Hyper acute and acute stroke services in Somerset decision FAQs

At the NHS Somerset Board meeting on 25 January 2024, the Board approved the recommendation to have a hyper acute stroke unit at Musgrove Park Hospital, Taunton and acute stroke units at both Yeovil District Hospital and Musgrove Park Hospital.

We will continue to update these FAQs and add more questions.

Full details of why and how the recommendation was made can be found in the decision-making business case.

The Board papers also outline the decision.

You can find the full list of FAQs throughout the review on our website - Stroke consultation FAQs - Our Somerset.

You can also find questions relating to stroke asked at our Board meeting in our Board meeting minutes:

28 March 2024 NHS Somerset Board meeting minutes.

25 January 2024 NHS Somerset Board meeting minutes.

What will the changes mean for stroke patients?
The new model would ensure that anyone who has a stroke is taken to the nearest hospital with a hyperacute stroke unit, ensuring they had access to the best care and treatment immediately. This may be Musgrove Park Hospital in Taunton, or an out of county provider for example Dorset County Hospital in Dorchester. The new model of care for stroke services will be: • A single hyper acute stroke unit at Musgrove Park Hospital in Taunton. • No hyper acute stroke unit at Yeovil District Hospital. • An acute stroke unit at both Musgrove Park Hospital in Taunton and Yeovil District Hospital. The clinical model has been developed by the clinicians involved in the stroke steering group using best practice guidance. The clinical model maps the journey from the pre alert of a stroke by the ambulance service through the hyper acute and acute stroke phases and incorporates the standards required at each part of the pathway including the pathway for those who may walk into Yeovil Emergency Department or who may have a stroke as an inpatient. The stroke steering group were clear that anyone having a suspected stroke should be taken to their nearest HASU. A single, centralised hyperacute stroke unit would be developed in Musgrove Park Hospital in Taunton. This unit would provide all the hyper acute care following stroke and refer appropriate

patients onward to Bristol Southmead Hospital for mechanical thrombectomy or neurosurgical management. This would provide a larger and more sustainable specialist stroke workforce, which would enable faster decision making and improved continuity of care 24/7, leading to improved equity of service and improved outcomes.

Some patients who may have gone to Yeovil for their stroke care would be taken to Dorchester as the nearest HASU for their hyperacute care and refer appropriate patients onward to Southampton for mechanical thrombectomy or neurosurgical management.

Acute stroke care would be provided by dedicated stroke teams in Taunton, Dorchester and at Yeovil, with dedicated acute stroke beds at each site and staffed as per the 2016 National Stroke Clinical Guideline. Somerset patients and those patients who live nearer to Yeovil but may have a Dorset postcode would be transferred back to Yeovil so they are closer to family.

Following implementation this will mean:

- The ambulance service would take all suspected stroke patients to nearest hyper acute stroke unit.
- Yeovil District Hospital Emergency Department (A&E) would not receive suspected stroke patients at any time unless patient walks in or has a stroke as an inpatient.
- Patients who would have previously been taken to Yeovil District Hospital will now go to Musgrove Park Hospital in Taunton or Dorset County Hospital, in Dorchester for their hyper acute stroke care.
- Any Somerset people and those people who live nearer to Yeovil even though they have a Dorset postcode e.g. Sherbourne and other surrounding villages, who have had their hyper acute stroke care at Dorchester will be transferred to Yeovil District Hospital following their hyper acute stroke care.
- There would be some changes to the medical, nursing and Allied Health Professional workforce.
- Once ready for rehabilitation, patients would ideally be discharged closer to home following their acute care – either home or to a community hospital.
- There will be an impact on other health systems, primarily Dorset.
- Transient Ischaemic Attack (TIA) services would be delivered 5 days a week at Yeovil District Hospital and at weekends patients would be directed to TIA services at Musgrove Park Hospital, Taunton.

Now that a decision has been made, when will the changes take place?

