 3,914 | 13,397 |

These growths are based on an annualised figure for the current financial year based on the first 7 months of actuals.

**Figure 14 SUS Costs – 2013/14 to 2016/17**

| 13/14 Total Costs | 14/15 Total Costs | 15/16 Total Costs | 16/17 Total Costs (Annualised) | Grand Total |
|---|---|---|---|---|
| £13,176,864 | £13,366,489 | £14,788,890 | £15,091,884 | £50,135,842 |

Further work is required to further validate the activity and costs profiles outlined above and to complete a more detailed activity and cost profile by CCG and by Provider. It is our intention to utilise the Greater Manchester Stroke Operational Delivery templates as a starting point to inform discussions with our Provider and CCG colleagues on the data capture, validation and ownership of this information which will be a core part of the Business Intelligence and Finance work stream.

### 5.5.7 Impact of New Technology – Intra Arterial Thrombectomy (mechanical clot retrieval)

The literature review outlined in Section 6 of this document outlines the Intercollegiate Working Party conclusions in relation the mechanical thrombectomy, concluding that it is an effective treatment for selected patients. It also highlights there will be significant challenges to the implementation of this treatment in the UK. Section 3.5.3 of the *National Guidelines for stroke Fifth Edition 2016* also notes there will be significant implications for the organisation of acute stroke services and referrals into tertiary neurosurgical and interventional neuroradiology services.

As part of the 'desk top review' process the Clinical Director, Yorkshire and the Humber Clinical Networks also prepared a report for consideration by T&F members (which included the NHS England Lead representative for this work). The key points to note are as follows:

**Epidemiology and demand -** There are 80,000 stroke admissions in England per year, 12% of whom receive intravenous thrombolysis. Patients eligible for thrombectomy include:

- Those with proximal occlusion of the internal carotid or middle cerebral arteries presenting early after stroke would be considered for thrombectomy. They have extensive thrombus, are much less likely to respond to intravenous thrombolysis and have large strokes, severe disability and long lengths of stay;
- Those who do not respond to intravenous thrombolysis; and
- Those for whom thrombolysis is contraindicated e.g. pregnant women or those on anticoagulants.

The number needed to treat for one good outcome (NNT) lies between 2.6 and 8 i.e. between 1000 and 3,000 people each year lives would be transformed by the intervention.

- 8,000 patients per year will be suitable for treatment;
- 495 patients were treated during 2015 – 16; and
- 2% stroke patients will be treated in year one arising to 8% over five years.

**Selection criteria**

Those presenting with within 4.5 hours of onset of symptoms **AND** either:

a. Where there has been an inadequate response to intravenous thrombolysis OR
b. Those who are unable to receive intravenous thrombolysis (on anticoagulants, pregnant or recent surgery).

**AND** have proximal occlusion in the anterior cerebral circulation on imaging
**AND** have a National Institute of Health Stroke Score (NIHSS) >5
**AND** were previously independent in activities of daily living (Rankin score < 3)
**AND** can have thrombectomy within six hours of the onset of symptoms.

A final decision as to whether mechanical thrombectomy for acute ischaemic stroke will be routinely commissioned is planned to be made by NHS England at some time in 2017 following a recommendation from the Clinical Priorities Advisory Group.

Subject to the outcome of the recommendations of the Clinical Priorities Advisory Group there is recognition that any future proposals across the West Yorkshire and Harrogate footprint will need to take account of NHS England's commissioner developments and timelines associated with this technology advance.

### 5.5.8 'Desk top review' summary

The outcome of 'desk top review' process has shown the following:

- No significant changes to the assumptions based on the data outlined in the Strategic Clinical Network 'Blueprint' are required;
- Although some Trusts have improved their performance against some of the *Stroke Sentinel National Audit Programme (SSNAP)* metrics, variation in the quality of our specialist hyper acute services and pathways continues to exist. Further work is therefore required to reduce this variation;
- In order to ensure all our patients are able to access high quality services no matter where they live and no matter what time of day/night they are admitted, further changes may be required to ensure our future specialist hyper acute and acute service delivery models of care are as safe and resilient as possible, deliver consistent quality services over 7 days (including early supported discharge at weekends), improved access to imaging and new technologies;
- Across the Yorkshire and Humber footprint a number of hyper acute services have experienced resilience issues which have required emergency commissioning and provider arrangements to be put in place. We want to determine the optimal service delivery models that will further improve the resilience of our specialist hyper acute and acute stroke services so they are 'fit for the future' and we minimise the risks of our services experiencing resilience issues;
- It is important that work continues to further improve care across the whole care pathway (prevention, primary care, hyper acute and acute care, community services through to stroke after care) in order to further improve outcomes and ensure

services and care pathways are working effectively to further improve patient experience and outcomes and avoid delays;

The 'desk top review' process has re-inforced the view of our clinical colleagues and other key stakeholders that we need to progress our case for change with a view to gaining NHS England approval to proceed to the next phase so that we can develop our proposals with our population and key stakeholders in line with the NHS England Assurance Process and key requirements.

## 6. Literature Review

During Q3 2016/17 as part of their literature review the Stroke/HAS T&F Group made reference to the latest available evidence in the public domain to inform the development of this Strategic Case for Change. These include the following:

- ***The National clinical guidelines for stroke: Fifth Edition 2016;*** [27]
- ***NHS Stroke Services: Configuration Decision Support Guide;*** [28]
- ***Greater Manchester Stroke Operational Delivery Network Annual Report: July 2015 – 2016*** [29]***;*** *and*
- ***East Midlands Clinical Senate and East Midlands Clinical Network programme.*** [30]

In addition to the above it is important to note that, as outlined earlier, the *Current State Assessment 2015* included a comprehensive literature review which also appraised the evidence available in the public domain about the effectiveness of hyper-acute and acute stroke care.

The information and recommendations referenced in this literature review have informed the development of our Strategic Case for Change and subject to approval of the Strategic Case for Change (as part of the NHS England Stage 1 Assurance process) will also be subject to further review by the T&F Group and other key stakeholders to inform the development of our future proposals as part of our evidence based approach to transformation.

The foreword of the *National Clinical Guideline for Stroke: Fifth Edition 2016* states the guideline is the most comprehensive and up to date document on how stroke care should be provided, covering the whole pathway from pre-hospital to long-term management. It is designed not just for clinicians but also for patients and their families and carers, and those with responsibilities for commissioning stroke services.

It highlights the available evidence for the treatment of stroke continues to grow steeply and includes significant updates from the 2012 edition. The preface of the guideline summarises what's new in 2016 as follows:

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[27] Royal College of Physicians. Intercollegiate Stroke Working Party. National clinical guideline for stroke. Fifth Edition, 2016.

[28] NHS England. Stroke Services: Configuration Decision Support Guide. Available from http://emsenate.nhs.uk/downloads/documents/End_of_Life/Stroke/Stroke_Services_Configuration_Support_Guide.pdf

[29] Greater Manchester Stroke Operational Delivery Network. Annual Report, July 2015 – July 2016.

[30] East Midlands Clinical Senate and East Midlands Clinical Network programme. Available from http://emsenate.nhs.uk/cardiovascular/work-programmes/stroke

- Mechanical Thrombectomy for acute ischaemic stroke (section 3.5 of the guidelines);
- Urgent brain imaging within 1 hour of hospital arrival for suspected stroke (section 3.4 of the guidelines);
- Acute blood pressure management in intracerebral haemorrhage (section 3.6 of the guidelines);
- Urgent management of suspected minor stroke and TIA irrespective of risk stratification (section 3.2 of the guidelines);
- Incorporation of clinical psychology/clinical neuropsychology, dietetics and orthoptics expertise into the multi-disciplinary stroke rehabilitation team (section 2.4 of the guidelines);
- Changes in the practice of early mobilisation after acute stroke (section 3.12 of the guidelines);
- Pragmatic management of swallowing difficulties in end-of-life stroke care (section 2.15);
- Mechanically-assisted methods for gait training in people who are unable to walk after stroke (section 4.9.4); and
- Lower blood pressure targets for secondary stroke prevention compared with previous NICE guidelines (section 5.4).

It is important to note that the *Fifth Edition 2016 guideline*, evidence, recommendations and bibliography are set out over 147 pages and therefore the information referenced in this part of the literature review are not exhaustive. They have been referenced at this stage as examples that have informed the whole pathway discussions that have been taking place with wider stakeholders.

*The NHS Stroke Services: Configuration Decision Support Guide*[31] was developed using best practice guidelines and narrative already available to avoid replicating work and to ensure consistency. In particular the guide made reference to the following documents and service reviews that shaped their core narrative:

- Planning and delivering service changes for patient: A good practice guide for commissioner and the development of proposals for major service changes and reconfiguration (NHS England)
- Effective Service Change: A support and guidance toolkit (NHS England);
- Healthcare for London acute stroke review documentation;
- The NHS Midlands and East stroke service review documentation;
- NHS London reconfiguration guide 2011;
- Improving Stroke Services: A guide for commissioners (Department of Health, 2006); and
- Birmingham, Solihull and Black Country stroke services review documentation.

## 6.1 Commissioning approaches and overall structure of stroke services

The *Fifth Edition 2016* guidelines include a number of key recommendations to commissioning organisations in relation to the overall structure of stroke services. Key messages are as follows:

[31] NHS England. Stroke Services: Configuration Decision Support Guide. Available from http://emsenate.nhs.uk/downloads/documents/End_of_Life/Stroke/Stroke_Services_Configuration_Support_Guide.pdf footnote (footnotes 99, 100,

- **Commissioning whole pathways -** commissioners should ensure their commissioning portfolio includes the whole stroke pathway from prevention (including neurovascular services) through acute care, early rehabilitation, secondary prevention, early supported discharge, community rehabilitation, systematic follow up, palliative care and long-term support (section 6.1.1 A);

- **Organisational Structures -** effective stroke care will only occur if the organisational structure facilitates the delivery of the best effective treatments at the optimal time; for example, intravenous thrombylisis (a recommended treatment) can only be given within 4.5 hours of stroke onset if people arrive the appropriate setting within that time (section 2.2);

- **Acute medical services implications/inter-dependencies -** recommendations related to hyper acute care have significant implications for the organisation of acute medical services within any 'health economy' (section 2.3); and

- **Commissioning at regional or sub regional level** - those who commission and provide stroke services are required to configure these services to achieve the maximum benefit to the population from the delivery of time-sensitive treatments, and to consider issues relating to the co-location of other emergency services beyond the scope of the guideline (section 2.2.3)

## 6.2 Improving outcomes through integrated commissioning of stroke care

Section 3.2 of the *NHS Stroke Services: Configuration Decision Support Guide* highlights that there is considerable scope to improve patient outcomes through integrated commissioning of stroke. It states many strokes are preventable and the impact of stroke can be minimised if specialist treatment and care is available and people have a better chance of making a good recovery. This approach can mean a more effective use of resources across the whole health and social care system through strokes avoided shorter length of hospital stays and reduced disability costs.

The guide also highlights the key elements of good practice within high quality stroke care (section 3.3 refers). It states:

***'High performing stroke services are well integrated across primary, emergency, acute and social care, delivered by stroke-skilled and specialist staff, and treat stroke as a medical emergency.'***

Specifically they are likely to provide the following:

- **Prevention** – maximising the opportunities for preventing stroke through effective targeted access to the highest quality advice or prevention in primary and secondary risk management (section 3.3)
- **Acute care** – treat transient ischaemic attack (TIA) as a warning comparable to chest pain. People seen by ambulance staff outside hospital are screened for suspected stroke or TIA. Admission to a specialist stroke unit for assessment and treatment by a multi-disciplinary team (section 3.3)
- **Rehabilitation** – patients who need ongoing inpatient rehabilitation should be treated in a specialist stroke rehabilitation unit and offered a minimum of 45 minutes of active therapy required for a minimum of 5 days per week. All patients should be screened within six weeks to identify mood disturbance and cognitive impairment. Provide early rehabilitation and mobilisation supported by transfer of care to home as soon as possible, patients with residual stroke related problems followed up within 72hrs by specialist stroke rehabilitation services (section 3.3); an
- **Longer term care** – carers should be provided with a named point of contact for stroke information and information about the patient's diagnosis and management plan and practical training to help them provide care. Provide psychological and emotional support for patients and carers (section 3.3).

Section 3.2 of the *NHS Stroke Services: Configuration Decision Support Guide* describes the key elements of a high quality stroke service which maximise opportunities to further improve outcomes and have informed our Strategic Case for Change recommendations. The key messages are as follows:

- **Prompt admission to a specialist stroke unit** - the most important care for people with any form of stroke is prompt admission to a specialist stroke unit (section 3.2);
- **The quality of the stroke unit** - is the single biggest factor that can improve a person's outcome following a stroke (section 3.2); and
- **Hyper acute stroke services** - enable patients to have rapid access to staff with the right skills and equipment to be treated 24/7 on a dedicated stroke unit staffed by specialist teams where they will receive expert care, including assessment, access to a CT scan and clot-busting drugs (if appropriate) within 30 minutes of arrival at the hospital (section 3.2).

### 6.3 High quality care – hyper acute stroke services

Section 3.4 of *The National Clinical Guideline for Stroke: Fifth Edition 2016* states stroke is a medical emergency and if outcomes are to be optimised there should be no time delays in diagnosis and treatment with any patient with acute onset of a neurological syndrome with persisting symptoms and signs of suspected stroke need urgent diagnostic assessment to differentiate between acute stroke and other causes. The key recommendations outlined in section 3.4.1 are as follows:

- **Direct admission to a hyper acute stroke unit –** to be assessed for emergency stroke treatments by a specialist physician without delay (section 3.4.1 A);
- **Brain imaging –** Patients with suspected acute stroke should receive brain imaging urgently and at most within 1 hour of arrival at hospital (section 3.4.1 B);
- **Thrombolysis –** interpretation of acute stroke imaging for thrombolysis decisions should only be made by healthcare professionals who have received appropriate training (section 3.4.1 C);
- **Endovascular therapy –** Patients with ischaemic stroke who are eligible for endovascular therapy should have a CT angiogram from aortic arch to skull vertex immediately. This should not delay the administration of intravenous thrombolysis (section 3.4.1 D); and
- **MRI –** MRI with stroke-specific sequences (diffusion-weighted imaging, T2*) should be performed in patients with suspected acute stroke when there is diagnostic uncertainty (section 3.4.1 E).

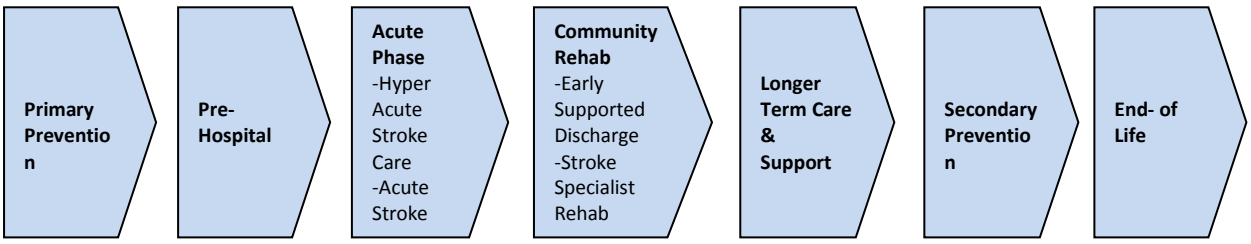
The guidelines also makes reference to the major reorganisations of stroke services that have taken place in some parts of the UK to improve hyper acute stroke care. It states recent evidence from Manchester and London suggest that such care should be available in 24 hours a day, 7 days a week hyper acute stroke centres and should be for all people with acute stroke, not just those suitable for intravenous thrombolysis[32].

Section 2.2.3 of this guidance states the health and societal cost consequences should be positive because more effective stroke care will reduce long-term rehabilitation and care costs.

## 6.4 Comprehensive stroke services and pathways

The literature review has highlighted the importance of taking a 'whole system' and 'whole pathway approach' to improving stroke care for our population. The *NHS Stroke Services: Configuration Decision Support Guide* sets out the criteria different parts of the stroke pathway need to meet the deliver high quality care to patients and achieve the step change improvement (section 3.4.)

It highlights that adopting a whole pathway approach to the provision of stroke services is crucial to maximising the clinical outcomes. It describes the objectives of a comprehensive stroke pathway and services framework that covers the following:




**NB: The size shapes outlined above are not indicative of time**

## 6.5 Community rehabilitation and early supported discharge

Section 6.4 of *The NHS Stroke Services: Configuration Decision Support Guide* states Rehabilitation services should be commissioned to reduce limitation in activities, increase participation and improve the quality of life of people with stroke using therapeutic and adaptive strategies. With stroke being the third largest cause of disability in the UK (*Newton et al, 2015)*, providing rehabilitation is cost-effective in reducing long-term disability and the costs of domiciliary and institutional care.

[32] Royal College of Physicians. Intercollegiate Stroke Working Party. National clinical guideline for stroke. Fifth Edition, 2016. (Ramsey et al, 2015.) pg 13

With regard to rehabilitation the guidelines state that comparative studies suggest that in the UK face-face therapist-patient contact time is lower than in other European countries *(Putman et al, 2006, Putman et al 2007.)* Recommendations include:

- People with stroke should accumulate at least 45 minutes of appropriate therapy every day, at a frequency that meets their goals for as long as they are willing and capable of participating and showing measureable benefit; and
- In the first two weeks after following stroke, therapy targeted at the recovery of mobility should consist of frequent, short interventions every day, typically beginning between 24 hours and 48 hours after stroke onset.

The guidelines highlight that one in 12 people with stroke in the UK have to move to a care home because of their stroke *(Intercollegiate Stroke Working Party, 2016 pg 32),* and conversely, about a quarter of care home residents have had a stroke, often in association with other co-morbidities. It makes reference to the current position in relation to rehabilitation and makes a number of recommendations intended to reduce dependency and as far as possible improve the quality of life for people with stroke who live in care homes.

### 6.6 End-of-life care (palliative care)

Section 2.15 of the *National Clinical Guideline for Stroke: Fifth Edition 2016* highlights that about one in 20 people with acute stroke will be receiving end-of-life care within 72 hours of onset, and one in seven people will die in hospital (*Intercollegiate Stroke Working Party, 2016*), making stroke one of the most lethal acute conditions in modern medicine. The guidelines highlight that this means that providing high quality end-of-life care is a core activity for any multi-disciplinary stroke team.

### 6.7 Technology

From a telemedicine perspective section 2.4 of the *Fifth Edition Guidelines* state observational evidence suggests that telemedicine is associated with more protocol violations and longer treatment times *(Meyer et al, 2008, Dutta et al, 2015.)* Furthermore, unless telemedicine is used as part of an otherwise well-developed acute stroke service, outcomes may suffer *(Heffner et al, 2015.)*

The literature review concludes mechanical thrombectomy is an effective treatment for selected patients. It also highlights there will be significant challenges to the implementation of this treatment in the UK. Section 3.5.3 of the *National Guidelines for Stroke Fifth Edition 2016* also notes there will be significant implications for the organisation of acute stroke services and referrals into tertiary neurosurgical and interventional neuroradiology services.

### 6.8 Support to carers

The guidelines note that the *2014 Care Act*[33] enshrines the legal duty of a Local Authority to assess any carer who requests an assessment and appears to require support and includes a number of recommendations related to this.

[33] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

### 6.9 Stroke services for younger adults

The *Fifth Edition 2016 guidelines* highlight that stroke occurs at all ages and about a quarter of people with stroke are aged under 65 years and observes that some younger adults feel that general stroke services do not meet their needs and outline a number of recommendations specific to younger adults.

### 6.10 Access to psychological care

The *Fifth Edition 2016 guidelines* state that psychological care should be provided by stroke services across acute and community settings and highlight that national audits continue to highlight inadequate service provision. It also provides recommendations related to self-management.

### 6.11 Length of stay in a hospital or institution

Studies show a significant variation in the length of stay in a hospital or institution between organised Stroke Units (comprehensive, rehabilitation, and mixed rehabilitation stroke wards) compared with alternative care, favouring organised Stroke Units (Ma et al, 2004, Garraway et al, 1980, Svensson et al, 2012, Solling et al, 2009, Fagerberg et al, 2000, Cabral et al, 2003, Hankey et al, 1997, von Arbin et al, 1980, Laursen et al, 1995, Indredavik et al, 1991, Stroke Unit Trialists' Collaboration, Cochrane Database, 2007, Strand et al, 1985, Livingstone and Bunn, 2014; Fitzpatrick 2013; Hunter et al, 2013; Sun et al, 2013).

### 6.12 Cost effectiveness

Studies included in this review suggest that Stroke Units and specifically ASU and HASU are cost effective. However, Quinn (2011) highlights that there are multiple challenges to conducting a proper economic evaluation of stroke care and caution must be taken when considering the findings.

Fuentes and Diez-Tejedor (2009) and Guzauskas et al (2012) found in their review evidence that specialist Stroke Units are the most cost effective and efficient way to deliver care when compared to stroke teams or general wards.

The *National Audit Office (2010)*[34] concluded that ASU and HASU are cost effective as they improve health outcomes and reduce mortality (though they draw attention to the limitations in the modelling used). The cost saving made by ASU and HASU may be related to the prompt delivery of specialist care. NICE (2010) suggest that a higher number of patients receiving essential brain imaging within 1 hour of arrival at hospital may result in some marginal additional costs in provision of out of hours' services, but would result in savings due to increased number of patients being identified as eligible for thrombolysis.

Penaloza-Ramos et al (2014) and Switzer et al (2012) also suggest that an increased rate of thrombolysis improves the cost effectiveness of ASU and HASUs. NICE (2010) also state that increasing the proportion of patients who have a swallowing assessment in specialist units would incur minimal additional costs but increase cost savings by avoiding complications from dehydration or malnutrition.

[34] https://www.nao.org.uk/wp-content/uploads/2010/02/0910291.pdf

### 6.13 Governance and quality improvement

The *Fifth Edition guidelines* emphasise the importance of governance and quality improvement which includes collecting appropriate data in a timely manner, analysing the data and acting upon the findings. It recommends Clinicians should participate in the national stroke audit, keeping a quality register for people admitted, regular review of service provision, multi-disciplinary leadership to the process of clinical audit and participating in clinical networks.

It states General Practitioners should regularly audit the primary and secondary prevention of stroke within their practice and maintains a register of people with stroke or TIA.

### 6.14 Network approaches

Both East Midlands and Manchester have adopted a Network approach highlighting the benefits of working as a Network and the value that Networks can bring.

The East Midlands Clinical Network support the administration of a stroke clinical advisory group in order to oversee and provide directional guidance for the clinical area. Included in their terms of reference are the following:

- Clinically and managerially oversee the development and delivery of stroke specific network strategies focusing on achieving maximum health gain/benefit for the East Midlands' population;
- Facilitate the delivery of consistent, high quality care in line with national guidance with an emphasis on ensuring equitable provision of services and a seamless transition in care across the whole patient journey;
- Ensure the network's activities focus on quality and productivity;
- Oversee the development of clinical pathways and models of care for recommendation to commissioners (NHS Commissioning Board and Clinical Commissioning Groups), for implementation at local level;
- Recommend clinical policies and procedures for endorsement for use across the East Midlands;
- Promote and ensure consistency of participation with and data entry to the Sentinel Stroke National Audit Programme (SSNAP);
- Review SSNAP results and local work plans for continuous quality improvement across all domains of care;
- Advise the network area's health community on clinical issues relating to stroke care; and
- Foster a culture of clinical leadership and patient/public engagement in the development and assurance of stroke service provision.

The Greater Manchester Stroke Operational Delivery Network are provider funded and their *Annual Report July 2015 – July 2016* describes how they add value to local stroke care by:

- Being a focal point for stroke in Greater Manchester;
- Providing a voice for patients, carers and voluntary sector organisations;
- Facilitating a strategic approach to improving local stroke outcomes across the whole pathway;

- Providing a governance structure through which organisations can hold each other to account with mechanisms to identify and address issues and risks;
- Involving key stakeholders e.g. networking, peer support and sharing of best practice; and
- Providing forums for discussion and resolution of issues and facilitating service improvements.

## 7. Conclusions, recommendations and next steps

### 7.1 Conclusion

There is strong evidence that outcomes following stroke are better if people are treated in specialised centres, even if this increases travelling time following the event, and this is likely to be the case in West Yorkshire & Harrogate. Ongoing rehabilitation should, however, be provided at locations closer to where people live, and they should be transferred to these as soon as possible after initial treatment.

The importance of taking a 'whole system' and 'whole pathway approach' to improving stroke care has also been highlighted through discussions with our local clinicians and other key stakeholders (reflecting our agreed vision for stroke care) and is in line with work taking place elsewhere e.g. Manchester and our literature review findings.

Across West Yorkshire and Harrogate, significant work has already taken place in our Hospitals and our Ambulance Service to improve the quality of care and outcomes for stroke. Work has also taken place across our place based footprints to further reduce the risk of stroke through the implementation of a range of initiatives e.g. atrial fibrillation and hypertension pathway developments and implementation of prevention strategies.

The outcome of our work, to date, suggests that in order to further improve quality and stroke outcomes for our patients further work is now required to determine the optimal service delivery models across the West Yorkshire and Harrogate footprint so that our services are 'fit for the future'.

Our work to date has been supported by the Strategic Clinical Network, which included consultants and doctors and other clinical and non-clinical stakeholders across the West Yorkshire and Harrogate STP footprint.

The recommendations made are in line with new models of care described in the *NHS 5 Year Forward View*. Work taking place in other areas such as Manchester and London, and our strategic vision and priorities set out in the public summary of the *West Yorkshire and Harrogate Draft Sustainability and Transformation Plan* published November 2016.

### 7.2 Recommendations

As a result of the work we have done to date, we believe the information outlined in this Strategic Case for Change demonstrates that if we are to further improve the quality of our specialist stroke services, outcomes and experience for our patients further work is required to ensure that our services are resilient and 'fit for the future'

In view of this we recommend that we begin the work to develop our proposals to determine the optimal service delivery models and pathways that need to be in place across the West Yorkshire and Harrogate footprint set in the context of ensuring that we are maximising the opportunities to further improve care and outcomes for our population along the whole stroke care pathway.

### 7.3 Next steps

The Strategic Case for Change (V6.0) reflects comments from the following stakeholders:

- West Yorkshire Healthy Futures Stroke/HAS Task and Finish (T&F) Group members (includes Trust and Ambulance service clinical representatives and CCG commissioner clinical chair and Chief Officer representatives);
- West Yorkshire Association of Acute Trust (WYAAT) colleagues (including Medical Directors and Chief Officers);
- Urgent and Emergency Care Network colleagues (representation includes clinical and non clinical representatives from acute, non acute and primary care providers, commissioners, Healthwatch and Local Authorities);
- Healthy Futures Clinical Forum members (includes CCG and Acute and Ambulance Provider clinical representatives); and
- Healthy Futures Collaborative Forum (11 CCG's and NHS England.)

Subject to the approval of the Healthy Futures Collaborative Forum (HFCF) on 7 March 2017 the Strategic Case for Change will be submitted to NHS England as part of the Stage 1 NHS England Assurance process.

The Clinical Senate will also be asked to review the Strategic Case for Change to determine whether they support our recommendations to commence further work to develop proposals to determine the optimal service delivery models for the population of West Yorkshire and Harrogate. Subject to the outcome of our discussions with NHS England we will also be seeking the Clinical Senate's views on the key areas that we should focus on in order to strengthen our discussions with key stakeholders to inform the development of our proposals.

Subject to approval of the Strategic Case for Change we will produce a public summary/easy read version at the earliest opportunity and this will be avaialable on the website.

We have developed a communications and engagement toolkit to inform discussion with our staff, Overview and Scrutiny Committees, Health and Well Being Boards, Governing Boards, Voluntary Sector, MPs, Media and other key stakeholders. On the 1 February 2017 we began a 6 week period of engagement with our population across the West Yorkshire and Harrogate STP footprint (led by Healthwatch) to gain their views on stroke care (prevention, primary care, 72hrs and rehabilitation through to after care). A mid point engagement review meeting is also scheduled.

A post engagement report will be prepared for consideration by key stakeholders and will inform the development of the next phase of our work (subject to NHS England approval to proceed to the Stage 2 Assurance process.)

Both the work that has taken place to date and the literature review highlight the importance of ensuring the whole stroke pathway is working effectively (from pre-hospital

to long-term management) in order to support timely repatriation from specialist hyper acute stroke services to acute stroke or community stroke services, avoid delays along the

whole care pathway and to maximise the opportunities to prevent stroke and improve outcomes and quality for our population.

In view of this, further discussions with the Yorkshire and Humber Academic Health Science Network (AHSN), the Primary and Community Care STP work stream lead, Public Health, place based stroke leads and other key stakeholders will take place to determine the current position in relation to these important elements of the care pathway to inform the next phase of our work particularly in relation to the following:

- Gaining an improved understanding of the current position in relation to place based prevention work;
- Establishing whether the atrial fibrillation and hypertension interventions are delivering the intended benefits in line with projections; and
- Timely access and availability of early supported discharge (ESD), community rehabilitation, end of life, longer term care and voluntary care sector provision .

It is our intention to expand the core membership of the T&F Group to include a member of the Patient and Involvement Regional Lay member Reference Group, a public health representative and a community services representative.

Subject to NHS England approval to proceed to Stage 2 Assurance process, work will commence on the next phase of the project plan which will include, modelling and discussion with key stakeholders in the following areas:

- Workforce e.g. in hours and out of hours, inter-dependencies between specialist and acute stroke care;
- Business Intelligence e.g. travel times, impact of cross boundary flows and 7 day standards;
- Finance (validation of CCG and Provider costs and financial modelling approach, assumptions and principles);
- Further Equality Impact Analysis (which includes Joint Strategic Needs Analysis across each of the place based footprints) to further inform our communication and engagement activities;
- Communications and engagement e.g. review of engagement outputs, Equality Impact Assessment update and review, preparatory work for the pre-consultation engagement (subject to approval to proceed) and ongoing dialogue with key stakeholders, e.g. our population, our staff and STP partners; and
- Further discussion with NHS England specialised commissioners regarding Intra-Arterial Thrombectomy developments e.g. timelines, capacity and demand assumptions, impact on pathways and repatriation policies.

**Anticoagulants –** A group of drugs used to reduce the risk of clots by thinning the blood.

**Atrial Fibrillation (AF)** - Irregular, chaotic heart rhythm.

**Care Pathway –** A tool used by healthcare professionals to define the sequence and timings of a set of tasks or interventions that should be performed on a patient who enters a healthcare setting (e.g. a hospital) with a specific problem.

**Commissioner (health services) –** Person or organisation that decides how to allocate the health budget for the service.

**Computed tomography (CT) –** An X-ray technique used to examine the brain.

**Early Supported Discharge (ESD) –** A team offering rehabilation in the community that replicates the stroke unit care; this enables earlier home discharge than would be possible if the team was not available.

**Hyperacute Stroke Unit (HAS**U) – A stroke unit that treats patients in the first few days of symptom onset.

**Hypertension -** High blood pressure.

**Intra-arterial Thrombectomy (IAT) –** Mechanical clot retrieval.

**National Institute for Health and Clinical Excellence (NICE) –** A special health authority set up within the NHS to develop appropriate and consistent advice on healthcare technologies, and to commission evidence based guidelines.

**Palliative Care –** Care that relieves rather than treats symptoms.

**Primary Prevention** - Methods to avoid occurrence of disease.

**Secondary Prevention** - Methods to diagnose and treat existent disease in early stages before it causes significant morbidity.

**Specialist –** A clinician who's practice is limited to a particular branch of medicine or surgery, especially one who is certified by a higher educational organisation.

**Stroke** - The damaging or killing of brain cells starved of oxygen as a result of the blood supply to part of the brain being cut off. Types of stroke include Ischaemic stroke caused by blood clots to the brain or haemorrhagic stroke caused by bleeding into/of the brain.

**Telemedicine –** The use of telecommunication and information technologies in order to provider clinical healthcare at a distance.

**Thrombolysis** - The breaking up of a blood clot (in strokes via the use of drugs). An example of a thrombolysis drug is alteplase, also sometimes called tPA.

**Transient ischaemic attack (TIA)** - A stroke which recovers within 24 hours of onset of symptoms.

**APPENDIX B**

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APPENDIX A

local healthwatch
working together

# Stroke Services

## Engagement report

April 2017

## Report foreword

Thank you to everyone who shared their views in February and March 2017 on how stroke services across West Yorkshire and Harrogate could be further improved to make sure they are fit for the future and meet peoples' needs across the area.

Over 900 people completed our engagement survey and we spoke to over 1500, providing us with many comments, all of which are very important to us.

The engagement work was led by Healthwatch and is all about the sustainability of quality stroke services and reducing the incidence of stroke happening in the first place, wherever possible. When we say engagement, what we really mean is conversations with the public and staff. This report sets out the findings from this important piece of work.

Further improving hyper- acute stroke and acute stroke services (hyper-acute refers to the first few hours and days after the stroke occurs) and making sure all stroke care services are 'fit for the future' has been highlighted as a priority in the draft Sustainability and Transformation Plan (STP) for the area.

