Scrutiny Review of Central Sussex Stroke Services

Report by the Health Overview and Scrutiny Committee (HOSC) Review Board

Councillor Ruth O'Keeffe (Chair)

Councillor Colin Belsey

Councillor Angharad Davies

Councillor Johanna Howell (District representative)

Councillor Mike Turner (Borough representative)

March 2017

Health Overview and Scrutiny Committee (HOSC) – 23 March 2017

The report of the Scrutiny Review of Central Sussex Stroke Services

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Recommendations

1	**The Board supports the reconfiguration of stroke services in the Central Sussex area and agrees that option 6 – the development of a fully compliant Hyper Acute Stroke Unit (HASU) with a co-located Acute Stroke Unit (ASU) at the Royal Sussex County Hospital – is the preferred option.**
2	**The Board supports the current plan for a new 30 bed HASU as part of the 3Ts redevelopment and recommends that the option to increase it to 34 beds is implemented depending on the outcome of the review of stroke services in West Sussex.**
3	**The Board recommends that the changes made to improve access for carers and relatives at the temporary HASU become a part of the permanent HASU – in order to accommodate the concerns of some patients and carers about travel, parking and access at the RSCH site. The Board also recommends that dialogue with patients and carers continues.**
4	**The Board recommends that BSUH recruits the necessary additional staff to the HASU as soon as is reasonably practicable to ensure that there are sufficient staff to provide a 24/7 service safely, effectively and sustainably.**

Background

1. NHS hospital trusts provide acute stroke services to patients showing symptoms of stroke. In response to growing evidence, some hospital trusts have begun to develop Hyper Acute Stroke Units (HASUs) that are designed to rapidly assess and stabilise patients suffering from stroke symptoms before discharging them to an Acute Stroke Unit (ASU) – either on site or at another hospital closer to home – to a rehabilitation centre, or back home.

2. In January 2014 local commissioners and providers met with the National Stroke Director and were informed that none of the five acute stroke services in Sussex were meeting national standards in stroke care.

3. This led to a review of stroke services by the Central Sussex Stroke Board which concluded that acute stroke services in the Central Sussex area – the area where Brighton & Sussex University Hospitals NHS Trust (BSUH) provides acute stroke services across two hospital sites – should be reconfigured to a single site HASU and ASU at the Royal Sussex County Hospital in Brighton (RSCH).

4. During September and October 2016, the local CCGs presented evidence to the health scrutiny committees of East Sussex, West Sussex and Brighton & Hove about the benefits and risks of the preferred option for reconfiguration. The East Sussex Health Overview and Scrutiny Committee (HOSC) resolved that the proposals constituted a "substantial development or variation to services" requiring appropriate NHS bodies to formally consult with the Committee – in accordance with health scrutiny legislation.

5. The local CCGs carried out a public engagement on the proposed changes to stroke services between November 2016 and 31 January 2017. The respondents were generally supportive of the proposals but raised some concerns about travel times for patients and access to the RSCH for carers.

HOSC Review Board

6. HOSC established a Review Board to respond to the Central Sussex Stroke Board's consultation with the Committee comprising Cllrs Colin Belsey, Angharad Davies, Johanna Howell, Ruth O'Keeffe and Mike Turner; the Review Board elected Cllr O'Keeffe as the Chair.

7. The Review Board agreed that the key question that it needed to consider was whether the proposals were in the best interests of the health service for the residents of East Sussex. Before reaching its conclusion, the Review Board set out to satisfy itself that it had considered the following lines of enquiry:

- whether the preferred option is the only viable option;
- whether RSCH has sufficient capacity and capability to accommodate the centralised stroke services; and
- how the preferred option will impact on travel times for patients and access for carers.

8. The Review Board agreed to exclude from consideration the performance of stroke services provided by East Sussex Healthcare NHS Trust (ESHT) because the reconfiguration there had already been implemented; and the Coastal West Sussex Stroke Programme Board's stroke service proposals, as it did not directly affect residents in East Sussex.

9. The Review Board met twice with commissioners and clinical staff, firstly on 12 December 2016 to look at the clinical case for change; and again on 23 February 2017 to consider the outcome of the public engagement and the proposals for staffing at the new HASU.

10. This report sets out the evidence the Board considered, along with its conclusions and its recommendations.

Review of the evidence

Improvements in stroke care

11. The Review Board heard from witnesses that stroke care has changed radically in recent years. Despite an aging, higher risk population, there have been significant improvements to stroke performance in Central Sussex over the past 13 years. These improvements have been the result of:

- the use of aspirin to reduce stroke recurrence;
- the use of thrombolysis (clot busting drugs);
- the performance of a thrombectomy (catheter inserted into the groin to break up blood clots in the brain causing stroke);
- the issuing of National Institute of Health and Care Excellence (NICE) clinical guidelines in 2008 on how best to provide stroke services, which emphasised the importance of rapid assessment and treatment of people displaying symptoms of a stroke; and
- the introduction in 2013 of the Sentinel Stroke National Audit Programme (SSNAP) by the Royal College of Physicians as a way to compare and encourage improvement in stroke services.

12. In recognition of growing evidence, some hospital trusts have begun to reconfigure their acute stroke services to include a Hyper Acute Stroke Unit (HASU). A HASU contains a highly specialised and experienced team of stroke experts who are able to assess, treat and rehabilitate patients much faster and more effectively than traditional stroke units.

