People and Health Scrutiny Committee

19 July 2022

Somerset Hyperacute Stroke Case for Change

For Review and Consultation

Portfolio Holder: Cllr P Wharf, Adult Social Care and Health

Local Councillor(s): N/A

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Brief Summary:

Fit for my Future (FFMF) is Somerset's strategy for how we will support the health and wellbeing of the people of Somerset by changing the way we commission and deliver health and care services. It is jointly led by Somerset Clinical Commissioning Group and Somerset County Council and includes the main NHS provider organisations in the county.

In 2019, FFMF developed a stroke strategy which provides recommendations for how the Somerset system can deliver the national ambitions across the whole stroke pathway.

One of the key recommendations from the strategy was to review the way Hyper Acute Stroke Unit (HASU) and Transient Ischaemic Attack (TIA) services are provided in Somerset. This would include a site selection process, and public consultation in line with national guidelines, and strategy.

Although clinical quality of services shows that both services perform relatively well against many of the key national indicators across the whole stroke pathway, both acute providers perform less well in the hyperacute and acute phase standards

Centralising acute stroke care will improve clinical outcomes for patients and creating a single specialist stroke workforce will increase the quality of care that is given and enhance flow throughout the stroke care pathway.

It is expected that the proposals for reconfiguring acute stroke services in Somerset will be significant. Therefore, it is expected that proposals for service change may need to go formal public consultation. Any public consultation will be undertaken in line with NHS England and Improvement guidance on 'Planning, assuring, and delivering service change for patients.'

This paper gives an update on progress on the hyperacute case for change, the options appraisal process and how we are engaging with Dorset representatives.

In terms of timescales, we are currently going through the Clinical Senate Review Panel. This means that if we do need to go to public consultation this is likely to be towards the end of the year.

Recommendation:

The Scrutiny Committee is asked to note the programme of work and provide comments on the direction of travel.

Reason for Recommendation:

The comments will be taken into consideration and will be included in the Pre-Consultation Business Case (PCBC).

1. Introduction

1.1 National Context

Stroke is both a sudden and devastating life event and a long-term condition. It is the fourth biggest killer in the UK, and a leading cause of disability. Over recent years, there have been significant advances in proven, highly effective methods of stroke treatment and care and this includes strong national evidence for optimising acute stroke care. These include hyperacute interventions (first seventy-two hours of having a stroke) such as brain scanning, and thrombolysis,

are best delivered as part of a 24/7 network and those areas where they have centralised stroke hyperacute care into a smaller number of well-equipped and staffed hospitals have seen the greatest improvements in care.

1.2 Local context

Somerset is a rural county with an older than average population, with the number of people over 75 expected to double in the next 25 years. This will result in a significant rise in demand for health and care services as more people are living with long term health conditions, especially frail and elderly people.

The Fit for My Future Programme (FFMF) was formed to develop the Strategy for Health and Care in Somerset and in 2019 a review of the current configuration of stroke services was carried out. One of the key recommendations from the strategy was to review the way Hyper Acute Stroke Unit (HASU) and Transient Ischaemic Attack (TIA) services are provided in Somerset.

The Getting it Right First-Time programme (GIRFT) led a review meeting for both YDH and SFT to identify examples of high-quality service delivery and look at areas of unwarranted variation in clinical practice in June 2018. The review identified that in Somerset, the services performed well clinically and emphasised that the services had progressed well with regards to the stroke community rehabilitation model. However, it identified the following domains as the most challenging:

• Rapid assessment by stroke nursing and medical teams

• Scanning within one hour

• Thrombolysis rate and door to needle times

• MDT therapy assessments

1.3 Why change acute stroke care in Somerset

It is projected that the number of strokes will increase by as much as 16% in Somerset by 2025 due to the rise in an ageing population with more complex health needs. This means that there will be an increasing demand for stroke care into the future. Stroke services in Somerset need to adapt so that the available specialist stroke workforce can provide the best possible outcomes to those that experience a stroke.

