Hyper acute and acute stroke services in Somerset post consultation FAQs

Following an options appraisal led by clinicians, people working in stroke services, key stakeholders and people with lived experience of stroke, a 12 week public consultation on acute hospital based stroke services in Somerset ran from 30 January 2023 to 24 April 2023.

During the consultation, people and communities living and accessing health and care in Somerset were asked to share their feedback on two proposed options:

- **Option A**: A single hyper acute stroke unit at Musgrove Park Hospital, Taunton and an acute stroke unit at both Musgrove Park and Yeovil District Hospital.
- **Option B:** A single hyper acute stroke unit and a single acute stroke unit at Musgrove Park Hospital, Taunton.

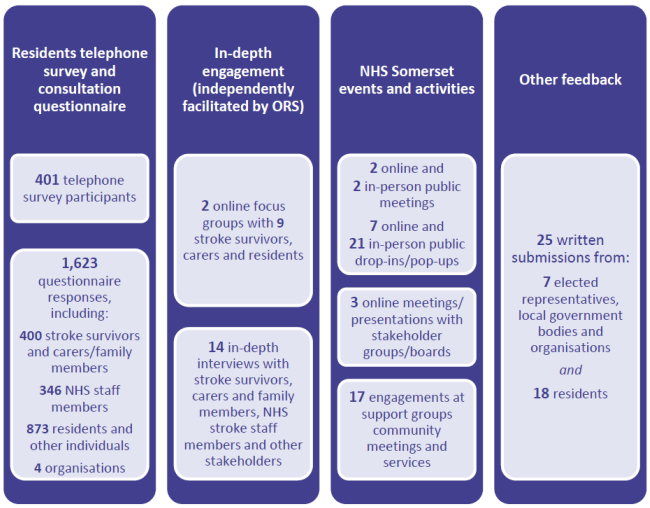
We have created an updated frequently asked questions document from questions we have received during and after the consultation.

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

How many people responded to the public consultation?

During the consultation period, residents and other stakeholders were invited to provide feedback on the stroke proposal through a wide range of methods. A consultation questionnaire for all residents, staff members, stakeholders and organisations was made available online and paper questionnaires were circulated widely and available on request.

NHS Somerset received written and email submissions from residents, stakeholders and organisations. Opinion Research Services (ORS) also independently facilitated in-depth engagement, designed and conducted by ORS, with staff at the Trust and representatives from communities that NHS Somerset were less able to reach.



ORS are independently analysing all the feedback received. The insights and themed report will inform the development of the decision-making business case (DMBC).

You can read more about how we reached people during the consultation on our website.

How did you reach people from communities more likely to be negatively impacted or that are not always well represented in public consultations?

To ensure we consulted with people who may be impacted by our proposals we:

- Focused on reaching out to people where they are, in their local neighbourhoods and local networks.
- We promoted the consultation and provided opportunities with the aim of covering the geography, demography and diversity of Somerset, and surrounding areas impacted including Dorset.
- We advertised widely to make sure people were aware of the consultation even if they chose not to participate.
- We produced materials taking into account the differing needs of our communities, including Easy Read and Aphasia friendly.
- We tested our communication materials with members of our public and patient stakeholder group and Healthwatch Somerset readers' panel.
- We worked with partners in surrounding areas, including Dorset, to maximise our engagement and communications reach in surrounding counties where local people may be impacted by any changes.

The Equality Impact Assessment (EIA) was utilised to inform our stakeholder analysis and engagement activities. A detailed stakeholder analysis was undertaken and informed our engagement and communications activity.

Following the mid-point review of the consultation survey responses at the mid-point of the consultation, we evaluated and adapted our consultation engagement and communication activity.

Opinion Research Services (ORS) an independent research organisation also undertook a Representative telephone survey where they sought to gain the views of a representative sample that was reflective of the geography and demography of Somerset and boarding counties.

ORS also held independent in-depth interviews and focus groups with staff, people with lived experience of stroke, and people from underrepresented communities.

You can read more about how we reached people during the consultation on our website.

Could you alternate hyper acute stroke services between the two Somerset hospitals?