There is strong evidence that outcomes following stroke are better if people are treated in specialised centres, even if this increases travelling time following the event. This is likely to be the case in West Yorkshire and Harrogate. Ongoing rehabilitation should, however, be provided at locations closer to where people live and they should be transferred to these as soon as possible after initial treatment.

The engagement work highlighted many findings including concern that a decision had already been made to reduce the number of hyper-acute stroke units (HASUs). **It's important to note that no decision at this stage of our review process has been made to reduce the number of units across West Yorkshire and Harrogate.**

A snap shot of some of the comments we received include:

- Many people said that they would travel further if it meant they were able to receive the best treatment and to be treated by specialists; however, they wanted their rehabilitation to be available closer to home. Although some people were worried that if they had to travel further the extra journey time could negatively affect their health, and would make it more difficult for their family to visit them.

- Those who had experienced a stroke described the excellent levels of care that they received in hospital, from being seen quickly, to accessing the most appropriate treatments and being kept informed throughout. They talked about staff being willing to help, whilst recognising that some were extremely busy. It was also felt that there should not be a difference in care during the week and at the weekend.

- Many described how stroke can be a life changing event which can be difficult for the patient and their families to deal with. It was felt that there was a need to ensure that the patient and their family are provided with the appropriate levels of emotional support and advice.

- The valuable role of voluntary and community organisations specialising in stroke support, particular on hospital wards, was recognised in the report.

- Many felt that there was a need to raise awareness of the signs and symptoms of a stroke, and what to do if you think someone is having a stroke.

We hope you find the report both interesting and informative.

Over the next few months we will be having more conversations with staff, partners, public, communities and stakeholders to develop options to further improve stroke services from prevention to after care for people living in West Yorkshire and Harrogate. Consultation will follow as appropriate in 2018.

Providing the best stroke services possible across the area is a priority is to us all and something we are committed to achieving.

Thank you again.

Dr Andy Withers
Chair of West Yorkshire and Harrogate Clinical Forum

Jo Webster
Senior Responsible Officer for West Yorkshire and Harrogate and Accountable Chief Officer for Wakefield Clinical Commissioning Group

**On behalf of West Yorkshire and Harrogate, Sustainability Transformation Partnership (STP).**

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## Appendices



# 1.0 Executive summary

Across West Yorkshire and Harrogate, health and social care services, including the NHS, are working together to look at better ways of delivering care for people who have a stroke. This has been highlighted as a priority in the draft Sustainability and Transformation Plan (STP) for the area.

The NHS is developing proposals to make sure everyone in our region gets the specialist care they need in the first few hours after a stroke and that stroke care and support is sustainable and fit for the future. We also know that preventing stroke taking place in the first place, and ongoing care, such as physiotherapy, speech therapy or emotional support is really important. The NHS thinks that by coordinating services better, more people could receive the care they need in a community setting, closer to home.

And by improving people's health and supporting people to stay well, health services could prevent people from having strokes and going to hospital in the first place.

Before decisions are made on the future of stroke services in West Yorkshire and Harrogate, Healthwatch organisations across the area wanted to find out what people think about the services that are currently provided and what would be important to them should they have a stroke, or care for someone who has now or in the future.

The engagement ran for six weeks, commencing on Wednesday 1st February until Wednesday 15th March 2017. A survey was designed to gain feedback from people who had experienced a stroke, the wider public and key stakeholders. This was shared via our communication and engagement channels and with a wide range of organisations.

We also used Facebook, Instagram and third party website advertising to promote the survey. The advert generated the following engagement:

Over **98,000** people saw the advert
**1,628** people clicked to find out more about the advert

The work has also been supported by the West Yorkshire and Harrogate Communications and Engagement network which includes colleagues from clinical commissioning groups, hospitals, community care providers and local authorities. This approach has enabled us to raise awareness of the stroke engagement work across the whole of the area using existing internal and external communication channels, for example information was sent to over 4,000 people who subscribe to the Kirklees Staying healthy e-bulletin.

Staff were also asked for their views on how best we move forward, with some hospitals, for example Harrogate and District NHS Foundation Trust, holding staff engagement sessions.

Health and Wellbeing Boards, Clinical Commissioning Group Governing Bodies, MP's and the Joint Health Overview Committee were also updated on the engagement work and asked to encourage people to have their say.

Regional and local media were also kept informed, and around 80 people who had registered an interest in STP updates were sent the stroke engagement survey link to complete.

We received **940** completed surveys either via face to face engagement activities **(830, 88%)** or social media advertising **(110, 12%)**. Of these, **49.2%** had previously had a stroke.

In addition to the survey we also received feedback via:

- **54 outreach sessions** meeting with voluntary and community groups, attending GP practices, rehab units, stroke wards, and libraries talking to approximately **1,544 people**
- **5 voluntary and community sector clinician led events** attended by **78 people**
- **15 semi-structured interviews** with people who had experience of stroke services in Bradford. It should be noted that as engagement had already taken place in Airedale, Wharfedale, Craven and Bradford in 2015, Healthwatch Bradford and District adopted a different approach

The key themes from the existing data and the engagement were as follows:

### Changes to stroke services

There was some concern that a decision had already been made to reduce the number of hyper acute stroke units (HASUs), with some questioning the value of the engagement.

People were concerned that if the number of units were reduced this could lead to the remaining units being unable to cope with demand and impact negatively on health outcomes.

It was suggested by many that funding should be increased to ensure all patients are able to access the best treatment immediately. There was a range of opinions as to whether this should be available in all local hospitals or whether it should be based in a few specialist centres. Many people said that they would travel further if it meant they were able to access the best treatment and to be treated by specialists; however, they wanted their rehabilitation to be available closer to home.

The main reasons for people wanting the services to be available in all hospitals were the distance, time and cost to travel, along with the challenges of parking. People were worried not only about how the extra journey time could affect the treatment and outcome for stroke patients but also how this would impact on the ability of carers and families to visit their loved one at this critical time, particularly those reliant on public transport.

Of those people that had experienced the newly reconfigured service in Airedale, Wharfedale, Craven and Bradford and had travelled further to access a HASU, and were then transferred to a hospital closer to home for their ongoing care were satisfied that it gave them the best clinical outcomes. People highly valued the specialist staff and treatments available during the first few hours after a stroke. Even when patients were in hospital far from home, most people did not identify the distance to travel as a significant problem – for some it was an inconvenience but they understood the need for the patient to be treated in the hospital which could give them the best chance of recovery. The main criticism was the difficulties visitors encountered trying to park at the hospital.

### Acute stroke services

Many people described the excellent levels of care that they received in hospital, from being seen quickly, to accessing the most appropriate treatments and being kept informed throughout. They talked about staff being willing to help, although some did feel that the staff were overworked so were sometimes unable to meet the needs of the patients.

Some reported an absence of specialist care at the weekend – no specialist consultants, and agency/bank nurses who some felt deliver poor quality care. It was also felt that there should not be a difference in care during the week and at the weekend.

Some people felt that paramedics and A&E staff need to receive more training on how to recognise and manage strokes. Particular reference was made to young people and how they are more likely to be misdiagnosed.

There were many instances where people reported delays in being seen and treated in A&E. Once they had been diagnosed some then had to wait a long time before a bed became available and they were not always admitted to a stroke ward. They felt that these delays in accessing treatment and not being admitted to a stroke ward had resulted in long term damage and had impacted negatively on their recovery.

Some people would have liked to have been given the choice of being admitted to a side room or a bay, as some felt isolated being in a side room on their own. They would have preferred to be in a bay so they could be near other people and be more visible to staff.

Whilst on the ward some patients were given the opportunity to speak to people from the Stroke Association that had experienced a stroke, they had found this very useful and felt it should be offered on all stroke wards.

### Discharge process

Comments on discharge ranged from people feeling that they were in hospital longer than they needed to be, to those that felt pressured to leave too soon.
When people were discharged, some were sent home without the appropriate aids, adaptations and home care being in place, and some had to source the support they required themselves.

Many people reported delays in accessing rehabilitation, such as physiotherapy and speech and language therapy.

They advised that they want to have a thorough assessment prior to being discharged, to ensure that they are ready to go home, and if they are, to have all the appropriate aids, adaptations and home care support in place prior to them being discharged. This should include assessing the needs of the whole family, especially in situations where the patient had previously been a carer for either their own children or partner.

That they, and their families are kept informed and involved throughout, so they know what to expect once they are discharged, are aware of what support is available and how to access it, this should include emotional support and financial advice. They would like to have a named person who is responsible for co-ordinating their care and who can provide them with support and advice.

For all organisations who are involved in their care to communicate with each other to ensure that the patient receives a seamless service. To support this, a suggestion was made that teams should be multi-disciplinary and include social care, speech and language therapy, physiotherapy and occupational therapy.

### Stroke services in the community

Many reported difficulties in being able to access rehabilitation services quickly once they were discharged, and when they did access it they were only provided the service for a limited time period which many felt was insufficient for their needs. They told us that they would like to receive regular reviews to ensure that they are receiving the appropriate level of care and support.

Stroke can be a life changing event which can be difficult for the patient and their families to deal with. It was felt that there was a need to ensure that people are provided with the appropriate levels of emotional support and advice, and where necessary have access to psychological therapies.

It was felt that more support should be provided for carers, so they know what to expect and how to support the person they are caring for. For many people this is the first time they have had to care for their loved one, and can be a very difficult time adapting to their new role. And as such they require emotional support, guidance and to be offered respite care.

Many people were unaware of the support the voluntary and community sector could provide, and requested that more information be provided to patients and their families / carers.

Of those that were aware of the support available they talked positively of the services provided by the following organisations; the Stroke Association, Speakability, Speak with It, Age UK and Scope.

They valued the support groups that they had attended and welcomed the opportunity to be able to speak to other people that had experienced a stroke. They felt that there should be more support groups, with specific groups for younger people and carers. Some were concerned that the funding of these organisations was inequitable and as such the provision of services was inconsistent across West Yorkshire and Harrogate. Of those that did provide services in their areas, there was some concern that the services may be cut.

People wanted the voluntary and community sector to provide befriending services to help reduce isolation; and support people in making meals, gardening, taking people shopping and supporting them to attend appointments. To support their recovery they also wanted to be able to access leisure facilities, such as swimming pools and gyms.

### Awareness and prevention

It was felt that there was a need to educate people on how to lead a healthier lifestyle using a wide range of approaches, such as leaflets, posters, social media, radio, television adverts, apps, delivering talks to people in a range of venues including community groups, places of worship, workplaces, schools and colleges.

It was suggested that having a patient talking about the impact stroke has had on their life and their families would be a powerful message that could support behaviour change. It was also felt that any campaign should make it clear that stroke can happen at any age.

GPs should undertake regular health checks of patients, especially those that are deemed to be high risk, and provide advice and support to lead a healthier lifestyle. Including providing access to smoking cessation, weight management, and exercise classes.

Many felt that there was a need to raise awareness of the signs and symptoms of a stroke, and what to do if you think someone is having a stroke. Some felt that the F.A.S.T. campaign didn’t raise awareness of all the signs and symptoms, and that some strokes could be missed.

## 2.0 Introduction

Across West Yorkshire and Harrogate, health and social care services, including the NHS, are working together to look at better ways of delivering care for people who have a stroke.

Stroke is a life changing event. And the care people receive in the first few hours after a stroke makes a difference to how well they can recover. This includes scans, tests and clot-busting drugs, which have to be delivered by highly trained staff working in specialist units at hospitals.

Evidence from elsewhere suggest outcomes following hyper-acute stroke are likely to be better if patients are treated in specialised centres, even if this increases travelling time following the event. Ongoing rehabilitation should however be provided at locations, closer to where people live, and they should be transferred to these as soon as possible after initial treatment.

At the moment, depending on where people live, they might experience different standards of care if they have a stroke. More needs to be done to make sure that no matter where people live they have access to specialist, high quality care - twenty four hours a day, seven days a week.

The NHS is developing proposals to make sure everyone in our region gets this specialist care they need in the first few hours after a stroke and that stroke care and support is sustainable and fit for the future. We also know that preventing stroke taking place in the first place, and ongoing care, such as physiotherapy, speech therapy or emotional support is really important. The NHS thinks that by coordinating services better, more people could receive the care they need in a community setting, closer to home.

And by improving people's health and supporting people to stay well, health services could prevent people from having strokes and going to hospital in the first place.

Before decisions are made on the future of stroke services in West Yorkshire and Harrogate, we wanted to find out what people think about the services that are currently provided and what would be important to them should they have a stroke, or care for someone who has now or in the future.

# 3.0 Our responsibilities, including legal requirements

## 3.1 Our responsibilities

Engaging people is not just about fulfilling a statutory duty or ticking boxes, it is about understanding and valuing the benefits of listening to patients and the public in the commissioning process.

By involving local people we want to give them a say in how services are planned, commissioned, delivered and reviewed. We recognise it is important who we involve through engagement activity. Individuals and groups play different roles and there needs to be engagement opportunities for both.

Engaging people who use health and social care services, and other stakeholders in planning services is vital to ensure services meet the needs of local communities. It is also a legal requirement that patients and the public are not only consulted about any proposed changes to services, but have been actively involved in developing the proposals.

## 3.2 Legal requirements

There are a number of requirements that must be met when discussions are being made about the development of services, particularly if any of these will impact on the way these services can be accessed by patients. Such requirements include the Health and Social Care Act 2012 and the NHS Constitution.

Health and Social Care Act 2012, makes provision for CCGs to establish appropriate collaborative arrangements with other CCGs, local authorities and other partners, and it also places a specific duty on CCGs to ensure that health services are provided in a way which promotes the NHS Constitution - and to promote awareness of the NHS Constitution.

Specifically, CCGs must involve and consult patients and the public:

- in their planning of commissioning arrangements
- in the development and consideration of proposals for changes in the commissioning arrangements, where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
- in decisions affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact

The Act also updates Section 244 of the consolidated NHS Act 2006 which requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSC) on any proposals for a substantial development of the health service in the area of the local authority, or a substantial variation in the provision of services.

The duties to involve and consult were reinforced by the NHS Constitution which stated: 'You have the right to be involved directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services'.

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'Equality of Opportunity', and c) foster good relations. To help support organisations to meet these duties a set of principles have been detailed in case law. These are called the Brown Principles;

- The organisation must be aware of their duty.
- Due regards is fulfilled before and at the time any change is considered as well as at the time a decision is taken. Due regards involves a conscious approach and state of mind.
- The duty cannot be satisfied by justifying a decision after it has been taken.
- The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
- The duty is a non-delegable one.
- The duty is a continuing one.

An Equality Impact Assessment (EQIA) will need to be undertaken on any proposals for changes to services that are developed through the programme, in order to understand any potential impact on protected groups and ensure equality of opportunity. Engagement must span all protected groups and other groups, and care should be taken to ensure that seldom-heard interests are engaged with and supported to participate, where necessary.

The Gunning Principles of Consultation are recommended as a framework for all engagement activity but are particularly relevant for consultation and would be used, in the event of a judicial review, to measure whether the process followed was appropriate. The Gunning Principles state that:

- Consultation must take place when the proposal is still at a formative stage
- Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response.
- Adequate time must be given for consideration and response
- The product of consultation must be conscientiously taken into account

## 4.0 Engagement process

Healthwatch organisations across West Yorkshire and Harrogate wanted to find out what people think about the services that are currently provided and what would be important to them should they have a stroke, or care for someone who has now or in the future. An engagement plan supporting this work was developed (see Appendix A). The engagement ran for six weeks, commencing on Wednesday 1st February until Wednesday 15th March 2017.

Existing data was collated and analysed to form part of the engagement process. The information considered as part of this exercise was any data from previous engagement and patient experience relating to stroke services.

As part of the plan a survey (see appendix B) was designed to gain feedback from people who had experienced a stroke, the wider public and key stakeholders. This was shared via our communication and engagement channels and with a wide range of organisations.

It should be noted that as engagement had already taken place in Airedale, Wharfedale, Craven and Bradford in 2015, Healthwatch Bradford and District adopted a different approach. This involved 15 semi-structured interviews with patients and carers identified through liaison with stroke rehabilitation wards at local hospitals.

Staff and volunteers from all West Yorkshire and Harrogate Healthwatch organisations (excluding Bradford and District as they took a different approach) contacted key organisations that were most likely to have an interest in stroke services and arranged outreach sessions. This included meeting with voluntary and community groups, attending GP practices, rehab units, stroke wards, and libraries. Overall, 54 face to face sessions were held across West Yorkshire and Harrogate talking to approximately 1,544 people.

In addition to the outreach sessions, 5 voluntary and community sector clinician led events were held in Calderdale, Kirklees, Leeds, Harrogate and Wakefield, for representatives from the voluntary and community sector (VCS) to talk to lead clinicians about stroke services across West Yorkshire and Harrogate and to provide an opportunity to take part in discussions.

We also used Facebook, Instagram and third party website advertising to promote the survey. The advert generated the following engagement:

Over 98,000 people saw the advert
1,628 people clicked to find out more about the advert

The work has also been supported by the West Yorkshire and Harrogate Communications and Engagement network which includes colleagues from clinical commissioning groups, hospitals, community care providers and local authorities.

This approach has enabled us to raise awareness of the stroke engagement work across the whole of the area using existing internal and external communication channels, for example information was sent to over 4,000 people who subscribe to the Kirklees Staying healthy e-bulletin.

Staff were also asked for their views on how best we move forward, with some hospitals, for example Harrogate and District NHS Foundation Trust, holding staff engagement sessions.

Health and Wellbeing Boards, Clinical Commissioning Group Governing Bodies, MP's and the Joint Health Overview Committee were also updated on the engagement work and asked to encourage people to have their say.

Regional and local media were also kept informed, and around 80 people who had registered an interest in STP updates were sent the stroke engagement survey link to complete.

## Equality

Engagement activity should include all protected groups and other relevant groups. Care should be taken to ensure that seldom-heard interests are engaged with and supported to participate, where necessary.

We monitored responses mid-way through the engagement to establish if any additional, more targeted engagement was required, to ensure that we were gaining views from the relevant protected groups. During the mid-point review it was highlighted that responses from key protected groups were low. To try to address this, it was agreed that the social media advertising should target males, people under the age of 65 and BME groups. In addition to the targeted social media advertising, Healthwatch organisations targeted their outreach sessions with key protected groups.

All engagement activity has been equality monitored to assess the representativeness of the views gathered during the engagement process. Where there are gaps in gathering the views of specific groups relating to the protected characteristics, this will need to be addressed as part of the next phase of engagement (pre-consultation) and prior to any formal consultation.

The data from the engagement activity will be combined with other data and research to develop the EQIA. This will help us to understand the potential impact of the proposals on different groups so that these can be fed into the decision making process.

## 5.0 Analysis of existing engagement

West Yorkshire and Harrogate STP have produced a report that pulls together all relevant engagement activity that has taken place during April 2012 to February 2017, across West Yorkshire and Harrogate. The report can be viewed here:

https://www.wakefieldccg.nhs.uk/fileadmin/STP/Publications/Engagement_and_consultation_mapping_document_-_March_2017_final.pdf

This report has been reviewed to establish if any engagement has previously taken place on stroke services. Airedale, Wharfedale, Craven and Bradford undertook engagement during 2015. The engagement that took place aimed to:

- communicate the change in hyper acute stroke unit arrangements (hyper-acute refers to the first few hours and days after the stroke occurs)
- understand the impact the change would have on local people
- find out what was important to people when accessing stroke services
- identify areas for potential service improvements

A range of engagement activities took place over a nine week period, from 13 July to 11 September 2015, and over 300 people's voices (views, opinions, insights, comments, experiences and suggestions) were heard.

In addition to this, during January to April 2016 Wakefield had also undertaken engagement as part of the pre-consultation phase that is taking place in South and Mid Yorkshire, Bassetlaw and North Derbyshire. By the end of the pre-consultation phase, they had received 247 online responses as well as written feedback from each of the events. They estimate that more than 500 face to face conversations took place.

South Yorkshire and Bassetlaw and North Derbyshire are proposing to make changes to hyper acute stroke services to improve the experience of patients needing stroke care in Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham and Sheffield. Their consultation closed on the 14 February 2017. Report findings are expected soon and you can view this here http://www.smybndccgs.nhs.uk/what-we-do/critical-care-stroke-patients

This may have an impact on people living on the boundary of West Yorkshire in regard to Pinderfields hospital admissions and we are working together with South Yorkshire , Bassetlaw and North Derbyshire commissioner to ensure any proposed changes (subject to the outcome of their consultation) inform our future proposals

The key themes raised across both pieces of engagement were:

- Fast ambulance response times / journey times to receive treatment
- Transfer times to receive treatment if presenting at other hospital sites
- Being seen quickly when get to a hospital

- Being seen and treated by knowledgeable staff
- Journey time and distance for visitors, and the cost of parking at the hospital
- More emotional support for patients, carers and family members
- To be able to access rehabilitation locally to aid recovery
- Information and communication need to be improved across services
- Involving family and carers (as they know the patient best and can advise while in critical condition)
- More education on the prevention of strokes

### Discharge and aftercare

Concerns were raised about aspects of discharge, rehabilitation and aftercare. These covered a wide range of specific issues including a reported under provision of speech therapy and physiotherapy; gaps in the provision of emotional support for patients, carers and family members, along with a lack of consistency when providing aids and adaptations to patients.

It was suggested there should be an increased focus on re-enablement and recovery and that more resources be put into rehabilitation and aftercare services locally, as getting the right information and support were deemed important to aid patient recovery and relieve anxiety and stress for patients and carers.

### Travel, transport and parking

The distance, time and cost to travel, along with the challenges of parking, were a concern. People were worried not only about how the extra journey time could affect the treatment and outcome for stroke patients but also how this would impact on the ability of carers and families to visit their loved one at this critical time, particularly those reliant on public transport.

Suggestions to address the concerns highlighted included providing help with travel costs for immediate family members e.g. a travel card, extended or open visiting times in order to avoid peak travel times, and some level of concession for parking.

### Treatment and care

There were concerns about moving the existing HASU at AGH to BRI and the impact, the additional distance, time and potentially different levels of service could have on the treatment and outcome of stroke patients living in Airedale, Wharfedale and Craven. Concerns were also raised for those people who self-present at AGH A & E not realising they are having a stroke; then having to be transferred to BRI before receiving treatment.

Suggestions proposed in relation to improving treatment and care included improving ambulance response time, ensuring there is a sufficient number of acute beds and creating a joined up fast track service from 999 and arrival through to assessment, tests and treatment.

### Staff

Whilst there were many positive comments in relation to staff and the care they provide, especially on Ward 5 at AGH, there were concerns about inadequate staffing levels, particularly specialist stroke staff and how staff shortages can result in delayed response time and limited contact time for patients. Also raised was whether general and agency nurses had the level of knowledge and skill, required for stroke care. There were also concerns raised in relation to the poor attitude of some staff and the impact of this on the patient/carer experience.

It was suggested that more specialist stroke staff were needed and that stroke training should be provided for general and agency nurses and, A & E staff.

### Information and communication

The need for improved information and communication between staff, patients and carers and between departments and across organisations were highlighted. In particular was the need of stroke patients and carers' to understand what has happened to them/their loved one during and after the stroke. Also raised was the need for appropriate forms of communication to be used with those patients whose ability to communicate has been impaired by the stroke.

It was suggested more information and advice about prevention of strokes, strokes and after care was required and that the patient information currently provided is reviewed to ensure it is easily understood and fit for purpose.

Further improving hyper acute stroke services (hyper-acute refers to the first few hours and days after the stroke occurs) and making sure all stroke care services are fit for the future has also been highlighted as a priority in the draft Sustainability and Transformation Plan (STP) for the area. This outlines how we want to improve people's health and wellbeing, for example by reducing incidence of stroke, premature mortality and further improving care quality, such as increasing the proportion of people scanned within 12 hours. As this engagement was limited to a few areas, it was agreed that engagement also needed to take place in the rest of West Yorkshire and Harrogate.

# 6.0 Analysis of engagement feedback

We received **940** completed surveys either via face to face engagement activities **(830, 88%)** or social media advertising **(110, 12%)**. In addition to the survey we also received feedback via:

- **54 outreach sessions** talking to approximately **1,544 people**
- **5 voluntary and community sector clinician led events** attended by **78 people**
- **15 semi-structured interviews** with people who had experience of stroke services in Airedale, Wharfedale, Craven and Bradford

## 6.1 Profile of the survey respondents

Appendix E provides a breakdown of the protected characteristics of the survey respondents. However it should be noted that approximately **25%** of people did not complete the equality monitoring form. In summary the survey respondents were:

- **60.3% (452)** were female and **38.3% (287)** were male
- **0.1% (1)** stated that their gender was different to the sex they were assumed to be at birth
- Respondents were aged between **17 and 101, with an average age of 58**
- **89.1% (636)** described themselves as heterosexual, **1.1% (8)** as lesbian, **1.3 % (9)** as gay, and **0.7% (5)** as bisexual.
- The majority of respondents, **88% (652)** described themselves as White, **5.1% (38)** as Asian or Asian British, **0.7% (5)** as Black or Black British, and **1.1% (8)** as Mixed or multiple ethnic groups
- **55.8% (406)** stated that they identified with Christianity, **27.7% (202)** no religion, **3.8% (28)** Islam, **0.8% (6)** Hinduism, **0.8% (6)** Judaism, **0.5% (4)** Buddhism, and **0.1% (1)** Sikhism
- **27.8% (203)** provide care for someone
- **23.6% (175)** described themselves as being disabled. With the majority having a disability that was physical or mobility impairment.

Where appropriate we analysed the data to establish if there were any variations in the views expressed by protected characteristics. These findings can be found in section 7.0.

## 6.2. Survey responses

**Q1. Which area do you live in?**

| Answer Options | % | No. |
|---|---|---|
| Bradford Metropolitan District | 8.8% | 82 |
| Calderdale | 7.9% | 74 |
| Harrogate and Rural District | 10.6% | 99 |
| Kirklees | 18.8% | 176 |
| Leeds | 20.0% | 187 |
| Wakefield District | 30.7% | 287 |
| Other | 3.2% | 30 |
| ***answered question*** | | **935** |
| ***skipped question*** | | **5** |

Other included Barnsley, Doncaster, Leicester, North Yorkshire, Rochdale, Selby, Sheffield, and York

**Q2. Are you completing this questionnaire as…**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| A member of the public | 79.4% | 740 | 75.6% | 62 | 73.0% | 54 | 62.6% | 62 | 77.1% | 135 | 79.2% | 145 | 89.5% | 256 |
| On behalf of a voluntary or community organisation | 3.1% | 29 | 1.2% | 1 | 5.4% | 4 | 2.0% | 2 | 5.1% | 9 | 1.1% | 2 | 3.5% | 10 |
| A health professional responding in a professional capacity | 11.1% | 103 | 13.4% | 11 | 10.8% | 8 | 27.3% | 27 | 9.7% | 17 | 14.2% | 26 | 3.5% | 10 |
| Other | 6.4% | 60 | 9.8% | 8 | 10.8% | 8 | 8.1% | 8 | 8.0% | 14 | 5.5% | 10 | 3.5% | 10 |
| ***Answered question*** | | **932** | | **82** | | **74** | | **99** | | **175** | | **183** | | **286** |
| ***Skipped question*** | | **8** | | **0** | | **0** | | **0** | | **1** | | **4** | | **1** |

Other included:

- Carer / family member / friend of someone who had a stroke

- Councillor
- Volunteer for Stroke Association
- CCG staff member
- Patient champion
- Physiotherapist
- Local government officer
- Press
- Retired health professional
- Speech and language therapy assistants
- Sensory services
- Retired health professional

**Q3. Have you or the person you care for had a stroke or a suspected stroke?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Yes | 49.2% | 455 | 58.5% | 48 | 63.0% | 46 | 55.7% | 54 | 42.6% | 75 | 58.0% | 105 | 41.1% | 116 |
| No | 50.8% | 469 | 41.5% | 34 | 37.0% | 27 | 44.3% | 43 | 57.4% | 101 | 42.0% | 76 | 58.9% | 166 |
| ***Answered question*** | | **924** | | **82** | | **73** | | **97** | | **176** | | **181** | | **282** |
| ***Skipped question*** | | **16** | | **0** | | **1** | | **2** | | **0** | | **6** | | **5** |

The area with the highest percentage of respondents who had a stroke or a suspected stroke was Calderdale with 63% of respondents, and Wakefield was the lowest with 41.1%

**Q4. Which hospital did you / or the person you care for initially attend when you had a stroke or a suspected stroke?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Airedale General Hospital | 2.0% | 8 | 17.9% | 7 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Bradford Royal Infirmary | 7.0% | 28 | 53.8% | 21 | 0.0% | 0 | 0.0% | 0 | 5.1% | 3 | 3.1% | 3 | 0.9% | 1 |
| Calderdale Royal Hospital | 12.3% | 49 | 10.3% | 4 | 79.5% | 35 | 2.3% | 1 | 13.6% | 8 | 1.0% | 1 | 0.0% | 0 |
| Dewsbury and District Hospital | 5.8% | 23 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 27.1% | 16 | 1.0% | 1 | 4.7% | 5 |
| Friarage Hospital | 0.5% | 2 | 0.0% | 0 | 2.3% | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Harrogate District Hospital | 9.0% | 36 | 0.0% | 0 | 0.0% | 0 | 72.7% | 32 | 0.0% | 0 | 2.1% | 2 | 0.9% | 1 |
| Huddersfield Royal Infirmary | 3.5% | 14 | 0.0% | 0 | 2.3% | 1 | 2.3% | 1 | 20.3% | 12 | 0.0% | 0 | 0.0% | 0 |
| Leeds General Infirmary | 17.5% | 70 | 7.7% | 3 | 0.0% | 0 | 4.5% | 2 | 6.8% | 4 | 60.8% | 59 | 0.9% | 1 |
| Pinderfields General Hospital | 24.1% | 96 | 2.6% | 1 | 0.0% | 0 | 4.5% | 2 | 13.6% | 8 | 5.2% | 5 | 74.5% | 79 |
| Pontefract General Infirmary | 2.8% | 11 | 2.6% | 1 | 2.3% | 1 | 0.0% | 0 | 0.0% | 0 | 1.0% | 1 | 7.5% | 8 |
| Skipton General Hospital | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| St James's University Hospital | 4.5% | 18 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 16.5% | 16 | 0.0% | 0 |
| Other | 11.0% | 44 | 5.1% | 2 | 13.6% | 6 | 13.6% | 6 | 13.6% | 8 | 9.3% | 9 | 10.4% | 11 |
| ***Answered question*** | | **399** | | **39** | | **44** | | **44** | | **59** | | **97** | | **106** |
| ***Skipped question*** | | **541** | | **43** | | **30** | | **55** | | **117** | | **90** | | **181** |

Other included:

- Barnsley
- Blackburn
- Bristol
- Burton on Trent
- Cyprus
- Darlington
- East Kilbride
- France
- Greece
- Ireland
- Hull

- Lanarkshire
- London
- Salford
- Scarborough
- Sheffield
- Tenerife
- U.S.A.
- York

**Q5. Was this the closest hospital to you when you had a stroke or a suspected stroke?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Yes | 79.5% | 314 | 89.7% | 35 | 90.9% | 40 | 88.4% | 38 | 65.5% | 38 | 67.0% | 65 | 85.6% | 89 |
| No | 17.2% | 68 | 7.7% | 3 | 6.8% | 3 | 9.3% | 4 | 34.5% | 20 | 25.8% | 25 | 11.5% | 12 |
| Not sure | 3.3% | 13 | 2.6% | 1 | 2.3% | 1 | 2.3% | 1 | 0.0% | 0 | 7.2% | 7 | 2.9% | 3 |
| ***Answered question*** | | **395** | | **39** | | **44** | | **43** | | **58** | | **97** | | **104** |
| ***Skipped question*** | | **545** | | **43** | | **30** | | **56** | | **118** | | **90** | | **183** |

The area with the highest number of respondents that attended the hospital closest to them was Calderdale with 90.9% of people, whilst 65.5% of respondents from Kirklees stated that they attended the hospital closest to them.

**Q6. Were you transferred to another hospital to continue with your treatment?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Yes | 27.4% | 108 | 35.9% | 14 | 6.8% | 3 | 20.9% | 9 | 48.3% | 28 | 26.3% | 25 | 25.7% | 27 |
| No | 69.8% | 275 | 61.5% | 24 | 93.2% | 41 | 72.1% | 31 | 51.7% | 30 | 69.5% | 66 | 73.3% | 77 |
| Not sure | 2.8% | 11 | 2.6% | 1 | 0.0% | 0 | 7.0% | 3 | 0.0% | 0 | 4.2% | 4 | 1.0% | 1 |
| ***Answered question*** | | **394** | | **39** | | **44** | | **43** | | **58** | | **95** | | **105** |
| ***Skipped question*** | | **546** | | **43** | | **30** | | **56** | | **118** | | **92** | | **182** |

The area with the highest number of people that were transferred to another hospital was Kirklees with 48.3% of respondents, and the lowest was Calderdale with 6.8%.



