Surrey Stroke Services Review

Commissioning next steps

October 2015

Effective commissioning of the whole pathway: the Surrey stroke services vision

Context

Following the publication of national guidelines and strategies, regions throughout England are reviewing whether stroke services meet the criteria for providing good stroke care. A review across Surrey is underway. Feedback has been sought from local people, clinicians, voluntary and community groups, an expert panel of national experts and other stakeholders. Data has been collected about the number of people using stroke services and the quality of the services provided.

The Review is being led by the Stroke Change Board, which is made up of general practitioners, clinicians and managers from the acute sector, representatives from community health services, service user and carer representatives, voluntary groups such as the Stroke Association, clinical commissioning groups (CCGs) and other interested parties. The group is chaired by Dr Claire Fuller, a GP and Acting Clinical Chief Officer of Surrey Downs CCG. Julia Ross, Chief Officer of North West Surrey CCG is the Senior Responsible Officer.

About 2,500 people in Surrey have a stroke each year. There are pockets of good practice and people are generally satisfied with the care they receive, particularly in the immediate acute phase. However the Review has found that services could be improved to provide even better care and to make sure that wherever in Surrey people live they have access to the same good quality care. Mortality rates are high in comparison to areas such as London that have streamlined their services, and commissioners and health service providers in Surrey want to ensure that Surrey residents have better outcomes.

With the support of local clinicians and national experts such as Tony Rudd and colleagues and considerable engagement from people using services, carers and the Stroke Association, the Stroke Change Board has compiled evidence about what comprises good stroke care. Alongside the South East Coast specification for stroke services, there is extensive evidence about what local people feel would improve care and what they would like to see in an improved pathway.

The Review has shown that it is important to consider the entire pathway of care, from prevention through to acute care through to recovery and rehabilitation in hospital and the community. Ongoing follow-up and support when people return home is a priority.

A summary of key information collected in the Review, and the processes used is provided in ‘The Story So Far.’

Planned next steps

At this stage in the Review, the Stroke Change Board believes that there is sufficient information regarding what 'good' care looks like and what a whole pathway of care should comprise for people suffering a stroke/TIA. The consensus is clear regarding high volume pathways, seven day working and the workforce required to deliver the benefits achieved in London and elsewhere.

The Stroke Change Board knows that elements of the current pathway in Surrey are disjointed, with delays and poor communication across acute and community care. To deliver changes across the pathway there needs to be an increase in workforce across all therapies, consultants and nursing care. All of the changes in delivery will require the Surrey stroke system to work together. Providers already offer a telemedicine network solution to increase OOH (out of hours) provision of thrombolysis, and greater integration will be required moving forwards to ensure the service specification can be delivered.

The Review suggests that HASU provision needs to be offered at three sites in Surrey to ensure appropriate volumes of activity and expertise. The data available regarding sustaining five ASU sites is more challenging, but suggests that there will not be the workforce available to support five sites. There are potential efficiency gains from co-location and reduced costs due to the need for reduced staffing, the ability to use beds flexibly, shorter length of stay and no repatriation costs.

For the whole pathway to work effectively community services need to be integrated and responsive. Community services in England achieving community SSNAP level A are integrated with acute care, have a push method for ESD (not a pull model) and their staff rotate between community and hospital.

Surrey commissioners wish to work with health systems to develop the best approaches for delivering the whole pathway of care. By 'health systems' we mean groups of acute, community and other providers working together across geographic areas. The plan is for commissioners to issue a Request for Proposals in January 2016, asking health systems to work together to plan how to achieve the outcomes required within a specified financial envelope (to be determined). The requirements would be clearly laid out regarding the 'must dos' for pathway delivery and an appropriate timescale agreed.

The system will be asked to develop around the three HASU sites (Frimley, St Peters/RSCH and SASH) and deliver the care pathway for the whole community in their 'system'.

Advantages of this approach are that:

- the system would be designed by those providing the care
- the whole pathway would be easier to performance manage and challenge
- the financial envelope would be clear, without the need for tariff disaggregation
- the public will be assured that any changes to stroke services are driven by clinicians
- an improved pathway may be delivered faster

However there are acknowledged challenges:

- the system may overstretch the available workforce to ensure local stroke provision
- the system may wish to continue with ASU-only sites for longer
- changes may not happen quickly enough
- providers may try to cut corners regarding workforce and not meet the requirements, for example of twice daily ward rounds and seven day working

To minimise these challenges, the commissioners plan to set out a specification for service. This already exists in the form of the South East Coast Stroke Service Specification, plus additional principles of what good care looks like gained from the Surrey Stroke Review (see appendices 1 and 2).