Alternating hyper acute stroke services between Taunton and Yeovil would still require additional stroke consultants on both sites or the need for them to travel to either site.

This option would be very confusing for the ambulance service as the crews would need to be very alert to the site being alternated and could result in a patient arriving on the site that is not receiving stroke patients that week and is not supported by the ambulance service. Therefore, this option would not be a viable option.

Did you consider alternative models apart from the ones consulted on?

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 options were assessed to decide how they would meet the following criteria:

- Quality of care – impact on patient outcomes
- Quality of care – impact on patient experience and on carer experience
- Deliverability
- Workforce sustainability
- Affordability
- Travel times for patients and their carers and visitors
- Impact on equalities.

The long list of options were given a pass or fail score to decide which solutions would be taken forward for further assessment in a short list.

The four solutions shortlisted were examined further and following insights from the public and patient group, were refined and reduced to two potential options. The potential pros and cons of each of the shortlisted options were discussed through the following perspectives:

- Patients
- Clinical outcomes
- Workforce
- Inequalities
- Finance
- Family and carers.

One potential solution for hyper acute stroke services and two potential solutions for acute stroke services were then taken out to public consultation.

The public consultation gathered further insights from local people about the proposed changes.

The public consultation is one part of a bigger piece of ongoing work, that continues to consider all aspects of the proposed changes to stroke services, including financial, geographical, logistic and operational considerations. Part of the process includes a further options appraisal where a range of information will be reviewed to identify a preferred option for the future.

Have you made a decision already about the future of the hyper acute stroke unit?

No, no final decision has been made. Based on the modelling and work we have done so far, we think that the only viable option for the future of the hyper acute stroke services is for there to be one hyper acute stroke unit at Musgrove Park Hospital in Taunton.

Throughout the development of the solutions we have gathered insights and feedback from a range of people, including people with lived experience of stroke, to inform and develop the proposals.

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. These were assessed to decide how they would meet the following criteria:

- Quality of care – impact on patient outcomes
- Quality of care – impact on patient experience and on carer experience
- Deliverability
- Workforce sustainability
- Affordability
- Travel times for patients and their carers and visitors
- Impact on equalities.

Locating a single hyper acute stroke unit at Yeovil District Hospital was considered as part of the long list of options. This did not pass the solutions criteria as it would lead to:

- An increase in travel time for more patients and their families in Somerset compared to one unit at Musgrove Park Hospital.
- The infrastructure needed for scanning and beds is not available.
- It would not address staffing issues.

Maintaining two hyper acute stroke units at Taunton and Yeovil was considered as part of the long list of options and as part of the short list of options. This did not pass the shortlist criteria as it would not meet the more than 600 stroke admissions a year criteria, it would not improve the access time to critical interventions, and would not address our staffing issues.

The final decision-making business case will take into account all aspects, including geographical, financial, logistical, operational and the public consultation feedback. All the evidence gathered will enable the NHS Somerset Board to make an informed decision on the best way forward.

Would an acute stroke unit at Yeovil District Hospital ease pressure on Musgrove Park Hospital, which is already busy due to having other specialist centres?

Irrespective of Musgrove Park Hospital having other specialist centres both sites are busy in terms of urgent and emergency care as they both have an Emergency Department.

Yeovil District Hospital does not have the infrastructure to cope with the additional numbers of emergency stroke patients that would arrive there if Musgrove Park Hospital did not have a hyper acute stroke unit and would require a substantial expansion of the service in an already busy site.

Option A, provides the option to have an acute stroke unit at both Musgrove Park Hospital and Yeovil District Hospital. This would mean that under option A, Yeovil District Hospital would maintain an acute stroke unit.

If you invested more in current services and recruit/train more staff would be able to maintain two hyper acute stroke units?

This review is not about saving money, we need to create safe and sustainable stroke services for the future.

There is a national shortage of stroke consultants, specialist stroke nurses and therapists. The shortage of specialist staff is a key driver of our proposals. We want to organise services so that we can use the staff we have more effectively. If our specialist stroke staff were based at one hyper acute unit, we would be better able to provide high-quality care 24/7, rather than spreading staff across two hyper acute units.