**Q7. Overall, how would you describe your experience of care when you had a stroke or a suspected stroke?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very Good | 44.7% | 174 | 55.3% | 21 | 50.0% | 22 | 55.0% | 22 | 31.0% | 18 | 50.0% | 47 | 39.0% | 41 |
| Good | 21.9% | 85 | 15.8% | 6 | 11.4% | 5 | 15.0% | 6 | 25.9% | 15 | 27.7% | 26 | 21.0% | 22 |
| Acceptable | 15.7% | 61 | 10.5% | 4 | 13.6% | 6 | 20.0% | 8 | 22.4% | 13 | 11.7% | 11 | 18.1% | 19 |
| Poor | 10.3% | 40 | 10.5% | 4 | 18.2% | 8 | 5.0% | 2 | 10.3% | 6 | 5.3% | 5 | 14.3% | 15 |
| Very poor | 7.5% | 29 | 7.9% | 3 | 6.8% | 3 | 5.0% | 2 | 10.3% | 6 | 5.3% | 5 | 7.6% | 8 |
| ***Answered question*** | | **389** | | **38** | | **44** | | **40** | | **58** | | **94** | | **105** |
| ***Skipped question*** | | **551** | | **44** | | **30** | | **59** | | **118** | | **93** | | **182** |

Across West Yorkshire and Harrogate, 66.6% of respondents rated their experience as either very good or good. The area with the highest number of respondents rating their experience as very good or good was Leeds at 77.7%, and Kirklees had the lowest with 56.9%.

**285** people (58.7% of respondents that had a stroke or a suspected stroke) provided an explanation for their answer. The main themes were:

- Many people described the excellent levels of care that they received in hospital, from being seen quickly, to accessing the most appropriate treatments and being kept informed. They talked about staff being willing to help although some felt that they were overworked so were sometimes unable to meet the needs of the patients.
- Many reported delays in being seen and treated in A&E. They felt that these delays in accessing treatment had resulted in long term damage. Some examples were given of where patients were waiting many hours in A&E before being seen, even when their GP had rung through to let the hospital know that the patient was having a stroke. Patients felt that they should be fast tracked to a stroke unit to start receiving the appropriate care as soon as possible.
- There were a few comments about patients being misdiagnosed and being sent home from A&E, even though it would transpire at a later date that they had had a stroke or TIA.
- There were reports of long waits in A&E following diagnosis whilst patients waited for a bed to become available. And when they were admitted it wasn't always to a stroke ward, which patients felt impacted negatively on their recovery.
- A few people commented that once admitted to a ward that they had been placed in a side room, which they had found quite stressful and isolating, and would have preferred the choice to be in a bay so they could be near other people.
- Comments on discharge ranged from people feeling that they were in hospital longer than they needed to be, to those that felt pressured to leave too soon.
- Some felt that there was a lack of co-ordination between services, and this was seen as more problematic when trying to organise across geographical boundaries.
- Many reported a lack of ongoing support once they were discharged from hospital, examples were given of aids, adaptations and home care not being in place, and having to source the support they required themselves.
- Some mentioned the lack of assessment of the needs of the patients and their families, particularly for those patients that had previously been carers for either their own children or partner.
- Some reported delays in accessing rehabilitation, such as physiotherapy and speech and language therapy. And when it was provided it was only for a short period of time and insufficient for the needs of the patients.

**Q8. Please tell us what could have improved your experience.**

**268** people (58% of respondents that had a stroke or suspected stroke) told us what could have improved their experience. Many people were happy with the care they had received and didn't feel that it could be improved. Of those that made suggestions the main themes were:

- Upon arrival at A&E people want to be able to access the right treatment and tests immediately, such as thrombolysis and scans. And to be cared for by staff who are stroke specialists.

- Once they have received a diagnosis they want to be admitted to a stroke unit, where they can start receiving physiotherapy and other rehabilitation services immediately.
- They want to be given the choice of being admitted to a side room or a bay, as some feel isolated being in a side room and prefer to be in a ward near other people.
- Whilst on the ward they would like the opportunity to speak to people that have experienced a stroke. Age UK and the Stroke Association were cited as examples of organisations that had provided useful support and advice to patients.
- They want to have a thorough assessment prior to being discharged, to ensure that they are ready to go home, and if they are, to have all the appropriate aids, adaptations and home care support in place prior to them being discharged.
- For all organisations who are involved in their care to communicate with each other to ensure that the patient receives a seamless service.
- That they, and their families are kept informed and involved throughout, so they know what to expect once they are discharged, are aware of what support is available and how to access it.
- Once they have been discharged, to receive regular reviews to ensure that they are receiving the appropriate level of care and support.
- To be able to access physiotherapy and other rehab services for as long as required, and for it not to be time limited.
- Raise awareness of the signs and symptoms of a stroke, and what to do if you think someone is having a stroke. Some people had gone to their GP rather than going straight to A&E.
- Ensure that stroke services also cater for younger people; it was felt by some that there is an assumption that strokes just affect older people.



**Q9. How important do you think the following are when accessing care in the first few hours after a stroke or a suspected stroke?**

**a. Fast ambulance response times**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 96.5% | 761 | 100% | 68 | 95.2% | 59 | 94.8% | 73 | 95.4% | 144 | 96.8% | 152 | 96.7% | 237 |
| Important | 3.0% | 24 | 0.0% | 0 | 1.6% | 1 | 5.2% | 4 | 4.0% | 6 | 3.2% | 5 | 2.9% | 7 |
| Slightly important | 0.1% | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.4% | 1 |
| Not important | 0.4% | 3 | 0.0% | 0 | 3.2% | 2 | 0.0% | 0 | 0.7% | 1 | 0.0% | 0 | 0.0% | 0 |
| ***Answered question*** | | **789** | | **68** | | **62** | | **77** | | **151** | | **157** | | **245** |
| ***Skipped question*** | | **151** | | **14** | | **12** | | **22** | | **25** | | **30** | | **42** |

**b. Being treated at a hospital close to home**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 61.6% | 476 | 77.9% | 53 | 68.3% | 41 | 72.0% | 54 | 51.0% | 75 | 57.4% | 89 | 61.1% | 146 |
| Important | 25.7% | 199 | 13.2% | 9 | 18.3% | 11 | 18.7% | 14 | 28.6% | 42 | 31.6% | 49 | 26.8% | 64 |
| Slightly important | 9.6% | 74 | 7.4% | 5 | 10.0% | 6 | 6.7% | 5 | 15.0% | 22 | 7.7% | 12 | 9.6% | 23 |
| Not important | 3.1% | 24 | 1.5% | 1 | 3.3% | 2 | 2.7% | 2 | 5.4% | 8 | 3.2% | 5 | 2.5% | 6 |
| ***Answered question*** | | **773** | | **68** | | **60** | | **75** | | **147** | | **155** | | **239** |
| ***Skipped question*** | | **167** | | **14** | | **14** | | **24** | | **29** | | **32** | | **48** |

Responses were analysed to establish if there was any variation in responses from those people that had had a stroke or a suspected stroke and had been transferred to another hospital. Results showed that those people that had a stroke and were transferred to another hospital 56% felt it was very important to be treated close to home, compared to 70% who had had a stroke but had not been transferred to another hospital.

**c. Being treated at a hospital where I can receive the scans, tests and drugs that I need**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 92.9% | 724 | 95.6% | 65 | 93.3% | 56 | 96.0% | 72 | 91.3% | 136 | 96.2% | 151 | 90.0% | 217 |
| Important | 6.7% | 52 | 4.4% | 3 | 6.7% | 4 | 4.0% | 3 | 8.7% | 13 | 3.2% | 5 | 9.1% | 22 |
| Slightly important | 0.4% | 3 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.6% | 1 | 0.8% | 2 |
| Not important | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| ***Answered question*** | | **779** | | **68** | | **60** | | **75** | | **149** | | **157** | | **241** |
| ***Skipped question*** | | **161** | | **6** | | **14** | | **24** | | **27** | | **30** | | **46** |

### d. Being treated by highly trained specialists

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 93.5% | 729 | 100% | 68 | 90.2% | 55 | 94.6% | 70 | 91.9% | 137 | 95.5% | 149 | 92.2% | 224 |
| Important | 6.2% | 48 | 0% | 0 | 9.8% | 6 | 4.1% | 3 | 8.1% | 12 | 4.5% | 7 | 7.0% | 17 |
| Slightly important | 0.3% | 2 | 0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.8% | 2 |
| Not important | 0.1% | 1 | 0% | 0 | 0.0% | 0 | 1.4% | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| ***Answered question*** | | **780** | | **68** | | **61** | | **74** | | **149** | | **156** | | **243** |
| ***Skipped question*** | | **160** | | **6** | | **13** | | **25** | | **27** | | **29** | | **44** |



### e. Being seen quickly when I get to a hospital

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 96.2% | 753 | 100% | 68 | 96.7% | 59 | 96.1% | 73 | 94.6% | 141 | 95.5% | 150 | 95.9% | 233 |
| Important | 3.7% | 29 | 0% | 0 | 3.3% | 2 | 3.9% | 3 | 5.4% | 8 | 4.5% | 7 | 3.7% | 9 |
| Slightly important | 0.1% | 1 | 0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.4% | 1 |
| Not important | 0.0% | 0 | 0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| ***Answered question*** | | **783** | | **68** | | **61** | | **76** | | **149** | | **157** | | **243** |
| ***Skipped question*** | | **157** | | **14** | | **13** | | **23** | | **27** | | **30** | | **44** |

### f. Safety and quality of the service

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 89.6% | 695 | 97.1% | 66 | 83.3% | 50 | 90.7% | 68 | 93.1% | 135 | 92.4% | 145 | 86.4% | 209 |
| Important | 10.1% | 78 | 2.9% | 2 | 15.0% | 9 | 9.3% | 7 | 6.2% | 9 | 7.0% | 11 | 13.6% | 33 |
| Slightly important | 0.4% | 3 | 0.0% | 0 | 1.7% | 1 | 0.0% | 0 | 0.7% | 1 | 0.6% | 1 | 0.0% | 0 |
| Not important | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| ***Answered question*** | | **776** | | **68** | | **60** | | **75** | | **145** | | **157** | | **242** |
| ***Skipped question*** | | **165** | | **14** | | **14** | | **24** | | **31** | | **30** | | **45** |

### g. Involving family and carers

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 89.6% | 695 | 73.5% | 50 | 65.0% | 39 | 72.0% | 54 | 66.4% | 97 | 73.7% | 115 | 67.8% | 164 |
| Important | 10.1% | 78 | 25.0% | 17 | 35.0% | 21 | 22.7% | 17 | 28.8% | 42 | 24.4% | 38 | 26.9% | 65 |
| Slightly important | 0.4% | 3 | 1.5% | 1 | 0.0% | 0 | 4.0% | 3 | 4.1% | 6 | 1.9% | 3 | 4.5% | 11 |
| Not important | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 1.3% | 1 | 0.7% | 1 | 0.0% | 0 | 0.8% | 2 |
| ***Answered question*** | | **776** | | **68** | | **60** | | **75** | | **146** | | **156** | | **242** |
| ***Skipped question*** | | **165** | | **14** | | **14** | | **24** | | **30** | | **31** | | **45** |

### h. Other

**97** people (10.3% of all survey respondents) commented on what else they viewed to be important within the first few hours of having a stroke or a suspected stroke. The main themes were:

- To be treated by qualified ambulance staff who have access to the appropriate equipment, and to be taken to a hospital that will provide the best care.

- When attending A&E to be seen immediately and to be able to access the latest treatments such as thrombolysis, thrombectomy and scans, and to be treated by staff who are stroke specialists.
- To be able to be admitted to a stroke unit to ensure that they receive the best care.
- Many people said that they would travel further if it meant they were able to access the best treatment and to be treated by specialists; however, they wanted rehab to be available closer to home. Although, it should be noted that some people wanted all services to be available locally.
- There was some concern that the number of stroke units would be reduced, and this reduction could lead to the remaining units being unable to cope with demand and impact negatively on health outcomes. Some people also expressed concern that their families would have to travel further to visit them in hospital or attend appointments.
- Ensure patients and their families are provided with appropriate levels of aftercare and support, and that this should include emotional support.
- For all organisations who are involved in their care to communicate with each other to ensure that the patient receives a seamless service.
- That they, and their families are kept informed and involved throughout, so they know what to expect once they are discharged, are aware of what support is available and how to access it.



**Q10. How important do you think the following are when accessing after care for people who have had a stroke?**

**a. Be able to access rehabilitation services close to home to help you recover**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 79.7% | 623 | 88.2% | 60 | 70.5% | 43 | 88.3% | 68 | 76.4% | 113 | 76.4% | 120 | 81.0% | 196 |
| Important | 18.4% | 144 | 8.8% | 6 | 26.2% | 16 | 11.7% | 9 | 21.6% | 32 | 19.1% | 30 | 18.6% | 45 |
| Slightly important | 1.7% | 13 | 2.9% | 2 | 3.3% | 2 | 0.0% | 0 | 1.4% | 2 | 3.8% | 6 | 0.4% | 1 |
| Not important | 0.3% | 2 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.6% | 1 | 0.0% | 0 |
| ***Answered question*** | | **782** | | **68** | | **61** | | **77** | | **148** | | **157** | | **242** |
| ***Skipped question*** | | **158** | | **14** | | **13** | | **22** | | **28** | | **30** | | **45** |

**b. Be able to access a range of rehabilitation services, such as physiotherapy, speech and language therapy, emotional support**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 87.7% | 682 | 97.1% | 66 | 83.6% | 51 | 90.7% | 68 | 89.9% | 134 | 81.5% | 128 | 87.9% | 210 |
| Important | 12.1% | 94 | 2.9% | 2 | 16.4% | 10 | 9.3% | 7 | 9.4% | 14 | 18.5% | 29 | 11.7% | 28 |
| Slightly important | 0.3% | 2 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.0% | 0 | 0.4% | 1 |
| Not important | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| ***Answered question*** | | **778** | | **68** | | **61** | | **75** | | **149** | | **157** | | **239** |
| ***Skipped question*** | | **162** | | **14** | | **13** | | **24** | | **27** | | **30** | | **48** |

**c. Be involved in decisions about my care**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 84.0% | 652 | 89.7% | 61 | 80.0% | 48 | 85.3% | 64 | 87.8% | 129 | 79.6% | 125 | 83.3% | 200 |
| Important | 14.8% | 115 | 10.3% | 7 | 20.0% | 12 | 14.7% | 11 | 10.2% | 15 | 19.1% | 30 | 15.4% | 37 |
| Slightly important | 0.9% | 7 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 2.0% | 3 | 0.6% | 1 | 0.8% | 2 |
| Not important | 0.3% | 2 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.6% | 1 | 0.4% | 1 |
| ***Answered question*** | | **776** | | **68** | | **60** | | **75** | | **147** | | **157** | | **240** |
| ***Skipped question*** | | **164** | | **14** | | **14** | | **24** | | **29** | | **30** | | **47** |

### d. Being treated by highly trained specialists

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 87.0% | 676 | 94.1% | 64 | 76.7% | 46 | 88.0% | 66 | 89.8% | 132 | 82.2% | 129 | 90.9% | 219 |
| Important | 12.1% | 94 | 5.9% | 4 | 18.3% | 11 | 10.7% | 8 | 9.5% | 14 | 17.2% | 27 | 8.7% | 21 |
| Slightly important | 0.8% | 6 | 0.0% | 0 | 5.0% | 3 | 0.0% | 0 | 0.7% | 1 | 0.6% | 1 | 0.4% | 1 |
| Not important | 0.1% | 1 | 0.0% | 0 | 0.0% | 0 | 1.3% | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| ***Answered question*** | | **777** | | **68** | | **60** | | **75** | | **147** | | **157** | | **241** |
| ***Skipped question*** | | **163** | | **14** | | **14** | | **24** | | **29** | | **30** | | **46** |

### e. Safety and quality of the service

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 86.8% | 670 | 97.1% | 66 | 75.0% | 45 | 88.0% | 66 | 89.8% | 132 | 82.6% | 128 | 89.1% | 212 |
| Important | 12.8% | 99 | 2.9% | 2 | 23.3% | 14 | 12.0% | 9 | 10.2% | 15 | 16.8% | 26 | 10.9% | 26 |
| Slightly important | 0.4% | 3 | 0.0% | 0 | 1.7% | 1 | 0.0% | 0 | 0.0% | 0 | 0.6% | 1 | 0.0% | 0 |
| Not important | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| ***Answered question*** | | **772** | | **68** | | **60** | | **75** | | **147** | | **155** | | **238** |
| ***Skipped question*** | | **168** | | **14** | | **14** | | **24** | | **29** | | **32** | | **49** |

### f. Involving family and carers

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Very important | 75.7% | 578 | 85.3% | 58 | 63.2% | 36 | 82.2% | 60 | 75.5% | 111 | 78.3% | 123 | 73.9% | 173 |
| Important | 21.6% | 165 | 14.7% | 10 | 35.1% | 20 | 12.3% | 9 | 22.4% | 33 | 21.0% | 33 | 22.2% | 52 |
| Slightly important | 2.2% | 17 | 0.0% | 0 | 1.8% | 1 | 4.1% | 3 | 2.0% | 3 | 0.6% | 1 | 3.0% | 7 |
| Not important | 0.5% | 4 | 0.0% | 0 | 0.0% | 0 | 1.4% | 1 | 0.0% | 0 | 0.0% | 0 | 0.9% | 2 |
| ***Answered question*** | | **764** | | **68** | | **57** | | **73** | | **147** | | **157** | | **234** |
| ***Skipped question*** | | **176** | | **14** | | **17** | | **26** | | **29** | | **30** | | **53** |

### g. Other

**88** people (9.3% of all survey respondents) provided comments on other areas that they viewed to be important when accessing aftercare following a stroke. The main themes were:

- They want to have a thorough assessment prior to being discharged, to ensure that they are ready to go home, and if they are, to have all the appropriate aids, adaptations and home care support in place prior to them being discharged.
- To ensure that the needs of the whole family are assessed, especially in situations where the patient had previously been a carer for either their own children or partner.
- For all organisations who are involved in their care to communicate with each other to ensure that the patient receives a seamless service.
- That they, and their families are kept informed and involved throughout, so they know what to expect once they are discharged, are aware of what support is available and how to access it.
- Once they have been discharged, to receive regular reviews to ensure that they are receiving the appropriate level of care and support.
- To be able to access physiotherapy and other rehab services close to home for as long as required, and for it not to be time limited.
- Stroke can be a life changing event which can be difficult for the patient and their families to deal with. Need to ensure that people are provided with the appropriate levels of emotional support and advice, and where necessary have access to psychological therapies.

- There was some concern that services may be reduced which could result in patients and their families having to travel further to attend appointments.

**Q11. Please let us know if you have any suggestions on how social care could support patients and their families / carers following a stroke.**

**414** people (45.3% of all survey respondents) provided suggestions on how social care could support patients and their families / carers following a stroke. The main themes were:

- For a social worker to be assigned to each stroke unit / ward, to make sure that a thorough assessment of needs can take place prior to discharge, and to ensure that all the appropriate aids, adaptations and home care support are in place prior to them being discharged.
- For those people that are not ready to go home, to be provided with an intermediate care beds / rehabilitation unit to support them in their recovery.
- For all organisations who are involved in their care to communicate with each other to ensure that the patient receives a seamless service. To support this, a suggestion was made that teams should be multi-disciplinary and include social care, speech and language therapy, physiotherapy and occupational therapy.
- That they, and their families are kept informed and involved throughout, so they know what to expect once they are discharged, are aware of what support is available and how to access it, this should include emotional support and financial advice. They would like to have a named person who is responsible for co-ordinating their care and who can provide them with support and advice.
- Once they have been discharged, to receive regular reviews to ensure that they are receiving the appropriate level of care and support.
- To be able to access physiotherapy and other rehab services close to home for as long as required, and for it not to be time limited.
- Access to support groups and social activities, to help reduce isolation and to give people an opportunity to speak to other stroke patients. Specific mention was made to the services provided by the Stroke Association and Speakability.
- To provide support for carers, so they know what to expect and how to support the person they are caring for. For many people this is the first time they have had to care for their loved one, and can be a very difficult time adapting to their new role. And as such they require emotional support, guidance and to be offered respite care.

**Q12. Please let us know if you have any suggestions on how the voluntary and community sector could support patients and their families / carers following a stroke.**

**381** people (40.5% of all survey respondents) provided suggestions on how the voluntary and community sector could support patients and their families / carers following a stroke. The main themes were:

- Many people were unaware of the support the voluntary and community sector could provide, and requested that more information be provided to patients and their families / carers. They want to know what is available and how to access it.
- Of those that were aware of the support available they talked positively of the services provided by the following organisations; the Stroke Association, Speakability, Speak with It, Age UK and Scope. Some were concerned that the funding of these organisations was inequitable and as such the provision of services was inconsistent across West Yorkshire and Harrogate. Of those that did provide services in their areas, there was some concern that the services may be cut.
- People wanted the voluntary and community sector to provide befriending services to help reduce isolation; and support people in making meals, gardening, taking people shopping and supporting them to attend appointments.
- They valued the support groups that they had attended and welcomed the opportunity to be able to speak to other people that had experienced a stroke. They felt that there should be more support groups, with specific groups for younger people and carers.
- To support their recovery they wanted to be able to access leisure facilities, such as swimming pools and gyms.
- They wanted to be able to access support and advice on how to cope with a stroke, and for this to include emotional support and financial advice. It was suggested by some that a telephone helpline should be available.
- To provide support for carers, so they know what to expect and how to support the person they are caring for. For many people this is the first time they have had to care for their loved one, and can be a very difficult time adapting to their new role. And as such they require emotional support, guidance and to be offered respite care.



## Prevention

**Q13. Did you know that having a healthy diet, exercising regularly, stopping smoking and cutting down on the amount of alcohol you drink can reduce your risk of having a stroke?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Yes | 96.1% | 742 | 92.4% | 61 | 95.1% | 58 | 98.7% | 74 | 96.6% | 144 | 98.1% | 151 | 94.6% | 226 |
| No | 1.8% | 14 | 3.0% | 2 | 1.6% | 1 | 0.0% | 0 | 2.0% | 3 | 0.6% | 1 | 2.9% | 7 |
| Not sure | 2.1% | 16 | 4.5% | 3 | 3.3% | 2 | 1.3% | 1 | 1.3% | 2 | 1.3% | 2 | 2.5% | 6 |
| ***Answered question*** | | **772** | | **66** | | **61** | | **75** | | **149** | | **154** | | **239** |
| ***Skipped question*** | | **168** | | **16** | | **13** | | **24** | | **27** | | **33** | | **48** |

**Q14. Please let us know if you have any suggestions on how we can support and educate people to help reduce their risk of having a stroke.**

**384** people (40.8% of all survey respondents) made suggestions on how we can support and educate people to help reduce their risk of having a stroke. The main themes were:

- Many felt that there was already enough support and education available, and some questioned whether it had any impact on changing people's behaviour.
- It was suggested that children should be taught in school how to lead a healthy lifestyle, and the impact on their health if they don't.
- Many were aware of the F.A.S.T. campaign and felt that there needed to be similar campaigns to educate people on prevention. It was suggested that having a patient talking about the impact stroke has had on their life and their families would be a powerful message that could support behaviour change. It was also felt that any campaign should make it clear that stroke can happen at any age.
- Some felt that the F.A.S.T. campaign didn't raise awareness of all the signs and symptoms, and that some strokes could be missed. People also felt that there needed to be more awareness of what to do if they suspect they are having a stroke.
- GPs should undertake regular health checks of patients, especially those that are deemed to be high risk, and provide advice and support to lead a healthier lifestyle.
- Provide services to support people to lead a healthier lifestyle, such as smoking cessation, weight management, and exercise classes.
- Deliver talks to people in a range of venues including community groups, places of worship, workplaces, schools and colleges.
- Educate via leaflets, posters, social media, radio, television adverts, and apps.

**Q15. Please tell us if you have any further comments about how we can improve stroke services across West Yorkshire and Harrogate**

**282** people (30% of all survey respondents) made comments on how we can improve stroke service across West Yorkshire and Harrogate. The main themes were:

- Ambulances to arrive quickly and commence treatment.
- Recruit and train more specialist stroke staff.
- Upon arrival at A&E people want to be able to access the right treatment and tests immediately, such as thrombolysis, thrombectomies and scans. And to be cared for by staff who are stroke specialists.
- To increase the numbers of bed in stroke units to ensure all stroke patients are able to be admitted to the best place to support their recovery.
- Increase funding to ensure all patients are able to access the best treatment immediately. There was a range of opinions as to whether this should be available in all local hospitals or whether it should be based in a few specialist centres. Of those that commented, most felt that it should be provided in their local hospital, as they were concerned that the additional travel time could lead to negative health outcomes, and would mean their families having to travel further to visit them.
- That they, and their families are kept informed and involved throughout, so they know what to expect once they are discharged, are aware of what support is available and how to access it. This should include information on emotional support and financial advice.

- They want to have a thorough assessment prior to being discharged, to ensure that they are ready to go home, and if they are, to have all the appropriate aids, adaptations and home care support in place prior to them being discharged.
- For all organisations who are involved in their care to communicate with each other to ensure that the patient receives a seamless service.
- Once they have been discharged, to receive regular reviews to ensure that they are receiving the appropriate level of care and support.
- To be able to access physiotherapy, clinical psychology and other rehab services close to home for as long as required, and for it not to be time limited.
- To raise awareness of how to prevent a stroke, the signs and symptoms of a stroke, and what to do if you think someone is having a stroke.

## 6.3 Feedback from outreach sessions and VCS events

### Calderdale

Calderdale Healthwatch met with Heath Stroke Group, Calderdale Stroke Support Club, Calderdale Health Forum and held an event for the VCS. During these activities they spoke to 70 people. The main themes raised were:

#### Future of stroke services

- There was concern that decisions had already been made and that the stroke unit in Calderdale would be closing, and patients would have to travel to Huddersfield which they didn't want to do.
- There was concern that an increase in travel time to access a HASU could result in negative health outcomes. And some questioned whether a HASU would deliver any better care, citing examples of other areas that had adopted this model and had seen no benefits or improvements. It was felt that the proposals were finance driven as people were happy with the care they currently received, so didn't feel it needed to be changed.
- There was concern that if people had to travel further this would impact on their families being able to visit them in hospital. Families and friends were seen as vital in supporting people in their recovery.
- There was concern that HASUs wouldn't be able to cope with the demand placed upon them if the number of units were reduced. It was felt that there was a need to look at recruitment and retention of stroke specialists, and there was some concern that if units are closed staff may leave.
- Queried how patient records would be shared between Hyper Acute Stroke Units (HASU) and stroke units in different locations. As currently there is no process in place and communication between different organisations is poor.

#### Staffing

- Paramedics and A&E staff need to receive more training on how to recognise and manage strokes. Particular reference was made to young people and how they are more likely to be misdiagnosed.
- To increase the amount of space on the wards for patients with immediate care needs, there should also be a specialist intermediate facility built for stroke survivors who need ongoing care to get back on their feet before they go home.
- Some reported an absence of specialist care at the weekend – no specialist consultants, and agency/bank nurses who deliver poor quality care. It was felt that there should not be a difference in care between during the week and at the weekend, and felt that if the new HASUs would be staffed appropriately 24/7, then this could be an improvement.

#### Discharge process

- Patients should have a thorough assessment prior to being discharged, to ensure that they are ready to go home, and if they are, to have all the appropriate aids, adaptations and home care support in place prior to them being discharged.

There was some concern that social workers at the hospital were inexperienced and they didn't know about the community support that is available for people, so often stroke survivors are left not knowing what support is out there.

- People should be able to access rehab immediately upon discharge, currently they have to wait approximately 10 weeks for a physiotherapy appointment.
- The process for ensuring you have the funding you need in place for the care you have been assessed as needing should be simplified and more clearly explained. Some people are told "you need this service" but then told "you'll have to pay £45 per day for it though". Then when they find out they have to pay, they turn the support down.

### Prevention

- Need to raise awareness with the public on how to prevent a stroke, signs and symptoms of a stroke, and what to do it you suspect someone is having a stroke. Awareness needs to be raised with younger people as there is an assumption that strokes only affect older people.

### Support groups

- People that attended support groups and clubs were very positive about the support that they provided. There was some conern about the long term funding of these groups. In a climate where money is tight, they would like to see more VCS organisations pooling their resources and sharing buildings so they can keep services open.
- They felt there needed to be an acknowledgement of the increasing need for stroke support services - more people having strokes and more people surviving them - so why are we reducing funding for support in the community and the hospitals? Why aren't there intermediate care beds?
- There needs to be variety in the types of support available – different things are appropriate for different people – a day centre is not right for everyone, but it is for some. There is very limited choice in Calderdale – even less so now that Heath Stroke Club is closing. Stroke survivors felt it was so important to have community support available – something that's like a family wrapped around you to stop you from feeling alone and to help you get through.
- Many people told us about the need for more support for their relatives such as briefings on possible changes for the person they care for – these could be minor attitude changes or personality differences – and these can be life changing.
- Younger patients were not always listened to and often were not treated with dignity.
- There was a really strong focus from the group that stroke was an emotionally life-changing event – there is a great deal of medical/clinical care available to help people to move on from stroke, but there is not the corresponding emotional support to help you to move forward. Giving time to addressing emotions was essential. When members of the Stroke Association came onto the ward and told them they also had had a stroke, they immediately experienced empathy and realised for the first time that someone understood what they were feeling. This bonding helped with their adapting to all the changes that were happening to them.

- There is a need for more support from voluntary sector/local authority/community services with less eligibility criteria. At the moment, it can feel like there are a lot of barriers to access these types of support and that your need has to fit certain criteria for you to be able to get help you need.
- There is now a carers station at Ward 7 in Calderdale delivered by the Stroke Association, where carers and people who have had strokes can get information about how to manage after stroke. There is also a 6 month review that takes place, where people who were provided with some information are then seen 6 months down the line to see how their support needs have changed.

## Harrogate

Healthwatch North Yorkshire met with exercise groups, attended outpatients, stroke units and held an event for the VCS. During these activities they spoke to 62 people. The main themes raised were:

- Lack of support from rehabilitation, in particular mental health services, services tend to be focused on physical health.
- People needed to be reassured about preventative measures and the provision of rehabilitation services.
- Some questioned the use of the term hyper acute stroke units, and suggested that should use the term emergency or something more understandable.
- There was some concern about the possible reduction in the number of HASUs, and that a decision had already been made.
- Some felt that the survey had been designed to get buy in for a change in the number of HASUs, and were cynical about the purpose of the survey and engagement process.

## Kirklees

Healthwatch Kirklees met with community groups and held an event for the VCS. During these activities they spoke to 171 people. The main themes raised were:

- People were aware that the first few hours after a stroke are crucial, so they want to be seen quickly and to be treated by highly trained specialists, with access to the best treatment such as scans and thrombolysis.
- To receive this treatment most people were happy to travel to access it, their priority wasn't location but ability to have the best treatment quickly. Although there was concern about being taken in an ambulance further away and whether this could delay them receiving treatment. Some people also expressed concern that if they were taken to a hospital further away it may be difficult for family to attend.
- People trust that paramedics will take the patient to the best hospital for their condition. They expect that the paramedics will have had the appropriate training to start treating patients whilst in the ambulance. And that they will liaise with the hospital that they are bringing in a potential stroke patient, so the patient can be seen and treated upon arrival.

- There was some concern around the number of HASU's being reduced and the increase in patients. This led to some questions around whether funding will be available to pay for the increase in stroke patients? If the number of HASUs are reduced this will lead to a decrease in beds, how will they cope with demand? Even if the numbers of HASUs are not reduced, would they be able to cope with the 20% increase in number of stroke patients by 2020 as predicted?
- Many felt that there was a need to increase awareness with the general public of the signs that a stroke is occurring and what to do if you suspect someone is having a stroke.
- Whilst most people were happy to be treated in a hospital further away within the first few hours, for ongoing rehabilitation they wanted to be treated closer to home, where they could have the support of their family and friends.
- They want to be able to access rehabilitation immediately and do not want to have to wait.
- They want to be treated by highly trained staff. Specialist care is key but there was some concern about the ability to recruit the right people.
- Need high standard of care across the patch and to ensure that there isn't a postcode lottery.
- Stroke impacts on patient and the family / carers too, need a key link person / co-ordinator to support people through the change, and to provide practical advice such as how to access support groups, care packages, funding etc. Also need to be mindful about those people that don't have family / carers close by to provide the ongoing support.
- Need to involve patients and their family / carers in decisions about their ongoing care.
- GPs need to be better at referring patients to the third sector, as patients can usually access these services quicker than NHS / Social Care services.
- Need integration across NHS, VCS, and Social Care. To ensure that provide a seamless service throughout.