To this specification, the commissioners will add the conditions, criteria, outcomes and quality requirements to be achieved. This will include some of the important principles that the Stroke Review has established as important. Examples *may* include providing a fully integrated end-to-end pathway, greater emphasis on follow-up care in the community, six month reviews, preference for having a co-located model, achieving workforce standards, achieving SSNAP Level A within 18 months and so on.

The commissioners will set out the financial envelope available based on a capitated payment model and clarify how the risks will be managed. A model that shares the risk is likely to be proposed, but the specifics of this are not finalised.

Providers will be invited to work collaboratively to propose how they would deliver the requirements by working differently together. Where appropriate, an Alliance Contract or Lead Provider arrangement or similar could be considered.

The commissioners will engage in dialogue with the systems as they develop proposals, so aspects of the system are working together to focus on how to get the best outcomes for people affected by stroke.

This would be a dialogue process to establish most capable providers.

The commissioners will ensure the process meets Monitor's criteria by ensuring that competition between providers was encouraged, that the nature of benefit to people using services is highlighted and that the benefits could not feasibly have been achieved through other means (such as by providers acting independently).

Commissioners have engaged with the local authority (HOSC and Health and Wellbeing Board) throughout and have meetings scheduled to discuss the proposed way forward.

To be clear, if substantial variations to services are proposed, CCGs and providers may need to undertake some level of public consultation in due course. Extensive engagement has already been undertaken as part of the review, as outlined in the Story So Far. CCGs have a statutory duty to ensure people are informed of and invited to offer views about changes, and these views must be considered as part of the decision-making process.

The *Duty to involve service users in development of proposals*, contained at 13Q and 14Z2 HSCA 201 and associated guidance widen the scope for fulfilling the duty to consult to include providing the public with the information or using feedback gained during ongoing engagement activities rather than solely formal consultation routes. However, if there is a potential significant variation in acute services, some type of consultation or ongoing engagement may be required.

Rather than expanding into a full public consultation at this stage, the commissioners believe it is first better to have clarity about the exact service configuration being proposed. Instead of commissioners specifying the form this will take, the plan is for commissioners to specify the outcomes and constraints, and for systems to respond with solutions.

Table 1 lists the broad timeline.

Table 1: Potential timeline

Month	Key milestones
November 2015	Clinical Senate Review Legal review and risk assessment HOSC review Notification of providers of planned approach
December 2015	Finalise specification, financial envelope and other materials Incorporate initial feedback from Clinical Senate Committee in Common meeting to agree next steps
January 2016	Final Clinical Senate report Issue Request for Proposals Issue documentation relating to engagement in the Review
February 2016	Discussions with market
March 2016	Proposals received
April 2016	Evaluation
May 2016	Ongoing dialogue
June 2016	Confirmation of provider(s), scope and next steps
July 2016	Mobilisation which may include consultation

Support from Clinical Senate

South East Coast Clinical Senate has agreed to review some of the information collected as part of the Review and to provide feedback about the following question:

> **To what extent will Surrey's planned approach and materials give health systems the information they need to develop clinically robust stroke services across the pathway?**

The Review has drawn heavily on the advice provided by the South East Coast Clinical Senate to other areas regarding key issues to prioritise, gaps to fill and interdependencies. A South East Coast service specification is in existence and there is a clear steer from local people about priorities. Therefore the Stroke Change Board feel that it would add less value for Clinical Senate to repeat advice given to other areas or explore the clinical effectiveness and evidence-base of the specification. Instead, the Stroke Change Board believes that Clinical Senate could provide significant insight into whether the proposed approach and materials available to date (as documented in the Story So Far and embedded files) are sufficient to help health systems and teams to develop clinically robust services across the whole pathway of care.

It is important to note that Stroke Change Board acknowledge gaps in the information available to date. There is a lack of detailed information about the workforce or finances in community care, and the interfaces between hospital, community care and voluntary sector and primary care services. These are things that the Review team is currently actively pursuing. Details about preventive services are also being sought. More detailed financial information and benchmarking is due by the end of November 2015 and work is also underway to validate further SSNAP data. The Board would like Clinical Senate to bear in mind this ongoing work when commenting on the material.