When you have small hyper acute stroke units it is difficult to recruit the specialised staff because the on call requirements are very onerous for the on-call staff. Having larger hyper acute stroke units attracts more staff and enables staff to see enough patients to ensure they maintain and build their expert skills.

National guidelines state that the minimum number of consultants required for a hyper acute stroke unit is 6. This is the minimum based on the need to cover a 24/7 shift rota. Taking into account our population demographics and prevalence of stroke in Somerset, we estimate that we would need 8 consultants to cover a single hyper acute unit in Somerset.

If we were to continue with two hyperacute units we would need 16 consultant to run a 24/7 service on both sites plus associated specialist therapies and nursing staff and the support infrastructure e.g. scanners.

Can Somerset introduce mobile acute stroke unit (as seen in Scandinavian countries) to administer life-saving treatment before travelling to hospital?

Mobile stroke units (MSUs) are ambulances equipped with brain imaging equipment and specialist staff that are capable of delivering thrombolysis or identifying large artery occlusion when equipped with CT angiography.

The Royal College of Physicians National Stroke Guidelines 2023 have reviewed the evidence regarding the use of mobile stroke units. They note that in data largely from non-randomised trials with a standard ambulance comparator group and blinded outcome assessments, after deployment of an MSU, patients with ischaemic stroke had a better clinical outcome, were more likely to receive thrombolysis and incur shorter onset to thrombolysis times (Turc et al, 2022a).

However, it is too early to be certain what the effects of MSUs are on an unselected stroke population, the cost-effectiveness of MSU care, how to integrate MSUs into pre-hospital pathways and how these might be applied across both rural and urban regions. Ongoing randomised trials may answer some of these questions, although modelling of costs and benefits applied across different regions and service models is likely to be required (Chen et al, 2022).

Could we use primary care centres (sites) for initial diagnosis with a view to only transporting those who absolutely need to be to the specialist treatment at the hospital?

Early diagnosis and treatment are imperative to improve outcomes after stroke. A brain scan is required to help make the diagnosis and treatment decision. Using a primary care centre as an initial screening and diagnosis stage would increase the risk of unnecessary delays in obtaining the diagnosis and initiating treatment, particularly where there is already difficulty in accessing prompt appointments in primary care.

Ambulance service staff are trained in the use of pre-hospital screening tools to detect stroke, such as the FAST (Face, Arm, Speech, Time) test, and the MEND (Miami Early Neurological Deficit) tool. They also are more likely to know where the closest stroke treatment centre.

In some areas of the country there is early research and evidence regarding Stroke Video Triage, whereby the paramedics assessing a patient with suspected stroke can communicate via video-link with a stroke specialist in the stroke treatment centre. This may increase the ability to detect patients with conditions mimicking stroke and reduce the unnecessary conveyance of vulnerable people who have not experienced a stroke. NHS England are currently piloting Stroke Video Triage across a number of regions in the UK. If the evidence from these pilot studies shows that Stroke

Video Triage is safe and effective, it may help to enable the appropriate conveyance of people with stroke, and reduce unnecessary conveyance of people with a condition mimicking stroke.

Would there be worse outcomes for patients due to delayed treatment for people who would have to travel further to access hyper acute stroke care?

The options appraisal which led NHS Somerset to determine the proposals which went out to public consultation was informed by a detailed travel analysis.

Patients would be taken to their nearest hyper acute stroke unit which may be outside of Somerset. For some people this change would mean that their initial journey to hospital by ambulance could take longer. We worked with Southwest Ambulance Service NHS Foundation Trust to understand how this would impact on ambulance travel time to hospital.

Although patients are more likely to be taken to a hospital closer to where they live, ambulance crews make decisions based on several different factors – there aren't set rules about which hospitals people in each area are taken to.

Getting to hospital quickly is important when you have a stroke, but it's also important to be seen by specialist staff quickly when you arrive and to have access to the best treatment available. One hyper acute stroke unit at Musgrove Park Hospital would be better able to support this care by providing rapid access to the right expertise and specialist equipment 24/7.