## Leeds

Healthwatch Leeds met with stroke groups, attended outpatients, stroke units and held an event for the VCS. During these activities they spoke to 94 people. The main themes raised were:

- Importance of listening to patients
- Rehabilitation services, such as physiotherapy should not have a cut-off point and they should be available as long as patients need them, funded by the NHS. Physio should continue for a minimum of 1-2 years to maximise the 'potential' rehabilitation of the person. Likewise specialist speech therapy should be available longer as communication difficulties cause so many other barriers to recovery.
- Improving communication between wards, hospitals, clinics and the community teams
- More consistent approaches across stroke services- Increase or decreases services appropriately based on patient's individual condition
- Involvement of the 3rd sectors organisation

- Sharing feedback between hospital, community and other related stroke service such as community support groups
- Stroke associations will arrange feedback from patients to LGI and on how best to improve services
- Electronic record sharing will help to improve the efficiency of the stroke service.
- Improve coordination of appointments between each service in the stroke support package provided in the first 6 weeks.
- Involving community dietician in stroke management
- Be able to access rehabilitation services close to home
- Every stroke is different, they need to explain how it affects me individually and then put appropriate social care in place.
- Support groups are extremely useful, needs to be more groups with more funding for activities that help people recovering from stroke.
- Suggested that could have a 'one stop shop', where you can go for speech, physio, and luncheon club, socialising, activities to reduce loneliness and isolation.

## Wakefield

Healthwatch Wakefield met with stroke groups, community groups, attended outpatients, stroke units, libraries and held an event for the VCS. During these activities they spoke to approximately 1,225 people. The main themes raised were:

- People understood the clinical case for a change to fewer, more specialised stroke units once it was explained by a stroke specialist.
- One person felt that the survey itself wasn't focused well enough for 'at risk' groups.
- People felt more attention / education should be given to what one should do when someone has a stroke, i.e. that time is of the essence, call an ambulance don't take someone to A&E yourself because otherwise there are pathways that you might miss and so on.
- In Wakefield there is an assumption that a specialised stroke unit would stay in Pinderfields or at worst be at Leeds which doesn't feel like a big issue for most.

## 6.4 Feedback from interviews undertaken in Airedale, Wharefedale, Craven and Bradford

### 6.4.1 Introduction

In 2015 stroke services in Airedale, Wharfedale, Craven and Bradford were reconfigured, with a single Hyper Acute Stroke Unit based at Bradford Royal Infirmary receiving patients from across the area. At the time of this change, engagement was carried out by the local CCGs and Healthwatch with local stroke support groups and the wider public; the findings from this engagement have already been considered as part of the current project.

To add further insight, Healthwatch Bradford and District carried out in-depth interviews with patients and carers who have experienced the new stroke pathway in the area. Our conversations with people covered their journey through the pathway, from the onset of stroke through hospital treatment and rehabilitation:

- Pre-hospital (Symptoms - including F.A.S.T. -/+, ambulance response, pathway decisions)
- At hospital (pathway, communication, treatment by staff, information and attitude)
- Visiting (including: transport, parking, visiting times)
- Discharge (communication, speed, information, community support)
- Anything you would improve or change?
- What made the biggest difference?

Our aim was to test out whether the issues that people had raised during previous engagement as potential concerns were reflected in the experiences of people who had received care for a stroke since the new pathway was introduced.

In this report we provide a summary of people's experiences through each stage of the patient journey. Four detailed case studies illustrate the overall experience of stroke care in Airedale, Wharfedale, Craven and Bradford.

### 6.4.2 Method

Healthwatch Bradford and District carried out fifteen interviews with stroke survivors and/or members of their families to gain an in-depth understanding of people's experiences of stroke services in our district. The one criterion was that their stroke had occurred since August 2015, which was when the HASU at Airedale General Hospital (AGH) relocated to Bradford Royal Infirmary (BRI).

A semi-structured style of interview was chosen because it would provide comparable, qualitative data whilst allowing the people we met to talk about what was important to them, in their own words. We drew up open-ended questions to cover someone's experience of the different stages in the pathway from first symptoms to post-discharge (if applicable) and to cover visiting and communication. Prompts were added to the

interviewer's document to help the interviewer guide the people we spoke to. A note taker was present at every interview to capture the responses.

It was important to Healthwatch Bradford and District to speak to people who were treated in Bradford hospitals alone as well as people whose treatment was split between Bradford and Airedale as a result of the pathway change in 2015.

We organised visits to two stroke rehabilitation wards – Ward 5 at AGH and Ward F3 at St Luke's Hospital, Bradford. Over three visits to these hospitals we completed seven interviews with patients or visiting family members. Before our visits, staff on the wards had identified specific patients or families who were well enough and willing to speak to us and we were introduced on arrival.

We also spoke to eight people who had been discharged from hospital in the last year to hear about the whole pathway through to support after discharge. Initial contact with these people was made by the stroke specialist nurse at AGH and a community stroke nurse from Bradford Teaching Hospitals Foundation Trust (BTHFT). We then made arrangements to carry out interviews in people's own homes.

### 6.4.3 Profile of people interviewed

- **9** were male and **6** were female
- They were aged between **32 and 82, with an average age of 65**
- **12** described themselves as White, **2** as Black or Black British, and **1** as Asian or Asian British
- **10** stated that they identified with Christianity, **3** no religion and **1** Islam
- All people who gave their sexual orientation identified as **heterosexual**
- **3** provide care for someone
- **3** described themselves as having a disability.

### 6.4.4 Findings

Overall we found that most people we spoke to from the Airedale area of the district understood why they had been taken to Bradford for their initial care, knew they would be transferred back to a local hospital as quickly as possible and were satisfied that it gave them the best clinical outcomes. People highly valued the specialist staff and treatments available during the first few hours after a stroke.

#### a. Pre-hospital

#### F.A.S.T. test

During our conversations with people, five described initial symptoms that wouldn't be picked up by the F.A.S.T. (Face Arms Speech Time) test, for example: dizziness, nausea, confusion, loss of mobility, difficulty walking, and loss of consciousness. One of these people specifically suggested that awareness should be raised about the additional symptoms of stroke that are not picked up by the F.A.S.T. test. We were told by one person that it was the F.A.S.T. campaign that enabled them to positively identify stroke.

### Calls to 999/111

Most people called 999, two people called 111, one person took their husband directly to the hospital and another person was taken to hospital by the family after a visit from the GP, who made a referral to the Ambulatory Care Unit at Airedale General Hospital. Most people were happy with the help they received from the services prior to an ambulance arriving, and several told us that someone stayed on the line until the ambulance or first responder arrived.

### Ambulance response

In the majority of cases the ambulance arrived promptly, within 10-20 minutes, although there were a couple of occasions when delays occurred for up to an hour. Delays in the cases highlighted were due to difficulty in moving the patient, requiring a second crew, or due to being in a rural location, when an ambulance was some distance away.

An example of a delay is when a relative called 999 for a woman who had started to feel dizzy, started slurring her words, collapsed and lost consciousness. An ambulance arrived within 10 minutes. A second crew was requested to assist in moving the patient, as she was on a second floor and access was limited. There was a delay of around an hour before the second crew arrived due to the rural location at the far end of the Craven area. The family wondered why the ambulance service didn't request help from the Fire Service or Mountain Rescue who were closer at hand.

All of the people who talked directly about the ambulance crews were complimentary; comments included 'the crew were lovely' and 'the crew were very fast, really professional'.

All of the patients who were F.A.S.T. positive were correctly taken to BRI. Some people were taken to AGH, when it wasn't clear they had suffered a stroke and were F.A.S.T. negative. The people who were taken by ambulance to AGH initially and subsequently received a diagnosis of a stroke were then transferred by ambulance to BRI.

### b. At hospital

During our conversations, people rated different periods of their care. Most people rated their care highly.

**Q1. Overall, how would you rate your initial treatment (HASU)?**
Not all respondents were able to remember the HASU stage of their care.

| Answer Options | No. |
|---|---|
| Excellent | 9 |
| Good | 3 |
| Fair | 0 |
| Poor | 0 |
| Inadequate | 0 |
| ***Answered question*** | **12** |
| ***Skipped question or n/a*** | **3** |

**Q2. Overall, how would you rate your experience of the rehabilitation ward?**

| Answer Options | No. |
|---|---|
| Excellent | 8 |
| Good | 5 |
| Fair | 0 |
| Poor | 1 |
| Inadequate | 0 |
| ***Answered question*** | **14** |
| ***Skipped question or n/a*** | **1** |

### Single pathway

Almost all people from the Airedale area were accepting of having to go to BRI because they knew it was where they'd get the treatment they needed, despite the further distance and travelling time: 'care over two hospitals doesn't matter as long as you're getting the treatment. BRI is travelling distance so it's fine'.

People recognised that their stay in BRI wasn't for long and were pleased to be transferred to AGH as it was closer to home. There was an understanding that living in a rural area often means having to travel further for health services.

One person who had experienced several strokes would have rather not gone to BRI; this was the one thing he would have changed about his experience. His wife said 'it wasted time. It wasted a bed for someone at BRI'. This seemed to be in light of feeling that care at AGH was better and that he didn't receive thrombolysis or specialist treatment at BRI.

One patient said they didn't really know which hospital they were at, 'it was all a bit of a blur'.

### Hyper Acute Phase

Most people were satisfied with their initial care and treatment during the Hyper Acute phase; they valued the speed and efficiency of tests/treatment and the caring attitude of staff who kept them informed.

Four of the patients from our fifteen interviews received thrombolysis, two were unsure about what treatment they had received. Of those who did not receive thrombolysis, one patient was told that he could have had thrombolysis but did not get to BRI within the required time window.

Several people talked about how much they noticed a difference between the highly specialised care and treatment during the Hyper Acute phase and the care they received after moving on to other wards or a different hospital. People were still broadly positive about the care but expressed concerns that there were fewer nurses and therefore they were 'stretched' and couldn't provide the same level of care. The sister of a patient discussed the difference between initial treatment in intensive care at BRI and on the stroke ward, saying 'it's a different ball game on there'. She said that the nurses on Ward 9 were very busy and overstretched.

### Information & communication

Overall the majority of people felt aware of what was going on and where possible they were involved and informed about decisions affecting them.

One person at AGH told us, 'I don't like taking pills, so I've been pushing to ease off on my medication in here, and they've let me. It was the wrong thing to do it turns out, but they were supportive'. He felt that he has been making progress and staff have encouraged him to do more on his own. He is now standing, rather than sitting in the shower. 'Without doubt they've communicated well and involved me'.

At AGH a carer told us that she was given lots of time to ask questions and if the stroke specialist nurse didn't have time to talk to her, she made sure someone else would. The stroke specialist nurse also gave her a book about stroke, which explained about the specific stroke her husband had suffered. As a family, they felt supported and that communication had been clear.

## c. Visiting

### Transport

Healthwatch interviewed people from across the Bradford & Airedale area, including some who lived who lived as far away as Settle and Upper Wharfedale areas. Most people had access to a car and visitors either drove themselves or were offered a lift. Two people caught a bus to visit patients at the hospital, one specifically because of the difficulty of parking. She walked for 25 minutes after getting off the bus. Another person said that as her husband was at the BRI for one night she didn't visit him there but if he was there for longer she would have caught the train and got a taxi from the station rather than take her car.

Even when patients were in hospital far from home, most people did not identify the distance to travel as a significant problem – for some it was an inconvenience but they understood the need for the patient to be treated in the hospital which could give them the best chance of recovery.

### Parking

The majority of people we spoke to mentioned parking as an issue and many were very critical, especially of Bradford Royal Infirmary. One interviewee told us 'It was difficult for people to visit due to the parking… There is even less parking at the moment due to all the building work'. She told us that her husband had two small children when he visited. He had to find a street to park in and then take the children and car seat with him, which he found stressful.

At BRI other people described parking as 'horrendous' or 'a nightmare', 'the car park is busy and too expensive and there's never any space on the road'. One person told that her family tried for 1.5 hours to find a parking space, which resulted in them missing most of visiting time.

Parking permits were mentioned by about a third of people we spoke to. At BRI one person highlighted that staff told the family about parking permits, which made life easier for them. Another person said that another visitor told her about that she could get a parking permit after two weeks. At AGH two people said that staff had let them know about concessionary parking; another stated that friends told her about the permit and staff didn't mention it.

### Visiting times

The majority of people interviewed were offered flexible times to visit patients, especially when they had further to travel and when the person was very unwell. One person said 'He could pop in when he wanted' – she didn't think it could always have been at visiting times. Another person said that on Ward 9 at BRI the staff didn't restrict her to visiting times because they knew she was coming a long way, which she was grateful for. She did suggest this might be because they were short staffed and at least she could help make him a cup of tea and keep an eye on him.

This was reiterated by another person stating that staff let her stay most of the day near the beginning of her husband's stay. She said that staff encouraged visitors because 'each looked after their own… I shaved, cleaned his eyes, which meant one less job for the orderlies'.

There were a few negative comments. One person said that not receiving visitors until 2pm on the main ward at BRI was hard. A person staying at St. Luke's said 'visiting times were very strict and need to adopt the LGI (Leeds General Infirmary) stroke department hours, which are 2pm – 9pm'.

Patients and family members highlighted the importance of visiting. One younger patient said, 'We have a big family and we were allowed to use the family room. We had 12 people at one time! It was important to see the kids but not on the ward. My husband could see me whenever he wanted to with our 4 year old'.

There was one comment about a nurse not being happy that a patient had too many visitors around his bed. Another patient with a large family made sure they visited on a rota system so as to avoid this issue.

### d. Discharge

Seven of the people we spoke to were still in hospital and unable to answer questions about leaving hospital or support in the community.

For one patient who had been in hospital for several months following a severe stroke, it was frustrating that going home didn't seem to be in sight. There had been a visit from the team to the family home to assess what might be needed for discharge, but it was decided that her circumstances meant it was not currently realistic. 'There doesn't seem to be any kind of halfway house option, like a cottage hospital or anything like there used to be.'

Some people told us how they felt that therapy built up to discharge – 'they were quite active, trying to build your confidence to come home'. Even though some patients we spoke to in the hospitals didn't know when they would be going home, they said that staff were talking to them about progress towards discharge and being encouraged to go off the ward for short periods or out with family for 'a change of scene'. People felt this was important for their wellbeing and helpful to the rehabilitation process.

We spoke to one patient who had experienced several strokes. He told us that on a previous occasion he had a long wait for an ambulance – it was meant to take him home in the morning and hadn't arrived by 8.30pm. So when he came to be discharged after his most recent stroke, the family decided to pay for a taxi instead.

We asked people to rate support after leaving hospital.

**Overall, how would you rate the support after leaving hospital?**

| Answer Options | No. |
|---|---|
| Excellent | 3 |
| Good | 3 |
| Fair | 1 |
| Poor | 0 |
| Inadequate | 0 |
| ***Answered question*** | **7** |
| ***n/a*** | **8** |

A few people waited 4-8 weeks for physiotherapy or speech therapy after discharge and felt that this wait was too long and had held back their recovery, but they were positive about therapy once it started, one saying that he'd 'never been let down - can't grumble'.

People were positive about visits from community stroke nurses and phone calls from stroke specialist nurse at Airedale.

### e. What made the biggest difference to people?

People mentioned a range of different aspects including: caring staff, flexibility of visiting times, honesty, effective communication, ambulance response, prescribing the right drugs/treatment at the right time, physiotherapy and other therapists, and the specialist stroke nurses.

*'How they dealt with us in A&E. Straight away they said "we're going to be coming at you quick and fast with questions but that's how we've got to work." It's people being up front with you and telling you exactly what you need'.*

The majority of respondents highlighted the physiotherapists, speech therapists and specialist stroke nurses as making the biggest difference to them. One person said that the physio was really important and he couldn't have progressed without it. He said that it helped him psychologically that he was being told he was progressing. Another person highlighted that the physiotherapists at St. Luke's hospital had a positive impact on his mood.

The specialist stroke nurses at both BRI and AGH were mentioned as making a big difference to people. *'She knows her stuff and helps you understand, and she's very approachable.'*

One person said that different people were important during different phases – 'The stroke nurse was a rock in the beginning but the OT gave vital support to feel how I was feeling'. She also said that a senior nurse while she was on the ward gave her one-to-one time, and drew diagrams to explain her stroke, which she really appreciated.

Whilst there were a number of factors that people considered to make the biggest difference to them, staff who cared and took time to talk and explain what was going on had a positive impact for both patients and families.

### f. What would people change or improve about stroke care?

There were a range of suggestions mentioned including: improving staffing levels, greater education about stroke, reducing the waiting time to see the physio after leaving hospital, adding a TV to side rooms, more gel dispensers on the ward, improved access to the consultant and greater consideration for the emotional impact of stroke.

One person told us about the ‘hello my name is’ campaign, which they thought was important. She stated:

‘*At BRI they’re really good at “hello my name is” and that really made a difference. Even if you’d met them before they’d still introduce themselves again because when you’re stressed you can’t remember who’s who…they don’t do that at Airedale, and although now I’ve got to know everyone, at first I didn’t. It made a big difference to the family at BRI and they should do it at Airedale more.’*

Another person thought that more staff, especially at night, would be beneficial as it took two staff members every time he needed to be hoisted e.g. for going to the loo.

One man thought a family member should be allowed to stay overnight. Due to his Islamic beliefs he was concerned about being tended to by a female nurse or carer when visiting the toilet and was ‘more comfortable with his wife’. However, he did note a male nurse has supported him.

## Case studies

The following four case studies illustrate some of the emerging themes and highlight different elements of a patient's journey through the current stroke pathway in Bradford & Airedale.

**Case study: S**

Healthwatch interviewed S, a woman in her early fifties from North Yorkshire who had a stroke in 2016, though she had none of the lifestyle risk factors. She was alone and out of the house when she began to feel sick and dizzy and 'couldn't walk right'. Her husband picked her up and rang 111 who said they'd ring an ambulance once the couple had reached home, which was a few minutes away. By this time she couldn't move her left hand side and her speech was affected. 111 called an ambulance and it arrived promptly. S was taken to resus in A&E at BRI.

S said she didn't recognise her first symptoms through F.A.S.T.; she told us that after her experience of stroke, she thought that additional symptoms such as difficulty walking, nausea and dizziness should also be advertised in awareness campaigns.

The doctor she saw at BRI explained thrombolysis to her clearly and after receiving it she was moved up to Ward 9. S told us that the thrombolysis had a very quick and visible effect - her movement increased and her speech improved. The nurses carried out some tests such as the sip test and communicated really clearly with her about why they were doing things. S said she couldn't fault the ward.

Her husband and daughter visited her at BRI; she said "parking's a nightmare at Bradford but I don't think it would really matter which hospital you go to. Never enough parking." After two nights at BRI, S was transferred to Ward 5 at AGH, which was full. She said that 'they worked very hard but were probably understaffed'.

Being treated in two different hospitals didn't bother S, especially because treatment at BRI was excellent. She said it was nice to be transferred back to AGH though, because it was closer for her husband and their children to visit.

S saw a physiotherapist once at AGH but told us that no emotional or psychological support was offered to her. She thought a family member could have benefited from some support and that 'there's the physical side of the stroke, but no talking about "how are you doing in yourself?"'.

Discharge a few days later was smooth and the stroke specialist nurse gave her a booklet with lots of information in it. S's stroke has left her largely unaffected apart from some weakness on her left hand side. A physiotherapist has visited her twice and she feels that the level of help has been appropriate. She would have liked to talk more with a consultant about the chances of having another stroke.

**Case study: T**

Healthwatch spoke to both T and his wife, who live in Bradford. T is in his sixties and had a stroke in early 2016. At the time we spoke to him, he still couldn't walk, had some left hand side paralysis and his speech was affected. He had retired not long before the stroke and used to be active. They said that getting out is hard because they have to order a wheelchair taxi.

On the morning of T's stroke his wife discovered him unconscious. She called 999 and a rapid response team arrived in less than ten minutes. An ambulance was called because two people weren't enough to get T downstairs. T's wife said that the crew were 'very fast, really professional' and someone stayed on the line until they arrived.

It was a quick journey to BRI A&E, where T had a scan that identified a brain stem stroke. T was very ill and was treated in intensive care before being transferred to Ward 9.

T gradually improved, though he still 'couldn't talk, couldn't eat, couldn't do anything'. T's wife said that Ward 9 was 'fabulous' though she thought it was understaffed. Communication was very good.

Visiting was really important to both T and his family. T's wife said that 'parking's horrendous' at BRI. They found out from another visitor that after two weeks they were eligible for a parking permit – no staff member had informed them.

T was at BRI for a couple of months before spending a similar length of time on ward F3 at St Luke's. Therapy sessions increased and staff were responsive to T's needs.

After T was discharged an occupational therapist came regularly and both T and his wife have been pleased with the community stroke nurses and the information they have provided.

T was told upon discharge that he'd have to wait eight weeks for physiotherapy at home, so the family decided to hire someone privately for that time. T's wife felt very frustrated that all the good work done by the physiotherapists at St Luke's could have been undone by such a long period without therapy, and thinks that physiotherapy after discharge should be a priority.

T and his wife agreed that it was the caring attitude and communication from staff throughout his treatment that made the biggest difference to them.

**Case study: M**

Healthwatch spoke to M and his wife who live in the Airedale area. M is in his late seventies and had a stroke late in 2016, which has left him with some right hand side paralysis and difficulty speaking. At the time of M's stroke, his wife noticed that 'he was thrashing around and didn't sound right'. She rang 999 an ambulance arrived in 15 minutes but another had to be called due to steep access to the house. M was taken to BRI. His wife decided not to go with him but rang later that morning and visited in the afternoon.

M has no memory of being taken to BRI, or of his initial treatment there. By the time M's wife visited, he was on a general ward. She doesn't know what treatment he had or whether he had been on Ward 9 at all – 'they may well have told me but I wouldn't have been in the state of remembering'.

M's wife was very negative about him being on the general ward, telling us that an instance of poor communication could have put M's life at risk, which she felt might not have happened if M had been on the specialist stroke ward. She told us that the ward 'looked a mess and was very cluttered' and that she thought it was understaffed. M spent two days on the ward at BRI, and he was told they were waiting for a bed at AGH before he could be transferred.

On both days that M was at BRI, M's wife visited him. She chose to take the bus and then walk for 25 minutes because of how bad parking is, telling us 'I didn't even try with the car - you'd be mad. The facility for people travelling a distance isn't great. It wouldn't be okay if you couldn't walk.'

M's wife was pleased when M was transferred back to AGH but it 'wasn't a problem with him going to BRI in the first place - that's where the systems are'.

M spent seven weeks at AGH on Ward 5. Both M and M's wife were positive about the treatment, facilities and quality of care. M's wife compared BRI and AGH, saying the difference was 'one star - five stars' but realises that M's negative experience at BRI was not of a stroke ward. M had some sort of therapy most days at AGH.

When asked what had made the biggest difference, M's wife said it was 'the aftercare - the visits of the physios and speech therapists. You can't get that everywhere. That makes the difference between, say, coming home and then what happens?' As M appeared to still be benefiting from physiotherapy at the time of the interview, M's wife was hoping that the standard eight weeks' support would be extended.

**Case study: C**
Healthwatch spoke to C, a 50 year old man from North Yorkshire who had a stroke in 2017, just a fortnight before our interview.

On the day of his stroke, C felt dizzy and vomited before realising he couldn't walk. His wife called 999. 'Everything felt wrong. I said to my wife, I think I've had a stroke.'
The ambulance arrived and took him to Airedale A&E where he had some tests and scans; he was there for three hours before it was confirmed that he'd had a stroke and would have to be taken to BRI.

By the time C arrived at BRI, the window to receive thrombolysis had passed. He was told that he'd had an unusual type of stroke, which meant his symptoms weren't detected by the FAST test. He said that the hospital team were great; he was constantly monitored, and saw a specialist consultant.

C received quite a few visitors at BRI and told us that it was really good to see them. He said that his parents struggled a bit with travelling all the way into Bradford, and they found it hard to park, but he was only there one night.

The transfer back to Airedale was quite late in the evening; 'it was a well-run operation, no waiting about or anything'. The crew knew that the motion was really difficult for him and they were really good at trying to make the journey as comfortable as possible.
At the time Healthwatch spoke to C, he was still being treated at AGH. He told us that staff on Ward 5 had all been good and that he was pleased with the communication. He was receiving occupational therapy and physiotherapy every day and had had some speech therapy.

Psychological support was offered to him, but at the time he had felt he didn't need it. He said he now realises the impact and talked about how devastating the stroke was – 'I thought I was fit, I never thought something like this could happen.'

C highlighted physiotherapy as making the biggest difference and told us that he's been reassured that therapy will continue after he's been discharged. He feels he is making progress, that nurses encourage him to do more by himself, and talk things through with him.

'I wish I hadn't had a stroke, obviously, but I've no complaints at all.'

## 7.0 Equality

The survey had a full equality monitoring form. We monitored responses mid-way through the engagement to establish if any additional, more targeted engagement was required, to ensure that we were gaining views from the relevant protected groups. During the mid-point review it was highlighted that responses from key protected groups were low. To try to address this, it was agreed that the social media advertising should target males, people under the age of 65 and BME groups. In addition to the targeted social media advertising, Healthwatch organisations targeted their outreach sessions with key protected groups. This did see a slight increase in responses.

The data has been analysed to understand if the respondents were a match to the local demographic profiles and also to understand if there were any trends or differences in responses by particular communities or groups. Where there are gaps in gathering the views of specific groups relating to the protected characteristics, this will need to be addressed as part of the next phase of engagement (pre-consultation) and prior to any formal consultation.

Approximately 25% of survey respondents chose not to complete the equality monitoring form, and some were partially completed. Equality monitoring data from the interviews have also been included in the following tables.

### Sex

From experience of previous surveys we know that women are much more likely to respond to surveys and often take more responsibility for family health, so the increased response rate is somewhat expected.

| Area | Local profile % | Respondents profile % | Differential |
|---|---|---|---|
| West Yorkshire & Harrogate | | | |
| Male | 49.1% | 38.7% | -10.4 |
| Female | 50.9% | 59.9% | +9.0 |
| Bradford | | | |
| Male | 49.2% | 41.8% | -7.4 |
| Female | 50.8% | 55.7% | +4.9 |
| Calderdale | | | |
| Male | 51.1% | 40.3% | -10.8 |
| Female | 48.9% | 59.7% | +10.8 |
| Harrogate | | | |
| Male | 48.8% | 39.7% | -9.1 |
| Female | 51.2% | 57.4% | +6.2 |
| Kirklees | | | |
| Male | 49.4% | 34.9% | -14.5 |
| Female | 50.6% | 65.1% | +14.5 |
| Leeds | | | |
| Male | 49.0% | 41.9% | -7.1 |
| Female | 51.0% | 57.4% | +6.4 |
| Wakefield | | | |
| Male | 49.1% | 37.0% | -12.1 |
| Female | 50.9% | 61.3% | +10.4 |

## Age

| Area | Local profile % | Respondents profile % | Differential |
|---|---|---|---|
| West Yorkshire & Harrogate | | | |
| 16-24 | 12.7% | 2.5% | -10.2 |
| 25-44 | 27.5% | 17.0% | -10.5 |
| 45-59 | 18.9% | 27.5% | +8.6 |
| 60-64 | 5.8% | 11.4% | +5.6 |
| 65-74 | 8.0% | 25.9% | +17.9 |
| 75-84 | 5.2% | 12.8% | +7.6 |
| 85 and over | 2.0% | 2.9% | +0.9 |
| Bradford | | | |
| 16-24 | 12.2% | 5.1% | -7.1 |
| 25-44 | 28.2% | 35.6% | +7.4 |
| 45-59 | 17.8% | 23.7% | +5.9 |
| 60-64 | 5.1% | 15.3% | +10.2 |
| 65-74 | 6.8% | 16.9% | +10.1 |
| 75-84 | 4.7% | 3.4% | -1.3 |
| 85 and over | 1.8% | 0.0% | -1.8 |
| Calderdale | | | |
| 16-24 | 10.5% | 0.0% | -10.5 |
| 25-44 | 26.5% | 13.3% | -13.2 |
| 45-59 | 20.8% | 33.3% | +12.5 |
| 60-64 | 6.5% | 15.0% | +8.5 |
| 65-74 | 8.6% | 28.3% | +19.7 |
| 75-84 | 5.2% | 10.0% | +4.8 |
| 85 and over | 2.1% | 0.0% | -2.1 |
| Harrogate | | | |
| 16-24 | 9.3% | 1.6% | -7.7 |
| 25-44 | 24.5% | 12.7% | -11.8 |
| 45-59 | 21.5% | 25.4% | +3.9 |
| 60-64 | 6.8% | 9.5% | +2.7 |
| 65-74 | 10.1% | 30.2% | +20.1 |
| 75-84 | 6.6% | 20.6% | +14.0 |
| 85 and over | 2.9% | 0.0% | -2.9 |
| Kirklees | | | |
| 16-24 | 12.0% | 2.4% | -9.6 |
| 25-44 | 27.1% | 15.0% | -12.1 |
| 45-59 | 19.2% | 30.7% | +11.5 |
| 60-64 | 6.1% | 11.0% | +4.9 |
| 65-74 | 8.3% | 28.3% | +20.0 |
| 75-84 | 5.0% | 10.2% | +5.2 |
| 85 and over | 1.9% | 2.4% | +0.5 |
| Leeds | | | |
| 16-24 | 15.4% | 1.5% | -13.9 |
| 25-44 | 28.7% | 20.6% | -8.1 |
| 45-59 | 17.7% | 21.3% | +3.6 |
| 60-64 | 5.3% | 8.1% | +2.8 |
| 65-74 | 7.5% | 25.7% | +18.2 |
| 75-84 | 5.1% | 16.9% | +11.8 |
| 85 and over | 1.9% | 5.9% | +4.0 |
| Wakefield | | | |
| 16-24 | 10.9% | 2.8% | - 8.1 |
| 25-44 | 26.4% | 13.8% | -12.6 |

| Area | Local profile % | Respondents profile % | Differential |
|---|---|---|---|
| 45-59 | 20.8% | 29.8% | +9.0 |
| 60-64 | 6.5% | 10.6% | +4.1 |
| 65-74 | 9.3% | 25.2% | +15.9 |
| 75-84 | 5.6% | 13.8% | +8.2 |
| 85 and over | 2.0% | 4.1% | +2.1 |

## Religion

| Area | Local profile % | Respondents profile % | Differential |
|---|---|---|---|
| West Yorkshire & Harrogate | | | |
| Christian | 55.6% | 56.1% | +0.5 |
| Buddhism | 0.3% | 0.5% | +0.2 |
| Hindu | 0.6% | 0.8% | +0.2 |
| Judaism | 0.3% | 0.8% | +0.5 |
| Muslim | 10.6% | 3.9% | -6.7 |
| Sikhism | 0.8% | 0.1% | -0.7 |
| Other religion | 0.3% | 3.8% | +3.5 |
| No religion | 24.9% | 27.6% | +2.7 |
| Bradford | | | |
| Christian | 45.9% | 51.3% | +5.4 |
| Buddhism | 0.2% | 0.0% | -0.2 |
| Hindu | 0.9% | 1.3% | +0.4 |
| Judaism | 0.1% | 0.0% | -0.1 |
| Muslim | 24.7% | 12.8% | -11.9 |
| Sikhism | 1.0% | 0.0% | -1.0 |
| Other religion | 0.3% | 2.6% | +2.3 |
| No religion | 20.7% | 21.8% | +1.1 |
| Calderdale | | | |
| Christian | 56.3% | 48.3% | -8.0 |
| Buddhism | 0.3% | 1.7% | +1.4 |
| Hindu | 0.3% | 0.0% | -0.3 |
| Judaism | 0.1% | 0.0% | -0.1 |
| Muslim | 7.3% | 3.3% | -4.0 |
| Sikhism | 0.2% | 1.7% | +1.5 |
| Other religion | 0.4% | 1.7% | +1.3 |
| No religion | 28.1% | 38.3% | +10.2 |
| Harrogate | | | |
| Christian | 68.6% | 64.7% | -3.9 |
| Buddhism | 0.3% | 0.0% | -0.3 |
| Hindu | 0.1% | 0.0% | -0.1 |
| Judaism | 0.2% | 1.5% | +1.3 |
| Muslim | 0.4% | 0.0% | -0.4 |
| Sikhism | 0.1% | 0.0% | -0.1 |
| Other religion | 0.3% | 8.8% | +8.5 |
| No religion | 22.9% | 23.5% | +0.6 |
| Kirklees | | | |
| Christian | 53.4% | 58.4% | +5.0 |
| Buddhism | 0.2% | 0.0% | -0.2 |
| Hindu | 0.4% | 0.7% | +0.3 |
| Judaism | 0.0% | 0.7% | +0.7 |
| Muslim | 14.5% | 2.2% | -12.3 |

| Area | Local profile % | Respondents profile % | Differential |
|---|---|---|---|
| Sikhism | 0.8% | 0.0% | -0.8 |
| Other religion | 0.3% | 7.3% | +7.0 |
| No religion | 23.9% | 29.2% | +5.7 |
| Leeds | | | |
| Christian | 55.9% | 50.0% | -5.9 |
| Buddhism | 0.4% | 1.4% | +1.0 |
| Hindu | 0.9% | 0.7% | -0.2 |
| Judaism | 0.9% | 2.1% | +1.2 |
| Muslim | 5.4% | 2.8% | -2.6 |
| Sikhism | 1.2% | 0.0% | -1.2 |
| Other religion | 0.3% | 7.7% | +7.4 |
| No religion | 28.2% | 27.5% | -0.7 |
| Wakefield | | | |
| Christian | 66.4% | 61.6% | -4.8 |
| Buddhism | 0.2% | 0.0% | -0.2 |
| Hindu | 0.3% | 1.3% | +1.0 |
| Judaism | 0.0% | 0.4% | +0.4 |
| Muslim | 2.0% | 4.4% | +2.4 |
| Sikhism | 0.1% | 0.0% | -0.1 |
| Other religion | 0.3% | 3.5% | +3.2 |
| No religion | 24.4% | 25.3% | +0.9 |