Early in January 2016, commissioners plan to issue health systems with:

- the South East Coast service specification (appendix 1)
- additional outcomes that health systems are expected to fulfil (draft at appendix 2)
- background information (draft material in the 'Story So Far' which will be updated and revised in light of new information due over the next month)
- a request for health systems to develop strategies to meet the specification and outcomes (ie Request for Proposals and outline of dialogue approach)
- criteria against which health systems will be evaluated (draft at appendix 3)

The Board is interested to hear whether Clinical Senate feels this approach is appropriate and to receive any suggestions about the draft documentation, particularly in terms of how the information could be made more useful for health systems being asked to develop strategies for next steps.

Appendix 1
SEC Service Specification

Embedded here is the South East Coast Stroke Service Specification.

SE Stroke Service Specification.pdf

Appendix 2
Additions to the SEC Service Specification

Outputs to be delivered

The SESCN service specification is in the final stages of agreement and has received input from the Surrey stroke community. It is a comprehensive document describing the service to be delivered from acute presentation to community rehabilitation, six month reviews and beyond.

Commissioners are inviting health systems in Surrey to work collaboratively to design a system to deliver the optimum whole pathway of care for stroke. Systems will be asked to demonstrate how they will deliver all of the components below:

1. Delivery of the South East Coast service specification
2. SSNAP level A across the whole pathway and all domains within two years
3. Sustainable delivery of the national standards within SSNAP and the local SE SCN quality standards
4. Integration across the whole pathway including ESD and community care
5. Repatriation of specialist care that can safely be delivered within Surrey (including for example spasticity management and video fluoroscopy, but excluding thrombectomy)
6. Clear plans for linking with specialist care outside the area, such as thrombectomy
7. Sustainability and resilience regarding the workforce
8. Consistency and equity for the Surrey population
9. Demonstrate that the recommendations from the ‘expert panel’ who have supported the Surrey review, the SEC Clinical Senate, recommendations from Surrey redesign events with service users and clinicians, feedback from the RCP peer review and other evidence have been taken into account when designing the whole pathway of care
10. Delivery of services within a fixed financial envelope

Appendix 3
System assessment criteria

Health systems will submit proposals regarding how they will meet the SEC service specification for stroke and the additional criteria outlined in Appendix 1. Commissioners will assess these proposals based on criteria similar to those outlined below.

Note that these are DRAFT criteria. They are currently being refined. They are provided here as an example to show that a structured assessment process will be used. The criteria have been adapted by those used successfully within the Midlands. Tony Rudd has provided advice about their use and adaptation.

The criteria will be assessed by a panel including local commissioners, service user and carer representatives, the Stroke Association, representatives from the national stroke team and expert panel of clinicians.

General quality of service

	Description	Evidence
1.	Please provide a concise summary of clinical structure to support delivery of a high quality Hyper Acute Stroke Unit to promote continuous measurement and improvement of the HASU service.	A diagram outlining the clinical structure of the institution (and partnering institution) may be submitted if appropriate.
2.	Demonstrate all clinical services take responsibility for all aspects of data collection, keeping stroke register, and participating in national stroke audit (SSNAP) either directly of via upload of equivalent local data that enables comparison with regional and national peers)	Please provide details of your current rate of data entry to the SSNAP and your future arrangements to ensure 100% submission of data and how this would be used to monitor and feedback on clinical outcomes to Multi-Disciplinary Teams and individuals Evidence needs to demonstrate consideration across all three service areas (HASU/ASU and TIA) (Activity numbers will be provided for Trust to support the submission of evidence): Evidence of historical achievement of stroke targets to demonstrate good track record supporting the delivery of high quality care Evidence a sustainable system of coding for stroke patients is in place. Evidence of local guidance should be in place to support the collection of data between community and across service providers Evidence of accurate and explicit records of patients are recorded and shared using agreed protocols between all hospital, community and social care practitioners and individuals in a timely way