Changes will not happen overnight, but will be phased over the next 18 months. We will continue to update staff, stakeholders and local people on our progress.

Implementation is planned to take place over an 18-month timescale. Coordination between Somerset Foundation Trust and Dorset County Hospital, along with South Western Ambulance Service (SWASFT) is key to enable successful implementation and will be key to the detailed implementation planning following a decision.

Governance for implementation will be the responsibility of Somerset NHS Foundation Trust and Dorset County Hospital.

A joint implementation group will be established (Joint Stroke Co-ordination Board (Somerset and Dorset)) to cover timing and communication of implementation, equity of access and pathways

which work across both organisations. NHS Somerset will be a member of this group as involved assurance.

More details on implementation of the changes can be found in section 14 of the decision-making business case.

When will changes take place at Dorset County Hospital?

The changes at Dorset County Hospital to provide a comprehensive hype acute stroke services unit (HASU) represent a significant change to the pre-existing model at Dorset County Hospital.

The HASU is set to be formally established and opened by the end of April of this year.

As part of these changes Dorset County Hospital continues to work closely with University Hospitals Dorset to ensure consistency and sharing of good practice across the whole of the stroke pathway, including initial specialist management, access to thrombolysis and mechanical thrombectomy, early supported discharge and rehabilitation.

Governance for implementation will be the responsibility of Somerset NHS Foundation Trust (SFT) and Dorset County Hospital (DCH).

A joint implementation group will be established (Joint Stroke Co-ordination Board - Somerset and Dorset) to cover timing and communication of implementation, equity of access and pathways which work across both organisations. NHS Somerset ICB will be a member of this group as part of the assurance process.

Exceptions to implementation will come back to the NHS Somerset ICB Oversight. Assurance of implementation and go-live - including milestones and go/no go gateways – will be in place before the new model of care goes live.

How did you arrive at the decision?

In developing the proposed options, a series of workshops were held with people working in stroke services, key stakeholders including the Stroke Association, and people with lived experience of a stroke. Together they looked at how local stroke services could be improved. These sessions were used to develop a long list, then a short list, of potential solutions for the future.

The four solutions shortlisted were examined further and following insights from the public and patient group, were refined and reduced to two potential options.

These two potential solutions were then taken out to public consultation. This was to gather further insights from local people about the proposed changes.

The public consultation is one part of a bigger piece of ongoing work that considers all aspects of the proposed changes to stroke services including financial, geographical, logistic and operational considerations.

Analysis of the public feedback, further detailed modelling of financial and operational considerations was undertaken. An options appraisal of the two options taken to public consultation was conducted.

The options appraisal showed that option B was no longer a deliverable option – option B proposed creating one hyper acute stroke unit and one acute stroke unit at Musgrove Park Hospital.

The further modelling has shown that it would not be feasible to provide the significant investment required to deliver this model of care. The extra resources required at both Musgrove Park Hospital and Dorset County Hospital would not be sustainable.

The further modelling has shown it is not possible to deliver the entirety of Option B at the Dorchester County Hospital site and even a partly implemented solution would require significant capital investment which would have to be diverted from other planned improvements in Somerset, to support both Dorchester County Hospital and Musgrove Park Hospital to provide stroke services and could not be implemented within the two year timetable set.

The consultation feedback also highlighted the important role family and loved ones play in the recovery and wellbeing of stroke patients. An acute stroke unit at Yeovil District Hospital would enable patients to return to Yeovil, if that was closer to their home.

The recommendation to discount option B by the Stroke Project Board was accepted by the NHS Somerset Board on 30 November 2023.

You can read the full paper outlining the options appraisal on our website.

Following the selection of the preferred option, further modelling and evaluation was conducted supported by our stroke steering group. This evidence forms the detail in our decision-making business case. The decision-making business case was presented to the NHS Somerset Board at the Board meeting on 25 January 2024 to make a decision on the best way forward.