## Ethnic Group

It should be noted that:

- White British includes English, Welsh, Scottish, Northern Ireland, British.
- White Other includes Irish, Gypsy or Irish Traveller, any other white groups.
- Asian/Asian British includes Indian, Pakistani, Bangladeshi, Chinese and any other Asian background.
- Mixed/multiple ethnic background includes White and Black Caribbean, White and Black African, White and Asian and other mixed/multiple ethnic background.
- Other ethnic group includes Arab and any other ethnic group.

| Area | Local profile % | Respondents profile % | Differential |
|---|---|---|---|
| West Yorkshire & Harrogate | | | |
| White/White British | 79.3% | 86.0% | +6.7 |
| White other | 3.4% | 0.9% | -2.5 |
| Mixed/multiple ethnic group | 2.1% | 1.1% | -1.0 |
| Asian/Asian British | 12.3% | 5.2% | -7.1 |
| Black/African/Caribbean/ Black British | 2.0% | 0.9% | -1.1 |
| Other ethnic group: Arab | 0.9% | 0.2% | -0.7 |
| Bradford | | | |
| White/White British | 63.9% | 72.2% | +8.3 |
| White other | 3.6% | 2.5% | -1.1 |
| Mixed/multiple ethnic group | 2.5% | 0.0% | -2.5 |
| Asian/Asian British | 26.8% | 13.9% | -12.9 |
| Black/African/Caribbean/ Black British | 1.8% | 2.5% | +0.7 |

| Area | Local profile % | Respondents profile % | Differential |
|---|---|---|---|
| Other ethnic group: Arab | 1.5% | 0.0% | -1.5 |
| Calderdale | | | |
| White/White British | 86.7% | 88.7% | +2.0 |
| White other | 3.0% | 1.6% | -1.4 |
| Mixed/multiple ethnic group | 1.4% | 1.6% | +0.2 |
| Asian/Asian British | 8.3% | 4.8% | -3.5 |
| Black/African/Caribbean/ Black British | 0.4% | 0.0% | -0.4 |
| Other ethnic group: Arab | 0.2% | 0.0% | -0.2 |
| Harrogate | | | |
| White/White British | 91.7% | 91.2% | -0.5 |
| White other | 4.7% | 1.5% | -3.2 |
| Mixed/multiple ethnic group | 1.1% | 0.0% | -1.1 |
| Asian/Asian British | 1.5% | 0.0% | -1.5 |
| Black/African/Caribbean/ Black British | 0.7% | 1.5% | +0.8 |
| Other ethnic group: Arab | 0.3% | 1.5% | +1.2 |
| Kirklees | | | |
| White/White British | 76.7% | 90.8% | +14.1 |
| White other | 2.5% | 1.4% | -1.1 |
| Mixed/multiple ethnic group | 2.3% | 0.7% | -1.6 |
| Asian/Asian British | 16.0% | 2.1% | -13.9 |
| Black/African/Caribbean/ Black British | 1.9% | 0.7% | -1.2 |
| Other ethnic group: Arab | 0.6% | 0.0% | -0.6 |
| Leeds | | | |
| White/White British | 81.1% | 80.8% | -0.3 |
| White other | 4.0% | 3.5% | -0.5 |
| Mixed/multiple ethnic group | 2.6% | 3.4% | +0.8 |
| Asian/Asian British | 7.8% | 4.8% | -3.0 |
| Black/African/Caribbean/ Black British | 3.4% | 0.7% | -2.7 |
| Other ethnic group: Arab | 1.1% | 2.1% | +1.0 |
| Wakefield | | | |
| White/White British | 92.8% | 87.9% | -4.9 |
| White other | 2.6% | 1.3% | -1.3 |
| Mixed/multiple ethnic group | 0.9% | 0.4% | -0.5 |
| Asian/Asian British | 2.6% | 6.5% | +3.9 |
| Black/African/Caribbean/ Black British | 0.8% | 0.4% | -0.4 |
| Other ethnic group: Arab | 0.3% | 0.0% | -0.3 |

## Disability

It should be noted that census data collected asks people to identify if their day to day activities are limited a lot or a little, where as our equality monitoring asks people if they would describe themselves as disabled. This data has been combined to create an overall percentage of people that have some level of difficulty with day to day activities.

| Area | Local profile % | Respondents profile % | Differential |
|---|---|---|---|
| West Yorkshire & Harrogate | 17.8% | 23.5% | +5.7 |
| Bradford | 17.3% | 7.6% | -9.7 |
| Calderdale | 18.0% | 20.0% | +2.0 |
| Harrogate | 15.6% | 26.8% | +11.2 |
| Kirklees | 17.7% | 22.2% | +13.3 |
| Leeds | 16.7% | 21.8% | +5.1 |
| Wakefield | 22.1% | 32.0% | +9.9 |

## Carers

| Area | Local profile % | Respondents profile % | Differential |
|---|---|---|---|
| West Yorkshire & Harrogate | 10.1% | 27.7% | +17.6 |
| Bradford | 9.8% | 35.4% | +25.6 |
| Calderdale | 10.5% | 29.8% | +19.3 |
| Harrogate | 10.3% | 15.9% | +5.6 |
| Kirklees | 10.3% | 32.9% | +22.6 |
| Leeds | 9.5% | 23.8% | +14.3 |
| Wakefield | 11.3% | 28.6% | +17.3 |

## Lesbian, Gay, Bisexual and Transgender

It should be noted that accurate demographic data is not available for these groups as it is not part of the census collection. The most up to date information we have about sexual orientation is found through the Office of National Statistics (ONS), whose Integrated House Survey for April 2011 to March 2012 estimates that approximately 1.5% of the UK population are Gay/Lesbian or Bisexual. However, HM Treasury's 2005 research estimated that there are 3.7 million LGB people in the UK, giving a higher percentage of 5.85% of the UK population.

Transgender and Trans are an umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. One study suggested that the number of Trans people in the UK could be around 65,000 (Johnson, 2001, p. 7), while another notes that the number of gender variant people could be around 300,000 (GIRES, 2008b).

| Area | Lesbian, Gay and Bisexual % | Transgender % |
|---|---|---|
| West Yorkshire & Harrogate | 3.0% | 0.1% |
| Bradford | 2.5% | 0.0% |
| Calderdale | 3.6% | 0.0% |
| Harrogate | 1.5% | 0.0% |
| Kirklees | 5.0% | 0.7% |
| Leeds | 0.7% | 0.0% |
| Wakefield | 4.0% | 0.0% |

## Under representation

As can be seen from the tables above the reach of the survey has met with a representative sample of some of our communities. However to understand what, if any, under representation existed between known demographic profiles and people responding to the survey, the section below highlights any difference of -5.0 or more;

- Males were under represented across all geographical areas
- People under the age of 44 were under represented across all geographical areas except Bradford where under representation was just for people under the age of 24.
- Muslims were under represented in all geographical areas except Wakefield.
- Asian or Asian British were under represented in all geographical areas except Wakefield.
- Black / Black British were under represented across all geographical areas except Harrogate.
- Disabled people were under represented in Bradford.

Where there are gaps in gathering the views of specific groups relating to the protected characteristics, this will need to be addressed as part of the next phase of engagement (pre-consultation) and prior to any formal consultation.

## Analysis

Utilising the themes identified across the survey in the open questions, analysis has been undertaken to understand if there is any difference in the responses to these questions by people from protected groups. Caution should be applied as some themes are raised by relatively few people.

### Younger people

Some younger people described being misdiagnosed when they first presented at A&E, the assumption was that this was because they were younger and that clinicians assume strokes occur in older people. They want to ensure that clinicians receive appropriate stroke awareness training to prevent these misdiagnoses occurring.

They also described how services that were in place to support people following a stroke were designed for older people and as such did not always meet their needs. They mentioned the negative impact on their finances and childcare, and how they want services to support them in returning to work. They felt that there should be more support groups, with specific groups for younger people.

### Asian or Asian British

A few people mentioned the need to have support groups that meet the needs of different community groups, with specific mention made for support groups for South Asian women, and rehabilitation services that were culturally sensitive.

### Muslim

One man thought a family member should be allowed to stay overnight. Due to his Islamic beliefs he was concerned about being tended to by a female nurse or carer when visiting the toilet and was ‘more comfortable with his wife’.

### Disability

Some people highlighted the need for staff to be trained so they understand how they should support the needs of those patients that have existing conditions. Specific mention was made to dementia patients, people with mental health conditions, and learning disabilities.

Information should be provided in a range of formats to ensure that they are accessible, specific mention was made to people with hearing impairments and the need for staff to be deaf aware.

### Carers

In the assessment that is undertaken to assess the patients’ needs prior to discharge, this should include assessing the needs of the whole family, especially in situations where the patient had previously been a carer for either their own children or partner. The patient may no longer be able to continue with their caring role and as such additional support may need to be put in place.

Support should be provided for carers, so they know what to expect and how to support the person they are caring for. For many people this is the first time they have had to care for their loved one, and can be a very difficult time adapting to their new role. They require emotional support, guidance and to be offered respite care.

They felt that there should be more support groups, with specific groups for carers.

The data from the engagement activity will be combined with other data and research to develop the EQIA. This will help us to understand the potential impact of any proposals on different groups so that these can be fed into the decision making process.

This will subsequently inform any further consultation activity.

# 8.0 Summary of key themes from existing data and the engagement

## Changes to stroke services

There was some concern that a decision had already been made to reduce the number of hyper acute stroke units (HASUs), with some questioning the value of the engagement.

People were concerned that if the number of units were reduced this could lead to the remaining units being unable to cope with demand and impact negatively on health outcomes.

It was suggested by many that funding should be increased to ensure all patients are able to access the best treatment immediately. There was a range of opinions as to whether this should be available in all local hospitals or whether it should be based in a few specialist centres. Many people said that they would travel further if it meant they were able to access the best treatment and to be treated by specialists; however, they wanted their rehabilitation to be available closer to home.

The main reasons for people wanting the services to be available in all hospitals were the distance, time and cost to travel, along with the challenges of parking. People were worried not only about how the extra journey time could affect the treatment and outcome for stroke patients but also how this would impact on the ability of carers and families to visit their loved one at this critical time, particularly those reliant on public transport.

Of those people that had experienced the newly reconfigured service in Airedale, Wharfedale, Craven and Bradford and had travelled further to access a HASU, and were then transferred to a hospital closer to home for their ongoing care were satisfied that it gave them the best clinical outcomes. People highly valued the specialist staff and treatments available during the first few hours after a stroke. Even when patients were in hospital far from home, most people did not identify the distance to travel as a significant problem – for some it was an inconvenience but they understood the need for the patient to be treated in the hospital which could give them the best chance of recovery. The main criticism was the difficulties visitors encountered trying to park at the hospital.

## Acute stroke services

Many people described the excellent levels of care that they received in hospital, from being seen quickly, to accessing the most appropriate treatments and being kept informed throughout. They talked about staff being willing to help, although some did feel that the staff were overworked so were sometimes unable to meet the needs of the patients.

Some reported an absence of specialist care at the weekend – no specialist consultants, and agency/bank nurses who some felt deliver poor quality care. It was also felt that there should not be a difference in care during the week and at the weekend.

Some people felt that paramedics and A&E staff need to receive more training on how to recognise and manage strokes. Particular reference was made to young people and how they are more likely to be misdiagnosed.

There were many instances where people reported delays in being seen and treated in A&E. Once they had been diagnosed some then had to wait a long time before a bed became available and they were not always admitted to a stroke ward. They felt that these delays in accessing treatment and not being admitted to a stroke ward had resulted in long term damage and had impacted negatively on their recovery.

Some people would have liked to have been given the choice of being admitted to a side room or a bay, as some felt isolated being in a side room on their own. They would have preferred to be in a bay so they could be near other people and be more visible to staff.

Whilst on the ward some patients were given the opportunity to speak to people from the Stroke Association that had experienced a stroke, they had found this very useful and felt it should be offered on all stroke wards.

### Discharge process

Comments on discharge ranged from people feeling that they were in hospital longer than they needed to be, to those that felt pressured to leave too soon. When people were discharged, some were sent home without the appropriate aids, adaptations and home care being in place, and some had to source the support they required themselves.

Many people reported delays in accessing rehabilitation, such as physiotherapy and speech and language therapy.

They advised that they want to have a thorough assessment prior to being discharged, to ensure that they are ready to go home, and if they are, to have all the appropriate aids, adaptations and home care support in place prior to them being discharged. This should include assessing the needs of the whole family, especially in situations where the patient had previously been a carer for either their own children or partner.

That they, and their families are kept informed and involved throughout, so they know what to expect once they are discharged, are aware of what support is available and how to access it, this should include emotional support and financial advice. They would like to have a named person who is responsible for co-ordinating their care and who can provide them with support and advice.

For all organisations who are involved in their care to communicate with each other to ensure that the patient receives a seamless service. To support this, a suggestion was made that teams should be multi-disciplinary and include social care, speech and language therapy, physiotherapy and occupational therapy.

### Stroke services in the community

Many reported difficulties in being able to access rehabilitation services quickly once they were discharged, and when they did access it they were only provided the service for a limited time period which many felt was insufficient for their needs. They told us that they would like to receive regular reviews to ensure that they are receiving the appropriate level of care and support.

Stroke can be a life changing event which can be difficult for the patient and their families to deal with. It was felt that there was a need to ensure that people are provided with the appropriate levels of emotional support and advice, and where necessary have access to psychological therapies.

It was felt that more support should be provided for carers, so they know what to expect and how to support the person they are caring for. For many people this is the first time they have had to care for their loved one, and can be a very difficult time adapting to their new role. And as such they require emotional support, guidance and to be offered respite care.

Many people were unaware of the support the voluntary and community sector could provide, and requested that more information be provided to patients and their families / carers. Of those that were aware of the support available they talked positively of the services provided by the following organisations; the Stroke Association, Speakability, Speak with It, Age UK and Scope.

They valued the support groups that they had attended and welcomed the opportunity to be able to speak to other people that had experienced a stroke. They felt that there should be more support groups, with specific groups for younger people and carers. Some were concerned that the funding of these organisations was inequitable and as such the provision of services was inconsistent across West Yorkshire and Harrogate. Of those that did provide services in their areas, there was some concern that the services may be cut.

People wanted the voluntary and community sector to provide befriending services to help reduce isolation; and support people in making meals, gardening, taking people shopping and supporting them to attend appointments. To support their recovery they also wanted to be able to access leisure facilities, such as swimming pools and gyms.

### Awareness and prevention

It was felt that there was a need to educate people on how to lead a healthier lifestyle using a wide range of approaches, such as leaflets, posters, social media, radio, television adverts, apps, delivering talks to people in a range of venues including community groups, places of worship, workplaces, schools and colleges.

It was suggested that having a patient talking about the impact stroke has had on their life and their families would be a powerful message that could support behaviour change. It was also felt that any campaign should make it clear that stroke can happen at any age.

GPs should undertake regular health checks of patients, especially those that are deemed to be high risk, and provide advice and support to lead a healthier lifestyle. Including providing access to smoking cessation, weight management, and exercise classes.

Many felt that there was a need to raise awareness of the signs and symptoms of a stroke, and what to do if you think someone is having a stroke. Some felt that the F.A.S.T. campaign didn't raise awareness of all the signs and symptoms, and that some strokes could be missed.

## 9.0 Conclusion

This engagement process has provided a snapshot of the views of the public, from across West Yorkshire and the Harrogate District on stroke services.

The report will be shared with the West Yorkshire and Harrogate health partners, to support them in the development of proposals for the future of stroke services in West Yorkshire and Harrogate.

This report will be made publically available and feedback provided to those respondents who have requested it.

We would like to thank all respondents who have given their time to share their views.

# Appendix A – Communications and engagement action plan

| | WEEK COMMENCING | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activity** | 12/12 | 19/12 | 26/12 | 2/1 | 9/1 | 16/1 | 23/1 | 30/1 | 6/2 | 13/2 | 20/2 | 27/2 | 6/3 | 13/3 | 20/3 | 27/3 | April |
| Develop survey to gather patient views | | | | | | | | | | | | | | | | | |
| Healthwatch in West Yorkshire and Harrogate to contact organisations to set up outreach sessions | | | | | | | | | | | | | | | | | |
| Healthwatch in West Yorkshire and Harrogate to set up an event in their area for VCS | | | | | | | | | | | | | | | | | |
| Commence engagement across West Yorkshire and Harrogate | | | | | | | | | | | | | | | | | |
| Healthwatch in West Yorkshire and Harrogate to attend VCS outreach sessions | | | | | | | | | | | | | | | | | |
| Healthwatch in West Yorkshire and Harrogate to host VCS event in their area | | | | | | | | | | | | | | | | | |
| Healthwatch in West Yorkshire and Harrogate to raise awareness of the engagement. | | | | | | | | | | | | | | | | | |

| WEEK COMMENCING | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activity** | 12/12 | 19/12 | 26/12 | 2/1 | 9/1 | 16/1 | 23/1 | 30/1 | 6/2 | 13/2 | 20/2 | 27/2 | 6/3 | 13/3 | 20/3 | 27/3 | April |
| Survey and information to be uploaded to website and intranet. | | | | | | | | | | | | | | | | | |
| STP partners to be provided with a communications pack to support communications with staff, key stakeholders, PRGs and VCS | | | | | | | | | | | | | | | | | |
| Survey to be shared on social media | | | | | | | | | | | | | | | | | |
| Analysis of both existing and data from current engagement. | | | | | | | | | | | | | | | | | |
| Production of engagement report. | | | | | | | | | | | | | | | | | |
| Present the report to Stroke Task and Finish group and make any final amends. | | | | | | | | | | | | | | | | | |
| Feedback to the public on the outcome of the engagement and next steps. | | | | | | | | | | | | | | | | | |

## Appendix B – Survey

# Stroke services survey

Across West Yorkshire and Harrogate, health services are working together to look at better ways of delivering care for people who have a stroke and making the services sustainable and fit for the future.

Stroke is a life changing event. And the care you receive in the first few hours after a stroke can make difference to how well you can recover. This includes scans, tests and clot-busting drugs, which have to be delivered by highly trained staff working in specialist units at hospitals.

Evidence from elsewhere suggest outcomes following hyper-acute stroke are likely to be better if patients are treated in specialised centres, even if this increases travelling time following the event. Ongoing rehabilitation should however be provided at locations, closer to where people live, and they should be transferred to these as soon as possible after initial treatment.

At the moment, depending on where you live, you might experience different standards of care if you have a stroke. More needs to be done to make sure that no matter where you live you have access to specialist, high quality care - twenty four hours a day, seven days a week.

Health services are developing proposals to make sure everyone in our region gets this specialist care in the first few hours after a stroke. We also know that ongoing care, such as physiotherapy, speech therapy or emotional support is really important. The NHS think that by coordinating services better, more people could receive the care they need in a community setting, closer to home.

We want to make sure our services are fit for the future and that we make the most of new technology, the skills of our valuable workforce whilst maximising opportunities to improve outcomes for local people.

And by improving people's health and supporting people to stay well, the NHS could prevent people from having strokes and going to hospital in the first place.

Before decisions are made on the future of stroke services in West Yorkshire and Harrogate, we want to hear from you.

The survey has been created jointly by all of the Healthwatch organisations across West Yorkshire and Harrogate. Healthwatch is independent of the NHS and has been asked by West Yorkshire and Harrogate health services to engage with patients, carers and the wider public. We are working together to find out more about what you think about possible new ways of providing the care that you need when you have a stroke or care for someone who has.

Healthwatch Kirklees are pulling together all the feedback that people have shared with Healthwatch across West Yorkshire and Harrogate, and they will be sharing it with the West Yorkshire and Harrogate health services. Please note that any views you share will remain confidential, and no personal identifiable information will be shared when reporting on the findings of the engagement.

The survey can also be completed online at:
https://www.surveymonkey.co.uk/r/WYStrokeServices

Thank you for taking the time to complete this survey.

## About you

| **Q1. Are you completing this questionnaire as…** | |
|---|---|
| | A member of the public |
| | On behalf of a voluntary or community organisation |
| | A health professional responding in a professional capacity |
| Other (please say) | |

| **Q2. Which area do you live in?** | |
|---|---|
| | Bradford Metropolitan District |
| | Calderdale |
| | Harrogate |
| | Kirklees |
| | Leeds |
| | Wakefield |
| Other (please say) | |

| **Q3. Have you or the person you care for had a stroke or a suspected stroke?** | |
|---|---|
| | Yes (please go to question 4) |
| | No (please go to question 9) |

## Your experience of stroke services

If you or the person you cared for has had a stroke or a suspected stroke, we would like to know a little bit more about what your experience was like.

| **Q4. Which hospital did you / or the person you care for initially attend when you had a stroke or a suspected stroke?** | |
|---|---|
| | Airedale General Hospital |
| | Bradford Royal Infirmary |
| | Calderdale Royal Hospital |
| | Dewsbury and District Hospital |
| | Friarage Hospital |
| | Harrogate District Hospital |
| | Huddersfield Royal Infirmary |
| | Leeds General Infirmary |
| | Pinderfields General Hospital |
| | Pontefract General Infirmary |
| | Skipton General Hospital |
| | St James's University Hospital |
| Other (please say) | |

| **Q5. Was this the closest hospital to you when you had a stroke or a suspected stroke?** | |
|---|---|
| | Yes |
| | No |
| | Not sure |

| **Q6. Were you transferred to another hospital to continue with your treatment?** | |
|---|---|
| | Yes |
| | No |
| | Not sure |

| **Q7. Overall, how would you describe your experience of care when you had a stroke or a suspected stroke?** | |
|---|---|
| | Very Good |
| | Good |
| | Acceptable |
| | Poor |
| | Very Poor |
| Please explain your answer | |

| Q8. Please tell us what could have improved your experience. |
|---|
| |

## Stroke services

| Q9. How important do you think the following are when accessing care in the first few hours after a stroke or a suspected stroke? | | | | |
|---|---|---|---|---|
| | Very important | Important | Slightly Important | Not Important |
| Fast ambulance response times | | | | |
| Being treated at a hospital close to home | | | | |
| Being treated at a hospital where I can receive the scans, tests and drugs that I need | | | | |
| Being treated by highly trained specialists | | | | |
| Being seen quickly when I get to a hospital | | | | |
| Safety and quality of the service | | | | |
| Involving family and carers | | | | |
| Other (please say) | | | | |

| **Q10. How important do you think the following are when accessing after care for people who have had a stroke?** | | | | |
|---|---|---|---|---|
| | **Very important** | **Important** | **Slightly Important** | **Not Important** |
| Be able to access rehabilitation services close to home to help you recover | | | | |
| Be able to access a range of rehabilitation services, such as physiotherapy, speech and language therapy, emotional support | | | | |
| Being treated by highly trained specialists | | | | |
| Be involved in decisions about my care | | | | |
| Safety and quality of the service | | | | |
| Involving family and carers | | | | |
| Other (please say) | | | | |

| **Q11. Please let us know if you have any suggestions on how social care could support patients and their families / carers following a stroke.** |
|---|
| |

| **Q12. Please let us know if you have any suggestions on how the voluntary and community sector could support patients and their families / carers following a stroke.** |
|---|
| |

## Prevention

| **Q13. Did you know that having a healthy diet, exercising regularly, stopping smoking and cutting down on the amount of alcohol you drink can reduce your risk of having a stroke?** | |
|---|---|
| | Yes |
| | No |
| | Not sure |

| **Q14. Please let us know if you have any suggestions on how we can support and educate people to help reduce their risk of having a stroke.** |
|---|
| |

| **Q15. Please tell us if you have any further comments about how we can improve stroke services across West Yorkshire and Harrogate.** |
|---|
| |

## Equality monitoring

In order to ensure that we provide the right services and to ensure that we avoid discriminating against any section of our community, it is important for us to gather the following information. No personal information will be released when reporting statistical data and data will be protected and stored securely in line with data protection rules. This information will be kept confidential.

**1. What is the first part of your postcode?**

| | |
|---|---|
| Example | HD6 |
| **Yours** | |

☐ Prefer not to say

**2. What sex are you?**

☐ Male ☐ Female

☐ Prefer not to say

**3. How old are you?**

| | |
|---|---|
| Example | 42 |
| **Yours** | |

☐ Prefer not to say

**4. Which country were you born in?**

☐ Prefer not to say

**5. Do you belong to any religion?**

☐ Buddhism
☐ Christianity
☐ Hinduism
☐ Islam
☐ Judaism
☐ Sikhism
☐ No religion
☐ Other (Please specify in the box below)

☐ Prefer not to say

**6. What is your ethnic group?**

**Asian or Asian British:**

☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ Other Asian background (please specify)

**Black or Black British:**

☐ Caribbean
☐ African
☐ Other Black background (please specify)

**Mixed or multiple ethnic groups:**

☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Other mixed background (please specify)

**White:**

☐ English/Welsh/Scottish/Northern Irish/British
☐ Irish
☐ Gypsy or Irish Traveller
☐ Other White background (please specify)

**Other ethnic groups:**

☐ Arab
☐ Any other ethnic group (please specify)

☐ Prefer not to say

**7. Do you consider yourself to be disabled?**

☐ Yes ☐ No

☐ Prefer not to say

**Type of impairment:**

Please tick all that apply

☐ **Physical or mobility impairment**
(such as using a wheelchair to get around and / or difficulty using their arms)

☐ **Sensory impairment**
(such as being blind / having a serious visual impairment or being deaf / having a serious hearing impairment)

☐ **Mental health condition**
(such as depression or schizophrenia)

☐ **Learning disability**
(such as Downs syndrome or dyslexia) or cognitive impairment (such as autism or head-injury)

☐ **Long term condition**
(such as cancer, HIV, diabetes, chronic heart disease, or epilepsy)

☐ Prefer not to say

**8. Are you a carer?**

Do you look after, or give any help or support to a family member, friend or neighbour because of a long term physical disability, mental ill-health or problems related to age?

☐ Yes ☐ No

☐ Prefer not to say

**9. Are you pregnant?**

☐ Yes ☐ No

☐ Prefer not to say

**10. Have you given birth in the last 6 months?**

☐ Yes ☐ No

☐ Prefer not to say

**11. What is your sexual orientation?**

☐ Bisexual (both sexes)

☐ Gay (same sex)

☐ Heterosexual/straight (opposite sex)

☐ Lesbian (same sex)

☐ Other

☐ Prefer not to say

**12. Are you transgender?**

Is your gender identity different to the sex you were assumed at birth?

☐ Yes ☐ No

☐ Prefer not to say

Thank you for taking the time to complete this survey.

Thank you for taking the time to complete this survey. Please return to:

FREEPOST NHS PMO
Healthwatch Bradford and District
Alice Street
Keighley

BD21 3JD

**Please return no later than Wednesday 15th March 2017. Unfortunately, we cannot accept any responses after this date.**

**If you would like to know more about the results of this survey or if you want more information about what will happen to your feedback, please leave your name and contact details for how you would prefer us to get in touch on the contact form below. Please note this will be kept separate from your survey so we will not be able to trace your comments back to you**

| | |
|---|---|
| Name: | |
| Address: | |
| Telephone number: | |
| Email address: | |

| Preferred method of contact (please tick one) | |
|---|---|
| Email | |
| Post | |
| Telephone | |

## Appendix C – Timetable of outreach sessions

| Date | Healthwatch | Activity | Number of participants |
|---|---|---|---|
| 13/2/2017 | Calderdale | Calderdale Stroke Support Group - presentation and discussion | 20 |
| 14/02/2017 | Wakefield | Wakefield Over 50's Action Group – presentation and discussion | 45 |
| 16/02/2017 | Wakefield | St George's Community Centre - stall | 40 |
| 16/02/2017 | Wakefield | City of Sanctuary – presentation and discussion | 32 |
| 20/02/2017 | Wakefield | Ossett Stroke Club – presentation and discussion | 23 |
| 20/02/2017 | Wakefield | South Elmsall Library – stall | 50 |
| 21/02/2017 | Wakefield | Pinderfields Hospital – stall | 300 |
| 21/02/2017 | Harrogate | Exercise with Parkinson's class - presentation and discussion | 8 |
| 21/02/2017 | Harrogate | Exercise after Stroke class - presentation and discussion | 18 |
| 21/02/2017 | Leeds | Stroke Outpatient clinic Leeds General Infirmary- 1.1 conversations | 7 |
| 21/02/2017 | Wakefield | Stroke Support Group – presentation and discussion | 21 |
| 21/02/2017 | Wakefield | TIA Clinic at Pinderfields Hospital – 1.1 conversations | 20 |
| 22/02/2017 | Kirklees | Dewsbury Sports Centre – PALS exercise session – 1.1 conversations | 25 |
| 22/02/2017 | Kirklees | Healy community centre stay and play children centre – presentation and discussion | 10 |
| 22/02/2017 | Kirklees | Staincliff and Healey Children centre – presentation and discussion | 8 |
| 22/02/2017 | Wakefield | Age UK Friendship Group – presentation and discussion | 21 |
| 22/02/2017 | Wakefield | Hemsworth Community Centre – stall | 28 |
| 23/02/2017 | Leeds | Stroke Outpatient clinic - Seacroft hospital - 1.1 conversations | 33 |
| 23/02/2017 | Harrogate | Outpatients Ward, Harrogate Hospital – 1.1 conversations | 15 |
| 23/02/2017 | Harrogate | Oakdale Ward (Stroke, Neurology, Oncology and Haematological conditions) Harrogate Hospital – 1.1 conversations | 5 |
| 23/02/2017 | Wakefield | Pinderfields Hospital Stroke Clinic – 1.1 conversations | 37 |
| 23/02/2017 | Wakefield | 5 Towns Stroke Club – presentation and discussions | 42 |
| 24/02/2017 | Wakefield | Warrengate surgery – 1.1 discussions | 154 |
| 24/02/2017 | Harrogate | Exercise after Stroke class - presentation and discussion | 10 |
| 27/02/2017 | Leeds | Morley / Gildersome Stroke Club – focus | 13 |

| Date | Healthwatch | Activity | Number of participants |
|---|---|---|---|
| | | group | |
| 27/02/2017 | Wakefield | Lupset Stroke Club – presentation and discussion | 12 |
| 28/02/2017 | Kirklees | Trinity Centre Luncheon Club - 1.1 conversations | 20 |
| 01/03/2017 | Wakefield | Pontefract Library – stall | N/A |
| 01/03/2017 | Kirklees | Batley Resource Centre – Young at Heart Group - 1.1 conversations | 9 |
| 01/03/2017 | Leeds | Stroke rehabilitation, hyper acute, acute ward and CDU at LGI – 1.1 conversations | 30 |
| 02/03/2017 | Wakefield | Outwood Stroke Group – presentation and discussion | N/A |
| 02/03/2017 | Wakefield | Pinderfields Hospital – stroke clinic – 1.1 conversations | 26 |
| 03/03/2017 | Kirklees | One stop shop Carlinghow and Wilton Children's Centre - 1.1 conversations | 10 |
| 06/03/2017 | Wakefield | St Georges Community Centre – presentation and discussion | 18 |
| 06/03/2017 | Wakefield | South Elmsall Stroke Group – presentation and discussion | 13 |
| 06/03/2017 | Wakefield | Westfield Centre – stall in library | 26 |
| 07/03/2017 | Wakefield | Speakability – presentation and discussion | 25 |
| 07/03/2017 | Wakefield | Prospect surgery – 1.1 conversations | 23 |
| 07/03/2017 | Wakefield | Hemsworth Library – stall | 23 |
| 08/03/2017 | Kirklees | Batley East Children's Centre - 1.1 conversations | 7 |
| 08/03/2017 | Kirklees | Batley Resource Centre Foyer- 1.1 conversations | 10 |
| 08/03/2017 | Wakefield | Pontefract Library – stall | 12 |
| 09/03/2017 | Calderdale | Heath Stroke Club - 1.1 conversations | 12 |
| 09/03/2017 | Wakefield | Pinderfield Hospital – stroke clinic – 1.1 conversations | 62 |
| 09/03/2017 | Wakefield | Kinsley and Fitzwilliam Community Centre – presentation and discussion | 25 |
| 09/03/2017 | Kirklees | Batley Resource Centre Lunch Club- 1.1 conversations | 25 |
| 13/03/2017 | Wakefield | TIA Clinic Pinderfields – 1.1 conversations | 32 |
| 13/0/2017 | Wakefield | Westfield Resource Centre – presentation and discussion | 14 |
| 13/03/2017 | Wakefield | South Elmsall Library – stall | 17 |
| 14/03/2017 | Kirklees | Dewsbury Hospital Ward 4, Stroke Rehab Unit- 1.1 conversations | 15 |
| 14/03/2017 | Wakefield | TIA Clinic Pinderfields – 1.1 conversations | 27 |
| 14/03/2017 | Wakefield | Eastmoor Surgery – 1.1 conversations | 18 |
| 14/03/2017 | Wakefield | Lift Up Friends – presentation and discussion | 23 |
| 14/03/2017 | Calderdale | Calderdale Health Forum - presentation and discussion | 25 |