As part of the development of the decision-making business case we are reviewing our travel time analysis. The stroke steering group have also reviewed the national clinical recommendations for best practice.

The clinical outcomes were considered in detail as part of the options development. The proposals were supported by the Clinical Senate and NHS England.

NHS England have recognised and considered the issues that arise from rurality in their Configuration Decision Support Guide for stroke services.

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 improved outcomes arise from careful attention and treatment to maintain homeostasis, skilled nursing and medicine to avoid complications and early intervention to treat complications before they become life-threatening.

There is no doubt that intravenous thrombolysis given to the right patients in the right way also increases the likelihood of avoiding long-term disability, although it has no effect on overall mortality. Currently, even in the most active centres, only about 20% of unselected stroke admissions are treated with thrombolysis. The remaining patients are excluded from treatment because they arrive too late for the treatment to be useful or they have other contraindications that would make treatment too hazardous to justify.

If patients are treated within three hours of the onset of symptoms, for every seven patients treated, one person will have a major stroke converted into one that leaves little or no long-term disability.

Reorganisation of stroke services therefore needs to consider where the benefits lie for the population that the hospitals are serving. In areas of high population density there can be no

excuse not to provide high quality care, including access to intravenous thrombolysis to the whole population.

However, in rural areas compromises might need to be made as 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.

In their Configuration Decision Support Guide, NHS England use the example of a rural area currently with two underperforming stroke services about 30 miles apart. In their example they note that the two hospitals cannot run 24/7 services because of insufficient stroke consultants. In the example they give, one hospital has two funded consultant posts, but one is vacant despite repeated advertisements. The two hospitals do not both have 600 stroke admissions a year, meaning that neither has a sufficient volume of cases to maintain the necessary levels of experience and expertise. In addition, both hospitals are dependent on the stroke physicians to help run the general medical rota, meaning that having a specialist stroke rota is unfeasible while also complying with the European Working Time Directive.

Centralising services onto one site therefore seems logical but doing so would mean that a population of about 70,000 patients will be up to 90 minutes' drive away from the stroke centre. This would result in about 110 patients a year having to travel the 90 minutes, of whom about 22 would have been suitable for thrombolysis but will arrive too late for treatment. Of these, three would have had a better outcome if they had received thrombolysis. However, travelling that extra distance will mean that all 110 patients will get better quality care in the specialist centre and far more than three will have improved outcomes as a result.

The example as set out above has many similarities to our situation in Somerset. So, while not ideal, it is necessary to be pragmatic and organise services that will provide the greatest good for the greatest number of people and not fail to do this because it is thought that equality must be preserved at all costs. As stated in the NHS England Decision Support guide, maintaining poor services for all must not be an option even where it is not possible to provide thrombolysis for the entire population.

In their Decision Support Guide on stroke services, NHS England have recommended that the following factors should be considered when looking into redesigning stroke services in rural areas:

- clinical and financial critical mass standards achievable in urban areas may not always be feasible in low population density areas
- balance between volumes, travel times and financial viability
- standards that must not be compromised are:
    - specialist assessment on admission (24 hours a day) and daily thereafter during hyper acute phase
    - stroke unit staffed and equipped in line with best practice specification
    - 24-hour access to scanning
    - access to thrombolysis, but less important than other aspects of care access to therapy.

Would the increase in the number of patients at another hospital negatively impact the stroke unit at that hospital?

As part of the Pre-Consultation Business Case we considered the impact the proposals would have on neighbouring areas. We received letters of support for the two proposals from Dorset County Hospital, Royal United Hospitals Bath, Salisbury NHS Foundation Trust, and South Western Ambulance Service.

Dorset County Hospital have been active members of our review and are supportive of the changes these proposals would bring to Dorset County Hospital. They will be taking these proposals into account as they develop their own plans for their hyper acute stroke unit at Dorset County Hospital.

