AGENDA

Joint Health Scrutiny Committee - BNSSG

Date: 15 November 2021
Time: 10.30am
Venue: Kingswood Civic Centre

Distribution:

Bristol City Council Health Scrutiny Committee Councillors: Jos Clark, Paul Goggin, Tom Hathway, Mohamed Makawi, Brenda Massey, Graham Morris, Chris Windows

North Somerset Health Scrutiny Committee Councillors: Caroline Cherry, Ciaran Cronnelly, Sandra Hearne, Ruth Jacobs, Huw James, Timothy Snaden, Roz Willis
South Gloucestershire Health Scrutiny Committee Councillors: April Begley, Liz Brennan, Robert Griffin, Shirley Holloway, Trevor Jones, John O'Neill, Sarah Pomfret

Issued by: Julia Parkes
Tel: 01454 865428
E-mail: julia.parkes@southglos.gov.uk

Date: 4 November 2021

OTHER LANGUAGES AND FORMATS

This information can be made available in other languages, in large print, braille or on audio tape. Please phone 01454 868009 if you need any of these or any other help to access Council services.

AGENDA

1. COVID-19 - Guidance on attending meetings

PUBLIC HEALTH GUIDANCE FOR ATTENDEES AT PUBLIC MEETINGS

We have taken guidance from our Public Health team to inform our approach relating to attending public meetings recognising that the risks of Covid19 have not disappeared. This means that when you attend Kingswood Civic Centre for public meetings you will be encouraged to follow a number of rules and common-sense steps to minimise the risks to everyone and these are set out below.

You must not attend meetings if you have covid19 symptoms and must follow government guidance. It remains a legal requirement to self-isolate if you test positive for covid19.

You must not attend if you have come into contact with an individual who is COVID-positive or suspected.

Lateral Flow Tests

We encourage you to prior to attending public meetings to take a lateral flow test. These can be ordered for free from https://www.gov.uk/order-coronavirus-rapid-lateral-flow-tests. If you test positive you **must not** attend the meeting.

Face Coverings

Whilst the legal requirement to wear face coverings and social distancing has been lifted the Government expects and recommends that people wear face coverings in crowded areas. It is a personal decision, but masks reduce the chances of passing on the virus to other people and we support the guidance offered by Professor Chris Whitty who advised that people should consider wearing masks:

- in any situation that is indoors and crowded, or indoors with close proximity to other people.
- if required to wear a mask by any competent authority.
- if someone else is uncomfortable with you not wearing a mask, then common courtesy would mean putting on a face covering.

Therefore, the Council will expect you to continue to wear face coverings when moving around the meeting spaces and when using communal areas and public spaces within our buildings. It is not a requirement to wear a face covering when seated. However, the 2metre social distancing between individuals in the Council chamber may not always be possible, and therefore you may wish to continue wearing a face covering when seated, although this will be a personal choice.

One Way Systems and Ventilation

Whenever possible the Council Chamber and Committee Room 1 will be combined to

enable a one-way system to be used. Please follow one-way systems where they remain in place. Adequate ventilation in the chamber and committee rooms will be in place when meetings are taking place.

Cleaning and Sanitising

An enhanced level of cleaning will take place in council buildings. Please use the sanitising wipes provided in the public meeting rooms to wipe down surfaces before and after use. Maintain good hand hygiene – using sanitiser provided when entering buildings and regular hand washing.

Refreshments

Please bring your own water or other appropriate refreshments and take away any rubbish with you following the meeting.

2. Welcome and Introductions

3. Evacuation Procedure

If the fire alarm siren sounds, leave by the fire exit door in the Council Chamber, go down the staircase and assemble in the staff car park at the rear of the Civic Centre. If access to this fire exit is unavailable, there is a secondary fire exit route through the training suite corridor and down the staircase to the front of the building. Do not run or use the lifts. If you have mobility problems tell the Democratic Services Officer who will assist you.

4. Apologies for Absence

The Joint Committee to note apologies for absence and substitutions.

5. Declarations of interest

To note any declarations of interest from Councillors. They are asked to indicate the relevant agenda item, the nature of the interest and in particular whether it is a disclosable pecuniary interest

6. Chair's Business

To note any announcements from the Chair.

7. Minutes of the Virtual Meeting held on 15 March 2021 (Pages 7 - 12)

Minutes to be checked for accuracy and signed by the Chair (attached)

8. Public Forum (Pages 13 - 14)

The total time allowed for this item is 30 minutes.
Members of the public and members of council may participate in Public Forum.
The detailed arrangements for so doing are set out in the **Public Information Sheet** at the back of this agenda.
Public Forum items should be emailed to julia.parkes@southglos.gov.uk and please note that the following deadlines will apply in relation to this meeting:-
Petitions, Statements and Questions – must be received, no later than, the working day prior to the meeting. For this meeting, your submission must be received in this office, no later than **12.00 noon on Friday 12 November 2021.**

9. BNSSG Stroke Programme (Pages 15 - 112)

10. Integrated Care System (ICS) Progress Update (Pages 113 - 134)

Minutes

of the Virtual Meeting of

The Joint Health Overview and Scrutiny Committee

Monday, 15 March 2021

Virtual Meeting

Meeting Commenced: 11.15 am Meeting Concluded: 1.25 pm

Councillors:
North Somerset Council (NSC): Ciaran Cronnelly (JHOSC Chair for the meeting); Caroline Cherry; Ruth Jacobs; Huw James; Timothy Snaden; Roz Willis

Bristol City Council (BCC): Brenda Massey (BCC HOSC Chair); Harriet Clough; Eleanor Combley; Gill Kirk;
Apologies: Paul Goggin; Celia Phipps; Chris Windows

South Gloucestershire Council (SGC): Sarah Pomfret (SGC HOSC Chair); Robert Griffin; Shirley Holloway; John O'Neill; Matthew Riddle
Apologies: April Begley

Councillors also in attendance: Asher Craig BCC; Shirley Holloway (Thornbury Town Council),

Council officers: Christina Gray (Director of Public Health, BCC), Sara Blackmore (Director of Public Health SGC), Gill Sinclair (Deputy to the Head of Legal Governance and Democratic Services SGC), Leo Taylor (Scrutiny Officer, NSC), Dan Berlin (Scrutiny Advisor BCC), Brent Cross (Scrutiny Officers NSC), Neil Young (Democratic Services SGC).

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG): Becky Balloch (Communications and Engagement Lead), Rebecca Dunn (Deputy Director of Transformation), Sebastian Habibi (Programme Director, Healthier Together), Robert Jones (Quality Improvement and Engagement Manager/Stroke Association), David Moss (Head of Primary Care Contracts), Rebecca Murch (Head of Internal Communication), Dr Phil Simons (Primary Care Clinical Lead), Michelle Smith (Communications Lead), Fritha Voaden (Insights and Engagements Officer), Alex Ward-Booth (Communications and Engagement Lead), Jeremy Westwood (Project Manager)

North Bristol Trust: Chris Burton (Medical Director, North Bristol Trust), Dr Phil Clatworthy (Clinical Lead), Anthony Dorman & Liz Perry (BNSSG Stroke Programme Leads). Vicky Mathias (External Comms)

University Hospitals Bristol and Weston: Dr Clare Holmes (Clinical Lead)

Other representation: Esme Mutter (Stroke Association), Chris Priestman (Stroke Health Integration Team), Chris Priestman and Professor Stephen Hill (Lived Experience Representatives), Phillipa Cozens (Sirona Care & Health)

1 Welcome and Introductions

The Chairman welcomed all present.

2 Declarations of interest

None.

3 Chair's Business

There was no Chair's Business.