	Description	Evidence
3	Demonstration of a stroke management group to oversee service delivery and improvement review of performance standards, impact of new guidance and methods for improvement of service	Evidence of management group including TORs, minutes and action plans. Schedule of meetings
4	Please describe your approach to continuous quality improvement including, ensuring that the evidence base of clinical practice is reviewed and where necessary guidelines and protocols updated e.g. with NICE guidance, national and local audit reports etc. and how this contributes to delivery of QIPP and value for money.	Evidence of protocols to review clinical evidence including implementation of action plans Please describe your priorities and processes to review, update, implement and monitor practice of all relevant guidelines and protocols ensuring consistency and co-ordination between Trust and interface with other provider pathways. Evidence of length of time it takes to implement change IT/management infrastructure
5	Please describe how your systems for clinical risk management and investigation will be applied to Stroke services including reviews of morbidity and mortality and identification and investigation of adverse incidents using root cause analysis methodology. Please provide details of any complaints or material litigation i.e. previous, pending or threatened litigation or other legal proceedings, relating to stroke service. This statement should include any remedial steps subsequently taken	Please provide information on of any complaints and quality issues including SI or never event RCA's regarding stroke services for 2012/13 & and 2013/14., Data should be not be patient identifiable Number of complaints/RCA's and summary of complaints including action plan and lesson learnt SSNAP Mortality figures 2014/15 mortality figures (available from Autumn/Winter 2014)
6	A Quality Account. □ Any external reviews that may have taken place from outside organisations such as CQC, Patient Experience, Royal Colleges, HEE. □ A National Clinical Audit and Patient Outcomes Programme (NCAPOP) report.	Evidence of reviews and reports
7	Please provide details of how your standard policies on Infection Control, HCAI's, Management of Clinical Waste, Medicines Management, Data Handling, Dignity Privacy and Confidentiality of service users and other relevant policies, will be applied to the services described in the specification.	Evidence of polices and application Evidence of local audits

	Description	Evidence
8	Please describe how staffs are trained to assess the needs for end of life care including discussions with relatives. (Specification	Evidence of training Evidence of pathway
9	Please provide your proposal high level overview of your plans to ensure that patient records and patient information are accessible at Hub & Spoke sites if part of proposal	Current information protocols and proposal of future plan to ensure seamless care across Trust and out of area pathways
10	Please describe arrangement for evaluation of implementation phase to ensure that there is a clear plan to evaluate the new service for all sections	Evaluation process

Clinical quality

	Description	Evidence
1.	Please define your current stroke management patient pathway form ambulance handover to assessment and admission	Basic pathway for the management of stroke patients highlighting where patients are seen and if there are any joined up pathways
2.	Provide evidence that the service has a pre-alert pathway and process for transferring stroke patients form A+E to HASU	Ambulance protocol for FAST track Evidence of protocol to manage pre-alert Evidence of clear pathways between A+E and acute care
3	A radiology service responsible for the following: CT scanning 24/7 CT reporting by radiology/stroke consultant 24/7 A contingency plan for scanner breakdown	Evidence of access Evidence of protocols (including prioritisation) Evidence of reporting of scans by radiology/stroke consultant 24/7 Rota as evidence for CT scanning and reporting Evidence of CT interpretation skills
4	Thrombolysis pathway	Evidence of effective pathway
5	Evidence of appropriately trained staff in assessment and administration of thrombolysis	Rota to demonstrate 24/7 care Training records to demonstrate competency Evidence of identified clinical lead (i.e one A+E and one radiology) Evidence of A+E staff training/knowledge of pathway
6	Evidence of 24/7 availability of appropriately trained staff in assessment of suspected stroke patients for thrombolysis tx	Evidence of training and rota to support availability Evidence of achievement of target e.g SSNAP Rota to demonstrate 24/7 on-site availability of staff trained in assessment of suspected stroke who are ineligible for thrombolysis Training records to demonstrate competency
7	Evidence of provision of 24/7 consultant cover provided by at least 6 consultants on a rota able to make thrombolysis and hyper-acute treatment decisions	Evidence of trained staff and 24/7 rota to support access to thrombolysis and tx decisions