13. The Lead Stroke Clinician from BSUH described the process by which a HASU specialist team works when a patient with a suspected stroke arrives at the hospital:

- The specialist team is alerted by the Emergency Department of the approach, via ambulance, of a stroke patient;
- the specialist team, comprising a consultant, specialist nurse, junior doctor, and student, head to an A&E patient assessment area separate from the main Emergency Department;
- the specialist team rapidly assess the patient for signs of a stroke, or of a stroke mimic;
- the team takes the patient personally to CT scan;
- the team takes the patient to receive thrombolysis (as appropriate);
- the team phone the HASU to get a bed ready for the patient to be admitted to the unit.

14. The patient will typically spend the first three days in the HASU before moving to an ASU for the remainder of their hospital stay, unless specialist neurological rehabilitation is required.

15. Examples presented to the Board of the improvements delivered by HASUs included:

- stroke services were reconfigured in London in 2011 from 32 acute stroke units to 8 HASUs and a further 24 ASUs to provide care after the first 72 hours. This has achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay[1].
- SSNAP Data shows that since its reconfiguration from two ASUs to a HASU at a single site at the Eastbourne District General Hospital (EDGH), admission to the ESHT HASU in under 4 hours was, at 83.6%, significantly above the national average.

[1] Analysis of the options for the reconfiguration of Brighton and Sussex University Hospital NHS Trust's stroke services, High Weald Lewes Havens Clinical Commissioning Group, 2016

- a hybrid ASU-HASU model in Manchester, where there was a choice of where to take patients, has seen less clinical improvement.

16. However, a HASU's effectiveness rests on its ability to 'front-load' expertise in a proficient manner at the moment a patient arrives at the hospital. This means that in order to gain and maintain sufficient clinical expertise the process of rapidly assessing patients before admitting them needs to be performed repeatedly, so a HASU must have a 'clinical critical mass' of at least 600 patients per year[2]. HASUs also require more staff than traditional stroke units and should be located at a tertiary care centre.

Timeline for developing options for reconfiguration

17. In January 2014, local commissioners and provider organisations met to review their progress towards meeting the NICE stroke guidelines. At the meeting, the National Stroke Director presented future requirements for stroke services, SSNAP data, and the early findings of the reconfiguration of stroke services in London. The South East Clinical Network (SECN) then presented data that showed none of the five acute stroke services were meeting the NICE standards.

18. It was acknowledged by health and care organisations at that meeting that the approach to stroke care was inconsistent across Sussex and that there were opportunities for improvement. A collective agreement was reached between local authorities, providers, Clinical Commissioning Groups (CCGs), and NHS England to do something about stroke performance in the region. A Central Sussex Stroke Board was formed – made up of more than 20 local clinicians including hospital doctors, GPs, nurses, therapists, patient representatives and paramedics – to review the stroke services in that area.

19. The Central Sussex Stroke Board carried out a gap analysis of the existing stroke services compared to the NICE standards of best practice. The gap analysis showed that one of the biggest gaps between the NICE standards and the actual service was in the number of patients using the stroke units at Princess Royal Hospital (PRH), Haywards Heath, and Royal Sussex County Hospital (RSCH), Brighton, on an annual basis. The total across both stroke units was 750 compared to the recommended guidelines of 600 *per unit*. Below this number it is hard to deliver the core NICE standards, such as 7-day-a-week consultant-led ward rounds and 24/7 anti-clotting treatment. The gap analysis identified that the existing BSUH service:

- did not deliver thrombolysis 7 days per week;
- was below average on admitting patients to a stroke ward within 4 hours;
- had lower than expected staffing levels; and
- did not have consultant-led ward rounds 7 days per week.[3]

20. The Central Sussex Stroke Board concluded that quality of care could only be significantly improved by service change and asked BSUH to develop a proposal for how acute stroke services could be reconfigured to deliver stroke care in accordance with the NICE standards. BSUH proposed that emergency stroke services be centralised to a combined HASU and ASU at the RSCH, with local outpatient services remaining at PRH.

21. Sussex CCGs then asked the South East Clinical Senate (SECS) to convene an expert clinical review group (ECRG) – chaired by the National Stroke Director and comprising 18 local and national specialists – to look at the proposal alongside patient feedback and independent modelling on travel times. The ECRG published its findings in December 2015, agreeing that a single specialist stroke unit was appropriate and that the RSCH was the far superior location for

[2] Review of proposals for future stroke services in Sussex, South East Clinical Senate, December 2015

[3] Report to HOSC: Sussex Stroke Review, High Weald Lewes Havens Clinical Commissioning Group, 29 September 2016

it. The ECRG also recommended that other options were more explicitly considered before public consultation.[4]

Options considered by the CCG Governing Bodies

22. In early 2016, the Central Sussex Stroke Board asked BSUH to develop other options that met the standard of a maximum ambulance travel time of 45 minutes. The table below sets out all of the options[5].