4 Minutes

Resolved: that the minutes of the meeting on 25th October 2019 be approved subject to the following typographic correction: a reference in Minute 3 to a local hospital be amended to read "Thornbury Hospital".

5 Public Forum

There were no items referred to the Committee under Public Forum.

6 Proposed amendment to the Joint Committee's Terms of Reference (ToR)

Resolved: that the proposed minor amendments to the Committee's Terms of Reference, as set out on the agenda, be adopted.

7 BNSSG Stroke Programme

Chris Burton (Medical Director NBT and Chair for the BNSSG Stroke Programme Board) in introducing the presentation on the Stroke programme, emphasised the partnership approach taken to the development of the programme which brought together a diverse range of people around a shared vision for future stroke care in the region. These included: key clinicians; the charitable sector; social care staff and service managers; and people with lived experience.

The presentation was structured around the following four aims:

- to share progress on the BNSSG Stroke Programme;

Members received an outline of the challenges associated with strokes; the programme vision for stroke care; national evidence; the case for change; the co-design/partnership approach to programme development; and the emergent engagement themes. This part of the presentation also included representation from two participants in the "lived experience group", whose personal experience had contributed to guiding the development of the programme.

- to seek JHOSC feedback on the plan for public consultation;

- to seek JHOSC feedback on the draft evaluation criteria for decision-making; and
- to agree how JHOSC would like to engage with the proposals for change once approved for consultation by the BNSSG CCG Governing Body

Before inviting Members comments and queries on the presentation, the Chairman thanked the team for the comprehensive and detailed presentation and particularly welcomed the open and frank contributions from the lived experience group representatives.

The Stroke Programme team responded to Members' comments and queries as follows:-

a) Had the team factored-in post-covid issues such as blood clots and other cardiology issues? - *These problems presented early and had already been picked up in the programme.*

b) Parish & Town Councils needed to be involved in the consultation, together with local resident groups and the farming community – *This would be taken into account;*

c) Would any weighting be attached to the evaluation criteria? – *It was likely that a combination of quantitative and qualitative factors would be used in the evaluation. A group had been established, as part of the governance structure, with oversight of the evaluation process.*

d) The clear focus on prevention was welcomed: was this something that BNSSG was leading on or working with Public Health and if so, what would this look like? - *They were still working with partners on this. It would build on work already going on in Primary Care around, for example, lifestyle, hearty rhythm disturbances, public health lifestyle measures etc).*

e) It made sense for hyperacute services to be focussed where there was expertise but were there any concerns around services being moving away from local hospitals and anticipated difficulties convincing local communities of the need for these changes? - *There was a shortage of workforce with the required skills. Clinical evidence and NICE Guidance were that workforce should be consolidated to maximise available skills. Proposals to move care were necessary if the programme ambitions were to be achieved and they were carefully considering how best to introduce this into the conversation going forward. Where distances were greater such as in North Somerset, the focus was around quicker transport and "equalling out" travel time where possible.*

f) Given the critical importance of treating stokes in the first hour, were there lessons that could be learnt from the Scottish Highlands were "clot busting" injections could be administered by paramedics? - *unlike the situation with heart attacks, in the case of Haemorrhagic stokes, a brain scan would be required first to avoid making matters worse. There were significant challenges around equipping ambulances with CT scanners.*

g) Had consideration been given to the needs of people with leaning difficulties – *They were in touch with leads in the community, the acute providers. and learning disability teams to establish links with key stakeholders. It was*

recognised that focus was needed around planning discharge and this was being taken into account in the planning of out-of-hospital services.

h) Inequality maps showed significant pockets of depravation in Bristol and North Somerset. Members wanted assurance around the development of mitigation proposals and the extent of the work around prevention – *the guiding principle underpinning the programme was maximising access for the whole population. Location, travel times and deprivation effects were all key considerations and built into the decision-making criteria. Prevention also a workstream of its own so would have proper focus across all factors. Members would have an opportunity to scrutinise these plans when recommendations were brought forward.*

In concluding discussions it was:-

Resolved:

(1) that the update report and progress made by the BNSSG stroke programme in planning for consultation be noted;

(2) that the plan for public consultation, taking into account the flexibilities that may be required in delivering the consultation in the context of the pandemic and any other government restrictions at that time, be supported;

(3) that the draft evaluation criteria developed for the decision-making process be supported;

(4) that the proposed process, involving discussion with the JHOSC, for fixing a date by which the JHOSC must provide comments on any proposals arising from the consultation, be noted; and

(5) that, in confirming how the JHOSC would like to be consulted with on our proposals once the decision to consult has been made, it be agreed that a workshop be arranged by the CCG during the consultation phase (between June and September 2021).

8 Bristol and South Gloucestershire Community Surge Testing

Christina Gray (Director of Public Health BCC) and Sara Blackmore (Director of Public Health SGC) presented the report updating Members on the extraordinary work of the Bristol and South Gloucestershire local authorities, local communities and partners around the recent community surge testing and analysis undertaken between 7th and 15th February in response to the recent emergence of known variants of concern of the Covid-19 virus in the Bristol and South Gloucestershire areas.

Members noted the following recommendations set out in the report:-

- that we should expect, and prepare for, the emergence of changes in the virus;
- that case identification and isolation of case and contacts remains the most important action in containing the virus;
- that local authorities will need to maintain capacity and capability to support outbreak management and to support individuals to isolate; and

- that it will continue to be important to support national and global efforts to understand and enable science to “stay ahead” of the virus. This may well require the collection of additional case samples to support this effort.

Resolved: that the report and recommendations set out above be noted.

9 Integrated Care System (ICS) Progress Update

Sebastian Habbibi (programme director Healthier Together Partnership) and David Moss (Integrated Care Partnership Discovery Programme Director) presented the report providing an update on the ICS programme. The report covered:

- ICS designation and continuing evolution of partnership working;
- structural implications of the Government white paper: ‘Integration and Innovation: working together to improve health and social care for all;
- progress on formalising how we will work together through the development of a Memorandum of Understanding; and
- ICS work at “place” level – the integrated Care Partnership Discovery Programme

Members raised the following points (with responses shown in italics): -

a) There were considerable uncertainties about: the future shape of the ICS, particularly around social care funding; the role of local authorities and democratic accountability; and the question of whether the Government ends competitive procurement. The report indicated that further conversations were needed before the legislation was enacted. Were those opportunities being offered by Government/officials? - *to some extent yes though the draft bill had not yet been published. Links were being provided to NHS England officials (on behalf of the Department of Health and Social Care) who had been identified as leading on the development of guidance around key issues such as governance, new financial framework for ICSs, and workforce development etc.*

b) There were also considerable concerns about budgets and these might be pooled or shared. It was noted that there were plans for the ICS to be in place as shadow form from April. How would this happen without clarity on funding? - *the notion of shadow running within April next month specifically related to the Integrated Care Partnerships and providers at “place” level. This was mostly about reaching an understanding with providers on footprints and the specifics of community mental health. Assurance was given that there was no expected changes to the current financial regime in the 2021-22 financial year. At high level, the understanding was that local government would continue to hold statutory responsibility (and funding) for social care and a new ICS body would hold responsibility for Health budgets (expanded to include some of budgets currently held by NHS England, notably budgets for local primary care and some specialised services.*

In concluding discussions, a view was put that Members required much more clarity going forward and it was formally requested that regular updates be provided to Members as negotiations progressed.

It was also requested that it be formally noted that, for accountable Councillors

serving local residents, there was considerable concern and dissatisfaction with the process as it was currently unfolding.

Before closing the meeting, the Chairman agreed that these concerns be formally recorded in the minutes.