	Description	Evidence
8	Evidence of daily assessment of all TIA pts by stroke team Anticipated throughput high/low risk TIA admissions per year	Evidence of training and rota to support availability Activity levels for high and low risk admissions Assumption on activity for increased levels of HASU activity Evidence of referral to 24/7 access for high risk patients and 7 days for low risk patients
9	Protocol to manage HASU bed capacity to ensure is accessible and pts are transferred as quickly as possible and patients are stepped down to ASU as appropriate	Bed capacity protocol Evidence of management of system pressures while protecting HASU beds
10	Evidence of time of senior review after admission	Evidence of rotas SSNAP data
11	Urgent access to essential investigations e.g echo etc	Access to investigations and waiting times
12	Evidence of consultant led HASU team to meet the requirements of the service volumes the trust is offering to provide	Evidence of rota outlining ward schedules
13	Evidence of consultant 7 day ward rounds for HASU and ASU – twice daily	Evidence of rotas to support
14	Proposals to support arrangement for timely repatriation to appropriate local stroke unit if required	Protocol for transfer – if required to ASU or community bed
15	Evidence of sharing information between HASU and ASU if not co-located	Evidence of information sharing protocols – notes/scans etc
16	Clear access to tertiary centres	Protocols and pathways in place and waiting times to transfer available
17	Access to brain imaging (MRI and CT), carotid imaging (including ultrasound, MRA, CTA) CEA should be undertaken as soon as possible and within 7 days of symptoms	Pathways for the specific investigations Evidence of protocols for acces Waiting times
18	100% of appropriate patients to receive continuous physiological monitoring by trained staff as per the service specification	Protocols in place Training records available
19	Evidence of timely discharge from ASU site with appropriate packages	Evidence of audit plans
20	Achievement of SSNAP level A across all domains (acute and community)	SSNAP data

ASU criteria

	Description	Evidence
1.	Plan to support timely admission and discharge from HASU > ASU > home	Proposed pathways
2.	A radiology service responsible for provision of the following: CT scanning and reporting MRI reporting Ultrasonic angiography	Details of on-site service availability Protocols and access times
3	Evidence of 7 day consultant ward rounds	Named lead clinics and and remit Details of availability of staff to deliver these services
4	Evidence of MDT working	Details of meetings and MDT
5	Availability of supporting services e.g orthoptics, podiatry, orthotics, dietetics	Protocols and waiting times
6	Availability of rehab facilities e.g access to physio gym, OT kitchen, SALT equipment	Details of availability
7	Evidence of effective referrals to ESD for 40% of stroke patients	Activity levels Response times SSNAP data
8	Evidence of effective pathways for non ESD patients (CNRT)	Activity levels Response times
9	Evidence that patients not requiring therapies can still access nursing advice and psychological support if required	Activity levels for non-therapy patients
10	Plan for management of average LOS	Current LOS and plans to improve
11	Information sharing	Protocols in place and evidence available: GP Stroke Association support worker Community teams
12	Evidence of consultant led ASU team including dedicated junior medical team trained in stroke	Evidence of cover and junior doctor complement
13	SSNAP action plan to be developed to ensure that any domain not achieving SSNAP A has an action for improvement	Action plan developed
14	Evidence of the use of outcome measures e.g Rankin score	Evidence of use of rankin scores
15	Evidence of a protocol to initiate suitable secondary prevention measures in all appropriate patients	Evidence of protocols
16	ASU has support to all appropriate diagnostics	Evidence of pathways

TIA

	Description	Evidence
1.	Provide a concise summary of clinical structure to support delivery of a high quality TIA service	A diagram outlining the structure may be submitted
2.	If developing hub and spoke model – provide evidence of your plans to ensure that patient records and patient information are accessible at hub and spoke sites	Current information protocols and proposal for future plans
3	Evidence of pathways to support identification of TIA as per the service specification	Evidence of pathways and protocols
4	Evidence of 7 day outpatient high risk TIA clinics – inc. collaborative working assumption to enure services can be maintained	Rotas for 7 day working
5	Information on internal audit data collection	Activity and response times
6	Evidence of TIA patients receiving secondary prevention	
7	Evidence of information sharing with GP	
8	Evidence of patients satisfaction across whole pathway of care	Patient experience

ESD onwards

	Description	Evidence
1	Describe how the community pathway will be delivered for all patients leaving the stroke unit including ESD, non-ESD, community bed based care referrals and patients transferred directly to care homes	Detailed description of whole pathway of care: Description must include all clinical quality markers to be delivered

