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To whom it may concern

Dear Sir/madam

Thank you for giving me an opportunity to comment on the letter that the NHS organisations in Sunderland and South Tyneside received from the ST&S health overview and scrutiny committee which sets out the issues they have with the decisions that the CCGs have made re Path to Excellence, specifically on the reference to my comment at the meeting

> '6.1.1 Furthermore, throughout the consultation Members were told that the only safe service choice was to centralise all acute and hyper-acute Stroke services into a specialist unit on one site. However, at a meeting of the Northumberland, Tyne and Wear and North Durham STP OSC (19 March, Gateshead Civic Centre), Members were unequivocally told that every DGH should have services treat acute stroke and it was only those hyper-acute cases that needed to go to a Specialist Unit (ref: Mr Bas Sen, Consultant in Emergency Medicine, Director of Emergency Care, Associate Medical Director Newcastle Upon Tyne Hospitals NHS Foundation Trust and Co-chair Urgent and Emergency Care Network Clinical Reference Group, UEC Programme and Lead Clinician Clinical Hub)'

My comments have been mis-interpreted and I would like the opportunity to clarify what I meant in my statement below:

Common emergencies will continue to go to local A&E departments however time critical emergencies, and stroke is one, will be taken to specialist stroke centres also known as hyper-acute stroke units (HASU) where they can get the highest quality of care [(1)] . Studies have shown that patients treated in HASUs have decreased mortality [(2)]. The model will be similar to the regional trauma services very successfully implemented in our region in 2012 with reduction in mortality between 25-50%, where the life threatening time critical trauma goes to major trauma centres (MTC) and the less critical trauma continues to go to the local A&E. The proposed stroke model for the region provides for the strokes that may walk into the local hospital as well as if a patient develops a stroke on one of the hospital wards. The strength of this model lies in the network based approach so regardless of where the patient presents he/she will be transferred to the stroke centre (HASU) with minimal delay to receive high quality high tech care.

I hope this clarifies the situation and apologies for any confusion caused.

References

1. *Michael Allen, Kerry Pearn, Emma Villeneuve, Thomas Monks, Ken Stein, Martin James. Feasibility of a hyper-acute stroke unit model of care across England: a modelling analysis. BMJ Open 2017;7:e018143*

2. *Angus I.G. Ramsay, PhD; Stephen Morris, PhD; Alex Hoffman, MSc; Rachael M. Hunter, MSc; Ruth Boaden, PhD; Christopher McKevitt, PhD; Catherine Perry, PhD; Nanik Pursani, MA; Anthony G. Rudd, MB, BChir; Simon J. Turner, PhD; Pippa J. Tyrrell, MD; Charles D.A. Wolfe, MD; Naomi J. Fulop, PhD . Effects of Centralizing Acute Stroke Services on Stroke Care Provision in Two Large Metropolitan Areas in England. Stroke. 2015;46:2244-2251. DOI:10.1161/STROKEAHA.115.009723*

Yours sincerely

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