In Somerset there are two acute hospital-based stroke services, one at Musgrove Park Hospital, part of Somerset NHS Foundation Trust (SFT) and one at Yeovil District Hospital NHS Foundation Trust (YDH), with community stroke rehabilitation provided at Williton and South Petherton Community Hospitals. Both acute providers have Hyper Acute Stroke Units (HASU) and Acute Stroke Unit (ASU) services. Currently neither provider has the number of specialist staff, particularly medical staff needed to provide the units with 24/7 consultant cover, which is a requirement of the national standards set out in the Royal College of Physicians (RCP) National Clinical Guidelines for Stroke. Nationally there is a shortage of specialist trained medical staff taking up the specialist training programme.

To address this, we have convened the Stroke Transformation Steering Group and have been meeting monthly to discuss the updates following publication of the Stroke Strategy and developed the case for change for service reconfiguration and undertaken an options appraisal process.

Progress update:

• Engagement activities are underway, and we have established a stakeholder group of key voluntary sector organisations and people with lived experience. The public and patient stakeholder group were invited to attend a number of engagement events including events in March and May to discuss case for change and the emerging solutions and a workshop in June to gain feedback on the four shortlisted options. To gain further insights we have also attended local stroke clubs and had a series of individual conversations with people with lived experience, their carers and loved ones.

• Equalities Impact Assessment (EIA) created and being used actively to identify who might be impacted by any proposed solutions

• Case for Change has been approved and the Pre-Consultation Business Case (PCBC) is being developed and the Clinical Senate Review process and NHSE/I assurance process has started.

1.4 Options Appraisal

Long list

We identified a long list of 9 options for the reconfiguration of hyper-acute stroke services following the 2019 Stroke Strategy in collaboration with the Stroke Transformation Group and 2022 public and patient stakeholder workshop. It was the starting point for wider discussion and engagement of potential solutions.

1 DO NOTHING

- There would be no change to the current delivery model
- HASU and ASU services would continue to be delivered in both Taunton and Yeovil in the same way

2 SINGLE MEDICAL DELIVERY TEAM

- There would be no change to the current delivery model
- HASU and ASU services would continue to be delivered in both Taunton and Yeovil
- There would be a single medical workforce would be shared across both sites

3 YDH & DCH

- YDH and Dorset County Hospital (DCH) develop model for sharing: -
- A – Hyper-acute take for Stroke at weekends and bank holidays to improve sustainability at both organisations
- B - Option A plus YDH and DCH create a single clinical team to

4 NO YDH HASU AT W/END & BANK HOLIDAY

No Hyper-Acute take at YDH on weekends and bank holidays

A - YDH ED continues to receive suspected stroke patients to scan, diagnose and start thrombolysis 5 days a week

B – YDH ED would not receive suspected stroke patients at weekends/bank holidays

5 SFT ONLY HASU

Option 5A

- SWASFT take all suspected strokes to their nearest emergency department (A&E)
- Yeovil emergency department (A&E) continues to receive all suspected stroke patients and scan, diagnose, and start thrombolysis, 7 days a week
- Patients would then be transferred to Taunton for HASU care. Patients would return to Yeovil for their ASU care
- Impact on Dorset in this option

Option 5B

- SWASFT take all suspected strokes to their nearest emergency department (A&E)
- Yeovil emergency department (A&E) continues to receive suspected stroke patients to scan, diagnose and start thrombolysis, 7 days a week
- Patients would then be transferred to Taunton for both HASU and ASU care. Patients would be discharged closer to Yeovil following their acute care
- Impact on Dorset for this option

6 HASU / ASU ON SINGLE SITE - SFT

Option 6A

- SWASFT take all suspected strokes to their nearest emergency department (A&E)
- Yeovil emergency department (A&E) continues to receive suspected stroke patients to scan, diagnose and start thrombolysis, 7 days a week
- Patients would then be transferred to Taunton for both HASU and ASU care. Patients would be discharged closer to Yeovil following their acute care
- Impact on Dorset for this option

Option 6B

- SWASFT would take all suspected stroke patients to nearest HASU
- Yeovil emergency department (A&E) would not receive suspected stroke patients at any time
- Patients would go to Taunton for both HASU and ASU care
- Patients would be discharged closer to Yeovil following their acute care
- Impact on Dorset for this option