Chairman

Joint Health Overview and Scrutiny Committee
Public Information Sheet

Petitions, Statements and Questions

Members of the public and members of council, provided they give notice in writing or by electronic mail to the proper officer of the host authority (and include their name and address and details of the wording of the petition, and in the case of a statement or question a copy of the submission), by no later than 12 noon of the working day before the meeting, may present a petition, submit a statement or ask a question at meetings of the committee. The petition, statement or question must relate to the terms of reference and role and responsibility of the committee.

The total time allowed for dealing with petitions, statements and questions at each meeting is thirty minutes.

Statements and written questions, provided they are of reasonable length, will be copied and circulated to all members and will be made available to the public at the meeting

There will be no debate in relation to any petitions, statements and questions raised at the meeting but the committee will resolve;

(1) "that the petition / statement be noted"; or
(2) if the content relates to a matter on the agenda for the meeting:
"that the contents of the petition / statement be considered when the item is debated";

Response to Questions

Questions will be directed to the appropriate Director or organisation to provide a written response directly to the questioner. Appropriately redacted copies of responses will be published on the host authority's website within 28 days.

Details of the questions and answers will be included on the following agenda.

Joint Health Overview and Scrutiny Committee

15 November 2021

Report of: BNSSG Stroke Programme

Title: Thematic Report: BNSSG Stroke Public Consultation

Ward: BNSSG

Officer Presenting Report: Chris Burton (Stroke Programme Senior Responsible Officer and Medical Director, North Bristol NHS Trust) & Sian Barry (Stroke Programme Director, BNSSG CCG)

Contact Email Address: Jeremy.westwood@nhs.net / Sian.barry@nhs.net

Recommendation
The committee is asked to:

1. Note this update report and the progress made by the BNSSG stroke programme
2. Note the activity delivered and the feedback and key themes heard from the public consultation, as described in the independent thematic report
3. Consider whether the committee supports it as a full and meaningful consultation, particularly considering flexibilities required in delivering the consultation in the context of the pandemic and any government restrictions at that time
4. Confirm JHOSC are content to provide a formal response to the consultation to commissioners, as per Section 244 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and under The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013) by 29th November 2021
5. Note the development of the DMBC and associated next steps for the stroke review programme

Overview

Recommendation 1.
The Bristol, North Somerset & South Gloucestershire (BNSSG) Stroke Programme has galvanised stakeholders from all backgrounds and professions around a shared vision for

stroke care for the future; a vision for everyone in BNSSG to have the best opportunity to survive and thrive after stroke.

There are compelling reasons to change the provision of stroke care in BNSSG:

- Demand for stroke care is increasing by 3-5% every year and the specialist stroke workforce available to provide care is limited.
- The provision of stroke services varies depending on where people live in BNSSG.
- Outcomes for people that have a stroke in BNSSG vary depending on where they receive treatment and our current service provision does not consistently meet national standards.
- NHS commissioners have a responsibility to ensure that every pound spent on behalf of tax payers offers as much health benefit to the population as possible and the way stroke services are currently organised and configured does not consistently deliver that.

To address the case for change, clinicians of all professions, people with lived-experience of stroke, voluntary sector workers, social care staff, and service managers have been working together to redesign the stroke service provided to people in BNSSG. They have worked to produce evidence-based proposals directly in line with the draft National Stroke Service Specification with the aim of ensuring that everyone in BNSSG will benefit from life-changing treatment in a specialised hyper-acute stroke unit, usually in the first 72 hours following a stroke.

Clinicians, patients, and health and care leaders are also looking at how best to improve community-based stroke support across BNSSG. Our ambition is for a new integrated community stroke service that will support the delivery of the proposals for hospital care and, most importantly, ensure that everyone in the BNSSG area has improved, and equal, access to rehabilitation care at home and in the community following a stroke.

On 15 March 2021, the Stroke Programme engaged with JHOSC to share the proposed consultation plan, outline proposals and draft evaluation criteria. This meeting noted the progress made in planning for consultation and supported the plan for public consultation; the meeting further supported the draft evaluation criteria.

The JHOSC noted the proposed process involving discussion with the JHOSC for fixing a date by which the JHOSC must provide comments on the proposals from the consultation and agreed that a workshop be held during the consultation period (June to September) for the JHOSC to review the consultation proposals.

The BNSSG programme team developed a Pre-Consultation Business Case (PCBC) that described proposals for reconfiguring stroke services across the BNSSG area. This was approved by the BNSSG CCG Governing Body on 1 June 2021. The Governing Body approved the proposals for public consultation and to undertake formal consultation with Bristol, North Somerset and South Gloucestershire local authorities, through the JHOSC, on the proposals and options for change as set out in the PCBC.

A workshop for JHOSC members was held on 11 August 2021. The BNSSG programme teamreminded JHOSC members of the consultation proposals and presented an interim report of the consultation progress. This included an overview of the process and events undertaken, other methods of engagement, and the monitoring of responses in accordance with the Equalities Impact Assessment developed for the consultation.

A copy of the public consultation document is appended as Appendix 1 to this report. A full set of consultation documents including FAQs is available on the BNSSG Stroke Consultation website: https://bnssghealthiertogether.org.uk/stroke-services/

The public consultation was delivered between 7 June and 3 September 2021. Since then we have commissioned an independent analysis of the responses to the consultation to carefully review and report on the views and feedback we have heard. The full independent Thematic Review of the consultation is appended to this report as Appendix 2.

Recommendation 2.
BNSSG CCG entered a 12-week period of formal consultation on proposals to improve stroke services on 7 June 2021.

The Stroke Programme team developed the materials required for public consultation supported by external expertise and with full engagement of members of the Programme Board and particularly the representatives with lived experience of stroke services. A detailed consultation strategy and Equality Impact Assessment (EIA) were developed to support the consultation exercise.

Consultation activity was comprehensive across the catchment area, focused on engaging those most impacted by the proposals, those with lived experience of stroke – patients and carers, the seldom heard, staff, those with protected characteristics under the equalities' legislation, community groups and stakeholders. A range of methodologies was used to inform local people about the proposals and to gather their views and feedback. The consultation was delivered in the context of the Covid pandemic and was delivered in accordance with government regulations in place at the time. It embraced a mix of digital and non-digital channels recognising that people like to, and are able to, engage in different ways. Activity included a mix of publicity and awareness-raising, listening events, focus groups, a survey, telephone polling, sharing of information, correspondence, social media discussion, and attendance at meetings and groups to talk through the proposals.

A total of 1,833 responses (representing 2,202 individuals) were received from a representative population sample including members of the public, people working in health and social care, organisations and interested parties such as organisational stakeholders.

An independent organisation, The Evidence Centre (TEC) was commissioned to analyse and report the key themes from the public consultation. The Final Thematic Report, attached as Appendix 1 presents a detailed analysis of the responses received and themes from the consultation.

Detailed themes are outlined across each key element of the proposals, but a number of overarching themes emerge:

- Support for the vision for stroke care for BNSSG including the community service
- A desire for more of each type of specialist unit
- Travel – time and transport issues, also for families and carers
- Capacity for a large geographical area and population.