## Appendix D - Activity undertaken by STP partners to raise awareness

| Activity | Number of people |
|---|---|
| **Bradford, Airedale, Wharfedale and Craven** | |
| Board papers to governing body meetings | Approx 15-20 |
| Staff bulletins | 125 staff |
| Staff briefings | 125 staff |
| **Calderdale** | |
| Email to VCS, PRG Network members, Practice managers, and VAC database | |
| VAC weekly newsletter | |
| Website | |
| Social media | Twitter account has 3,183 followers |
| Calderdale Health Forum – discussion item | 25 members of the public |
| **Harrogate and Rural District** | |
| GP newsletter | 50+ |
| Staff briefing | 40 at HaRD CCG and 112 at HDFT |
| Staff bulletin | 4,000 at HDFT |
| Social media | HaRD CCG - Near 7000 twitter followers and Facebook posts shared on local community group pages with over 35,000 followers<br>HDFT – 1,500 views of Twitter posts and 1,600 Facebook reach |
| Website | |
| Stakeholder newsletter - NHS Staff, Public Health Leads, Local Authority | 4,500 (HaRD CCG) and 400 (HDFT) |
| **Kirklees** | |
| Board papers to governing body meetings | |
| GP newsletter | 60 (across GHCCG and NKCCG) |
| Staff briefing | 80 (across GHCCG and NKCCG) |
| Staff bulletin | |
| Intranet | |
| Website | |
| Social media | GHCCG Twitter account has 5,395 followers and NKCCG has 4,171 followers |
| PRG Networks – dicussion item | 32 (across GHCCG and NKCCG) |
| Engagement assurance groups – discussion item | 13 members |
| Email to PRG's, VCS, Community Partnership, KOP Network and Voluntary Kirklees | 320 members / organisations (across GHCCG and NKCCG) |
| Al Mubarak Radio - information included in stroke campaign piece about engagement work. | App/Website listeners – 1400+ (713 via website plus app listeners)<br>Facebook views – 950 in total<br>Home receivers – cannot quantify but approximating 450-500 |
| Kirklees Staying healthy e-bulletin | 4,000 people who subscribe |

| Activity | Number of people |
|---|---|
| Leeds | |
| Patient Champion training - discussed in the training and emailed everyone with the link to the survey for completion. | 21 |
| Email to Community Network members and engagement assurance group members | 742 members |
| Website | 41 people viewed the page |
| Social media | Over 9,000 people viewed the tweet |
| PRG Network – item for discussion | 5 people |
| Wakefield | |
| Social media | Twitter account has 9,601 followers, had over 2,000 impressions |
| Intranet | 170 staff |
| Staff newsletter | 170 staff |
| Email to Community Engagement Partnership, VCS organisations, PRG members, colleges, hospices | 255 members / organisations |

# Appendix E – Equality monitoring data

**What is the first part of your postcode? e.g. HD1, WF10, BD4, LS13, HX6. If you would prefer not to say, please leave the box blank**

| | % | No. |
|---|---|---|
| BD1 | 0.1% | 1 |
| BD3 | 0.4% | 3 |
| BD4 | 0.1% | 1 |
| BD5 | 0.3% | 2 |
| BD6 | 0.4% | 3 |
| BD7 | 0.1% | 1 |
| BD8 | 0.3% | 2 |
| BD9 | 0.4% | 3 |
| BD10 | 1.0% | 7 |
| BD11 | 0.6% | 4 |
| BD12 | 0.9% | 6 |
| BD13 | 0.6% | 4 |
| BD16 | 0.9% | 6 |
| BD17 | 0.3% | 2 |
| BD18 | 0.9% | 6 |
| BD19 | 1.3% | 9 |
| BD20 | 1.2% | 8 |
| BD21 | 0.1% | 1 |
| BD22 | 0.1% | 1 |
| BD23 | 0.4% | 3 |
| BD24 | 0.1% | 1 |
| DL7 | 0.1% | 1 |
| DN2 | 0.1% | 1 |
| DN4 | 0.1% | 1 |
| HD1 | 1.0% | 7 |
| HD2 | 0.9% | 6 |
| HD3 | 1.3% | 9 |
| HD4 | 1.3% | 9 |
| HD5 | 1.3% | 9 |
| HD6 | 1.2% | 8 |
| HD7 | 1.2% | 8 |
| HD8 | 1.9% | 13 |
| HD9 | 1.6% | 11 |
| HG1 | 1.7% | 12 |
| HG2 | 2.5% | 17 |
| HG3 | 2.0% | 14 |
| HG4 | 0.6% | 4 |
| HG5 | 1.6% | 11 |
| HX1 | 0.6% | 4 |
| HX2 | 1.7% | 12 |
| HX3 | 2.0% | 14 |

| | % | No. |
|---|---|---|
| HX5 | 0.7% | 5 |
| HX6 | 0.3% | 2 |
| HX7 | 0.9% | 6 |
| LS1 | 0.1% | 1 |
| LS2 | 0.1% | 1 |
| LS4 | 0.4% | 3 |
| LS5 | 0.1% | 1 |
| LS6 | 0.3% | 2 |
| LS7 | 1.0% | 7 |
| LS8 | 0.9% | 6 |
| LS9 | 0.3% | 2 |
| LS10 | 0.6% | 4 |
| LS11 | 0.4% | 3 |
| LS12 | 0.6% | 4 |
| LS13 | 1.0% | 7 |
| LS14 | 1.3% | 9 |
| LS15 | 1.0% | 7 |
| LS16 | 0.6% | 4 |
| LS17 | 2.0% | 14 |
| LS18 | 0.7% | 5 |
| LS19 | 0.4% | 3 |
| LS20 | 0.3% | 2 |
| LS21 | 0.7% | 5 |
| LS22 | 0.9% | 6 |
| LS23 | 0.4% | 3 |
| LS24 | 0.1% | 1 |
| LS25 | 1.2% | 8 |
| LS26 | 1.2% | 8 |
| LS27 | 1.0% | 7 |
| LS28 | 1.9% | 13 |
| LS29 | 0.4% | 3 |
| OL14 | 0.9% | 6 |
| OL15 | 0.1% | 1 |
| PO12 | 0.1% | 1 |
| S72 | 0.3% | 2 |
| S75 | 0.1% | 1 |
| WF1 | 4.5% | 31 |
| WF2 | 6.8% | 47 |
| WF3 | 2.0% | 14 |
| WF4 | 3.5% | 24 |
| WF5 | 2.9% | 20 |
| WF6 | 2.3% | 16 |
| WF7 | 1.6% | 11 |
| WF8 | 3.2% | 22 |
| WF9 | 4.2% | 29 |

| | % | No. |
|---|---|---|
| WF10 | 1.5% | 10 |
| WF11 | 0.4% | 3 |
| WF12 | 0.9% | 6 |
| WF13 | 0.9% | 6 |
| WF14 | 2.0% | 14 |
| WF15 | 1.2% | 8 |
| WF16 | 0.7% | 5 |
| WF17 | 1.2% | 8 |
| WF19 | 0.1% | 1 |
| YO1 | 0.1% | 1 |
| YO26 | 0.3% | 2 |
| YO51 | 0.1% | 1 |
| ***Answered question*** | **73.0%** | **687** |
| ***Skipped question*** | **27.0%** | **253** |

**What sex are you?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Male | 38.3% | 287 | 37.5% | 24 | 40.3% | 25 | 39.7% | 27 | 34.9% | 51 | 41.9% | 62 | 37.0% | 87 |
| Female | 60.3% | 452 | 59.4% | 38 | 59.7% | 37 | 57.4% | 39 | 65.1% | 95 | 57.4% | 85 | 61.3% | 144 |
| Prefer not to say | 1.3% | 10 | 3.1% | 2 | 0.0% | 0 | 2.9% | 2 | 0.0% | 0 | 0.7% | 1 | 1.7% | 4 |
| ***Answered question*** | **79.7%** | **749** | **78.0%** | **64** | **83.7%** | **62** | **68.7%** | **68** | **82.9%** | **146** | **79.1%** | **148** | **81.8%** | **235** |
| ***Skipped question*** | **20.3%** | **191** | **22.0%** | **18** | **16.3%** | **12** | **31.3%** | **31** | **17.1%** | **30** | **20.9%** | **39** | **18.2%** | **52** |

**How old are you? e.g. 42**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| 16 and under | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| 17-25 | 2.9% | 20 | 6.8% | 4 | 0.0% | 0 | 1.6% | 1 | 3.1% | 4 | 2.2% | 3 | 2.8% | 6 |
| 26-35 | 6.8% | 47 | 16.9% | 10 | 5.0% | 3 | 3.2% | 2 | 6.3% | 8 | 7.4% | 10 | 6.0% | 13 |
| 36-45 | 11.2% | 77 | 18.6% | 11 | 11.7% | 7 | 9.5% | 6 | 9.4% | 12 | 14.0% | 19 | 9.2% | 20 |
| 46-55 | 19.5% | 134 | 13.6% | 8 | 16.7% | 10 | 20.6% | 13 | 25.2% | 32 | 16.2% | 22 | 21.1% | 46 |
| 56-65 | 21.5% | 148 | 28.8% | 17 | 28.3% | 17 | 20.6% | 13 | 20.5% | 26 | 14.0% | 19 | 21.1% | 46 |
| 66-75 | 23.1% | 159 | 11.9% | 7 | 30.0% | 18 | 23.8% | 15 | 24.4% | 31 | 24.3% | 33 | 22.9% | 50 |
| 76-85 | 12.4% | 85 | 3.4% | 2 | 8.3% | 5 | 20.6% | 13 | 8.7% | 11 | 16.9% | 23 | 13.8% | 30 |
| 86 and over | 2.5% | 17 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 2.4% | 3 | 5.1% | 7 | 3.2% | 7 |
| ***Answered question*** | **73.1%** | **687** | **72.0%** | **59** | **81.1%** | **60** | **63.6%** | **63** | **72.2%** | **127** | **72.7%** | **136** | **75.9%** | **218** |
| ***Skipped question*** | **26.9%** | **253** | **28.0%** | **23** | **18.9%** | **14** | **36.4%** | **36** | **27.8%** | **49** | **27.3%** | **51** | **24.1%** | **69** |

**Which country were you born in?**

| Answer Options | % | No. |
|---|---|---|
| Africa | 0.3% | 2 |
| Bangladesh | 0.1% | 1 |
| Canada | 0.1% | 1 |
| China | 0.3% | 2 |
| East Africa | 0.1% | 1 |
| England | 53.4% | 363 |
| Former Yugoslavia | 0.1% | 1 |
| France | 0.1% | 1 |
| Gibraltar | 0.1% | 1 |
| Great Britain | 2.5% | 17 |
| Guyana | 0.1% | 1 |
| Hong Kong | 0.1% | 1 |
| India | 0.9% | 6 |
| Ireland | 0.1% | 1 |
| Isle of Man | 0.1% | 1 |
| Jamaica | 0.1% | 1 |
| Malaysia | 0.1% | 1 |
| Northern Ireland | 0.6% | 4 |
| Pakistan | 0.1% | 1 |
| Poland | 0.1% | 1 |
| Romania | 0.1% | 1 |
| Russia | 0.1% | 1 |
| Scotland | 1.9% | 13 |
| UK | 36.5% | 248 |
| USA | 0.3% | 2 |
| Yorkshire | 0.9% | 6 |
| Zimbabwe | 0.1% | 1 |
| ***Answered question*** | **72.3%** | **680** |
| ***Skipped question*** | **27.7%** | **260** |

**Do you belong to any religion?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Buddhism | 0.5% | 4 | 0.0% | 0 | 1.7% | 1 | 0.0% | 0 | 0.0% | 0 | 1.4% | 2 | 0.0% | 0 |
| Christianity | 55.8% | 406 | 46.9% | 30 | 48.3% | 29 | 64.7% | 44 | 58.4% | 80 | 50.0% | 71 | 61.6% | 141 |
| Hinduism | 0.8% | 6 | 1.6% | 1 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.7% | 1 | 1.3% | 3 |
| Islam | 3.8% | 28 | 14.1% | 9 | 3.3% | 2 | 0.0% | 0 | 2.2% | 3 | 2.8% | 4 | 4.4% | 10 |
| Judaism | 0.8% | 6 | 0.0% | 0 | 0.0% | 0 | 1.5% | 1 | 0.7% | 1 | 2.1% | 3 | 0.4% | 1 |
| Sikhism | 0.1% | 1 | 0.0% | 0 | 1.7% | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| No religion | 27.7% | 202 | 21.9% | 14 | 38.3% | 23 | 23.5% | 16 | 29.2% | 40 | 27.5% | 39 | 25.3% | 58 |
| Other (please specify) | 6.5% | 47 | 12.5% | 8 | 1.7% | 1 | 8.8% | 6 | 7.3% | 10 | 7.7% | 11 | 3.5% | 8 |
| ***Answered question*** | **77.4%** | **728** | **78.0%** | **64** | **81.0%** | **60** | **68.6%** | **68** | **77.8%** | **137** | **75.9%** | **142** | **79.7%** | **229** |
| ***Skipped question*** | **22.6%** | **212** | **22.0%** | **18** | **19.0%** | **14** | **31.4%** | **31** | **22.2%** | **39** | **24.1%** | **45** | **20.3%** | **58** |

**Other**

- Animism/Paganism
- Ascension
- C of E
- Catholic
- Church of England
- Failed atheist
- InterFaith
- Methodist
- non-practicing Christian
- Pagan
- Pentecostal
- Protestant
- Roman Catholic
- Spiritualist

**What is your ethnic group?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Indian | 1.3% | 10 | 1.6% | 1 | 1.6% | 1 | 0.0% | 0 | 1.4% | 2 | 1.4% | 2 | 1.7% | 4 |
| Pakistani | 2.6% | 19 | 12.5% | 8 | 1.6% | 1 | 0.0% | 0 | 0.7% | 1 | 1.4% | 2 | 3.0% | 7 |
| Bangladeshi | 0.7% | 5 | 1.6% | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 1.3% | 3 |
| Chinese | 0.5% | 4 | 0.0% | 0 | 1.6% | 1 | 0.0% | 0 | 0.0% | 0 | 1.4% | 2 | 0.4% | 1 |
| Other Asian background | 0.0% | 0 | 0.0% | 0 | 0.1% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Caribbean | 0.4% | 3 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.4% | 1 |
| African | 0.3% | 2 | 0.0% | 0 | 0.0% | 0 | 1.5% | 1 | 0.7% | 1 | 0.0% | 0 | 0.0% | 0 |
| Other Black background | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| White and Black Caribbean | 0.3% | 2 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.7% | 1 | 0.0% | 0 |
| White and Black African | 0.3% | 2 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 1.4% | 2 | 0.0% | 0 |
| White and Asian | 0.5% | 4 | 0.0% | 0 | 1.6% | 1 | 0.0% | 0 | 0.0% | 0 | 1.4% | 2 | 0.4% | 1 |
| Other mixed background | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| English, Welsh, Scottish, Northern Irish, British | 86.1% | 638 | 70.3% | 45 | 88.7% | 55 | 91.2% | 62 | 90.8% | 128 | 80.8% | 118 | 87.9% | 204 |
| Irish | 0.8% | 6 | 1.6% | 1 | 1.6% | 1 | 0.0% | 0 | 0.7% | 1 | 1.4% | 2 | 0.4% | 1 |
| Gypsy or Irish Traveller | 0.1% | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.0% | 0 |
| Other White background | 0.9% | 7 | 1.6% | 1 | 0.0% | 0 | 1.5% | 1 | 0.7% | 1 | 1.4% | 2 | 0.9% | 2 |
| Arab | 0.1% | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.0% | 0 |
| Any other ethnic group | 0.1% | 1 | 0.0% | 0 | 0.0% | 0 | 1.5% | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 |
| Prefer not to say | 4.9% | 36 | 10.9% | 7 | 3.2% | 2 | 4.4% | 3 | 4.3% | 6 | 6.2% | 9 | 3.4% | 8 |
| ***Answered question*** | **78.8%** | **741** | **78.0%** | **64** | **83.8%** | **62** | **68.7%** | **68** | **80.1%** | **141** | **78.1%** | **146** | **80.8%** | **232** |
| ***Skipped question*** | **21.2%** | **199** | **22.0%** | **18** | **16.2%** | **12** | **31.3%** | **31** | **19.9%** | **35** | **21.9%** | **41** | **19.2%** | **55** |

**Other**

- South American

**Do you consider yourself to be disabled?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Yes | 23.6% | 175 | 4.7% | 3 | 20.0% | 12 | 26.8% | 19 | 22.2% | 32 | 21.8% | 32 | 32.0% | 73 |
| No | 73.5% | 545 | 90.6% | 58 | 78.3% | 47 | 69.0% | 49 | 72.2% | 104 | 76.9% | 113 | 66.2% | 151 |
| Prefer not to say | 3.0% | 22 | 4.7% | 3 | 1.7% | 1 | 4.2% | 3 | 5.6% | 8 | 1.4% | 2 | 1.8% | 4 |
| ***Answered question*** | **78.9%** | **742** | **78.0%** | **64** | **81.0%** | **60** | **71.7%** | **71** | **81.8%** | **144** | **78.6%** | **147** | **79.4%** | **228** |
| ***Skipped question*** | **21.1%** | **198** | **22.0%** | **18** | **19.0%** | **14** | **28.3%** | **28** | **18.2%** | **32** | **21.4%** | **40** | **20.6%** | **59** |

**Types of impairment:**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Physical or mobility impairment (such as using a wheelchair to get around and / or difficulty using your arms) | 65.9% | 120 | 60.0% | 3 | 50.0% | 6 | 55.0% | 11 | 67.6% | 23 | 58.1% | 18 | 72.4% | 55 |
| Sensory impairment (such as being blind / having a serious visual impairment or being deaf / having a serious hearing impairment) | 18.7% | 34 | 20.0% | 1 | 8.3% | 1 | 10.0% | 2 | 29.4% | 10 | 19.4% | 6 | 18.4% | 14 |
| Mental health condition (such as depression or schizophrenia) | 17.6% | 32 | 0.0% | 0 | 25.0% | 3 | 15.0% | 3 | 29.4% | 10 | 19.4% | 6 | 13.2% | 10 |
| Learning disability (such as Downs syndrome or dyslexia) or cognitive impairment (such | 3.3% | 6 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 2.9% | 1 | 9.7% | 3 | 2.6% | 2 |

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| as autism or head-injury) | | | | | | | | | | | | | | |
| Long term condition (such as cancer, HIV, diabetes, chronic heart disease, or epilepsy) | 37.4% | 68 | 20.0% | 1 | 41.7% | 5 | 30.0% | 6 | 41.2% | 14 | 51.6% | 16 | 32.9% | 25 |
| Prefer not to say | 8.2% | 15 | 20.0% | 1 | 8.3% | 1 | 15.0% | 3 | 8.8% | 3 | 6.5% | 2 | 6.6% | 5 |
| ***Answered question*** | **19.4%** | **182** | **6.1%** | **5** | **16.2%** | **12** | **20.2%** | **20** | **19.3%** | **34** | **16.6%** | **31** | **26.5%** | **76** |
| ***Skipped question*** | **80.6%** | **758** | **93.9%** | **77** | **83.8%** | **62** | **79.8%** | **79** | **80.7%** | **142** | **83.4%** | **156** | **73.5%** | **211** |

**Are you a carer? Do you look after, or give any help or support to a family member, friend or neighbour because of a long term physical disability, mental ill-health or problems related to age?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Yes | 27.8% | 203 | 39.1% | 25 | 29.8% | 17 | 15.9% | 11 | 32.9% | 48 | 23.8% | 34 | 28.6% | 64 |
| No | 69.2% | 505 | 57.8% | 37 | 66.7% | 38 | 78.3% | 54 | 64.4% | 94 | 73.4% | 105 | 69.6% | 156 |
| Prefer not to say | 3.0% | 22 | 3.1% | 2 | 3.5% | 2 | 5.8% | 4 | 2.7% | 4 | 2.8% | 4 | 1.8% | 4 |
| ***Answered question*** | **77.6%** | **730** | **78.0%** | **64** | **77.0%** | **57** | **69.7%** | **69** | **82.9%** | **146** | **76.5%** | **143** | **78.0%** | **224** |
| ***Skipped question*** | **22.4%** | **210** | **22.0%** | **18** | **23.0%** | **17** | **30.3%** | **30** | **17.1%** | **30** | **23.5%** | **44** | **22.0%** | **63** |

**Are you pregnant?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Yes | 0.8% | 6 | 1.6% | 1 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.7% | 1 | 1.3% | 3 |
| No | 96.7% | 703 | 96.9% | 62 | 98.2% | 55 | 94.1% | 64 | 97.9% | 140 | 97.2% | 139 | 96.0% | 217 |
| Prefer not to say | 2.5% | 18 | 1.6% | 1 | 1.8% | 1 | 5.9% | 4 | 1.4% | 2 | 2.1% | 3 | 2.7% | 6 |
| ***Answered question*** | **77.3%** | **727** | **78.0%** | **64** | **75.7%** | **56** | **68.7%** | **68** | **81.3%** | **143** | **76.5%** | **143** | **78.7%** | **226** |
| ***Skipped question*** | **22.7%** | **213** | **22.0%** | **18** | **24.3%** | **18** | **31.3%** | **31** | **18.7%** | **33** | **23.5%** | **44** | **21.3%** | **61** |

**Have you given birth in the last 6 months?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Yes | 0.7% | 5 | 3.1% | 2 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.9% | 2 |
| No | 96.9% | 697 | 95.3% | 61 | 98.2% | 54 | 95.5% | 64 | 98.6% | 140 | 97.1% | 134 | 96.4% | 217 |
| Prefer not to say | 2.4% | 17 | 1.6% | 1 | 1.8% | 1 | 4.5% | 3 | 1.4% | 2 | 2.2% | 3 | 2.7% | 6 |
| ***Answered question*** | **76.5%** | **719** | **78.0%** | **64** | **74.3%** | **55** | **67.7%** | **67** | **80.7%** | **142** | **73.8%** | **138** | **78.4%** | **225** |
| ***Skipped question*** | **23.5%** | **221** | **22.0%** | **18** | **25.7%** | **19** | **32.3%** | **32** | **19.3%** | **34** | **26.2%** | **49** | **21.6%** | **62** |

**What is your sexual orientation?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Bisexual (both sexes) | 0.7% | 5 | 3.1% | 2 | 0.0% | 0 | 1.5% | 1 | 0.7% | 1 | 0.0% | 0 | 0.4% | 1 |
| Gay (same sex) | 1.3% | 9 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 2.9% | 4 | 0.7% | 1 | 1.8% | 4 |
| Heterosexual/straight (opposite sex) | 89.1% | 636 | 85.9% | 55 | 92.9% | 52 | 90.9% | 60 | 89.2% | 124 | 88.4% | 122 | 88.8% | 198 |
| Lesbian (same sex) | 1.1% | 8 | 0.0% | 0 | 3.6% | 2 | 0.0% | 0 | 1.4% | 2 | 0.0% | 0 | 1.8% | 4 |
| Other | 0.4% | 3 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.0% | 0 | 0.4% | 1 |
| Prefer not to say | 8.3% | 59 | 10.9% | 7 | 3.6% | 2 | 7.6% | 5 | 9.4% | 13 | 10.9% | 15 | 6.7% | 15 |
| ***Answered question*** | **75.9%** | **714** | **78.0%** | **64** | **75.7%** | **56** | **66.7%** | **66** | **78.9%** | **139** | **73.8%** | **138** | **77.7%** | **223** |
| ***Skipped question*** | **24.1%** | **226** | **22.0%** | **18** | **24.3%** | **18** | **33.3%** | **33** | **21.1%** | **37** | **26.2%** | **49** | **22.3%** | **64** |

**Are you transgender? Is your gender identity different to the sex you were assumed at birth?**

| | WY&H | | Bradford | | Calderdale | | Harrogate | | Kirklees | | Leeds | | Wakefield | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Answer Options | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. |
| Yes | 0.1% | 1 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.7% | 1 | 0.0% | 0 | 0.0% | 0 |
| No | 96.0% | 677 | 93.7% | 59 | 98.2% | 54 | 94.0% | 63 | 96.4% | 133 | 94.7% | 126 | 97.3% | 217 |
| Prefer not to say | 3.8% | 27 | 6.3% | 4 | 1.8% | 1 | 6.0% | 4 | 2.9% | 4 | 5.3% | 7 | 2.7% | 6 |
| ***Answered question*** | **75.0%** | **705** | **76.8%** | **63** | **74.3%** | **55** | **67.7%** | **67** | **78.4%** | **138** | **71.1%** | **133** | **77.7%** | **223** |
| ***Skipped question*** | **25.0%** | **235** | **23.2%** | **19** | **25.7%** | **19** | **32.3%** | **32** | **21.6%** | **38** | **28.9%** | **54** | **22.3%** | **64** |

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**Report of Head of Governance and Scrutiny Support**

**Report to the West Yorkshire Joint Health Overview and Scrutiny Committee**

**Date: 28 November 2017**

**Subject: West Yorkshire and Harrogate Health and Care Partnership - a progress update and an outline of the next steps**

| | | |
|---|---|---|
| Are specific electoral Wards affected?<br>If relevant, name(s) of Ward(s): | ☐ Yes | ☒ No |
| Are there implications for equality and diversity and cohesion and integration? | ☐ Yes | ☒ No |
| Is the decision eligible for Call-In? | ☐ Yes | ☒ No |
| Does the report contain confidential or exempt information?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## Summary of main issues

1. This report introduces a progress update on the West Yorkshire and Harrogate Health and Care Partnership and an outline of the next steps (Appendix 1).

## Recommendation

2. Members are asked to consider the matters set out in Appendix 1 and identify any specific scrutiny action / activity.

.

## 1.0 Purpose

1.1 This report introduces a progress update on the West Yorkshire and Harrogate Health and Care Partnership and an outline of the next steps (Appendix 1).

## 2.0 Background information

2.1 In December 2015, the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) was established, drawing its membership from the five constituent West Yorkshire local authorities.

2.2 In November 2016, the JHOSC considered a report that set out the requirements for local NHS commissioning organisations to develop and submit place-based local Sustainability and Transformation Plans and presented the draft West Yorkshire and Harrogate Sustainability and Transformation Plan, for consideration.

2.3 As noted in the JHOSC's Terms of Reference, the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide for local NHS bodies to consult with the appropriate health scrutiny committee where there are any proposed substantial developments or variations in the provisions of the health service in the area(s) of a local authority.

2.4 It should be further noted that under the legislation officials from relevant NHS bodies are required to attend committee meetings; provide information about the planning, provisions and operation of health services; and must consult on any proposed substantial developments or variations in the provision of the health service.

2.5 With the lack of any nationally recognised definition of what constitutes a 'substantial' development or variation in the provision of the health service, it is recognised as good practice for NHS commissioners and providers to engage with the appropriate health scrutiny committees as early as possible to discuss any proposed service developments or variations in order to help define the necessary level of formal consultation.

## 3.0 Main issues

3.1 A progress update on the West Yorkshire and Harrogate Health and Care Partnership and an outline of the next steps is attached at Appendix 1.

3.2 It should be noted that specific consideration of Improving Stroke Services is included elsewhere on the agenda.

3.3 Appropriate NHS representatives have been invited to the meeting to discuss the details presented at Appendix 1 and address questions from members of the JHOSC.

## 4.0 Recommendations

4.1 Members are asked to consider the matters set out in Appendix 1 and identify any specific scrutiny action / activity.

## 5.0 Background documents[1]

5.1 None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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**APPENDIX 1**

# Report of the West Yorkshire and Harrogate Health and Care Partnership Lead Chief Executive to the West Yorkshire Joint Health Overview and Scrutiny Committee

## A progress update on the West Yorkshire and Harrogate Health and Care Partnership and an outline of the next steps

## Purpose

1. The purpose of this paper is to update the West Yorkshire Joint Health Overview and Scrutiny Committee (WY JHOSC) on the progress made and next steps on the West Yorkshire and Harrogate (WY&H) Health and Care Partnership since we last met with the WY JHOSC in March 2017.

2. It focuses on:

- Background to the partnership
- Communications and engagement
- Governance
- Programme update
- Finance and transformation funding
- "STP Progress Dashboard"
- Next steps

## Background to the Partnership

3. The West Yorkshire and Harrogate Health and Care Partnership aims to deliver the best outcomes for people in West Yorkshire and Harrogate (WY&H) and the Five Year Forward View. This means a focus on health inequalities, unwarranted variation in care, and finances.

4. Our partnership is the second largest in the country in terms of population, and therefore it is right that the majority of work happens in each of our six places which build on existing relationships and health and wellbeing strategies. This principle of subsidiarity applies to everything we do.

5. Overview and Scrutiny Committee chairs will be familiar with their local Health and Wellbeing Strategies. These are:

- Bradford, including Airedale Wharfdale and Craven;
- Calderdale;
- Harrogate (as part of the North Yorkshire system);
- Kirklees;
- Leeds; and
- Wakefield District.

6. These plans form the bulk of our WY&H work. Where we work collectively at WY&H level it is for one of three reasons:

- We need to look at how we best provide services across a wider footprint than place.
- There is benefit in doing the work once and sharing.
- We have a collective difficult issue and working together would help solve it.

## Communications and engagement

7. Strong communications and effective engagement are essential to the Partnership. We are working closely with Healthwatch in each place and at WY&H level.

8. Since our plan is formed from local place plans, it can be seen as a continuation of work that has been developed since 2012 at a local level, when Health and Wellbeing Boards were required to develop Health and Wellbeing Strategies. Therefore, in developing our proposals, we used all of the engagement and consultation across our six local places to guide us. When we published our plan, we included a compendium of the engagement and consultation work an easy read version and a public summary.

9. In August 2017 we published our engagement and consultation timeline – setting out our draft plans to engage and consult on the WY&H priorities and also the engagement and consultation timelines relating to each of the six local places. New work will be added to the timelines as the programmes develop so it is important to note these may be subject to change.

10. In September 2017, we published our draft communications and engagement strategy which sets out our principles for communications, engagement and consultation and our approach to working with local people. Engaging and communicating with partners, stakeholders and the public in the planning, design and delivery is essential if we are to get this right. We are committed to transparency and meaningful engagement in our work.

11. You can see an example of the way we work across WY&H in the engagement process on Stroke (see Stroke Section on page 9).

## Governance

### *Clinical Commissioning Groups and the WY&H Joint Committee*

12. We have consolidated the management structures of our 11 Clinical Commissioning Groups (CCGs). This means we have moved from 11 management teams to six, which makes CCG management structures co-terminus with their Local Authority partners in the six places in WY&H. This is a helpful step to supporting local plans.

13. The collaboration of the 11 CCGs across the area has been further strengthened by coming together as a Joint Committee. We have recruited an Independent Lay Chair and two lay member representatives for the Committee.

14. The third meeting of the Committee was held in public on the 7 November 2017 to discuss stroke, urgent and emergency care and elective care. The agenda, papers and a

recording of the meeting are available online at www.wyh-jointcommiteeccgs.co.uk**.** The next meeting in public will take place on the 9 January 2018.

***West Yorkshire Association of Acute Trusts***

15. An important part of the way we work is how our six Acute Trusts are working together. Our acute hospitals do this through the West Yorkshire Association of Acute Trusts (WYAAT). The board of each of the WYAAT trusts agreed to form a Committee in Common which is responsible for leading the work programme to deliver this ambition. Any case for change will be considered by the Committee in Common before being recommended to each of the individual trust boards for approval.