7 NO HASU IN SOMERSET

- No HASU in Somerset
- ASU beds retained at SFT and YDH

8 HASU ONLY AT YDH

- HASU only at Yeovil

9 HASU & ASU ONLY AT YDH

- HASU and ASU only at YDH

2 Defining the shortlist

Working with clinicians and colleagues at Somerset and Dorset Integrated Care Boards, Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust, Dorset County Hospital NHS Foundation Trust, Stroke Association, and public and patient stakeholders, we are reviewing the longlist of options to reduce to a short list of options which we will undertake a more detailed review to understand the impact of each option. This process has included:

- Longlist assessment using "pass/fail" hurdle criteria –May 2022
- Shortlist assessment by Steering Group –24/05/22
- Review of short list by FFMF Programme Board –09/06/22
- Consideration by the Clinical Reference Group
- Public and patient stakeholder group workshop –29/06/22

Hurdle criteria were used to turn the initial longlist into a shortlist, through the application of a series of "pass/fail" criteria. The criteria used in Somerset was based on those used by BNSSG in their stroke review. A small number of amendments were made to ensure they reflected the local context, and these were approved by the Stroke Steering Group, on 26th April 2022, as suitable and appropriate for use within Somerset.

The hurdle criteria applied were as follows:

Theme	Category	Specific criteria
Quality of Care - impact on outcomes	**Clinical Effectiveness**	Will this option lead to people receiving equal or better care/outcomes of care in line with national guidance standards or best practice ?
		Will this option result in more effective prevention in order to improve life expectancy in the system and reduce health inequalities?
		Will this option account for future changes in population size and demographics?
		Will this option lead to more people being treated by teams with the right skills and experience?
	Patient Safety	Will this option allow for patient transfers/emergency intervention within a clinically safe timeframe? Will travel time impact patient outcome?
		Will this option offer reduced levels of risk (e.g. staffed 24/7 rotas, provide networked care, implement standardisation?
	Patient and carer experience	Will this option improve continuity of care for patients (e.g. reduce number of hand offs across teams/organisations, increase frequency of single clinician/team being responsible for patients?
		Will this option enable greater opportunity to link with voluntary/community sector health and wellbeing services?
		Will this option improve quality of environment in which care is provided?
Deliverability	**Expected time to deliver**	Is this option deliverable within 2 years?
		Will this option deliver the required benefits?
	Co-dependencies	Does this option enable the system to maximise the role of and adapt to new technologies?
		Will this option rely on other models of care / provision being put in place and if so, are these deliverable within the necessary timeframe?
		Will the wider system be able to deliver on this change including the community and voluntary sector?
		Can the additional capacity requirements be delivered?
		Will it destabilize any other providers in a way that can not be managed? Yes response is negative here - need to adjust in final scoring
		Does the system have access to the infrastructure, capacity and capabilities to successfully implement this option in particular, a reduced length of acute stay with sufficient capacity outside of the acute trusts to support it ?
Workforce sustainability	**Scale of impact: existing staff**	Can the current staffing level cope with the changes across the system?
		Will this option improve the resilience of current staff (e.g. recruitment, retention)
		Will it support the talent management of existing staff e.g. enable maintenance and /or enhancement of skills, competencies, career pathways, enable them to work at the maximum capability of their role
		Is the staff travel, relocation or retraining required in line with organisational change principles? YES is negative for these questions and need to adjust in final scoring.
	Scale of impact: future workforce	Is it possible to develop the workforce model required to deliver the option e.g. skills base, new competencies, new roles etc against the anticipated timeline for implementation?
		Will it support the financial sustainability of the workforce e.g. reduction in agency spend

1.5 Impact on Dorset

Dorset undertook a Clinical Services Review, the outcome of which was a proposal to change the current configuration which has HASU services at each of their three acute hospitals: Poole General Hospital (PGH), Royal Bournemouth Hospital (RBH) and Dorset County Hospital (DCH) in Dorchester to one single HASU at RBH. This recommendation has since been reviewed, and the current proposal is for two HASU, one at RBH and one at DCH. This was to ensure that there is adequate coverage for West and North Dorset patients. The HASU at DCH is currently operational only five days per week, and so plans are being developed to increase the provision to seven days per week and the outcome of the business case should be known this month.