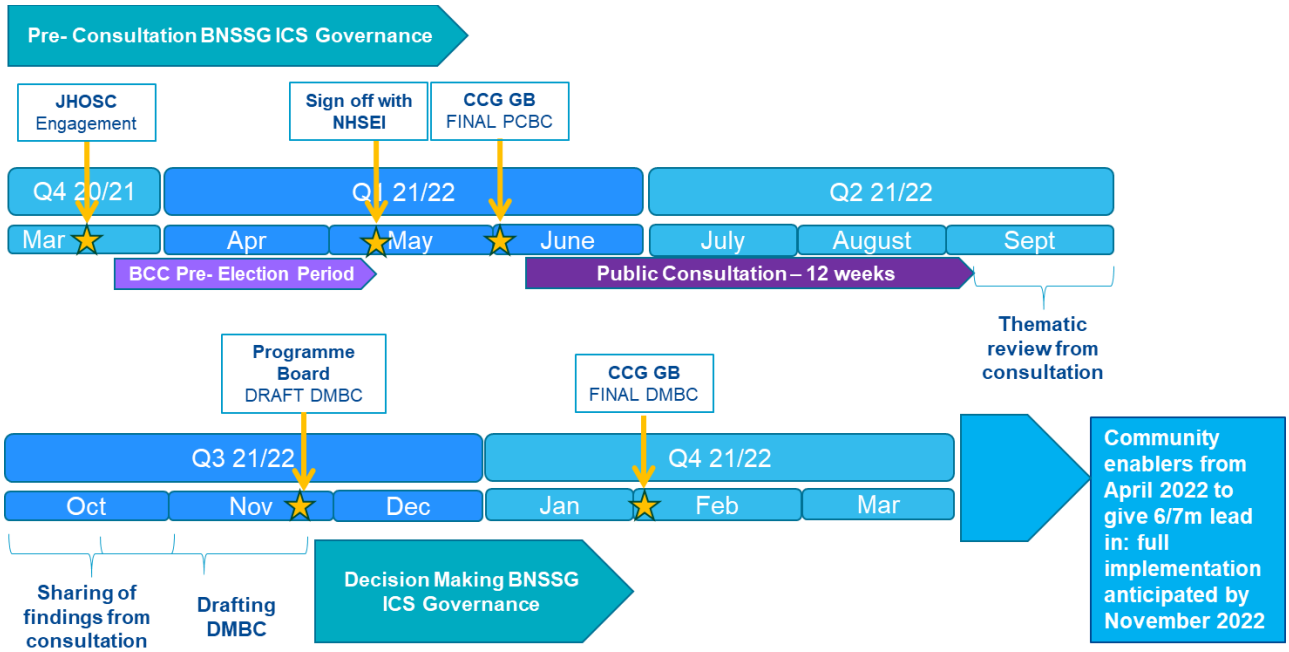
Recommendation 3.
We are pleased to share the outcome of our public consultation with JHOSC through the thematic report. We look forward to receiving JHOSC's own response to our consultation with members once they have had an opportunity to consider the report and its findings, alongside other evidence, information, and updates shared with JHOSC over the course of the programme. We would welcome JHOSC's feedback on the proposals as per Section 244 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and under The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013) by **29th November 2021**.

Recommendation 4.
The Stroke Programme team will now develop the Decision-making Business Case (DMBC) for review and consideration by the BNSSG CCG Governing Body. This will be based on the evidence compiled in the Pre-Consultation Business Case (PCBC), feedback from consultation, and further evidence compiled post-consultation. The responses to the consultation will be carefully considered as part of developing the DMBC, alongside clinical, quality, workforce, financial, estate and other information gathered as part of the stroke services review. We will undertake further evaluation of our options and recommend mitigations to reduce any negative impact the proposed changes could have. We will seek to ensure that progress to decision-making and implementation is fully informed by detailed analysis and consideration of the available data and evidence.

The final DMBC will be presented to the CCG Governing Body for decision at their February 2022 meeting.

The high level timetable for the BNSSG Stroke Programme can be seen in Figure 1 below.

Figure 1. Timeline for the BNSSG Stroke Programme



We will continue to keep JHOSC updated and provide regular updates and information to members as we progress through the decision-making and then implementation phases of our work.

Healthier **Together**

Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS

Improving stroke services in Bristol, North Somerset and South Gloucestershire

Have your say: 7 June to 3 September 2021

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group – who are we?

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) is responsible for planning and buying health services for the 1 million people who live in our area. BNSSG CCG is carrying out this public consultation on behalf of our wider Healthier Together Partnership of ten local health and care organisations.

Over the last two years we have worked with more than 500 people to look at ways to improve stroke services. These include:

- People who've had a stroke, their carers and families
- Doctors, nurses, therapy staff, and health and social care professionals
- Local councils
- Charities like The Stroke Association and Bristol After Stroke
- Members of the public.

Research and insight has informed the proposals set out in this booklet and now we would like people to have their say as part of this public consultation.

This booklet summarises the changes BNSSG CCG proposes and why. You can find out more about who we are at https://bnssgccg.nhs.uk/

You can read more about the consultation at bnssghealthiertogether.org.uk/stroke-services/

Contents

This document sets out proposed changes to stroke services in Bristol, North Somerset and South Gloucestershire. It focuses on services at Weston General Hospital, Bristol Royal Infirmary and Southmead Hospital.

Following consultation and once a decision has been made by the Governing Body of BNSSG CCG; the changes could be put into place over a 12-month period.

Introduction

Stroke is a serious, life-threatening condition that affects around five people in our area every day. One in eight people who have a stroke will die within a month, and two thirds leave hospital with a disability[1].

With the right specialist treatment, care and support, people can go on to live full and independent lives. We are proposing to change the way stroke services are organised and run in our area, so that everyone in Bristol, North Somerset and South Gloucestershire will have the best opportunity to survive and thrive after stroke.

Our vision – designed in partnership with people and communities – is an ambitious one. Under our proposals, we would bring our specialist teams and resources together, to improve people's care and outcomes and achieve the latest clinical quality standards. Everyone would have access to highly specialised treatments immediately on arrival in hospital, 24 hours a day, 7 days a week, wherever they live.

Over the last two years, we have reviewed the latest national evidence, and engaged with more than 500 people in our community. Our proposals have been co-designed with people including senior doctors, frontline stroke services staff, people who have experienced stroke, and those from partner organisations.

The proposals support the NHS Long Term Plan to make the NHS fit for the future, and to get the most value for patients. These proposals also build on the stroke prevention and longer term rehabilitation programmes already underway, and represent an exciting opportunity to improve survival and recovery rates for people affected by stroke in Bristol, North Somerset and South Gloucestershire.

Now we need to hear from you on the proposed changes. This is the opportunity to have your say and help us to transform stroke care for everyone in our area and ensure a high-quality and sustainable service for the future.

Dr Jonathan Hayes
Clinical Chair
of BNSSG CCG

Julia Ross
Chief Executive
of BNSSG CCG

1 What is a stroke?

A stroke is a life-threatening medical condition that occurs when the blood supply to part of the brain is cut off, either from a clot or if a blood vessel in the brain bursts (also known as a haemorrhage).

Stroke is a life-changing event, and a leading cause of death and disability in the UK. The NHS Long Term Plan set outs the ambitions for the NHS over the next 10 years, identifying stroke as a national clinical priority.

We share this ambition and want everyone in our area to have the best opportunity to survive and thrive after stroke.

With advances in treatment becoming increasingly specialised, we can improve the way our services are organised, preventing more stroke deaths each year. We can also reduce time spent in hospital so that more people can get home and live more independently, faster. Our aim is to ensure that everyone receives high-quality hospital care and ongoing help to live with the lasting physical, emotional and psychological effects of stroke.

Did you know?