    - Airedale NHS Foundation Trust
    - Bradford Teaching Hospitals NHS Foundation Trust
    - Calderdale and Huddersfield NHS Foundation Trust
    - Harrogate and District NHS Foundation Trust
    - Leeds Teaching Hospitals NHS Trust
    - Mid Yorkshire Hospitals NHS Trust

***Mental health and community providers***

16. Historically there is strong partnership working between the four providers of specialist mental health services across our area:

    - South West Yorkshire Partnership NHS Trust
    - Leeds and York Partnership NHS Foundation Trust
    - Bradford District Care NHS Foundation Trust
    - Leeds Community Healthcare NHS Trust [who deliver specialist Child and Adolescent Mental Health Services for WY&H]

17. This close working has been strengthened and reinforced through our partnership approach and the need to deliver the targets in the mental health programme. The group is considering the WYAAT committee in common model *(described in para 15 above)* as a way of formalising joint working

***Local authorities***

18. The West Yorkshire Health and Care Consultative Group is an informal forum to facilitate political consideration of the broad range of issues which impact on the efficiency and effectiveness of health and care services in West Yorkshire.

19. The Group adds value to formal, local decision-making structures (e.g. Health and Wellbeing Boards) by enabling politicians to consider and influence work at the West Yorkshire level.

20. Specifically, the Group is responsible for:

    - ensuring local government is an active participant in discussions about health and care services, and is clear that decisions are taken locally;

- sharing intelligence and information on health and social care issues where this has strategic implications for West Yorkshire;
- developing a vision for local government to lead different solutions for a sustainable health and care system that meets people's needs; and,
- coordinating any responses to central government on relevant matters.

21. The Group's membership is:

- Council leaders from the five West Yorkshire authorities; and,
- All portfolio-holders for health / adult social care from the five West Yorkshire authorities.

22. This means the Chair of each West Yorkshire Health and Wellbeing Board is a member of the Consultative Group. Local Authority Chief Executives are also invited to attend the Group's meetings.

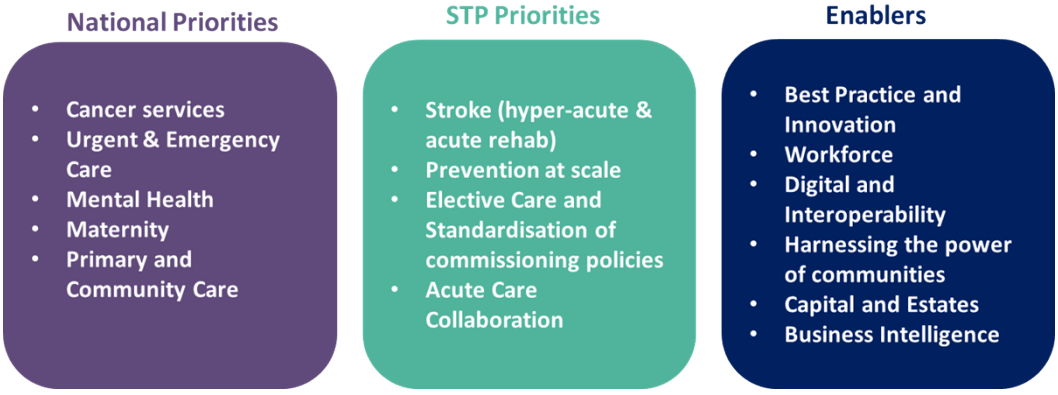
23. We are in the process of jointly appointing a senior officer hosted by Leeds City Council to work across the West Yorkshire to better support joint working.

***System Leadership Executive Group***

24. We have also established a System Leadership Executive Group, which includes representation from the above groups and each place. Although this group has no statutory decision making power in acts as a co-ordinating point for all of the work of the partnership.

## Programme updates

25. We have established a set of programmes, which are split between national priority areas, local WY&H priority areas and enabling workstreams.




26. Since our last update we have added maternity as a "national priority" overseen by the partnership – in response to the national 'better births' strategy.

27. We no longer have a separate 'specialised commissioning' workstream. This work continues to be led by NHS England who has commissioning responsibility for these services. Our leadership continues to work closely with NHS England on this, particularly through Acute Care Collaboration programme.

### *National Priority Programmes*

#### ***Urgent and emergency care***

28. UEC is one of the national service improvement priorities highlighted in the *'Next Steps on the Five Year Forward View'*. Targets for NHS 111 Online, 111 calls, GP access and urgent treatment centres. Targets have also been identified for the Ambulance Response Programme, and ensuring people only stay in hospitals for as long as need be. Specifically, our plans include:

    - **NHS 111:** Roll-out of NHS 111 online to cover 30% of people by March 2019; increasing clinical contact through NHS 111 calls to 50% by March 2018, and expand direct booking to GP practice sites from NHS 111.
    - **GP access:** Increase extended access so that 100% of people have evening and weekend appointments by March 2019.
    - **Ambulance services:** Increase hear, see and treat services, to reduce the need for people being taken to hospital.
    - **Hospital services:** Including delivery of the 95% four hour A&E waiting time standard; co-located GP support; consistent adoption of the frailty pathway and SAFER bundle and 50% of trusts having psychiatric liaison in place by October 2018
    - **Improving hospital to community care:** Reducing the rate of delayed transfers of care to a minimum of 3.5%; increasing the number of continuing healthcare assessments in the hospital; and delivering effective discharge consistently across West Yorkshire and Harrogate.

29. The WY&H Urgent and Emergency Care Board (UECPB) builds on a firm foundation of partnership working, shared learning and leadership to deliver the ambitions of WY&H Health and Care Partnership. It connects all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

30. The WY&H UECPB submitted a milestone tracker in June 2017 to NHS England. This sets out the expected milestones and achievements over the next two years in order to implement the national plan.

#### ***Maternity***

31. In support of NHS England's National Maternity Review, we have developed the WY&H Local Maternity System Board. The Board's vision for maternity services is to further improve safety for mum and baby, personalisation, choice and family friendly care. We believe every woman and their partner should have access to information to enable them to make decisions about care; and every woman and baby should be able to access support that is centred around their needs and circumstances.

32. We also believe that all staff working in maternity care should be supported to deliver care which is women centred. They should work in high performing teams, in organisations which are well led, and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

33. To achieve this, we will be:

- Developing a local vision for improved maternity services in order to ensure that there is access to services for women and their babies, regardless of where they live
- Ensuring women and their babies can access seamlessly the right care, in the right place at the right time
- Making sure that providers in WY&H, such as NHS hospitals and other health services, work together so that the needs and preferences of women and families are paramount.
- Putting in place necessary infrastructure to support services to work together effectively.
- Making sure that women, their partner, their families and local communities are involved in designing maternity services.
- Supporting a learning culture between NHS staff, partners and fostering workforce co-ordination and training.

***Primary and community care***

34. Strong primary and community services are an essential part of the WY&H Health and Care Partnership. This means broadening the definition of primary care and supporting the model to build resilience for professionals and the public. The programme of work is taking shape to address and make links to local plans and GP access. There is also a strong a focus on the *General Practice Forward View* and workforce. Our priorities are as follows:

- **Sustainable and resilient general practice:** Working to strengthen the resilience of general practice, for example through improving the condition of the estate to facilitate working at scale; closer working with community pharmacy, to make the most of existing capacity; effective use of the GP resilience fund, to support vulnerable practices and collaborative working.
- **Workforce:** Developing new roles non-registered workforce in Primary Care which includes practice management, care navigators, apprentices in primary care, medical assistants and Mental Health support workers; international recruitment; and flexible employment models.
- **Investment:** Higher rate of growth in investment in primary and community care - 15% growth to 2020-21.
- **New models of primary care:** Building on the learning from the vanguard programmes, to develop new integrated models of service delivery.
- **Improving access to general practice:** Extending the hours that general practice is open – so that 100% of the population has access to extended opening hours by April 2019.

35. We have a strong track record of innovation in this area, particularly through our participation in the national vanguard programme. Our partnership is helping facilitate the spread and adoption of what we know works well.

***Mental health***

36. In WY&H we are developing a local service framework for mental health and strong partnership on child and adolescent mental health services, forensics and suicide. Our ambitions include:

- A 40% reduction in unnecessary A&E attendance
- A zero suicide approach to prevention (75% reduction in numbers in mental health settings by 2020-21)
- A reduction in Section 136 place of safety episodes both in police and health based places of safety. Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety
- Elimination of out of area placements for non-specialist hospital care within 12 months
- A reduction in waiting times for autism assessment.

37. To help ensure that we meet these ambitions the four provider of specialist mental health services in WY&H are working together, alongside CCGs, to strengthen partnerships and share delivery of specialist mental health services. Through these closer working arrangements we will share best practice across the region, for example reducing out of area placements for non-specialist hospital care over the next 12 months. We are already achieving this in some areas across the partnership. Our aim is to ensure that people are supported in the least restrictive environment, ideally in a community setting close to home, rather than in hospital.

38. Our partnership has recently been successful in becoming a national new care model site for tertiary mental health services. This means that secondary mental health providers will manage care budgets for tertiary mental health services (currently commissioned by NHS England Specialised Commissioning) under a central programme taking an 'accountable care system' approach to managing and redesigning care for the local population. The combined budget for the two services is c£12m.Leeds Community Healthcare NHS Trust will be the lead provider for CAMHs T4 and Leeds & York Partnership Foundation Trust will be the lead provider for Adult Eating Disorders. This is an opportunity to develop high quality integrated services locally, in the least restrictive setting close to home, eliminating costly and avoidable out of area placements.

39. Earlier this year, a new perinatal mental health service has been launched which provides specialist care for pregnant women and new mothers. Pregnancy and childbirth is a uniquely vulnerable time for women where there is a substantially increased risk of developing an episode of mental illness – the most likely time in a woman's life. This new service will help to raise the awareness of perinatal illness within mental health services and improve access for women to appropriate specialist interventions from specially trained staff. The new perinatal mental health service will provide specialist and tailored care to pregnant women, new mothers and their families in Barnsley, Calderdale, Kirklees and Wakefield.

***Cancer***

40. Our cancer work is delivered through a partnership of health, social care, patients and charities called the WY&H Cancer Alliance and our published delivery plan sets out how we will deliver our objectives in greater detail. Five streams of work make up the delivery plan:

    - Tobacco control
    - Patient experience
    - Early diagnosis
    - Living with and beyond cancer
    - High quality services

41. We have established a West Yorkshire and Harrogate Cancer Alliance Board to oversee the implementation of our cancer plan. This includes representation from each place and health and care sector as well as the patient voice. The Board provides leadership, direction and assurance for the local delivery of the ambitions of the national cancer strategy, on behalf of the partnership. This includes agreeing, coordinating and assuring constituent local delivery plans.

42. We have recently secured £13.5 million of national funding to support work to improve early diagnosis and make more cancers curable through a range of projects. We have also secured £840,000 of additional transformation funding to support people living with and beyond a cancer diagnosis, and in particular to improve access to the four elements of the so-called Recovery Package – a holistic needs assessment and care plan; a treatment summary; a cancer care review and access to health and wellbeing events.

43. The focus of our programme is to deliver the best possible outcomes and experience for people affected by cancer, while spending the West Yorkshire and Harrogate pound as effectively as possible through delivering value for money care and treatment. We will do this through a set of clear ambitions and targets for improvement:

    ***Health and wellbeing***

    - Reduce adult smoking rates from 18.6% to 13%, resulting in around 125,000 fewer smokers and preventing around 11,250 admissions to hospital
    - Increase 1 year survival from 69.7% to 75% , equating to around 700 lives per year
    - Increase the proportion of cancers diagnosed early (stages 1 and 2) from 40% to 62%, offering 3,000 extra people the chance of curative or life extending treatment.

    ***Care and quality***

    - Increase the number of patients actively involved in providing feedback and contributing to service improvement over and above the annual national Cancer Patient Experience Survey (CPES)
    - Improve the patient's care journey to ensure current cancer waiting times standards are met and go further to deliver a '28 day to diagnosis' standard for 95% of people investigated for cancer symptoms. This could deliver faster diagnosis for

around 5,000 people currently diagnosed with cancer through the routine referral to treatment 'pathway'.

***Finance and efficiency***

- Deliver estimated efficiency savings of up to £12 million over 5 years based on lower treatment costs associated with earlier stage diagnosis for many forms of cancer.

## *WY&H priority programmes*

### ***Acute Care Collaboration***

44. Our six Acute hospitals do this through the West Yorkshire Association of Acute Trusts (WYAAT). More info about WYAAT is detailed in paragraph 15 above.

45. WYAAT has a joint work programme which includes four work streams:
    - specialist services;
    - clinical standardisation and networks;
    - clinical support; and
    - corporate services.

46. WYAAT is driving forward nine different projects .These include:

    - Developing a West Yorkshire Vascular Network - Clinical representatives from each Trust have been working together to develop a model for how we can develop a West Yorkshire vascular team and network. Developing the service as a single network will improve recruitment to local services and provide opportunities for staff to specialise in different aspects of vascular surgery.
    - Improving the pharmacy supply chain - pharmacy teams from acute trusts in west, north and east Yorkshire (covering WY&H and Humber, Coast and Vale) are working collaboratively to explore opportunities for optimising efficiency and value by establishing a shared medicines supply chain from the point of ordering to the point the medicine is available for use in clinical areas. Not only will the project bring efficiency savings, it will bring about supply chain performance improvement, release clinical time for patient care and support in managing any risk around supply shortages.
    - The WYAAT programme management office has been developing a range of governance and assurance processes to support the progression of the different programmes of work.

### ***Stroke***

47. We want to make sure our stroke services are 'fit for the future' and make the most of the skills of our valuable workforce and new technology whilst maximising opportunities to improve quality and outcomes for local people.

48. We also want to ensure that care across the whole stroke pathway is working effectively to meet the current and future needs of our population. At the last Joint

Committee of CCGs meeting an ambition of 89% identification and management of Atrial Fibrillation was agreed – this has the potential to save 190 lives over the next 3 years.

49. We have developed a strategic case for change for stroke which sets out a clear case for why we need to look at stroke care.

50. Our work has been informed by an extensive programme of engagement. Over 1,500 people gave their views via an online survey, outreach sessions with voluntary and community groups, and interviews with people in GP practices, rehabilitation units, stroke wards, and libraries. Stroke consultants also took part in sessions so that people could hear first-hand about the care and support available from health professionals.

51. We are developing proposals to determine the 'optimal' service delivery models, standardised pathways and clinical standards for our specialist stroke services (the care our patients receive in the first few hours and days after having a stroke)

***Prevention at Scale***

52. Preventing ill health is at the heart of our work and a theme that runs through all of our work. We want to develop a new relationship with communities, health and care services, so that there is an increased recognition that it is also choices and behaviours that can make and keep you well, rather than the services you receive. We have built into the way we work through Director of Public Health involvement in all programme structure.

53. In our November 2016 proposals we set ambitions relating to smoking, alcohol, people at risk of diabetes and workforce. Progress is as follows:

- *Smoking*: We set an ambition to reduce smoking from 18.6% to 13% (a reduction of 125,000 smokers). The recently published figures show we have reduced from 18.6% (2015) to 17.3% (2016). This equates to 23,300 fewer smokers. Using recent work by the Healthy London Partnerships on prevention and savings, this reduction will give £17.1m of healthcare savings over the next five years. This is good progress overall but masks differences across our area.

- *Alcohol*: Addressing alcohol related harm; including reducing alcohol related hospital admissions as well as a focus on primary prevention are part of our plan. This requires a joined up approach with all partners and highlights the importance of balancing the range of local need and inequalities.

- *High risk of diabetes*: We are adopting and applying the National Diabetes Prevention Programme to reduce the numbers of people with high risk of becoming diabetic. The programme provides education on healthy eating and bespoke physical exercise programmes to support people to lose weight – a key risk factor for type 2 diabetes. Leeds and Bradford are up and running. The remainder of the partnership operating as a single area has now signed up and

has overachieved referrals in its first month. Progress is satisfactory and there has been shared learning across the three patches.

***Elective care and standardisation of commissioning policies***

54. This programme supports the ambitions of the *Next Steps on the Five Year Forward View* document through reducing demand and meeting need more appropriately. This will increase the responsiveness of services to people in WY&H, improved access and support and achievement of clinical ambitions such as 18 week referral to treatment targets.

55. An objective of this programme is to achieve standardisation of key commissioning policies and protocols across the WY&H CCGs by 2020/21 and with the ambition of achieving the equivalent of approximately £50m in financial efficiency gains through managing demand to a more affordable level. It is agreed as an underpinning principle that not all CCGs will move to revised policies at the same time. The expectation is that there will be a rolling programme of implementation, resulting in an end-point where all CCGs are taking the same approach.

56. The approach we are taking was approved by the Joint Committee of CCGs at its 7 November 2017 meeting. The agenda, papers and a recording of the meeting are available online at www.wyh-jointcommiteeccgs.co.uk.

## *Enabling programmes*

**Innovation and best practice**

57. WY&H includes areas of national best practice. Health innovation is a significant part of the local economy and our partnership needs to consider how it secures opportunities for future growth.

58. Our partnership is also the vehicle for transforming health and social care at scale and we are building our experience of working together but we need to increase the scale and pace of change across the system - we need to be flexible, adaptive and willing to try new things. We are working closely with the Yorkshire and Humber Academic Health Science Network (AHSN) – the body that brings together industry, the NHS, universities and local government to:

- Map AHSN innovations and improvements to meet priorities, gaps or challenges
- Plug in programmes to other AHSN innovations and opportunities e.g. the local improvement academy, innovation exchange, national innovator accelerator,
- Co-create an improvement approach with each programme
- Create an understanding of analytic health economic and other input/support required
- Support the development and delivery of the sharing workshops/summits

53. An example of this is our stroke work. The AHSN have identified that by applying best practice we could increase the number of people with atrial fibrillation who are

effectively diagnosed and managed in primary care to 89%. We estimate that this would save around 190 lives over the next three years.

**Workforce**

59. Our workforce is our most important asset. Around 70% of the £5bn we spend each year pays for our workforce. In recent years they have made a huge contribution to ensure that services continue to deliver in very challenging times.

60. There are approximately 113,000 people working formally in health and care, and more than double that it informal unpaid carer roles. The total number of staff has been increasing year on year, but it is also true that the pressure and complexity of work has increased, and the ongoing pay restraint has made it particularly challenging for staff recruitment and retention. There are specific specialties and staff groups, such as emergency medicine; psychiatry; medicine; specialist radiology; gastroenterology; microbiology, histopathology where we know there are significant recruitment and retention issues.

61. Our Local Workforce Action Board (LWAB) is developing a WY&H workforce strategy which describes the issues and challenges we face and sets out our plans for action. It includes 10 recommended actions:

- ***Maximising the contribution of the current health and social care workforce***
  - Improving recruitment and retention in all areas
  - Exploiting skills development
  - Improving health and wellbeing of the workforce

- ***Getting more people training for a future career in health and social care***
  Increasing the numbers in training to work in health and social care roles, specifically focusing on support workers, the registered workforce (nurses, doctors and allied health professionals) and advanced clinical practitioners.

- ***Growing the general practice and community workforce to enable the 'left shift'***
  Increasing the numbers, developing new roles and changing the makeup of staff in primary and community care

- ***Transforming teamwork***
  Strengthening capability to implement new 'workforce team' models.

- ***Making it easier to work in different places and different organisations***
  Developing flexible employment models across organisations – including lead employers for some contracts, and new models of employment contracts

- ***Agreeing and tracking workforce productivity measures***
  Including a number of specific targets for productivity measures, including reductions in sickness absence, bank and agency spend and turnover.

- ***Strengthening workforce plans***
  Ensuring that the workforce issues are built into all of the WY&H work programmes, taking in to account national strategies and priorities.

- ***Establishing a workforce investment plan and fund***
  We will develop a comprehensive workforce investment plan and a strategic workforce investment fund. This will bring together employers, commissioners and national bodies around a sector wide approach.

- ***Establishing a 'workforce hub' in partnership with Health Education England***
  This hub would provide the infrastructure for joined up workforce planning and training across WY&H. It will undertake strategic workforce planning, education and development; a point of co-ordination across programmes and each place; and ensure improved workforce information and analysis.

- ***Establishing effective workforce infrastructure in each Place***
  We will strengthen workforce partnerships that exist in each place.

**Digital and Interoperability**

62. A significant focus of our work to date has been establishing an effective digital infrastructure which enables IT systems and organisations to connect. Our approach is based on the 'anytime, anywhere, any place' philosophy. This will allow health and care professionals to work across public sector buildings. We are taking forward three programmes of work:

    - We are procuring (buying) a Health and Social Care Network which will replace the separate health and local government networks that connect buildings to the required IT systems across the area. This procurement is being managed as a programme across the partnership completing in spring 2018 and then moving in to mobilisation. We will then be able to look at the current state of multiple connections in to shared buildings, with costs.
    - Funding has been made available to allow all our GP Practices to apply wifi. The programme is designed to give everyone access to wifi in the GP practices. This is currently live in Leeds and our intention is to roll out to the rest of the area in the next 12 months. Our ambition is that two thirds of practices will have wifi by March 2018. This will be free to use by the public, and also help by pointing them to health and care advice.
    - We are implementing something known as Govroam across the area. Govroam allows people visiting another organisation connected to govroam to log on to the wifi of the using the same username and password they use at their own organisation. This will realise savings on lost staff time spent arranging for connectivity and issuing temporary passwords. It will also save costs on procuring wireless networks, sharing multi-department spaces, and making the most of our buildings.

63. There is huge potential for digital technology to support healthier lifestyles, allow people to manage their own healthcare, wherever safe to do so, and enable people to benefit from more fully from health and care services. We have recently developed a partnership with the Good things foundation to develop and test digital way of working to support people with seeing and hearing difficulties to receive health

services in a way that works better for them. This pilot is backed with £50,000 of national funding.

**Harnessing the power of communities**

64. Working alongside our communities is an important part of our partnership - seeing the people we serve as assets and partners, and not as problems. We want a changed relationship with local people, built on trust and empowerment, where the benefits of self-care and prevention strategies can really flourish. This is an important part of our primary and community care programme.

65. We have good leadership from the voluntary and community sector, and we are attracting support from Healthwatch, NHS England, Nurture Development and National Voices to help us to think about our next steps. To make sure our work adds the greatest value possible and supports existing projects and groups across the area we started with a number of design workshops in the summer. The aim of these were to agree a shared set of principles and a common understanding of what we mean by 'communities doing more for themselves', 'co-production', 'asset based community development', 'co-design', and what the shared ambition for working with communities should be.

- We held our first Voluntary and Community Sector (VCS) event on the 6 November 2017 which brought together our WY&H programme leads to discuss VCS involvement in all the work streams. A follow up session will take place on the 1 December 2017.
- Healthwatch are currently exploring how we can generate different types of conversations with communities using social media.
- Healthwatch are keen to understand how we can take some of the social value ideas that exist in local government procurement and explore how they relate to NHS commissioning.
- We are holding an event on the 14 December 2017 to discuss how best WY&H programmes can embed our aspirations in respect of unpaid carers into all that we do.

**Capital and estates**

66. We have recently established a programme of work to understand how we can best work together to develop a better understanding of our estates and capital requirements to meet the requirement of changing clinical service models. Owen Williams, Chief Executive at Calderdale & Huddersfield NHS FT has agreed to lead this piece of work.

67. The organisations in WY&H are clear that in order to deliver the required transformational changes, we will need to work together and collaborate on those aspects of the change agenda which are better achieved across a wider footprint. We are also clear that in relation to our capital plans, we need to work together on the totality of our NHS capital plans.

68. There has been a process across 2017 to develop a prioritised list of capital proposals to be considered against the £325m that was announced as part of the Spring 2017 Budget and the capital resource that may become available as part of the Autumn 2017 Budget.

69. Our prioritised submission to NHS England and NHS Improvement in September 2017 contains schemes with a combined value of £185m. These included the following schemes:

- those which have a clear transformation impact across the West Yorkshire and Harrogate footprint, including the capacity of inpatient services for young people with mental health issues, developments around the way in which diagnostics services (radiology and pathology) are provided across West Yorkshire and Harrogate, an expansion of telemedicine and care services into care homes, and ambulance requirements given hospital services changes already underway;

- those related to priority acute reconfigurations across West Yorkshire and Harrogate. These include the scheme to develop the Calderdale Royal Hospital / Huddersfield Royal Infirmary sites and the redevelopment of the Leeds General Infirmary site;

- other schemes which impact across a more limited number of organisations, including schemes at Airedale General Hospital and Dewsbury District Hospital, as well as a number of provider digitisation schemes;

- a number of other schemes were not submitted but remain in view including a potential urgent care hub in Bradford, a potential development linked to better use of NHS capacity, a number of mental health schemes, a radiotherapy planning system, and the development of person-held care records.

70. We expect to hear shortly whether these proposals have been successful.

## Finance and Transformation funding

***Finance***

71. We are refreshing our financial plans, from those submitted in October 2016. The October 2016 submission was high level proposals that preceded the 2 year planning and contracting round, and was an integrated financial plan covering NHS, public health and social care expenditure. We aim to have this work completed in the next few months.

72. There are increasing resources going into health and social care - £5.7bn by 2020-21. We also know that need for care and services are growing at a faster rate than the money we have. If we delivered care in the way we do today, with no change and no efficiencies, the cost would be at least another £1billion by 2021. We need to make the best use of every £ we spend.

73. In November 2016 we set out in our draft proposals how we planned to deliver this level of efficiency improvement. We categorised these into a number of categories:

- "organisational" efficiencies (£0.6bn) in providers, CCGs and social care/public health
- "activity moderation" efficiencies (0.1bn)
- "West Yorkshire and Harrogate programme" efficiencies (£0.1bn)
- use of Sustainability and Transformation Fund (STF) income (£0.2bn)

74. As part of the financial planning assumptions used nationally, there is an expectation that NHS providers will be required to generate "organisational" efficiencies (£0.4bn) £through limiting clinical and operational variation, and ensuring that organisations actively seek out and address opportunities to obtain better value from resources available. Key to deliver of these efficiencies is the work being done locally through the West Yorkshire Association of Acute Trusts work programme, as well as the national programmes being undertaken locally (specifically the Carter efficiency programme and the "Getting It Right First Time" programme).

75. CCGs will also continue to drive efficiency improvements in all areas of their expenditure commitments, including continuing healthcare, prescribing, administration costs and in the commissioning of health services (£0.1bn). The planning also included an assessment of the efficiencies required and being planned in social care/public health (£0.1bn).

76. In addition to these "organisational" efficiencies, joint plans across our six "places" identified areas where the supply and demand for health services could be managed in a different way ("activity moderation" efficiencies). This included work on New Care Models (linked to the vanguards being undertaken in WY&H), opportunities presented through RightCare (a nationally-sponsored programme looking at resources and outcomes), self-care and preventing ill-health, and demand management.

77. The plans also included assumptions around the level of efficiency savings that could reasonably be expected from the WY&H programmes (described earlier in this briefing paper) and the availability of STF income (currently being accessed directly by providers in 2017/18 and 2018/19).

***Transformation funding secured***

| **Transformation funding secured** | |
|---|---|
| West Yorkshire Acceleration Zone (2016/17) | £8.6m |
| West Yorkshire Acceleration Zone (Q1 of 2017/18) | £4.3m |
| Primary care extended access (2016/17) | £1.7m |
| Mental Health Liaison (2017/18) | £0.2m |
| Mental Health Liaison (2018/19) | £0.6m |
| Diabetes (2017/18) | £2.7m |
| Cancer (2017/18) | £6.7m |
| Cancer (2018/19) | £6.8m |
| **Total** | **£32m** |

## "STP Progress Dashboard"

78. In July 2017 NHS England published a progress dashboard. The dashboard gives a composite rating (1 outstanding – 4 needs most improvement) for each of the 44 STPs. Performance Indicators reflect NHS England priority areas but the scope is narrower than our partnership and is NHS focused.

79. West Yorkshire and Harrogate was assessed as category 3 – making progress. We appear to be doing worse than average on the following areas:

- Emergency admissions rate
- Emergency bed days rate
- GP extended access
- MRSA rates
- C Diff rates

80. Rating has been positioned as a 'baseline' assessment – reflecting the fact that these partnerships are relatively immature and unlikely to have been able to significantly influence the majority of the indicators in the time they have been in existence. There is one measure which is a direct judgement of our 'system leadership' – our partnership scored category 2 of 4 on this measure, our leadership is 'established' defined as 'systems are working together at the system level, with organisations aware of the importance of effective system-level working and taking action to drive integration'.

## Next steps

81. We will be producing and publishing our response to the *'Next Steps on the Five Year Forward View'* document early in the new year. This will describe our plans to improve health and outcomes for the people in our region, and the governance and capacity arrangements we are putting in place to deliver them –since publishing our draft proposals in November 2016. We will also publish an easy read version, information in audio and BSL.

82. We are developing a WY&H Finance Strategy. This is a really important piece of work, building upon the work that has already taken place by our Finance Directors across WY&H, providing a coherent summary of the actions we will be required to undertake to deliver financial sustainability as one of the three key aims set out in the *Five Year Forward View*. The continuing ownership of the agenda and numbers will help ensure the success of the partnership.

83. Throughout everything we do we will continue to:

- develop and support our staff;
- have conversations with people who use services and their carers;
- work with our politicians, council leaders, Overview and Scrutiny Committees, Health and Wellbeing Board Chairs; and
- work at pace to implement positive change.

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 0113 3788666

**Report of Head of Governance and Scrutiny Support**

**Report to West Yorkshire Joint Health Overview and Scrutiny Committee**

**Date: 28 November 2017**

**Subject: Chairs Update**

| | | |
|---|---|---|
| Are specific electoral Wards affected?<br>If relevant, name(s) of Ward(s): | ☐ Yes | ☒ No |
| Are there implications for equality and diversity and cohesion and integration? | ☐ Yes | ☒ No |
| Is the decision eligible for Call-In? | ☐ Yes | ☒ No |
| Does the report contain confidential or exempt information?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## 1 Purpose of this report

1.1 The purpose of this report is to provide an opportunity for the Chair of the Joint Committee to give an update on any general matters in relation to the work of the Joint Committee not specifically included elsewhere on the agenda.

## 2 Main issues

2.1 Invariably, scrutiny activity can often take place outside the formal Joint Committee meetings. Such activity may involve a variety of actions and can include specific activity and actions of the Chair.

2.2 The purpose of this report is, therefore, to provide an opportunity for the Chair of the Joint Committee to give an update on any general matters in relation to the work of the Joint Committee not specifically included elsewhere on the agenda.

2.3 The report also provides an opportunity for members of the Joint Committee to identify and agree any further scrutiny activity that may be necessary.

2.4 The Chair will provide a verbal update at the meeting, as required.

## 3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and any additional details provided at the meeting.
b) Identify and agree any specific resolutions and/or matters that may require further scrutiny input or activity.

## 4. Background papers[1]

None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Report author: Steven Courtney
Tel: 0113 3788666

**Report of Head of Governance and Scrutiny Support**

**Report to the West Yorkshire Joint Health Overview and Scrutiny Committee**

**Date: 28 November 2017**

**Subject: Work Programme**

| | | |
|---|---|---|
| Are specific electoral Wards affected?<br>If relevant, name(s) of Ward(s): | ☐ Yes | ☒ No |
| Are there implications for equality and diversity and cohesion and integration? | ☐ Yes | ☒ No |
| Is the decision eligible for Call-In? | ☐ Yes | ☒ No |
| Does the report contain confidential or exempt information?<br>If relevant, Access to Information Procedure Rule number:<br>Appendix number: | ☐ Yes | ☒ No |

## Summary of main issues

1. This report provides an opportunity for members of the West Yorkshire Joint Health Overview and Scrutiny Committee to consider and agree the priorities for developing its future work programme.

## Recommendation

2. Members are asked to consider the matters set out in this report and agree the priorities for developing the future work programme of the West Yorkshire Joint Health Overview and Scrutiny Committee.

.

## 1.0 Purpose

1.1 This report provides an opportunity for members of the West Yorkshire Joint Health Overview and Scrutiny Committee to consider and agree its priorities and future work programme.

## 2.0 Background information

2.1 In December 2015, the West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC) was established, drawing its membership from the five constituent West Yorkshire local authorities.

2.2 As set out in the agreed terms of reference (Appendix 1), the West Yorkshire JHOSC has the following roles and functions:

- To scrutinise any proposed service configuration with West Yorkshire-wide implications and its impact on patients and the public when constituent Councils have delegated these powers to the West Yorkshire Health Scrutiny Committee.
- To meet regularly with NHS England to:
  - Receive updates on national developments and other matters from NHS England
  - To inform NHS England of common issues arising at the five West Yorkshire health scrutiny committees.
- To receive information on service proposals and other matters from West Yorkshire Commissioning Collaborative (known as 10CC)
- To share information on health issues from each of the local authority areas that may have an impact on the other local authority areas within West Yorkshire.
- To undertake shared development activities from time to time.

2.3 Prior to the formal establishment of the JHOSC, the Health Scrutiny Chairs of the five West Yorkshire Authorities met periodically on an informal basis focusing on the establishment and progress of the Health Futures Programme.

2.4 When considering the agreed Terms of Reference, the JHOSC previously noted that in the spirit of cooperation and transparency, where it was considered to be beneficial for a joint West Yorkshire approach to matters relating to Adult Social Care and/or Public Health, details would be considered by the JHOSC, on an issue by issue basis.