Workforce criteria

	Description	Evidence
1	Evidence and completion of leadership training for key members of the stroke team to support stroke service improvement Evidence of appropriate training offered to stroke clinical team Provision of and attendance at MDT stroke training governance programme	What is the training plan for the clinical team and how many days are allocated to training needs Evidence of appropriate training offered Evidence of study leave Evidence of provision of structure training plan for new and rotational staff Evidence of annual appraisal Evidence of completion of mandatory training
2	Detail the workforce as required to deliver the service specification and outcomes required and where there are gaps what are the plans to support delivery Demonstrate approaches to support the pathway delivery, such as band 4 in-reach support workers for ESD, rotational posts with the community and use of A+E/Elderly care/neurology consultants to support the national stroke consultant gaps	To be evidenced by increasing activity levels and as per the specification across the HASU/ASU , ESD and community care Specifically including numbers of WTE's per health professional
3	Describe how the system will work collaboratively to deliver the whole pathway	Integration with acute and community care demonstrated Close working with social services and the voluntary sector Mentorship policies Evidence of collaborative plans
4	Describe your proposals for HR and employment arrangements for staff	Evidence of current workforce gaps and plans to address vacancies Evidence for plans to increase activity volumes Evidence of collaborative working with the whole 'system'
5	Describe how the service will participate in research for stroke	Evidence of involvement in research
6	Describe how the system will respond to the potential growth in thrombectomy	Clear plans for increased activity Evidence of discussion with St George's for tertiary referrals
7	Describe how the system will work to maximise recruitment and retention across all disciplines	Evidence of workforce plan Links with HEE evident
8	Describe how the voluntary services will be linked in to provide stroke care	

Deliverability

	Description	Evidence
1	Submit a detailed mobilisation plan of all actions to be taken during mobilisation – for the whole system including the development of a stroke network	Plan
2	Provide evidence that the trust can support the following activity per annum XXXX stroke admissions XXXX TIA admissions XXXX Stroke mimic admissions And the ESD teams can increase by X numbers/yr	
3	Provide evidence of proposed bed capacity for HASU/ASU care and for community bed based care (if required)	
4	Provide details of any infrastructure developments that may be required to deliver the xxxx activity volumes and any interdependencies with other projects such as urgent care	High level summary to support activity levels predicted including costs
5	Provide detail on the care of mimic patients	Evidence of protocol
6	Provide a contingency plan to support a sustainable service	Draft plan
7	Describe your service proposals strengths – for the whole pathway of care	
8	Describe the key challenges and areas in need of development to deliver the whole pathway of care	

Improved strategic fit

	Description	Evidence
1	Evidence of an effective system wide response, And that this has been considered alongside the other 2 stroke 'systems' in Surrey	Evidence that the proposal was jointly developed with the community teams
2	Demonstrate an understanding of the impact on other services and inter-dependencies	Evidence to support increased activity
3	Demonstrate that all the work of the stroke review including the expert panel event has been taken into account when designing the local system	Evidence of the stroke review

Costs

	Description	Evidence
1	Demonstrate an effective business case based on the financial envelope provided to provide the whole pathway of care	Concise business plan Any economies of scale demonstrated Capital costs to be included
2	Evidence of sustainable operational processes to support the most cost effective service delivery: Activity v workforce Throughput of bed capacity Reduction in readmission of stroke Evidence of pooled resource has been considered	

Access

	Description	Evidence
1	Please describe current and future plans to ensure the stroke service delivers optimum patient experience and outcomes, Ensuring patients and their carers are informed throughout the care pathway on a regular basis	Provide evidence of any stroke specific patient satisfaction services used to monitor and improve quality of services Evidence that 100% of appropriate patients and carers receive high quality information and care plans
2	Describe the process of involving patients in the re-design of stroke services for your stroke 'system'	Evidence that local patients have been involved in the discussions and their feedback is represented
3	Please demonstrate that the system review has assessed the proposal to ensure there are no negative impacts on the proposed service on people who have protected characteristics (as listed in the Equality Act)	Evidence of an equality impact assessment Evidence of any action plans arising from this Evidence that patient leaflets will be available in different languages
4	Formal links exist with patient and carer organisations such as the stroke association	Evidence that all relevant local stroke groups have fed into the proposal and appropriate pathways in place, including voluntary organisations such as: TALK Dyscover Connect
5	Please provide details of how you will ensure education of service users presenting with conditions that can be self-managed and referral to health promotion and lifestyle services	Evidence of health promotion
6	Availability of car parking for HASU sites	Describe how an increase in activity will be managed
7	Provide an outline communications plans	Communication plan

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