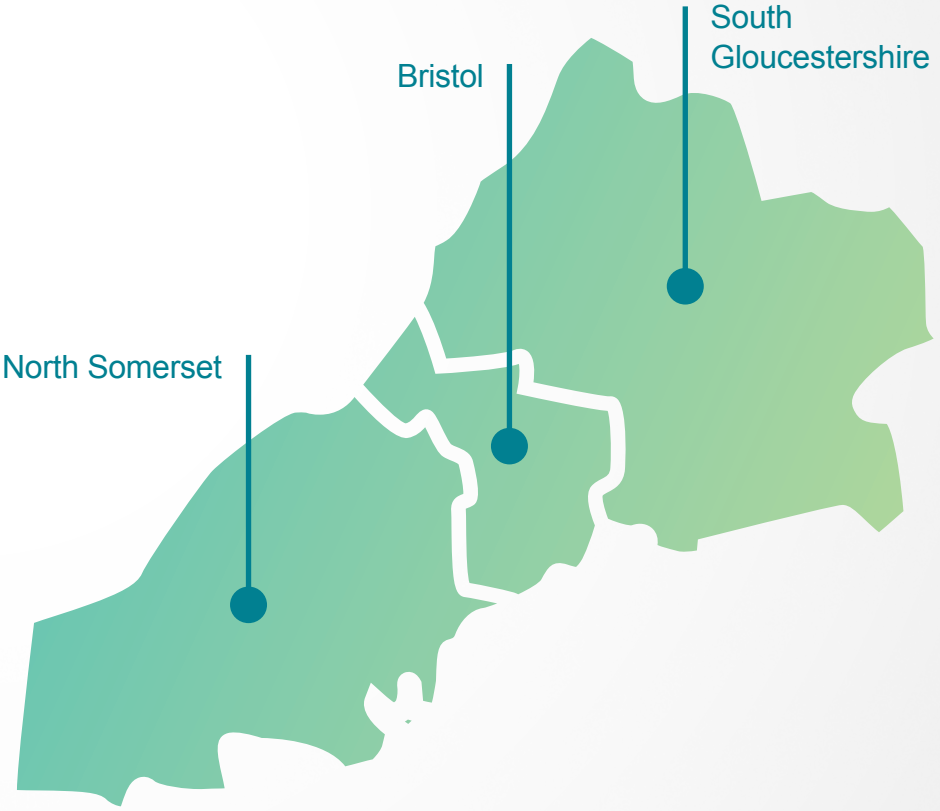
Around
1 in 50
people (approx. 18,700) in our area live with the long-term effects of a stroke, such as physical disability or cognitive impairment.

1 in 8
people who have a stroke die within a month

1 in 4
die within a year

Each year, around
1,500
people in Bristol, North Somerset and South Gloucestershire (BNSSG) have a stroke. That's around 5 people each day and this number is set to rise as the population continues to grow and people live longer.

Stroke affects people of all ages



Stroke has significant long term impacts

2 in 3
people who have a stroke leave hospital with a disability

Around
3 in 4
stroke survivors have weakness in an arm or leg

2 in 3
have problems seeing and half find it hard to swallow

1 in 3
find it hard to speak

1 in 2
have problems with vision[2]

Thanks to a combination of better prevention, and earlier and more advanced emergency treatment and care within 72 hours of a stroke, many more people are surviving and making a good recovery. There are also things we could do differently to give everyone in our area the best opportunity to survive and thrive after stroke.

The Ambulance Service and hospital teams saved my life when I had a stroke. We have first class doctors, nurses and paramedics. I had to stay in hospital much longer than I needed and I didn't get much help after I left except from the voluntary sector. It felt like I fell off the edge of a cliff."

Stephen, stroke survivor

How does the NHS currently care for people who've had a stroke?

There are five recognised stages of treatment and care for stroke.

Prevention
focuses on reducing factors that put people at risk of having a stroke, like high blood pressure.

Emergency treatment
for people with a suspected stroke or immediately after a stroke, usually in the first 72 hours, and where people have surgery if needed.

Ongoing acute hospital treatment and care
for those who need it with specialist staff who are experts in stroke and supporting people until they are well enough for the next stage of care.

Inpatient rehabilitation
(on a hospital site or in the community) for those who need additional specialist treatment and rehabilitation after the emergency and acute hospital stages.

Community care and life after stroke
ongoing treatment and care can be provided at home (or a care home) and at a variety of community based facilities, such as physio centres, gyms or community hubs, in the area where people live, and depending on the support required.

We're already taking action on **prevention** and improving **community care and life after stroke**. You can read more about our new Integrated Community Stroke Service on page 28.

We are seeking the public's views on emergency treatment, ongoing hospital treatment and inpatient rehabilitation services as part of this consultation.

How do we currently care for people who've had a stroke in our area?

At the moment, hospital stroke care differs across a number of locations in Bristol, North Somerset and South Gloucestershire, depending on where people live and when they require care.

Not all services are available all of the time and this can impact on an individual's long-term recovery.

- National guidelines[3] say everyone should be able to get emergency treatment and the most advanced care immediately at a specialist Hyper-Acute Stroke Unit (HASU).

  A HASU provides emergency treatment for people with a suspected stroke or immediately after a stroke, usually in the first 72 hours. Patients have surgery in the HASU if needed.

- We don't have a specialist HASU unit in our area, and instead people who have a stroke or a suspected stroke are taken to the closest hospital:

  – Bristol Royal Infirmary (8am – 11pm 7 days a week)

  – Southmead Hospital (24 hours a day / 7 days a week)

  – Weston General Hospital (9am-5pm Monday – Friday)

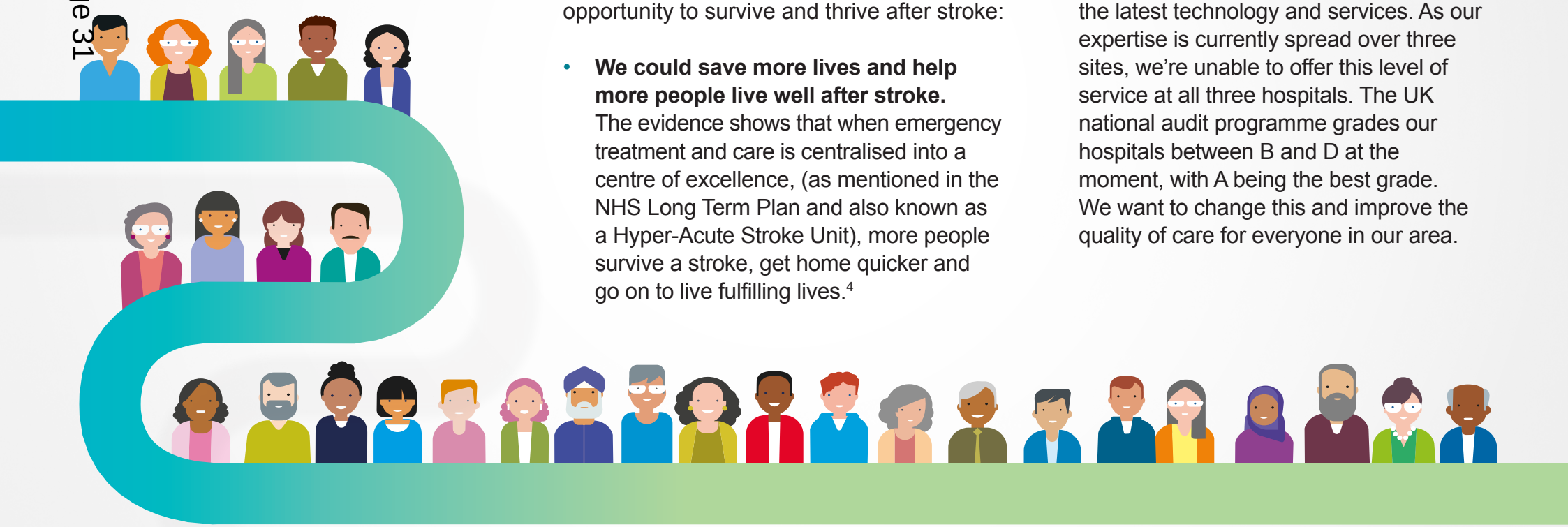
- People who need advanced emergency treatments, such as brain surgery, are always treated at Southmead Hospital. This means that while some people are taken to Bristol Royal Infirmary or Weston General Hospital first, once they are assessed, they could need to transfer to Southmead for specialist treatment.