The Board reviewed all the evidence and agreed with the recommendation to implement a hyper acute stroke unit at Musgrove Park Hospital, Taunton and acute stroke units at both Yeovil District Hospital and Musgrove Park Hospital.

Has all the data and modelling included in the decision making business case been checked?

Yes, all the data has been checked and validated against the different sources of data that are available for the programme, for example, hospital data, ambulance service data, and sentinel stroke national audit programme (SSNAP) data. All data has been analysed by a finance group and stroke project board, with representation from all health system partners, to ensure its credibility.

The conclusions have been tested and confirmed with our stroke steering group at all stages of development and support has been confirmed through the Somerset Integrated Care System (ICS) Finance, prior to asking the NHS Somerset Board to approve the recommendations.

Have you reviewed the travel time analysis from the pre-consultation business case?

Yes, we have analysed in further detail the travel time impacts. The Somerset Stroke programme commissioned additional geospatial modelling of travel and worked with Southwest Ambulance Service NHS Foundation Trust to understand the impact of the proposed changes on ambulance conveyance times to hospital.

Modelling continues to indicate that travel to a hyper acute stroke unit by ambulance will increase and that travel time to a hyper acute stroke unit will also increase. This increased travel time will

only impact up to the first 72 hours of emergency stroke care. Following the hyper acute stroke care patients would be transferred to an acute stroke unit which could be closer to home.

By implementing the proposal of centralising the Hyperacute Stroke Unit in MPH and for patients to be taken to their nearest HASU (which may be outside of Somerset), 98.9% of over 50's will be able to access a HASU by ambulance within 60 minutes in comparison to 99.9% in the current configuration.

Travel to a Hyperacute Unit will be longer for some people but there is strong clinical evidence that longer travel times will be offset by improved clinical outcomes through being admitted to a specialist stroke centre with access to stroke expertise 24 hours a day, seven days a week results, rather than being managed without these resources.

Full details of the travel analysis can be found in section 11.6 of the decision-making business case.

What are the benefits of the changes?

The new model of care for stroke services responds to the reasons why change was needed – our case for change.

It will deliver:

Workforce sustainability:

- Gives greater opportunity to explore more innovative and creative ways to recruit and retain specialist stroke staff.
- Creating a more attractive place to work, which will lead to improved recruitment and retention levels and lower vacancy rates.
- Future-proofs the stroke service against single point of failure risk with regards to senior specialist stroke consultant staffing and leadership.
- Allows greater flexibility in the range of workforce solutions available for an existing workforce.
- Meets the appropriate standards as set out in the relevant guidance documentation (e.g., British Association of Stroke Physicians and the National Stroke Clinical Guideline 2016).
- Bringing together the stroke service into one service two sites model.

Clinical Outcomes:

- Ensures and responds to the key standards set out in the clinical model.
- Ensures delivery of the recommended number of > 600 strokes per year.
- Delivers time critical interventions more quickly i.e., brain scan, within 1 hour, time to see a stroke specialist within I hour, door-to-needle time for stroke thrombolysis, proportion of
- patients receiving thrombolysis within 1 hour of hospital arrival, and proportion of patients
- admitted to the hyperacute stroke unit within 4 hours.
- Delivers a standalone ASU at Yeovil as recommended and with recommended staffing level (2016).
- Enables access to a safe and equitable service 24/7.

- Ability to use videotelemedicine across both sites 24/7, facilitating greater access to stroke.
- specialist input, particularly out-of-hours.
- Improvement in length of hospital stay.