Option	Description
1. No Change	HASU at RSCH and PRH meeting the current standards
2. No HASUs at BSUH	There will be no HASU on either site at BSUH. Patients with a suspected stroke from the BSUH catchment area will be re-directed to another nearest HASU within the region where they will be admitted if required.
3. Develop two fully compliant HASUs at RSCH and PRH	Patients with a suspected stroke will present and be admitted to both sites.
4. Develop a fully compliant HASU with co-located ASU at RSCH and an ASU at PRH.	Patients with suspected stroke will be conveyed to the HASU at RSCH where they will be admitted for the initial 72 hours of their stroke stay. Any patients requiring on-going stroke care will be transferred to their local ASU. The option assumes that all patients admitted to the RSCH HASU will be transferred to the ASU at RSCH or PRH.
5. Develop a fully compliant HASU at RSCH and an ASU at PRH	Patients with suspected stroke will present and be admitted to RSCH for the initial 72 hours of their stroke stay. Any patients requiring ongoing stroke care will be transferred to PRH for the duration of their treatment where appropriate.
6. Develop a fully compliant HASU with a co-located ASU at RSCH	No HASU or ASU provided at PRH. Patients with suspected stroke will present to RSCH where they will be admitted for the full duration of their stroke episode. The scenario with a HASU/ASU at RSCH will require 27 beds if there is a HASU at Worthing; 34 beds if there is no HASU at Worthing.
7. Develop a fully compliant HASU with a co-located ASU at PRH	This option assumes that there will be no HASU or ASU provided at RSCH

23. During August and September 2016, the Governing Bodies of the three CCGs involved in the reconfiguration – Brighton and Hove CCG, Horsham and Mid-Sussex CCG and High Weald Lewes Havens CCG (HWLH CCG) – reviewed all of the options and agreed that option 6 – the proposal for a single HASU with a co-located ASU at RSCH – was the best option for patients.

24. HWLH CCG Governing Bodies' appraisal of option 6 was that:

[4] Review of proposals for future stroke services in Sussex, South East Clinical Senate, December 2015
[5] Analysis of the Options, High Weald Lewes Havens Clinical Commissioning Group, 2016

- It is above the national figure of a minimum of 600 stroke admissions on each site – as recommended by SECN and SECS.
- The SECS ECRG strongly supported the option to integrate the stroke service onto a single site at RSCH.
- 100% of patients will reach a HASU in less than 45 minutes.
- It is compliant with the range of recommended stroke admissions required to maintain clinical competency and service quality and efficiency.
- It has potential for enhancing the quality and efficiency of the service at BSUH by bringing benefits of having a consolidated medical, nursing and therapy workforce.
- The proportion of BSUH stroke patients that will be affected by locating the service at RSCH represents 30% of total BSUH stroke activity (84 patients).
- Locating the HASU and ASU at RSCH will bring some disadvantages in relation to access due to the limited parking facilities available. However, public transport links to RSCH are good, with regular bus services stopping directly outside the hospital, and regular mainline train services into Brighton from London and the South Coast. There is also a bus service running between PRH and RSCH that is available for public use.
- The option was supported by affected services – South East Coast Ambulance Service NHS Foundation Trust (SECAmb), East Sussex County Council Adult Social Care Department, and Sussex Community NHS Foundation Trust (SCFT).[6]

25. The Review Board also heard that GPs had been consulted both at the CCG clinical executive level and at north and south locality meetings in the High Weald, Lewes and Havens area. Both locality meetings were unilateral in their support for option 6 and considered it the right model on the basis that the proposal was to confirm the arrangements set up following the temporary divert.

Temporary divert

26. Until February 2016 BSUH provided acute stroke services for 750 patients per year in the following configuration:

- a multidisciplinary unit on Solomon and Donald Hall wards at the RSCH in Brighton comprising 23 beds and admitting just over 76% of patients with a suspected stroke;
- a multidisciplinary unit occupying approximately one third of the Ardingly ward at the PRH in Haywards Heath comprising 12 beds and admitting just under 24% of patients with a suspected stroke;
- the Sussex Rehabilitation Centre (SRC) providing ongoing specialist neurological rehabilitation at PRH; and
- outpatient services at both sites.

27. During February 2016, BSUH instituted a temporary divert on safety grounds due to a shortage of staff, and all Ardingly Ward staff working on the stroke unit, along with all patients, were transferred to the RSCH. The SRC remained open at the PRH.

28. Following the temporary divert the stroke unit at the RSCH began operating as a HASU with a specialist team that met patients directly at A&E. The HASU comprises:

- 23 beds with access to another 4-9 beds nearby that are used flexibly depending on patient volume;
- 3 stroke consultants;

[6] Analysis of the options, High Weald Lewes Havens Clinical Commissioning Group, 2016

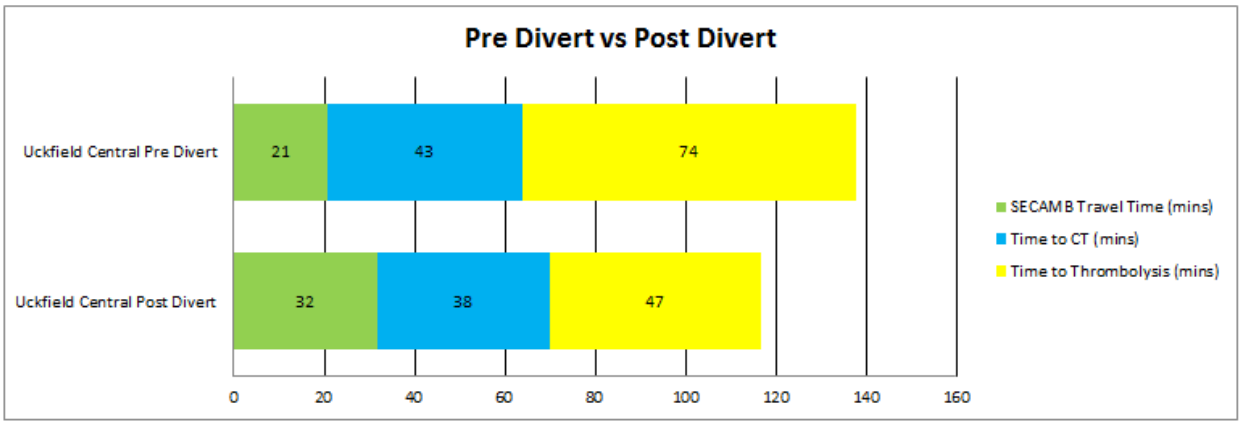
- one additional member of staff in addition to the PRH Ardingly ward stroke staff (an occupational therapist from the PRH).