- Due to increasingly specialised treatments and advances in care, as well as the limited number of specialist staff available, it is not possible for a specialist stroke team to be on three sites, 24 hours a day, 7 days a week. Therefore, after 11pm, Bristol Royal Infirmary automatically redirects ambulances with people who have had a suspected stroke to Southmead Hospital. Weston General Hospital does the same after 5pm and at weekends.

- After receiving emergency treatment, people are usually moved to an acute stroke ward to continue short-term treatment and care.

- Once well enough, rehabilitation (rehab) plays a significant role in helping people to regain their independence and live well after stroke. The length and type of rehab available currently varies. The availability of hospital and home-based rehab varies by location, and no area of Bristol, North Somerset and South Gloucestershire is able to provide 7 day a week access currently.

2 Why do we need to change stroke services in our area?



More people are at risk of having a stroke because our population is growing, getting older and living with more long-term health conditions.

Our healthcare teams work hard to provide high quality care. By organising our specialist care and resources into specialist units, we can give everyone the best opportunity to survive and thrive after stroke:

- **We could save more lives and help more people live well after stroke.** The evidence shows that when emergency treatment and care is centralised into a centre of excellence, (as mentioned in the NHS Long Term Plan and also known as a Hyper-Acute Stroke Unit), more people survive a stroke, get home quicker and go on to live fulfilling lives.[4]
- **Everyone could have access to our specialist teams and treatments 24 hours a day, 7 days a week.** This would happen regardless of where people live or what time of day or week they require treatment and care.
- **We could meet the National Standards for stroke care.** Increasingly, there are new and specialised treatments to reduce brain damage and disability after a stroke. These require highly skilled staff, and the latest technology and services. As our expertise is currently spread over three sites, we're unable to offer this level of service at all three hospitals. The UK national audit programme grades our hospitals between B and D at the moment, with A being the best grade. We want to change this and improve the quality of care for everyone in our area.

What changes are we proposing?

Our vision is that everyone in Bristol, North Somerset and South Gloucestershire has the best opportunity to survive and thrive after stroke, wherever they live. To achieve this, we're proposing three changes.

1. Improving emergency treatment

For everyone to be able to access highly specialised treatments straight away, 24 hours a day, 7 days a week. We propose taking everyone who has a stroke or a suspected stroke to a single **Hyper-Acute Stroke Unit (HASU)**. This is an emergency unit with specialist staff, equipment and technology.

2. Improving ongoing acute hospital treatment

For everyone who needs it, to receive ongoing hospital care in an **Acute Stroke Unit (ASU)**. This is a specialised stroke unit with staff who are specialists in caring for and supporting people who've had a stroke until they are well enough for the next stage of care. We are proposing that there are one or two Acute Stroke Units in our area.

3. Improving rehabilitation services

To provide specialist stroke rehab 7 days a week, whenever people are ready, ideally at home or when necessary in a specialist inpatient stroke rehab facility near to where they live. This would give everyone the best chance of fulfilling their goals and being as independent as possible after stroke.

For people who need additional specialist treatment and rehabilitation after the emergency and acute hospital stages but are not ready to return to where they live, we propose two specialist inpatient **Stroke Sub-Acute Rehabilitation Units (SSARU)** in different locations in our area.

We're already doing more to prevent stroke and improve care after people leave hospital or a inpatient rehab unit. Whilst not part of this formal consultation, we are also seeking feedback about the new Integrated Community Stroke Service. You can read more about this on page 20.

Proposal 1:

Improving emergency treatment

What would change?

Currently, ambulances take people who have a stroke or suspected stroke to their nearest hospital.

Not all hospitals have the latest specialist equipment and resources to provide the very best initial, emergency treatment and care. We would like to change this so that everyone who has a stroke or suspected stroke is taken by ambulance to a Hyper-Acute Stroke Unit (HASU) with specialist treatment and care available immediately.

We propose **Southmead Hospital** as the location for our HASU, as:

- Southmead Hospital already has the latest neuroscience facilities and equipment.
- More people in the area would have immediate access to a specialist team and the latest stroke treatment.
- Anyone who had a stroke while they were in another hospital in our area would be transferred to Southmead Hospital, unless they needed to stay at their original hospital for another medical reason. These people would be cared for by local teams who would have direct communications with the specialist stroke team at the HASU.
- Anyone who walks-in to Accident and Emergency (A&E) at the Bristol Royal Infirmary or Weston General Hospital would still be assessed and treated. If a stroke was confirmed, they would be transferred to Southmead Hospital where specialist treatment would be provided.

People living in Sedgmoor District (North of Somerset) are currently taken to Weston General Hospital. Under our proposals, Sedgmoor residents would be taken by ambulance to their nearest HASU, which is at **Musgrove Park Hospital**, Taunton. This would affect around 30 people a year. More information is in the Sedgemoor District Factsheet which accompanies this document.

Why do we need to change?

Research shows that people's health and quality of life improves when the most specialised stroke services are all in one place. A Hyper-Acute Stroke Unit (HASU) would provide immediate emergency treatment, 24 hours a day, 7 days a week, regardless of where people live.

- Evidence shows that survival rates could improve by 1%, meaning around 15 fewer deaths each year.[5]

- Neurological (brain and nervous system) and vascular (blood vessels) treatments are often required as part of emergency stroke treatment. Southmead Hospital is already the area's centre of excellence for treatment for these specialisms.

- Stroke survivors would be able to leave hospital quicker and live more independently after their stroke. Around thirteen people each year would be more independent a few months after stroke.[6]

"The proposed changes are in keeping with the NHS's intention to deliver the right care, in the right place, at the right time. National evidence shows the immediate transfer of patients to a specialist Hyper-Acute Stroke Unit, where specialist clinicians are able to provide the latest stroke treatments, improves patient outcomes such as minimising brain damage and reducing levels of disability.

"This single transfer to the proposed HASU would mean more patients have faster access to specialist emergency treatments, while significantly reducing the number of patients who require a transfer for specialist emergency treatments from one of the existing acute hospital sites. In addition, a single transfer would increase efficiency and the quality of services for the whole patient pathway – and ensure ambulances and paramedics are available for other 999 calls in the community."

Rhys Hancock, Senior Clinical Lead
South West Ambulance Service NHS Foundation Trust

- An increase in provision of a specialist treatment such as a 'thrombectomy'[7] would mean around 23 people leave Southmead Hospital with the same level of independence they had before stroke.[8]

- Around 57 people each year would avoid living permanently in a care home.[9]

- The creation of a HASU would enable staff to develop specialist knowledge and keep their skills up to date to help deliver the latest treatments and care.

Factors to consider:

Everyone would get the latest life-saving care and

7 in 10

people can reach Southmead Hospital by 'blue light' ambulance in just 30 minutes for immediate specialist care.

Analysis shows that ambulances can get those who need emergency treatment to Southmead Hospital within

45 minutes

which is within the recommended guidance of 60 minutes.