Inequalities:

- Delivers a 24/7 clinically sustainable service to the population of Somerset rather that the current in hours and out of hours variation.
- Improvement in door-to-needle times for stroke thrombolysis; this will mitigate the longer
- pre-hospital travel times experienced by some patients.
- Provides equity of patient outcomes.
- Delivers a Somerset TIA service to national standards.
- A stroke is a medical emergency and urgent treatment is essential. Urgent care is
- excluded from patient choice rules and as stroke care is considered to be urgent, patient choice does not apply to this service. Patients will be conveyed to the location of their
- nearest HASU.
- If the patient self presents, or has a stroke whilst an inpatient, they will be transferred (if
- appropriate) to the nearest HASU. For thrombolysis, direct transfer for thrombectomy or
- where transfer to a HASU is not deemed to be in the best interest of the patient the HASU
- consultant would support the formulation of a management plan involving the local ASU.
- Our proposals allow for a degree of patient choice for the post HASU care, both for Acute Stroke Care and Rehabilitation.
- For patients who have a TIA, patients are required to be seen urgently for specialist
- assessment and investigation within 24 hours of onset of symptoms. As this remains
- urgent care, patient choice does not apply to this service.
- There would be a risk to continuity of care because of repatriation between HASU and
- ASU which can be mitigated by ensuring that there is good handover of care and using
- trusted assessments fostered by the one team, two site approach in Somerset.

Financial sustainability:

- Reconfiguration of hospital services can provide a powerful means of improving quality in an environment where money and skilled health care workers are scarce.
- The Option has been modelled over 10 years to consider the demographic growth,
- changes in age specific stroke incidence, and activity projections.
- There is an opportunity to reduce the reliance on agency staff reducing cost.
- The benefits of delivering time critical interventions in the hyperacute phase more quickly
- means that outcomes are improved and support the opportunity to reduce long term care
- costs.

The DMBC states that 56% of the stroke patients (around 255 people) who are currently taken to the HASU at Yeovil District Hospital will in future be taken to the proposed HASU at Dorset County Hospital, Dorchester. If Dorset County Hospital has not succeeded to recruit the

necessary staff to open its HASU within the required two-year window, where will patients from north Dorset be taken for emergency treatment?
The governance for implementation will be the responsibility of Somerset NHS Foundation Trust (SFT) and Dorset County Hospital (DCH). A joint implementation group will be established (Joint Stroke Co-ordination Board (Somerset and Dorset)) to cover timing and communication of implementation, equity of access and pathways which work across both organisations. The ICB will be a member of this group. Exceptions to implementation will come back to the ICB for oversight and assurance, including milestones and go/no go gateways before any decisions made before go-live. Since publication of the papers, a letter has been received from Dorset County Hospital reinforcing their commitment to the process and implementation.
It is mostly understood that family members and other unpaid carers supplying emotional and practical support to patients of stroke can help towards good outcomes, quite apart from the essential knowledge that these carers have of the patient which can help the professionals provide appropriate care. While welcoming the suggestions for supporting unpaid carers' access to the 2 hospitals how can we be sure that these will be seen as an essential part of the decisions made? It is very easy to take carers for granted but they need to be involved in decisions and supported in their own right in the interests of the patient, after all the essential services that unpaid carers provide has been valued roughly as the same as the cost of the whole of the NHS. At least awareness is improving at last.
Throughout the programme of work, the engagement with the public and patient stakeholder group has always focused on the ability of carers to visit and be with their loved ones. They understand the compromises that need to be made to get specialist stroke care and have made suggestions such as leaflets for relatives and carers that give them information about options for community transport and the opportunity for open visiting hours to give adequate time for visiting. There was significant concern heard during the consultation that family and loved ones play an important role in a patient's recovery and the impact not being able to see loved ones could have on the wellbeing of patients and put alongside the strong public opinion heard through the public consultation around the adverse impact on families and carers if stroke services were completely removed from Yeovil, a recommendation was made to the ICB Board to discount Option B (a single hyper acute stroke unit and a single acute stroke unit at Musgrove Park Hospital, Taunton), and to work with Option A as a preferred option. Having considered the evidence of the impact of additional travel for visiting friends, families and carers, it was felt that the best decision needs to be made for patients and the impact has been mitigated through maintaining an Acute Stroke Unit at Yeovil, limiting the HASU stay to 72 hours and providing technology to connect patients and carers.
Being a stroke patient from the east of the county, my concern is the transit time to Taunton. I had to wait an hour for an ambulance to arrive but was in Yeovil resus in 25 mins. If I had to travel on to Taunton it would have taken at least an hour. As we are told time is the major factor in stroke damage every extra moment is a serious concern. Therefore Yeovil & Taunton should be kept. I would like to reinforce the consideration for travel, not just for carers but for the