29. Evidence provided to the Board shows that the concentration of resources at the temporary HASU has led to an improvement in the assessment time of patients. SSNAP data for April-July 2016 demonstrates a median time to scan of 38 minutes and 66.1% of patients seen within 1 hour. This is better than the national average and is similar to the period October-December 2015 when there were a third fewer calls (before the temporary divert).[7] The time from the CT scan to receiving thrombolysis has also fallen to 47 minutes (from 1 hour 14 minutes). Due to the reduction in assessment time and time to thrombolysis, even with an increase travel of up to 30 minutes for some patients in Mid Sussex, the average total time to thrombolysis for all patients is less than before the divert. This is illustrated in *Figure 1*.

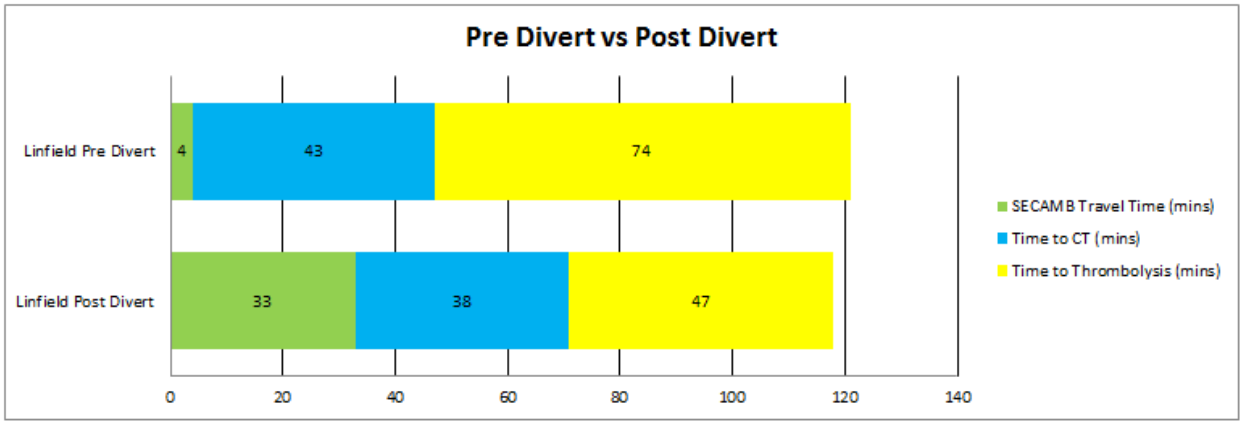
Figure 1 – Examples of treatment timelines showing the reduced average time to thrombolysis achieved by the temporary divert in HWLH area[8]

SECAMB travel	
Median time to CT	
Median time to thrombolysis	

Uckfield Central



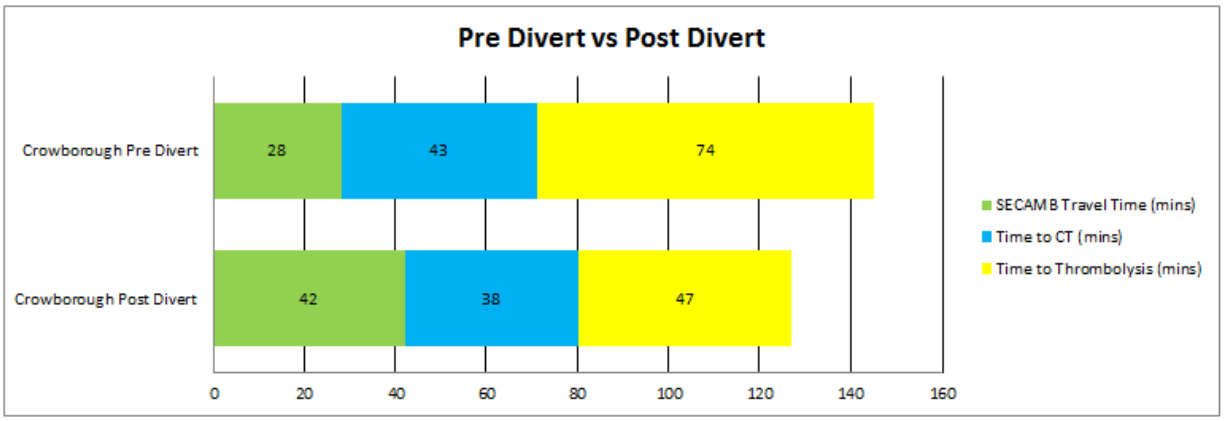
Lindfield



[7] Sentinel Stroke National Audit Programme (SSNAP) Data for Brighton & Sussex University Hospital NHS Trust (BSUH), July 2016

[8] Visual change in treatment timeline: HWLH CCG patients from PRH to RSCH, High Weald Lewes Havens Clinical Commissioning Group, February 2017