2.5 In November 2016, the JHOSC considered a report that set out the requirements for local NHS commissioning organisations to develop and submit place-based local Sustainability and Transformation Plans and presented the draft West Yorkshire and Harrogate Sustainability and Transformation Plan, for consideration.

## 3.0 Main issues

3.1 Since the formal establishment of the JHOSC, a number of issues / work streams have been considered by the Scrutiny Board, including:

- The Urgent and Emergency Care Vanguard
- Work of the West Yorkshire Association of Acute Trusts
- Cancer waiting times
- Autism assessments
- Stroke Services
- Access to dental service
- Specialised services

3.2 As set out elsewhere on the agenda, some of the above areas form part of the West Yorkshire and Harrogate Health and Care Partnerships established set of programmes. The details set out in the progress and next steps report are worthy considerations when considering the JHOSC's future work programme.

3.3 At its previous meeting, the JHOSC concluded that its future work programme should be developed to reflect the nine work programme / priority areas identified in the West Yorkshire and Harrogate STP; whilst also recognising the following matters be included as part of the considerations:

- Autism;
- STP Governance arrangements; and
- The Urgent and Emergency Care Vanguard.

3.4 The JHOSC also agreed there may be some merit in holding a more detailed development session for the JHOSC, to build a better and consistent understanding of the STP approach and to consider the level and timeliness of and scrutiny activity.

3.5 It should be noted that the NHS and the Centre for Public Scrutiny (CfPS) have come together to deliver a half-day workshop aimed at supporting and improving the understanding of those working on the day-to-day delivery of STPs in both the NHS and local government. Health Scrutiny Chairs from across the West Yorkshire and Harrogate STP footprint have been invited to attend the event, planned for 12 December 2017.

<u>West Yorkshire Joint Committee of Clinical Commissioning Groups</u>

3.6 As set out elsewhere on the agenda, the collaboration of Clinical Commissioning Groups across West Yorkshire and Harrogate have come together to form a Joint Committee. To date, the Joint Committee has met on three occasions – namely, 4 July 2017, 5 September 2017 and 7 November 2017. Minutes from the meetings held on 4 July 2017 and 5 September 2017 are appended to this report.

3.7 The next meeting of the Joint Committee is scheduled for 9 January 2018.

<u>Developing the work programme</u>

3.8 In continuing to develop its future work programme, the following matter are particularly highlighted as 'good practice' suggestions for the JHOSC to consider:

- Avoid duplication by having a full appreciation of any existing forums already having oversight of, or monitoring a particular issue.
- Ensure any Scrutiny activity has clarity and focus of purpose; adding value within an agreed time frame.
- Avoid pure "information items" except where that information is being received as part of an identified policy/scrutiny review.
- Seek advice about available resources and relevant timings, taking into consideration the overall workload of the JHOSC and the Health Overview and Scrutiny Committees across the constituent authorities.
- Build in sufficient flexibility to enable the consideration of urgent matters that may arise during the year

3.9 The following matters are also worthy of consideration when considering the development of a future work programme:

- As noted in the attached Terms of Reference, the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide for local NHS bodies to consult with the appropriate health scrutiny committee where there are any proposed substantial developments or variations in the provisions of the health service in the area(s) of a local authority.
- It is further noted that under the legislation officials from relevant NHS bodies are required to attend committee meetings; provide information about the planning, provisions and operation of health services; and must consult on any proposed substantial developments or variations in the provision of the health service.
- With the lack of any nationally recognised definition of what constitutes a 'substantial' development or variation in the provision of the health service, it is recognised as good practice for NHS commissioners and providers to engage with the appropriate health scrutiny committees as early as possible to discuss any proposed service developments or variations in order to help define the necessary level of formal consultation.

## 4.0 Recommendations

4.1 Members are asked to consider the matters set out in this report and agree the priorities for developing the future work programme of the West Yorkshire Joint Health Overview and Scrutiny Committee.

## 5.0 Background documents[1]

5.1 None

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

**WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE**

**TERMS OF REFERENCE AND WORKING ARRANGEMENTS**

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide for local NHS bodies to consult with the appropriate health scrutiny committee where there are any proposed substantial developments or variations in the provisions of the health service in the area(s) of a local authority.

Under the legislation health officers from NHS bodies are required to attend committee meetings; provide information about the planning, provisions and operation of health services; and must consult with the health scrutiny committee on any proposed substantial developments or variations in the provision of the health service.

Where proposals to change health services cross local authority boundaries there is a requirement to establish a joint health committee. In Yorkshire and the Humber, a protocol has been established between the 15 upper tier local authorities for establishing a joint health scrutiny committee where proposed changes affect more than one local authority area. Joint health scrutiny committees may also be established to consider other issues of mutual interest.

The chairs of the five West Yorkshire Councils health overview and scrutiny committees met on 21 November 2014 and agreed to pursue establishing a West Yorkshire Health Scrutiny Committee. The purpose of the West Yorkshire Health Scrutiny Committee is to; consider any proposals from the NHS for substantial variation in service that have West Yorkshire wide implications; to meet NHS England to discuss any matters with West Yorkshire wide implications; and to be the first place for dialogue between West Yorkshire Council's Scrutiny Panels and West Yorkshire Commissioning Collaborative (known as 10CC).

The West Yorkshire Health Scrutiny Committee has the following roles and functions:

- To scrutinise any proposed service configuration with West Yorkshire-wide implications and its impact on patients and the public when constituent Councils have delegated these powers to the West Yorkshire Health Scrutiny Committee.

- To meet regularly with NHS England to:

    - Receive updates on national developments and other matters from NHS England
    - To inform NHS England of common issues arising at the five West Yorkshire health scrutiny committees.

- To receive information on service proposals and other matters from West Yorkshire Commissioning Collaborative (known as 10CC)

- To share information on health issues from each of the local authority areas that may have an impact on the other local authority areas within West Yorkshire.

- To undertake shared development activities from time to time.

Working Arrangements

- The West Yorkshire Health Scrutiny Committee will meet at least four times a year as a formal body meeting in public.

- Each local authority will host one meeting a year and provide the administrative support to that meeting.

- Each local authority will nominate two members to sit on the West Yorkshire Health Scrutiny Committee

- The quorum for the West Yorkshire Health Scrutiny Committee will be five Members, with Members from at least three of the five local authorities present.

- Agenda, minutes and committee papers will be published on the websites of all the five local authorities.

**West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups**

**Minutes of the meeting held in public on Tuesday 4 July 2017**

Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1GF

| **Members** | **Initials** | **Role and organisation** |
|---|---|---|
| Marie Burnham | **MB** | Independent Lay Chair |
| Richard Wilkinson | **RW** | Lay member |
| Fatima Khan-Shah | **FKS** | Lay member |
| Dr James Thomas | **JT** | Clinical Chair, NHS Airedale, Wharfedale and Craven CCG |
| Dr Andy Withers | **AW** | Clinical Chair, NHS Bradford Districts CCG |
| Helen Hirst | **HH** | Chief Officer, NHS Bradford City & Districts |
| Dr Alan Brook | **ABr** | Clinical Chair, NHS Calderdale CCG |
| Matt Walsh | **MW** | Chief Officer, NHS Calderdale CCG |
| Dr Steve Ollerton | **SO** | Clinical Leader, NHS Greater Huddersfield CCG |
| Carol McKenna | **CMc** | Chief Officer, NHS Greater Huddersfield CCG |
| Dr Alistair Ingram | **AI** | Clinical Chair, NHS Harrogate & Rural District CCG |
| Amanda Bloor | **ABl** | Chief Officer, NHS Harrogate & Rural District CCG |
| Dr Alistair Walling | **AWa** | GP Clinical Lead, NHS Leeds South & East CCG |
| Dr Gordon Sinclair | **GS** | Clinical Chair, NHS Leeds West CCG |
| Visseh Pejhan-Sykes | **VPS** | Chief Finance Officer, NHS Leeds CCGs Partnership (deputy for Philomena Corrigan) |
| Dr David Kelly | **DK** | Clinical Chair, NHS North Kirklees CCG |
| Richard Parry | **RP** | Chief Officer, NHS North Kirklees CCG |
| Dr Phillip Earnshaw | **PE** | Clinical Chair, NHS Wakefield CCG |
| Jo Webster | **JW** | Chief Officer, NHS Wakefield CCG |
| **Apologies** | | |
| Dr Akram Khan | **AK** | Clinical Chair, NHS Bradford City CCG |
| Dr Jason Broch | **JB** | Clinical Chair, NHS Leeds North CCG |
| Philomena Corrigan | **PC** | Chief Executive, NHS Leeds CCGs Partnership |
| Moira Dumma | **MD** | Director of Commissioning Operations (Y&H), NHS England |
| **In attendance** | **Initials** | **Role** |
| Lou Augur | **LA** | Director of Delivery – West Yorkshire, North Region NHS England |
| Ian Holmes | **IH** | Programme Director, WY&H STP |
| Jonathan Webb | **JWe** | Director of Finance, WY&H STP |
| Stephen Gregg | **SG** | Joint Committee Governance Lead (minutes) |
| Karen Coleman | **KC** | WY&H STP Communication & Engagement Lead |

| **For items 03/17 and 04/17** | | |
|---|---|---|
| Rory Deighton | **RD** | Director, Healthwatch Kirklees |
| Dr Graham Venables | **GV** | Clinical Director, Y&H Clinical Networks |
| Jacqui Crossley | **JC** | Head of Clinical Effectiveness and Governance, Yorkshire Ambulance Services |
| Jonathan Booker | **JBo** | STP Senior analyst |
| Linda Driver | **LD** | STP Stroke Project Lead |

25 members of the public attended the meeting.

| Item No. | Agenda Item | Action |
|---|---|---|
| **01/17** | **Welcome, introductions and apologies** | |
| | The Chair welcomed everyone to the first meeting in public of the Joint Committee. Apologies were noted. MB said that the Committee brought together the 11 CCGs across WY&H. She emphasised that although the Committee supported the STP, the Committee only included CCGs and did not represent all of the partners involved in the STP.<br>MB highlighted that the role of the Committee was to make collective decisions on shared priorities across WY&H, and that it was not the business of the Committee to deal with issues in individual places.<br>**Open Forum**<br>Before the start of the formal meeting, there was an opportunity for members of the public to make representations or ask questions about the work of the Joint Committee. A Deputation was received from the campaign group Hands off Huddersfield Royal Infirmary (HRI):<br>• *How do the STP and local plans fit together? Would specialist stroke services be based at HRI? Was consideration being given to the availability of community based services to support stroke patients once they had been discharged?*<br>Members of the public asked questions about:<br>• *Had decisions already been taken to close hyper acute stroke units? The availability of detailed STP financial information and how decisions would be made about finance gaps within the STP? The validity of the evidence collected as part of the stroke engagement exercise and case for change? Who would ultimately make decisions about the configuration of stroke services?*<br>• *From the memorandum of understanding for the Joint Committee: what is a Lead commissioner/Contractor? What decisions are delegated to the Joint Committee? What happens when a CCG disagrees with a decision of the Joint Committee?*<br>• *The impact of budget reductions across WY&H on plans to close the A&E department at HRI?*<br>MB said that, where appropriate, answers to these questions would be provided as part of the relevant agenda items. If this was not possible, a full written response would be provided. These questions, and the answers to them, would be posted on the Joint Committee webpages following the meeting. | **SG/KC** |

| Item No. | Agenda Item | Action |
|---|---|---|
| | JW emphasised that this was a meeting in public, not a public meeting. Local issues should be taken up at place level. WY&H stroke questions would be addressed under the specific agenda items, and there would be a further opportunity for questions later in the meeting. | |
| **02/17** | **Declarations of Interest** | |
| | The register of interests of members of the Joint Committee was tabled at the meeting. The Chair reminded Committee members of their obligation to declare any interests they may have on any issues arising at meetings which might conflict with the business of the Committee. No further declarations were made. | |
| **03/17** | **Learning from patients and the public – Stroke** | |
| | MB emphasised the importance of public engagement in informing and shaping the design of care pathways, and introduced AW, who chaired the stroke Task and Finish Group. AW presented the background to the work and introduced the stroke specialists, including clinical advisors, who were in attendance today.<br>In 2013, the 10 WY CCGs had identified stroke as a priority for West Yorkshire. 3 elements had been highlighted – prevention, discharge and hyper acute stroke units (HASU). At that time, Airedale HASU had been forced to close as it had not been sustainable, and services had transferred to Bradford. This had emphasised the importance of sustainability across WY&H, which became a priority for the STP.<br>There were 3600 admissions a year across WY&H, which was expected to increase by 10%. There were 2 big issues involved with ensuring access to specialist care – workforce and capacity. The case for change recognised the need to further improve and ensure the sustainability of services.<br>Referencing 2 of the questions posed earlier, AW emphasised that no specific recommendation or decisions had yet been taken on the number of HASUs. Although the focus of today was on HASUs, he emphasised the need to address the whole stroke pathway and ensure that the right support services were available close to people's homes.<br>AW highlighted the need to engage with people to identify their needs. This would then be used to review the existing pathway and develop new clinical models over the coming months.<br>The Committee watched a short video featuring Malcolm and Sue. Malcolm had suffered a stroke, and the video presented the challenges that he and his family had faced.<br>RD then presented the results of a public engagement exercise led by Healthwatch in February and March 2017. Healthwatch had used a variety of methods to engage the public. Feedback from social media indicated that 98,000 people were aware of the engagement exercise.<br>940 surveys had been returned. 75% of respondents had direct lived experience of stroke, either as a patient or carer. The work had also included consultant-led focus groups and interviews. RD noted the main messages, which included immediate access to tests and treatment, effective discharge and follow up services, the role of voluntary organisations, and the need to join up services and provide ongoing support and review. The importance of prevention work had also been highlighted. | |

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| | RD said that the approach to stroke services met the Healthwatch principles of engagement. There had been transparent engagement from the start, with people with lived experience of stroke.<br>FKS congratulated Healthwatch on the report and methodology. The quality of engagement had been good. There was a recognised need to engage more effectively with some minority groups, including Eastern European and BME groups.<br>JW felt that it was an excellent piece of engagement work. She questioned whether more focus was needed on recognizing the signs of stroke.<br>SO highlighted some powerful messages, including the variation in care between weekdays and weekends and that some respondents had been diagnosed but not admitted.<br>DK questioned the variation in survey response rates. RD said that there were fewer in Bradford, as similar work had already been done in that area.<br>In response to a question from MB, RD said that there had been feedback to everyone who had participated in the engagement.<br>Responding to a question from FKS, KC said that engagement colleagues were exploring a variety of options for involving patients in the Task and Finish Group.<br>MB invited questions from members of the public:<br>• *How could quality stroke support be provided in the community in the light of financial challenges?*<br>• *How could Healthwatch be seen as independent?*<br>AW responded that the aim of the redesign was to improve quality and outcomes. There may be cost impacts, but the focus was firmly on quality.<br>RD said that Healthwatch was an independent charity, funded by local authorities. They had set out to listen to local people, and had no preconceived 'agenda'. | **KC** |
| | **The Joint Committee: Noted** the Stroke Services Engagement Report key findings and next steps. | |
| **04/17** | **Improving stroke outcomes** | |
| | JW presented the report, highlighting three main objectives: improving stroke outcomes, using resources efficiently and effectively and ensuring that stroke services were sustainable and fit for future. The focus of today was on specialist services, but there was a need to cover the whole pathway in future work.<br>The case for change recognised that high quality care in the first few hours was critical. There were significant workforce challenges in ensuring high quality services, 24 hours a day, 7 days a week. Clinical outcomes varied across WY&H and there was a need to learn from best practice and experience elsewhere, which indicated that outcomes were better when treatment was provided in specialist centres. Key factors to be taken into account included NICE guidelines and opportunities provided by new technology.<br>The case for change highlighted clearly the need to review existing services. There had been extensive engagement with key stakeholders, including the Clinical Senate, patients and the public, providers and Overview and Scrutiny Committees. | |

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| | The first stage of the NHSE assurance process had been completed. The next steps were to develop an outline business case and report back to the Joint Committee in November.<br>FKS welcomed the case for change. She identified some areas for further focus, including supporting carers/families to travel to specialist centres and prevention support for BME and Eastern European groups. JW acknowledged the need to do more to engage with some populations.<br><br>DK identified the need for greater consistency of post-stroke support across all places in WY&H. He felt that the Committee had an important role to play in addressing resourcing and workforce issues. JW said that this was a good example of how the STP and Joint Committee could support work across a WY&H footprint. AW added that the Task and Finish Group would be addressing the whole care pathway.<br><br>HH asked whether the identified risks around workforce and the sustainability of services could be managed within the proposed timeframe. JW responded that the current services were providing safe care, but that there was a need to strengthen resilience. At present, it was planned that options for change would be presented to the Joint Committee in November.<br><br>ABr noted that only a proportion of patients would benefit from HASU services, and emphasised the importance of effective ambulance care. JC added that the aim was a 'gold standard' pathway, with patients receiving the best possible care.<br><br>MB welcomed the report and the engagement that supported it. FKS added that the Lay Member Reference Group of the WY&H CCGs had been updated on the process so far.<br><br>MB invited questions from the public:<br><br>• *The finding that outcomes for stroke patients are better from specialist services was questioned, particularly in relation to thrombolysis.*<br>• *How will you ensure clinically led, evidence based care when dealing with financial challenges? Where is the money coming from?*<br>• *How will you ensure high quality care at home?*<br>• *Where will decisions be taken about the reconfiguration of services*<br>• *A comment was made that the Healthwatch findings supported the 'basics' of good care, follow up and local services.*<br><br>GV responded that thrombolysis had limited value, but that some stroke patients did benefit from it. All aspects of stroke care were much better organised in specialist centres and benefitted everyone who came through the service. Critical issues like swallowing, positioning and hydration were dealt with by specialist staff.<br><br>AW responded that the stroke work was strongly clinically driven and included acute hospital stroke leads. He added that investment in prevention services could reduce the number of strokes.<br><br>JW invited members of the public to submit any further questions outside of | **JW** |

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| | meeting.<br>MB welcomed the interim report and looked forward to firmer proposals on the way forward coming back to the Committee in November. | |
| | **The Joint Committee:**<br>• **Noted** progress to date**;**<br>• **Noted** the Engagement Report and Strategic Case for Change**; and**<br>• **Noted** the next steps and timelines**.** | |
| **05/17** | **The Operation of the Joint Committee** | |
| | SG presented the report, which set out the role, membership and purpose of the Joint Committee and how it would operate.<br>The report set out the basis on which the 11 CCGs in WY&H had delegated WY&H-level decisions to the Joint Committee. Appendix A included the Memorandum of Understanding for Collaborative Commissioning and the membership and terms of reference of the Joint Committee. It also covered the quorum for the Committee and the voting arrangements.<br>Appendix B presented the Committee's workplan. This set out the specific decision areas which had been delegated to the Joint Committee by the CCGs, including stroke, urgent care and cancer services.<br>To ensure appropriate challenge and transparency, the Joint Committee was Chaired by an Independent Lay Chair and also included 2 Lay members from the CCGs. Meetings were held in public and agenda papers, minutes and decision summaries would be posted on the Committee's webpages.<br>The Committee had set out some principles for involving the public, and would review these as the Committee developed.<br>The Committee workplan was firmly focused on what needed to be done at WY&H level to deliver the outcomes set out in the STP. The Committee's workplan had been prepared in late 2016 and was very high level. There was now a need to be more specific about the scheduling of decisions that would be coming to the Joint Committee.<br>HH highlighted the need to log and respond to all relevant questions and to post answers on the website.<br>MB noted the need to distinguish clearly between issues at WY&H level for which the Committee was responsible, and work at place level, which should be addressed locally.<br>JW noted the need to engage effectively at local place level and emphasised the '3 tests' which defined work at WY&H level. These were where WY&H – level work was needed to improve outcomes, share best practice of deal with common problems.<br>DK emphasised the need to establish greater clarity about the Committee workplan.<br>MB advised that the Committee needed to appoint a Deputy Chair. She proposed that Gordon Sinclair be appointed for a six months interim period. In response to a question from DK, MB explained that GS had extensive experience of chairing the Collaborative of CCGs over the past 3 years. He would act as Deputy for six months, whilst the 2 CCG Lay members gained experience of the operation of the Committee.<br>GS noted that if he was required to deputise, any conflicts would be identified | |

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| | and managed appropriately. He reiterated that the Committee had delegated responsibility for commissioning decisions.<br>MB invited questions from the public:<br>• *When would the earlier questions about the MOU be answered? Why were local authorities not represented on the Joint Committee in their role as commissioner?*<br>JW responded that the CCGs worked closely with local authorities at both place and WY&H level. Answers to all questions would be provided following the meeting. | |
| | The Joint Committee:<br>• **noted** the Memorandum of Understanding for Collaborative Commissioning including the Committee's Terms of Reference, membership and Workplan<br>• **noted** the appointment of the Independent Lay Chair and 2 Lay representatives, and **appointed** Gordon Sinclair as interim Deputy Chair for six months.<br>• **noted** how the public will be involved and the shared outcomes and targets towards which the Committee is working.<br>• **noted** the approach to refreshing the Committee's workplan and **requested** that an updated workplan be brought back to the Committee for approval in November 2017. | **SG** |
| **06/17** | **Any other business** | |
| | There was none. | |

**Next Joint Committee in public -** Tuesday 5th September 2017, Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1GF.

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West Yorkshire and Harrogate Sustainability and Transformation Partnership

**West Yorkshire & Harrogate Joint Committee of Clinical Commissioning Groups**

**DRAFT Minutes of the meeting held in public on Tuesday 5 September 2017**

Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1QF

| **Members** | **Initials** | **Role and organisation** |
|---|---|---|
| Marie Burnham | **MB** | Independent Lay Chair |
| Fatima Khan-Shah | **FKS** | Lay member |
| Dr Akram Khan | **AK** | Chair, NHS Bradford City CCG |
| Dr James Thomas | **JT** | Chair, NHS Airedale, Wharfedale and Craven CCG |
| Dr Andy Withers | **AW** | Chair, NHS Bradford Districts CCG |
| Helen Hirst | **HH** | Chief Officer, NHS Bradford City, Bradford Districts and AWC CCGs |
| Dr Alan Brook | **ABr** | Chair, NHS Calderdale CCG |
| Matt Walsh | **MW** | Chief Officer, NHS Calderdale CCG |
| Dr Steve Ollerton | **SO** | Chair, NHS Greater Huddersfield CCG |
| Ian Currell | **IC** | Chief Finance Officer, NHS Greater Huddersfield CCG |
| Dr Alistair Ingram | **AI** | Chair, NHS Harrogate & Rural District CCG |
| Amanda Bloor | **ABl** | Chief Officer, NHS Harrogate & Rural District CCG |
| Dr Jason Broch | **JB** | Chair, NHS Leeds North CCG |
| Dr Alistair Walling | **AWa** | GP Clinical Lead, NHS Leeds South & East CCG |
| Dr Gordon Sinclair | **GS** | Chair, NHS Leeds West CCG |
| Philomena Corrigan | **PC** | Chief Executive, NHS Leeds CCGs Partnership |
| Dr David Kelly | **DK** | Chair, NHS North Kirklees CCG |
| Richard Parry | **RP** | Chief Officer, NHS North Kirklees CCG |
| Pat Keane | **PK** | Deputy Chief Officer, NHS Wakefield CCG |
| Dr Phillip Earnshaw | **PE** | Chair, NHS Wakefield CCG |
| **Apologies** | | |
| Richard Wilkinson | **RW** | Lay member |
| Carol McKenna | **CMc** | Chief Officer, NHS Greater Huddersfield CCG |
| Jo Webster | **JW** | Chief Officer, NHS Wakefield CCG |
| Moira Dumma | **MD** | Director of Commissioning Operations (Y&H), NHS England |
| **In attendance** | **Initials** | **Role** |
| Lou Auger | **LA** | Director of Delivery – West Yorkshire, North Region NHS England |
| Ian Holmes | **IH** | Programme Director, WY&H STP |
| Jonathan Webb | **JWe** | Director of Finance, WY&H STP |
| Stephen Gregg | **SG** | Joint Committee Governance Lead (minutes) |
| Matt Ward | **MW** | STP Core Team |

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| **For items 14/17 and 15/17**<br>Emma Fraser | **EF** | Mental Health Programme Director |
| **For item 15/17**<br>Nicola Lees | **NL** | Chief Executive, Bradford District Care NHS Foundation Trust and Senior Responsible Officer for Mental Health programme |

10 members of the public attended the meeting.

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| **09/17** | **Welcome, introductions and apologies** | |
| | The Chair welcomed everyone to the meeting. Apologies were noted.<br>MB noted that the Joint Committee was made up of the 11 CCGs in West Yorkshire and Harrogate (WY&H). The Committee had delegated powers from individual CCGs to make collective decisions around specific work programmes, for example mental health, urgent care and stroke. Although the Committee supported the wider STP, it only included CCGs and did not represent all of the partners involved in the STP. It was not the business of the Committee to deal with issues in individual places within WY&H. | |
| **10/17** | **Open Forum** | |
| | MB introduced the Open Forum, which provided an opportunity for members of the public to make representations or ask questions about items on today's agenda. MB advised that no written questions had been received before the meeting, and invited verbal questions from members of the public.<br>*Q1 How would the CCGs address the problem of people with serious mental health problems sometimes being treated five hundred miles from home?*<br>HH said that reducing out of area placements was one of the main aims of the mental health programme and would be covered in detail under item 15/17. (Note: The questioner subsequently confirmed that the question had been answered under that item).<br>*Q2 Why had answers not been provided to questions raised at the last meeting?*<br>SG said that answers to all questions had been posted on the Joint Committee web page following the meeting. He would check that individual responses had also been sent out. | **SG** |
| **11/17** | **Declarations of Interest** | |
| | MB advised that the full register of interests of members of the Joint Committee was available on the Joint Committee web pages. MB asked Committee members to declare any interests that might conflict with the business on today's agenda. No further declarations were made. | |
| **12/17** | **Minutes of the meeting in public – 4th July 2017** | |
| | The Committee reviewed the minutes of the last meeting. | |
| | **The Joint Committee: Approved** the minutes of the meeting on 4th July 2017. | |
| **13/17** | **Actions and matters arising** | |
| | SG presented the action log. An update on patient involvement in the Stroke Task and Finish Group would be brought to the next meeting.<br>There were no other outstanding actions or matters arising. | **SG** |
| | **The Joint Committee: Noted** the action log. | |

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| **14/17** | **Patient stories** | |
| | HH welcomed Emma Fraser, the Mental Health Programme Director. To help the Committee to reflect on the direct experience of patients, HH introduced 2 video presentations in which Peter and Paul talked about their experiences as users of mental health services. Committee members commented on the power and impact of the stories. | |
| | **The Joint Committee: Noted** the patient stories. | |
| **15/17** | **Mental health update** | |
| | HH introduced the item and welcomed Nicola Lees, the Senior Responsible Officer for the Mental Health (MH) programme. The MH programme was well established and had clear aims and ambitions. It was important that each place had a strong local offer for people with mental health needs. Supporting people in crisis closer to home was a key aim.<br>EF presented an overview of the local service framework across WY&H, and the aims to reduce variation, develop more consistent pathways, support all to achieve the best standards and achieve economies of scale. She highlighted work on emergency care, suicide prevention, specialist Child and Adolescent Mental Health Services (CAMHS), autism and care closer to home. She also outlined proposals to develop joint commissioning.<br>NL highlighted a number of successes across WY&H, including work with a range of public services and the voluntary sector. PC asked how WY activity could add value to successful local work, such as multi-agency suicide prevention in Leeds. NL said that the WY work drew on a wide range of learning, including international work such as suicide prevention approaches in Detroit. HH noted that providers were working differently together to provide support, and that local places could learn from work across WY&H.<br>FKS asked how variation in outcomes was being addressed, particularly for higher risk groups. NL highlighted work in Bradford to reduce A&E attendance and eradicate out of area placements, with a strong focus on achieving better outcomes. She noted that 'out of area' was being defined as outside WY rather than place, which challenged the current national definition.<br>MW noted the current financial challenges and the need for clarity on the benefits of investment in acute and community services. NL highlighted the benefits of the 'Core 24' approach to improving access to services. HH agreed that more work was needed to support business cases.<br>AW noted the need to balance progress on transformational priorities with delivery of national targets, such as Early Intervention in Psychosis (EiP). NL noted that EiP was not part of the STP and was being addressed at place level. HH felt that the WY&H programme should continue to focus on the small number of priorities outlined today, including out of area placements. EF highlighted the need to understand variation between places and HH suggested that the peer review approach to be discussed under the next agenda item could usefully focus on mental health.<br>HH said that providers were working well together across WY&H, but she felt that there was scope for commissioners to share scarce commissioning resources and work together more effectively. She envisaged that a joint approach to commissioning acute MH services could be in place in shadow form from 2018/19, before full implementation in 2019/20. HH requested Accountable Officers to alert their mental health commissioning leads to the proposed joint work. | |

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| | MW asked about plans to engage local people in the MH programme. HH acknowledged that this needed strengthening further. | |
| | **The Joint Committee:**<br>1. **Endorsed** the continued work of the programme and the collaborative approach to Mental Health in WY&H.<br>2. **Supported** the proposal to further support improvements to services and delivery of the Mental Health 5 Year Forward View.<br>3. **Supported** the development of the new care models for CAMHs & Adult Eating Disorders, making best use of collective resources to improve services.<br>**4. Agreed** that proposals for a joint approach to commissioning acute mental health services be brought to the Joint Committee in March 2018. | **HH** |
| **16/17** | **Moving toward a framework for improvement** | |
| | MW introduced the report, which proposed a patient-focused, clinically led peer review/support approach, centred on improving outcomes. It would encourage the sharing of learning and constructive challenge, be light touch and bring together work at place and STP level. It was proposed that the initial focus of the approach would be on Urgent and Emergency Care (UEC).<br>MB welcomed an outcomes-based approach and emphasised the need for strong clinical involvement. AW supported the approach and highlighted the need for broad engagement through the STP Clinical Forum to be combined with specialist clinical expertise. In developing the approach, MW would strengthen the role of clinical engagement.<br>PK highlighted the value of learning from existing models, such as the Cancer peer review programme and PC noted the Local Government Association peer review approach. MW emphasised the value of drawing on a wide range of expertise from across the STP.<br>GS noted the need to ensure that the approach encouraged innovation and learning at local level. HH emphasised the need to learn from 'what works' and focus on outcomes, not process. DK welcomed the opportunity to 'sense check' the delivery of outcomes against stated ambitions.<br>Following the discussion under the previous item on mental health, IH advised that the approach could be undertaken concurrently on UEC and mental health, as different teams were involved. | |
| | **The Joint Committee: Agreed:**<br>**1.** Proposals to develop and test a clinically focused peer review process, which would focus initially on Urgent and Emergency Care and Mental Health and commence from January 2018.<br>2. That feedback on lessons learned would be brought back to the Joint Committee of CCGs. | **MW** |
| **17/17** | **Risk management and assurance** | |
| | SG reported that the Committee's work plan required it to oversee an assurance and risk management system and review significant risks to the achievement of STP objectives. The report proposed an approach that focused on:<br>• the delivery of the STP outcomes covered by the Joint Committee's work plan and<br>• risks to the Committee making robust and transparent decisions.<br>The Committee would draw on risks identified within Programmes and would share, via bi-monthly updates, the Joint Committee's Assurance Framework | |

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| | with STP Programmes and member CCGs. | |
| | **The Joint Committee: Agreed:**<br>1. An assurance framework, based on the principles outlined in the report.<br>2. That the framework be used to inform agenda-setting and work planning.<br>**3.** That the framework be presented for review by the Joint Committee at its meeting on 7th November 2017. | **SG** |
| **18/17** | **Joint Committee work plan** | |
| | IH noted that the Joint Committee of CCGs had delegated authority from individual CCGs to take decisions on their behalf. The scope of delegation was set out in the Memorandum of Understanding and the Joint Committee work plan agreed by individual CCGs.<br>The existing high level work plan was developed at the end of 2016 and there was now a need for greater detail on the specific decisions that the Joint Committee might take. The report set out a process for refreshing the plan and consulting the CCGs. A draft of the updated work plan would be brought to the Joint Committee development session in October 2017, then shared with the individual CCGs before being brought back to the Joint Committee in January 2018. Depending on the materiality of the proposed changes to the work plan, it might be necessary to seek formal agreement from the CCGs. Legal advice was being sought on the most appropriate approach.<br>AB noted the need to ensure sufficient time to allow Governing Bodies to be consulted.<br>MW noted the need to ensure that Committee members sighted their CCGs on all Joint Committee discussions and decisions. | |
| | **The Joint Committee**: Agreed the process for refreshing the work plan. | |
| **19/17** | **Any other business** | |
| | There was none. | |

**Next Joint Committee in public -** Tuesday 7th November 2017, Kirkdale Room, Junction 25 Conference Centre, Armytage Road, Brighouse, HD6 1QF.

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