patient themselves, as Yeovil especially is growing and more and more people will need services, I feel that splitting the sites is the best option as two hours is too much for those this side of the county.
As part of the process, the national guidance and research and evidence from implementing this guidance in other areas, was considered. It was agreed that the options for change should be in line with the draft National Stroke Service Model and address the current inequalities in stroke care provision across Somerset. The evidence is strong that being admitted to a specialist stroke centre with access to stroke expertise 24 hours a day, seven days a week, results in better outcomes than being managed without these resources. The impact of changes in travel time to the hospital need to be weighed against, and can be mitigated by, anticipated improvements in the speed of treatment when a patient arrives at the hospital (the "door-to-needle" (DTN) times. The purpose of reconfiguring stroke services in Somerset has been to realise our vision that for adult stroke care we will ensure the provision of acute hospital-based stroke services that are timely, easy to access, high quality and efficient, with stroke experts available 24 hours a day, 7 days a week, 365 days a year. It has been recognised that it is not possible to eliminate all aspects of current inequity and that in some rural areas, compromises might need to be made. Achieving a well-staffed unit working 24/7 that is also within a 45 – 60-minute drive in a blue light ambulance might not be possible. For example, travel to Taunton from Wincanton it is likely that the ambulance would convey you to Dorset County Hospital, increasing the journey time by 17-20 minutes compared to travelling to Yeovil District Hospital. Evidence from the reorganisation of stroke services in Northumbria, a rural area like Somerset, demonstrated a significant improvement of 26 minutes in average door-to-needle times after the reorganisation. A thrombolysis audit performed at MPH shows that it a realistic expectation that the preferred model could improve local door-to-needle times by a similar amount. In practice this should mean that the increased time spent travelling is offset by a quicker response once you would arrive at DCH. This very concern has been raised through other channels in recent weeks and we know that the public within Yeovil and to the East of Yeovil will require reassurance over this very issue, and this will be done as part of the implementation. A significant amount of work has been undertaken by the Somerset stroke steering group (a partnership of clinicians, people with lived experience of stroke and other health and social care staff from across Somerset as well as colleagues from Dorset) to design a new model for acute hospital-based stroke services that meets both clinical best practice and one that is grounded in what matters most to people and delivers the best outcomes for patients.
Dr Khalid Rashed, lead consultant stroke physician at Yeovil Hospital, says the true cost of removing the Yeovil HASU has been grossly under-estimated. The suggestion that the cost will be offset by improvement in health and functional recovery is flawed and based on no evidence

from any health cost economic analysis. Please explain why Dr Rashed, Somerset's most senior stroke physician, is wrong to come to this conclusion.
Based on the recommendation of our Finance Committee, the Board has agreed the financial case today and the Board will continue to oversee the financial assumptions as part of the implementation plan. Regarding the question about whether the changes are going to save money, the answer is categorically no. The intention is to invest £4 million of revenue and £1.8 million worth of capital in the service. The amount of detail behind that has been built up from staffing rotas from the ground upwards. More money will be invested in stroke services for Somerset and linked to that is the need to recruit more staff. The changes are focused on ensuring the best care and outcomes for people who have a stroke, meaning faster diagnosis and treatment, fewer deaths, and less disability. Whilst acknowledging that it is unlikely that the financial benefits associated with reducing long term disability will be cash releasing, these do reflect an avoided cost further along the pathway resulting from improved care in the hyper acute and acute phases of care. There is also focus on preventing strokes in the first place, which is a key aim of our 'take the pressure off' campaign which aims to raise awareness of the importance of identifying and treating high blood pressure.