Crowborough St. Johns and Crowborough West



30. Although travel times for some patients will have increased, the Board was informed that the divert has not had a significant impact on the 'call connect to hospital door' time – the time between the patient ringing 999 to SECAmb arriving at the hospital. SECAmb reported that 79.2 % of the 159 incidents between April and November 2015 (pre-divert) were Stroke 60 compliant (being treated at a hospital within 60 minutes of calling 999) compared to 78.1% of 137 incidents between April and November 2016, amounting to the equivalent of 1.5 people. The increase in time for the 30 non-compliant calls was less than 4 minutes.[9]

31. The Board heard that since the divert, significant pressures on social care have led to an increase in the length of stay for stroke patients at both the HASU and ASU to the national average of 13 days, from 9 days earlier in the year. However, bed spaces are effectively managed and the median admission time to the HASU from arrival at the hospital is 2 hours 38 minutes (3 hour 38 minutes is the national average); this includes when a patient arrives at the hospital for a different illness such as delirium and is later assessed by the specialist stroke team after exhibiting stroke symptoms. The percentage of patients admitted to the ward within 4 hours is 70.9%, which is above the national average (58.5%) but below the target of 90%[10].

32. Following treatment at RSCH, the percentage of patients requiring discharge to the SRC has fallen from 20% to 14%.

33. The Care Quality Commission (CQC) inspected the stroke services after the temporary divert as part of their wider BSUH inspection in March 2016 and commented:

> *We found that an outstanding service was being delivered by dedicated staff on the Stroke Unit. The service was being delivered in a very challenging ward environment in the Barry building. Staff spoke with passion and enthusiasm about the service they delivered and were focused on improving the care for stroke patients. The results of audits confirmed that stroke care at the hospital had improved over the past year*[11].

34. The temporary divert has the added advantage in that it has provided the Central Sussex Stroke Board with the benefit of being able to ask patients and carers about their experience of a single site, instead of just relying on modelling. According to feedback on the temporary divert, 100% of patients have said that they are happy to come back to RSCH for their acute stroke care.

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[9] Report for Central Stroke Programme Board, SECAmb, February 2017

[10] Sentinel Stroke National Audit Programme (SSNAP) Data for Brighton & Sussex University Hospital NHS Trust (BSUH), August-November 2016

[11] *Royal Sussex County Hospital (RSCH) inspection report*, Care Quality Commission (CQC), August 2016

Staffing arrangements of new HASU

35. Computer modelling has showed that, in order to accommodate 750 patients staying for an average length of time on an annual basis, a permanent HASU (with onsite ASU) at RSCH would require 27 beds. The new 3Ts hospital redevelopment currently under construction at RSCH includes firm plans for a 30 bed HASU ward next to neurology and radiology, which are used in the process of diagnosing stroke patients. Stage 1 of the 3Ts redevelopment will be completed by 2020.

36. The Review Board heard that the reduction in time to treatment at the temporary HASU is due its improved efficiency compared to the previous configuration, but it does not currently meet the minimum workforce requirements set out within the SECN Stroke Services Specification to be able to provide a 24/7 service.

37. Therefore, in order to provide a seven day service, the recruitment of an additional 2.75 WTE consultants in stroke medicine, and 4.74 WTE occupational therapists and physiotherapists is essential. 1.58 WTE speech and language therapists; 0.85 WTE dieticians and 0.98 WTE clinical psychologists are also identified as necessary to meet the standard but they will not be available to patients 7 days a week. An additional 7 WTE trained nurses are needed for compliance with the SECN specifications and are expected to come from the upskilling, and ongoing support of, the current stroke nursing staff using existing stroke training modules, practice educators, and practice development nurses available already at BSUH (see figure 2).

Figure 2 – current and proposed staffing arrangements at the HASU

	HASU & ASU beds (WTE) Inc. 22% uplift for cover	**Baseline Staffing**	**Variance against baseline**
Nursing - trained 2.9 WTE nurses per bed, 80:20 trained untrained skill mix, 1:2 nurse:patient ratio. 1.35 WTE per bed, 65:35 trained untrained skill mix	36.52	29.5	7.02
Nursing - untrained 2.9 WTE nurses per bed, 80:20 trained untrained skill mix, 1:2 nurse:patient ratio. 1.35 WTE per bed, 65:35 trained untrained skill mix	12.92	22.6	-9.68
Physiotherapy 1.0 WTE per 5 beds (HASU and ASU)	7.74	5	2.74
OT 0.68 WTE Occupational Therapist per 5 HASU beds. 0.81 WTE Occupational Therapist per 5 ASU beds	6	4	2
SALT 0.68 WTE Speech & Language Therapist per 10 HASU beds 0.81 WTE Speech and Language Therapist per 10 ASU beds	2.58	1	1.58
Dietetics 0.5 WTE Dietician per 20 beds	0.85	0	0.85
Clinical psychologist 1.0 Clinical Psychologist per 40 HASU beds 1.2 Clinical Psychologist per 40 ASU beds	0.98	0	0.98

38. The three CCGs will provide additional funding as part of a best practice tariff (BPT) in order to fund the increased staffing establishment.

39. Despite sufficient funding, issues remain around the availability of staff for the HASU. Recruitment and retention of staff is a nationwide issue, particularly the recruitment of consultants, speech and language (SALT), and other therapy staff.

40. The Review Board was assured that every effort will be made to recruit the necessary staff. The Board heard that the RSCH unit is popular with staff, with low turnover and sickness rates and has a waiting list of staff keen to work on the unit; BSUH staff have also generally been positive about the temporary divert. This is in part due to:

- the ethos, team spirit and sense of expertise at RSCH;
- the desirability of living in Brighton & Hove; and
- the CQC rating the temporary HASU as 'outstanding'.