Throughout the programme of work NHS Dorset and Dorchester County Hospital have been part of the steering group which has led on the options appraisal and shortlisting of options. The programme manager has been meeting regularly with NHS Dorset and Dorset County Hospital on to ensure that they are kept up to date with progress and to discuss any issues.

It is important that as we move towards a decision that an implementation plan can be developed by both Somerset and Dorset, and these will align over a period of time so that the changes can be implemented when it is safe to do so.

Does Yeovil District Hospital not currently have a 24/7 emergency stroke specialist service?

No, neither Yeovil District Hospital or Musgrove Park Hospital have a 24/7 emergency stroke consultant service.

Yeovil District Hospital has specialist stroke consultant cover between Monday and Friday. At weekends there is a daily telephone consultation for stroke patients. This means that if you are admitted with a stroke on Friday evening, you would not be seen by a stroke specialist consultant until Monday morning. There are also specialist stroke nurses who provide stroke care and support with thrombolysis seven days a week, from 8am to 6pm Monday to Friday and 9am to 5pm on weekends and can interpret scans and assess patients prior to thrombolysis.

Musgrove Park has specialist stroke consultant cover available between 9.00 am and 5.00 pm Monday to Friday, and 9.00 am and 3.00 pm on weekends. There are also three stroke practitioners who respond to thrombolysis calls from the Emergency Department seven days a week between 8.00 am and 8.00 pm. These skilled clinicians can interpret CT scans and assess patients prior to thrombolysis being given. They also see referrals for suspected strokes across the hospital wards.

Would staff at Yeovil District Hospital become deskilled if there was no stroke unit there?

One of the reasons we are reviewing hyper acute stroke services is because local stroke services need to be more sustainable.

There is a national shortage of stroke doctors, nurses and other specialists and our current local expert staff are spread across two hospital sites at Musgrove Park and Yeovil Hospital. It would be easier to fill rotas at a single specialist hyper acute stroke unit, and staff would have more opportunities to develop their skills and experience.

As part of our case for change we outlined how at present stroke services in Somerset are not set up to maximise the skills and experience of our staff 24 hours a day, 7 days a week. Currently, Yeovil District Hospital does not see the minimum recommended number of stroke patients (500–600 per year) for staff to maintain their skills and build expertise.

By having one central hyper acute stroke unit, staff would see a higher number of patients helping to ensure they maintain and build the specialist skills needed.

Could external accommodation and more hospital accommodation be made available for visitors?

Both hospitals have facilities available where families can stay overnight when people are really unwell.

The hospitals have a list of B&Bs that are a short distance from the hospital and there is a League of Friends bungalow on the Taunton site that can be used for relatives of patients who are critically unwell.

Both sites have the facilities for relatives to stay within the ward if their loved one is very unwell.

Could parking passes or tokens to reduce the cost of parking at Musgrove Park Hospital?

The current arrangements for parking passes are as follows:

- At Musgrove Park Hospital, Q park has a reduced parking scheme which can be requested for up to two family members.
- At Yeovil District Park Hospital, concessionary parking is available for some relatives and parking for patients at End of Life is free.
- At Dorset County Hospital, if a stroke patient is receiving palliative or end of life care, parking is free. If a patient remains in the stroke unit for longer than 7 days, relatives can obtain a concession parking permit for £12.50 a week.

Could the changes risk the loss of existing skilled staff making the recruitment issue worse?

There is always a risk of losing specialist staff especially when they do not know the outcome of this piece of work yet. Continuous dialogue with staff has been important and continues as we move on towards developing the decision-making business case.

What happens after the public consultation?

The public consultation is one part of a bigger piece of ongoing work, that continues to consider all aspects of the proposed changes to stroke services, including financial, geographical, logistic and operational considerations. Part of the process includes a further options appraisal where a range of information will be reviewed to get to a preferred option.

We expect to have this work completed early next year, so that in January we will be able to put forward a final decision-making business case to the NHS Somerset Board.

The final decision-making business case will take into account all of the aspects considered, including the public consultation feedback. This review is not about saving money, but focuses on creating safe and sustainable stroke services in Somerset. All of the evidence gathered will enable the Board to make an informed decision on the best way forward.