- Southmead Hospital can manage more people needing emergency treatment for stroke. Each week, around 19 people who would have gone to Bristol Royal Infirmary, and around 5 people who would have gone to Weston General Hospital, would go directly to Southmead Hospital to start treatment immediately. Currently, these people are transferred to Southmead Hospital following assessment.
- It would take longer for some people to get to Southmead Hospital, but they would benefit from receiving specialist care immediately, rather than being assessed and transferred for emergency treatment.
- About 30 people per year would attend Musgrove Park Hospital in Taunton.
- The best place for care may not be at the hospital closest to where people live.
- In order to provide specialist treatment at a Hyper-Acute Stroke Unit for everyone in our area, some family and friends would need to travel a little longer to visit someone who has had a stroke. However, under the proposals, people will spend less time in hospital and go home with the right support more quickly. More information is available in the Stroke Consultation Travel Times Factsheet.
- It would mean changes for our staff. Some staff would need to work differently or in a different location as part of a specialist stroke team.
- Under the proposed changes, the number of beds dedicated to supporting people with stroke in North Somerset would stay the same as now. However instead of providing care immediately after a stroke, a new SSARU on the Weston General Hospital site would provide specialist inpatient stroke rehabilitation instead.

What other options are there?

During the pre-consultation phase, we also explored having a Hyper-Acute Stroke Unit (HASU) at Bristol Royal Infirmary or Weston General Hospital, and whether we could have a HASU at multiple locations.

Based on the number of people in our area who have a stroke, one HASU would provide the best treatment and care. Two or more HASUs would not meet the guidelines for the number of admissions required to make the units sustainable. In addition, one unit enables the increasingly specialised range of stroke treatments to be available in a single place for people needing emergency treatment and reduces the number of transfers between hospitals.

Much of the technology and highly specialised neurological (brain and nervous system) and vascular (blood vessels) technology and equipment, often required as part of emergency stroke treatment, is already provided at Southmead Hospital. Southmead is considered to be the area's centre of excellence for stroke treatment.

Due to the specialist staff and equipment required, it is not possible to provide multiple units across the area.

As part of wider improvements to stroke services, we would like to further invest in rehabilitation and community-based services. This would support a greater number of people home to live independent lives, more quickly. Sustained support following hospital care is a critical part of long-term stroke recovery.

One unit

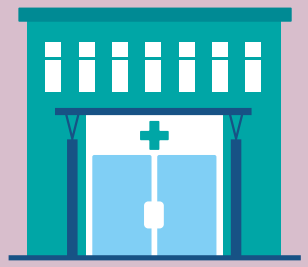
would mean the increasingly specialised range of stroke treatments available in a single place, for those who require emergency care.

"One thing I found when I was meeting people who had experienced a stroke was that care really varied. It was very dependent on where they were taken that first day by ambulance and which hospital they were taken to. That had a complete knock-on effect to the care they were given and the rehab they were offered which very often led to different outcomes for that individual."

Claire, stroke survivor

Proposal 2:

Improving ongoing acute hospital treatment



What would change?

After emergency treatment in a Hyper-Acute Stroke Unit (HASU), people receive their ongoing acute treatment and care in hospital.

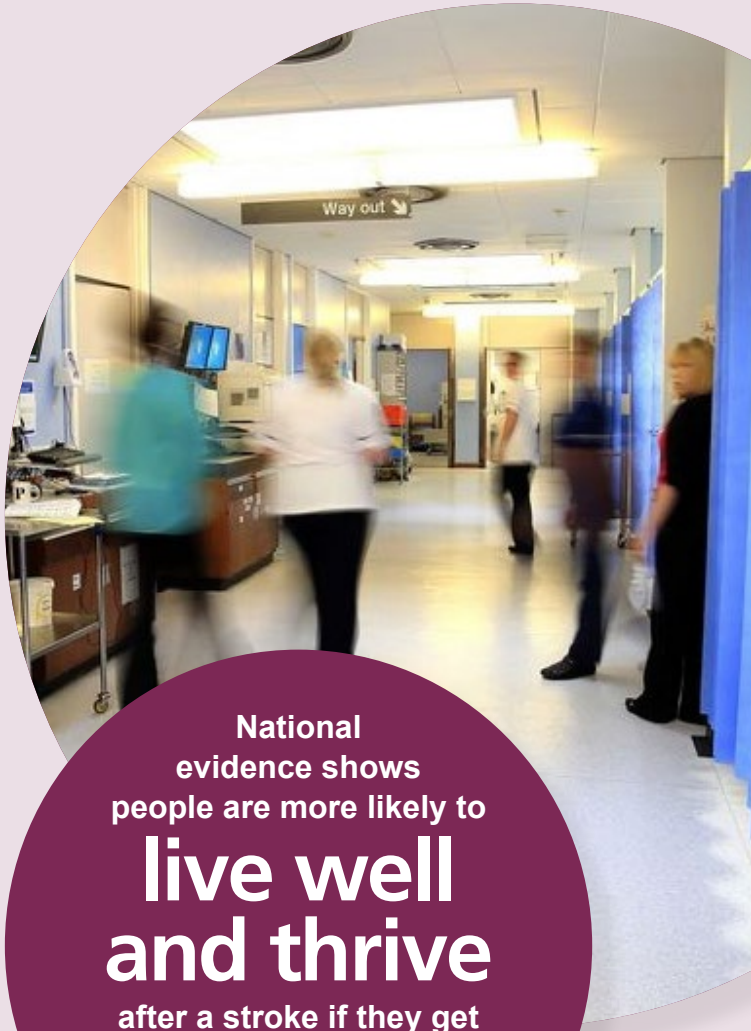
At the moment, with services spread across three hospitals, smaller stroke wards can become full and people might need to stay on a general ward. In addition, access to stroke specialists 24 hours a day, 7 days a week is not possible for everyone.

Under our proposals, more people would receive ongoing hospital treatment in an Acute Stroke Unit (ASU), where staff are specialists in stroke care. This would reduce the number of people admitted onto general wards, and ensure continuity of care following emergency treatment in the HASU.

We are proposing having **one Acute Stroke Unit (ASU) at Southmead Hospital** serving everyone in our area. The unit would be part of a centre of excellence situated alongside the HASU.

Some specialist stroke staff would continue to be based at the Bristol Royal Infirmary. They would care for anyone who has a stroke while they are in that hospital and who cannot be moved for medical reasons to the HASU or ASU at Southmead Hospital. This includes people receiving treatment in the heart hospital, or for cancer.

For the small number of people living in Sedgemoor District (North of Somerset) currently taken to Weston General Hospital, their nearest HASU and ASU is at Musgrove Park Hospital, Taunton. Therefore, once emergency treatment has finished, ongoing treatment and care on an ASU would continue at Musgrove Park Hospital. This would affect less than one person per week (about 30 per year). More information is available in the Sedgemoor District Factsheet.



National evidence shows people are more likely to

live well and thrive

after a stroke if they get ongoing treatment and care on a specialist Acute Stroke Unit (ASU).

Why do we need to change?

- National evidence shows people are more likely to live well and thrive after a stroke if they get ongoing treatment and care on a specialist Acute Stroke Unit (ASU).

- Overall, our current care is not meeting National Standards which means not everyone is getting the same high quality care. We would like everyone in Bristol, North Somerset South Gloucestershire to have all their specialist ongoing hospital stroke care in one place (an ASU), with equal access to the latest treatments and specialist staff.

- Southmead Hospital already has advanced and highly specialised equipment, and the latest treatments.

- Having one ASU at Southmead Hospital where the HASU would also be based, allows for several benefits. Firstly, it would reduce patient transfer between hospitals. It would also potentially reduce delays in treatment and care and would lead to an overall decrease in time spent in hospital.

- This proposal represents an efficient use of our specialist team and resources. By prioritising one ASU, we would be able to make further investment into community-based treatment and care so that more people could leave hospital quicker and live more independently after their stroke.

This proposal would mean some people from Bristol and North Somerset travelling further to visit friends and family in hospital. However, with specialist hospital stroke services and Integrated Community Stroke Services, people would receive ongoing care and support where they live more quickly. This is likely to reduce the length of time people spend in an ASU.

What other options are there?