Other stroke reviews

41. Whilst Central Sussex Stroke Board has been developing these options, the Coastal West Sussex Stroke Board has been considering whether to develop a single site HASU at St. Richards Hospital, Chichester, or Worthing Hospital. Kent CCGs are reviewing stroke services across the county including those provided at Tunbridge Wells Hospital, Pembury.

42. The Board received assurance that the outcomes of these reviews will have no effect on the decision in Central Sussex. However, there will be a knock-on effect if the Coastal West Sussex Stroke Board chooses St Richards Hospital as the preferred site for its HASU. This decision could increase the number of patients using the HASU at RSCH up to a potential total of 900 per year, requiring 34 rather than 27 beds. The Board was assured that the 3Ts redevelopment included capacity to increase the number of stroke beds from 30 to 34 should this eventuality arise.

43. Elsewhere, ESHT already reconfigured its stroke services onto a single site at the EDGH in 2012; and Surrey and Sussex Healthcare NHS Trust will not reconfigure its HASUs as the geographic isolation means that a HASU must remain at East Surrey Hospital, Redhill, in order to comply with the 45 minute travel time model.

Potential concerns about reconfiguration

44. The Review Board raised several potential concerns with NHS witnesses about the reconfiguration and its effect on the residents of the High Weald, Lewes and Havens area. Below is a summary of the questions and the responses from NHS witnesses:

Would there be an increase in the length of travel times for patients in parts of the High Weald, Lewes and Havens area?

- No travel time will be below the maximum 45 minutes and only patients near the PRH would see an increase of 30 minutes or more.
- Although travel times will increase for some patients, the greater capacity available at the single-site HASU will mean that the time to admission rates will fall.
- Not all patients affected by the changes in the High Weald, Lewes and Havens area would necessarily go to RSCH – SECAmb will transport patients to the most suitable HASU.

Will expected house building and population growth in the High Weald, Lewes and Havens area lead to an increase in the number of patients affected by the reconfiguration and greater traffic on the roads?

- The increasing number of new houses in the High Weald, Lewes and Havens area should have little effect on the number of stroke patients. New houses tend to be purchased by younger people and the average age of a stroke patient is 76 years.
- HWLH CCG estimates that the total number of residents suffering strokes could increase from 50 to 65 per year. Any increase in the number of stroke patients due to increased average age is likely to be offset by improvements in primary care based prevention of strokes, e.g., more vigorous management of hypertension and irregular heartbeat (atrial fibrillation).
- The number of patients in the High Weald, Lewes and Havens area is based on the location of their registered GP. In some cases people will have a stroke when not at home and will be taken to wherever the nearest stroke unit is located.
- Increased traffic congestion does not present the level of challenge people might think it does for ambulances; ambulances can make very good progress when they 'blue light' as traffic parts for them.

To what extent does the ambulance service (SECAmb) support the proposals?

- SECAmb support the preferred option. The ambulance trust noted in its written response that some patients have longer travel times to the temporary HASU at RSCH, but the trust recognised that the quicker treatment of patients on arrival, and simplification of the process in deciding where to take a patient, made up for the increased travel times[12].
- The HASU's specialist team speeds up the handover time from ambulance crew to hospital by treating the patients separately from A&E as soon as they arrive. This actually reduces the amount of time an ambulance spends with a single patient, despite the increased travel time.

What will be the effect on other stroke units where patients may be taken instead of the PRH?

- The Central Sussex Stroke Board looks at the impact of the temporary divert every time it meets and anecdotally it has had minimal impact on other providers, for example, the ESHT SSNAP data does not show a notable upsurge in demand on the EDGH stroke unit.

Does the RSCH have the capacity and capability to provide a HASU as its emergency department is rated by the CQC as inadequate and the Trust is rated overall inadequate?

- The temporary HASU is not affected by the 'inadequate' rated Emergency Department at RSCH because the process of assessing patients exhibiting symptoms of stroke on arrival at the hospital is done by the HASU's specialist team quickly and independently of A&E.
- The presence of this specialist clinical team helps to reduce the burden on the emergency medicine team by diagnosing patients who arrive at the hospital with stroke-like symptoms such as seizures, Bell's palsy, and migraines.

How do staff communicate with patients and carers about stroke services?

- The RSCH HASU holds 2-monthly patient group meetings with patients and carers to understand what information they were given about the transition from hospital to home care in order to understand how it can be improved and made clearer.
- Stroke patients often have issues with communication so the stroke unit is very sensitive to the needs of patients who may have learning difficulties.

[12] Report for Central Stroke Programme board, South East Coast Ambulance NHS Foundation Trust (SECAmb), February 2017

Engagement with the public

45. The CCGs carried out a public engagement exercise to gather people's views of the proposed reconfiguration of stroke services. The engagement ran for 12 weeks from November 2016 until 31 January 2017. The CCGs agreed that the engagement should focus only on the preferred option because of the overwhelming clinical evidence that it was the only viable option.

46. Each of the three CCGs carried out an agreed survey but HWLH CCG carried out more extensive engagement in the High Weald, Lewes and Havens area due to the request by HOSC for the CCG to carry out further targeted and proportionate engagement at the areas particularly affected and on groups with special knowledge and interest in the issue. HWLH CCG carried out two public events in Uckfield and Lewes that were widely promoted through fliers in 31 GP surgeries and at 24 other public locations such as libraries, shops and sheltered accommodation. Members of the Central Sussex Stroke Board also met with Lewes Havens Patient and Public Forum and High Weald Locality Patient Representative Group.