In 2020/21 416 patients were conveyed to YDH. If HASU services were centralised to SFT then more patients would be conveyed to Dorset County Hospital. Some patients who currently go to YDH would go to RUH and some to SFT depending on where in the county they live.

Initial modelling done for the case for change shows the impact for Dorset dependent on the percentage of patients that may be conveyed elsewhere from Yeovil.

% Of current YDH patients (418 in 2020/21)	**DCH, Dorset (Average number of pts per week)**			**RUH, Bath (Average number of pts per week)**		
	Total Impact	Of which strokes (45%)	Of which mimics (55%)	Total Impact	Of which strokes (45%)	Of which mimics (55%)
75	6.0	2.7	3.3			
50	4.0	1.8	2.2	4.0	1.8	2.2
25				2.0	0.9	1.1

Source: 2020/21 South West Ambulance service conveying data

We are currently undertaking more detailed activity modelling of the four shortlisted options to understand the impact of each shortlisted options more accurately.

Dorset CCG and Dorset County Hospital are part of the Stroke Transformation Group and will be involved in further conversations as the modelling details the impact on Dorset.

1.6 Engagement

A detailed engagement and communications have been developed and is updated as the programme of work progresses. Our engagement has been The Equality Impact Assessment (EIA) has been utilised to inform our stakeholder analysis and engagement activities. A stakeholder analysis has been undertaken and has informed our engagement activity. Our Equality Impact Assessments will continue to help shape our engagement and inform the groups we will involve in any public consultation.

The aim is to create meaningful engagement with local people and stakeholders to involve them in deliberations about the future configuration of acute stroke services in Somerset. The approach will be responsive and proportionate to the whole community. Throughout this journey we want to include people and communities and use their feedback to inform our thinking and solutions.

The Somerset Stroke Transformation Steering Group was established which includes clinical and managerial representation from both acute providers, Somerset CCG and FFMY, Stroke Association, SWASFT and Dorset health and care system, and an individual with lived experience. The transformation steering group have been involved in the long listing to short listing options appraisal and a meeting is being arranged to engage and talk through the work so far and the shortlisted options with several senior staff members including representatives from the ICS.

A public and patient stakeholder group of key voluntary sector organisations and people with lived experience have been established. The public and patient stakeholder reference group is a time limited group established to provide feedback on our developing solutions and offer their perspectives and insights on how we can inform and engage local people in the hyper acute stroke public consultation.

We have held a series of engagement events to review the case for change and discuss the emerging solutions. This included a workshop in June to gain feedback on the four shortlisted options.

Alongside engagement with our public and patient stakeholder group, to gain further insights to inform our thinking we are also attending local stroke clubs and having individual conversations with people with lived experience, their carers and loved ones.

A consultation engagement and communications plan are being developed. The public consultation will ensure that there is good opportunity to hear from

members of the public, service users, patient groups, particularly higher risk and seldom heard groups. These groups will be targeted in our ongoing engagement work leading up to the public consultation.

We will plan our consultation engagement activity with the advice and guidance of our public and patient stakeholder group.

We will provide a range of opportunities for involvement and engagement with our consultation; reaching out to people where they are, in their local neighbourhoods and in local networks, physically and digitally. We will take into consideration how we will consult with people in neighbouring counties who may be impacted by any changes. The communications and engagement team for NHS Somerset will liaise with communications and engagement colleagues in Dorset, so that their views and their patients and public who may be impacted by any changes to services in Somerset can be considered.

2. Financial Implication

Each shortlisted option is being modelled to understand the financial impact from both a revenue and capital perspective, including the impact on the Dorset health system. This will be shared as it becomes available.

3. Climate Implications

There may be increased travel times dependent on the options shortlisted.

4. Well-being and Health Implications

Each shortlisted option will be reviewed to understand the impact Wellbeing and health implications.

5. Other Implications

N/A

6. Risk Assessment

Risks will be considered as part of the ongoing assessment.

7. Equalities Impact Assessment

An Equality Impact Assessment (EIA) has been done and does not show any significant impact on equalities. We will continue to update the EIA as the programme progresses.

8. Appendices

There are no appendices