47. There were 46 respondents to the survey, including 5 on behalf of groups – 14 were from the High Weald Lewes Havens area, including one on behalf of the High Weald Patient Group. In addition to the survey respondents, a further 32 people attended the events and meetings in the High Weald, Lewes and Havens area. The Board heard that the responses provided qualitative data about people's experiences and opinions of stroke service but there were too few to be able to draw statistically significant conclusions.

48. The Review Board noted the following main themes that emerged out of the responses to the engagement:

- When asked *"how do you think the changes proposed for BSUH's stroke services will affect you?"* 20 out of 38 respondents to the question (and 10 of the 14 respondents in the High Weald, Lewes and Havens area) said the changes will improve services, be better for them, or won't affect them.
- Feedback from the events and meetings in the High Weald, Lewes and Havens was that attendees believed there was a clinically compelling rationale for the recommended change.
- The main concern of survey respondents was about longer ambulance journeys – 10 people expressed concern, 3 in the High Weald, Lewes and Havens area. However, this concern was not evident in the feedback from the events and meetings where stroke clinicians had been able to explain that any increase in the length of journey would be offset by the prompt and enhanced care available at the RSCH.
- There were also concern about the difficulties families and carers faced in travelling to, parking at, and accessing the RSCH (i.e., people with mobility issues have difficulties with the antiquated Barry Building). These were voiced by 6 respondents (2 in the High Weald, Lewes and Havens area).

49. Survey respondents also had the opportunity to add anything to what is already planned to minimise any possible consequences of the change, although 21 respondents did not add anything. The majority of suggestions focused on improving the ability of families and carers to travel to, park at, and access the RSCH. Specifically, respondents wanted BSUH to:

- make it easier for visitors to the RSCH, including improving parking (6 respondents);
- improve signage and accessibility at the RSCH (3 respondents);
- reduce parking costs (1 respondent);
- improve bus services (1 respondent).

50. Survey respondents also gave feedback on discharge and rehabilitation, including requesting:

- more support for carers as well as patients after discharge;
- more information at discharge on what will happen next, who to call in the event of any concerns, and on the support groups available;
- speaking with the voluntary sector to see how they could help with discharge and transportation;
- more and better rehabilitation, with therapy starting as soon as possible and going on as long as needed, and a focus on community therapy. [13]

51. The Review Board was informed that many of the requests had already been put into effect, including:

- Information about local voluntary sector organisations that can provide transport will now be included in information packs provided to patients and carers when they arrive on the ward.
- In September 2016 the RSCH car park was re-designated for visitors only freeing up significant spaces, and the 3Ts redevelopment includes a 350 capacity underground car park.
- The elevators in the Barry building have been repaired and signage improved – and the new 3Ts ward will be in a newly built, accessible building.
- HWLH CCG commissioned Sussex Community NHS Foundation Trust (SCFT) to expand stroke rehabilitation services across HWLH to the same standard as Lewes and the Havens area. The specifications of the SCFT contract (signed in November 2015) are also based on patient need not duration of treatment.

[13] Central Sussex Stroke Review Engagement feedback report, High Weald Lewes Havens Clinical Commissioning Group, 10 February 2017

Conclusion and recommendations

52. There is strong evidence that admitting patients suffering stroke symptoms straight to a properly staffed, consultant–led HASU improves their clinical outcomes.

53. HASUs rely on a specialist team that is able to meet patients at the emergency department to speedily and accurately diagnose and treat patients 24 hours per day, 7 days a week. However, this level of service requires higher levels of staffing and a minimum of 600 patients per year.

54. The number of admissions per year in the Central Sussex area to the two acute stroke units, at 750, is only just larger than the minimum number for one unit. This suggests that there is a very strong case for the reconfiguration of services to a single HASU.

55. The presence of an onsite tertiary care centre, which is essential for a HASU, both now and once the 3Ts project is complete, means that RSCH is the preferred location. Whilst HOSC has concerns about the inadequate rating the hospital's emergency department received, the HASU's specialist team ensures that care of stroke patients is not dependent on the Emergency Department. Evidence also shows that the specialist stroke team can relieve pressure on emergency medical staff by treating patients displaying stroke symptoms who would otherwise be admitted to A&E.

56. Following the temporary divert in February 2016, evidence has shown that the average time it takes to transport some patients in the Central Sussex area to a hospital with an acute stroke unit has increased; however, the evidence also shows that it takes less time to scan and treat these patients once they arrive, meaning that the overall time it takes to admit them to a bed at the HASU has reduced. Written evidence from SECAmb also shows that there has been relatively little impact on the time it takes from responding to a call and handing over a patient to a hospital's care.

57. The temporary divert has allowed commissioners to gather evidence about the patient, families, and carers' opinions of the service. Satisfaction with clinical care is high, but there remain concerns about the difficulty for carers and family members visiting patients in Brighton.

58. The Board welcomes the plans for a new 30 bed stroke unit as part of the 3Ts redevelopment project. However, if the West Sussex Stroke Board review results in the creation of a single HASU at St. Richard's Hospital in Chichester, 34 beds will be needed at RSCH. There appears to be a plan in the 3Ts redevelopment to increase the unit's capacity to 34 beds and the Review Board would want to see this implemented should the outcome of the West Sussex review necessitate it.

59. The Review Board recognises that the temporary HASU **does not provide a 24/7 service** and to do so requires the recruitment of additional staff. The Board notes that the additional funding has been made available to BSUH to recruit these staff and recommends that they are recruited as soon as is reasonably practicable. However, the Board also recognises that it will be a challenging task given the national shortage of SALT staff and stroke consultants.

60. Having reviewed the engagement process, the Board considers that it was proportional and targeted. The decision to carry out an engagement on a single proposal is also understandable given the apparent overwhelming clinical consensus for option 6.

61. The outcomes of the engagement process show that respondents were largely positive about the proposals, particularly amongst those who attended engagement events and meetings where clinicians were able to demonstrate the clinical evidence. The engagement did highlight areas of concern around access for patients and carers at the RSCH, and the Board welcomes the changes made by BSUH to address these concerns following the temporary divert. The Review Board recommends that these changes are included as part of the permanent HASU. The Board would also expect dialogue with patients and carers to continue, and further changes made to accommodate their needs where possible.

62. Having considered the evidence, the Board makes the following recommendations in relation to the proposals to reconfigure stroke services in the Central Sussex area.

Recommendations

1. The Board supports the reconfiguration of stroke services in the Central Sussex area and agrees that option 6 – the development of a fully compliant HASU with a co-located ASU at RSCH – is the preferred option.

2. The Board supports the current plan for a new 30 bed HASU as part of the 3Ts redevelopment and recommends that the option to increase it to 34 beds is implemented depending on the outcome of the review of stroke services in West Sussex.

3. The Board recommends that the changes made to improve access for carers and relatives at the temporary HASU become a part of the permanent HASU – in order to accommodate the concerns of some patients and carers about travel, parking and access at the RSCH site. The Board also recommends that dialogue with patients and carers continues.

4. The Board recommends that BSUH recruits the necessary additional staff to the HASU as soon as is reasonably practicable to ensure that there are sufficient staff to provide a 24/7 service safely, effectively and sustainably.

Appendix

Scope and terms of reference

The Review Board will consider whether the proposals to reconfigure stroke services in the Central Sussex area are in the best interests of the residents of East Sussex.

Before reaching its conclusion, the review board should satisfy itself that it has considered the following lines of enquiry:

- Whether the preferred option is the only viable option, for example:
- Whether RSCH has sufficient capacity and capability to accommodate the centralised stroke services
- How the preferred option will impact on travel times for patients and access for carers.

The HOSC Review Board will not consider:

- stroke services provided by East Sussex Healthcare NHS Trust (ESHT) because the reconfiguration has already been implemented.
- the Coastal West Sussex Stroke Programme Board's stroke service proposals, as they do not directly affect residents in East Sussex.

The Review Board will report its findings to the full HOSC at its 27 March 2017 meeting. The Committee will then decide whether to agree the recommendations of the Board.

Review Board Members

Councillor Colin Belsey

Councillor Angharad Davies

Councillor Johanna Howell (Wealden District Council representative)

Councillor Ruth O'Keeffe (Chair)

Councillor Mike Turner (Hastings Borough Council representative)

Review Board meeting dates

12 December 2016

- Adopted the terms of reference of the review
- Considered the clinical case for change
- Considered the proposed communication and engagement strategy

23 February 2017

- Considered the outcome of the public engagement
- Considered the proposals for staffing at the Hyper Acute Stroke Unit (HASU)

Witnesses

Dr Nicky Gainsborough, Stroke Consultant, Brighton & Sussex University Hospital NHS Trust (BSUH)

Ashley Scarff, Head of Commissioning and Strategy, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG)

Caroline Huff, Clinical Programme Director, Central Sussex and East Surrey Alliance

Dr Yvonne Underhill, GP Clinical Lead for Stroke, High Weald Lewes Havens Clinical Commissioning Group (HWLH CCG)

List of documents considered by the Review Board

Analysis of the options for the reconfiguration of Brighton and Sussex University Hospital NHS Trust's stroke services, High Weald Lewes Havens Clinical Commissioning Group, 2016
BSUH Stroke workforce, High Weald Lewes Havens Clinical Commissioning Group, January 2017
Central Sussex Stroke Review Communications and Engagement Strategy, High Weald Lewes Havens Clinical Commissioning Group, 2016
Central Sussex Stroke Review Engagement feedback report, High Weald Lewes Havens Clinical Commissioning Group, 10 February 2017
"Fewer but better clinics 'will save more stroke victims'", The Guardian, 4 February 2017
Getting it Right First Time Vascular Surgery BSUH Feedback report, Department of Health, 23 June 2016
Improving your stroke services, High Weald Lewes Havens Clinical Commissioning Group, 2016
Report for Central Stroke Programme board, South East Coast Ambulance NHS Foundation Trust (SECAmb), February 2017
Report to HOSC: Sussex Stroke Review, High Weald Lewes Havens Clinical Commissioning Group, 29 September 2016
Review of proposals for future stroke services in Sussex, South East Clinical Senate, December 2015
Royal Sussex County Hospital (RSCH) inspection report, Care Quality Commission (CQC), August 2016 (Extract on the Stroke Unit Donald Hall and Soloman Wards)
Sentinel Stroke National Audit Programme (SSNAP) Data for Brighton & Sussex University Hospital NHS Trust (BSUH) October 2015-July 2016, 2016
Visual change in treatment timeline: HWLH CCG patients from PRH to RSCH, High Weald Lewes Havens Clinical Commissioning Group, February 2017

Contact officer for this review:

Harvey Winder, Democratic Services Officer

Telephone: 01273 481796
E-mail: harvey.winder@eastsussex.gov.uk

East Sussex County Council
County Hall
St Anne's Crescent,
Lewes BN7 1UE