- Another possibility is to have one Acute Stroke Unit (ASU) for ongoing care and treatment at Southmead Hospital and an additional Acute Stroke Unit (ASU) at Bristol Royal Infirmary - meaning that there would be a number of dedicated stroke beds on the site. Having an additional ASU means there would be a number of dedicated stroke beds on the BRI site.

  Following clinical evaluation, Weston General Hospital would not be a viable additional ASU location. Patients using this hospital do not typically have other complex conditions that require specialist care on site. This means they can be safely transferred in order to receive specialist stroke care, in line with national best practice.

- Bristol Royal Infirmary is the proposed potential second location, because it has other specialist services for conditions with links to stroke. For example, common heart disorders can increase the risk of stroke and sometimes requires a patient to continue to be managed under a cardiac specialist. This is also true for specialist cancer treatment.

Factors to consider

In both options, people being treated at the Bristol Royal Infirmary for other primary conditions, e.g. cardiac care or cancer, would receive outreach care from specialist stroke staff.

A single ASU would mean a larger staff team on a single site, increasing training and development opportunities.

An additional ASU could provide greater resilience to bed pressures, as stroke patients could be accommodated on more than one hospital site.

A single ASU would support standardisation of treatment and care and enable the development of strong links with community services.

A second ASU would **cost £500,000 more per year to run**, as a result of dividing the specialist team across two locations. This would be in addition to the overall **£3m investment being made to improve stroke care** out of hospital and in the community.

About **400 people a year would require an additional ambulance transfer** from Southmead Hospital, to the second ASU at Bristol Royal infirmary following their first few days of emergency treatment. **This would bring people back to their local hospital, but could increase the amount of time spent in hospital overall**.

"Before the stroke I was just a normal, fit bloke but when I left hospital to continue my rehab and therapies at home, I still couldn't move my right arm at all and I couldn't stand for any length of time. I would have benefited from more physiotherapy sooner in hospital and with that, potentially, I could have been less disabled."

Chris, stroke survivor

Proposal 3:

Improving rehabilitation services

What would change?

People who've had a stroke often require rehabilitation from a specialist team of therapists, such as physiotherapy, speech and language or occupational therapy, to help improve independence and develop ways to live well with disability.

1 in 3
people who have a stroke live in North Somerset

This can start in hospital and continue where people live[10] and at a variety of community based facilities.

Currently, we have rehab units in large hospitals or community venues where people can stay for a few weeks if they aren't ready to go back to where they live after their emergency and acute hospital care.

We are proposing to change this and create **two specialist inpatient rehab units called Stroke Sub-Acute Rehabilitation Units (SSARU).** These units would bring together a range of services and therapies.

Given the needs of our communities, we would place one 12-15 bed SSARU on the Weston General Hospital site in North Somerset because:

- 1 in 3 people who have a stroke live in North Somerset.
- We know it is difficult for visitors to travel from North Somerset to other areas and public transport is limited.
- On average, people around Weston are more economically disadvantaged and more likely than others in North Somerset to have a stroke.

People from Sedgemoor District would continue their recovery at one of the specialist inpatient rehab units on the Weston General Hospital site in Weston-super-Mare once emergency and acute treatment at Musgrove Park Hospital had finished. You can read more about this in the Sedgemoor District Factsheet.

The second SSARU would be based in Bristol or South Gloucestershire to spread the services across the area and keep travel times as low as possible for as many people as possible. We would have 27-30 beds in this second unit and need your help to plan where it should be. We've suggested some options on page 27.

Why do we need to do this?

Our aim is for more people to continue their recovery at a Stroke Sub-Acute Rehabilitation Unit (SSARU) because with specialist support, more people are able to return to where they live more quickly, and live more independently after their stroke.

- Two units would ensure enough beds are available to meet the needs of the local population. In addition, we would have the specialist support and staff needed to deliver good quality, timely and effective care.
- The SSARU's would be located in two different areas to help address inequalities in health. For example, older people, those from deprived areas and Black and South Asian people are all more at risk of having a stroke. This would help to address inequalities in health and means everyone would get access to the specialist rehab they need more quickly, wherever they live, and bring our services in line with National Standards.

Factors to consider

Research undertaken during the pre-consultation phase shows three units as unviable, due to the numbers of specialist staff available. Stretching staff resources in this way could lead to delays in care and affect the quality of the service we could offer. To meet the same standards, it would cost £1m more to run three units in comparison to two units.

Some family and friends may need to travel a little longer to visit someone who has had a stroke. More information is in the Stroke Consultation Travel Times Factsheet.

Some health and care staff would need to travel to work in another unit.

It may be a little harder to coordinate with Local Authority social services from two units. However, we are setting up an Integrated Community Stroke service to ensure that coordination takes place.

Where are the options for a second rehab unit?

We're carefully considering the best place for the second SSARU. The location would need to have a gym, therapy space, quiet areas and private consultation rooms, parking and good public transport links. Options include:

Location	Benefits	Considerations
Elgar Unit at **Southmead Hospital**, Bristol	• Situated on the Southmead Hospital site, close to the Hyper-Acute Stroke Unit (HASU) • North Bristol location, accessible to people in both Bristol and South Gloucestershire • Unit already has facilities for providing rehab but is not stroke specific	• Alternative general rehab services would need to be established
Frenchay site, South Gloucestershire	• Site being redeveloped. Potential for purpose-built facilities to support stroke care • North Bristol location, accessible to people in both Bristol and South Gloucestershire	• Interim arrangements would be needed until new facility available
Skylark Unit at **The Meadows care home**, Yate, South Gloucestershire	• Current provider of community care with general rehab • Central South Gloucestershire location, improves geographical spread of rehab units	• Alternative general rehab services would need to be established • Limited gym and therapy space • Limited parking
South Bristol Community Hospital, Hengrove, Bristol	• Purpose-built stroke rehab unit and already has good facilities • South Bristol location, close to centre of Bristol • Good parking available	• South Bristol is closer to Weston General Hospital (compared to other options), so rehab units not as well spread out across the area as they could be and further from people in South Gloucestershire

4 New Integrated Community Stroke Service

Whilst not part of the formal consultation, we thought it might be useful to know a bit more about new, wider services being developed to support people with their longer-term rehab after a stroke once they leave hospital or a inpatient rehab unit (SSARU).

Co-designed with people affected by stroke, we're investing in a new **Integrated Community Stroke Service**, where all services (NHS, local authorities and voluntary organisations such as charities) work together more effectively. The service would include teams with occupational therapists, physiotherapists, speech and language therapists, nursing, rehab support workers, psychologists, dietitians, voluntary sector workers and social workers.

The service would help people in Bristol, North Somerset and South Gloucestershire leave hospital and get the care they need more quickly, including rehab at home and in the community, seven days a week. It would include emotional and psychological support, empower people and their families to manage their own health and wellbeing, and be as independent as possible.

We estimate that every person will have about four times as many contacts or interactions with community teams as they do now.

You can read more about this at:

bnssghealthiertogether.org.uk/stroke-services/

We'd really like your feedback, please see page 25 for more details.

"An integrated community stroke service will pull together the many different aspects of care and treatment that people need when recovering from stroke. It will ensure that the right support - from physio, speech and language therapy, dietetics, occupational therapy, psychology, nursing and key workers - is delivered where and when most needed. Support can be in people's homes, work and leisure places and for as long as required to support the best possible quality of life after stroke.

With one integrated community stroke service, there will be less need for people to tell their stories to different therapy providers again and again, and more tailored support wrapped around the individual. We are really excited to be working with acute, community, social care and voluntary sector colleagues to achieve this vision."

Phillipa Cozens, Specialist Services Manager
Sirona care & health

5 What would your stroke journey look like?

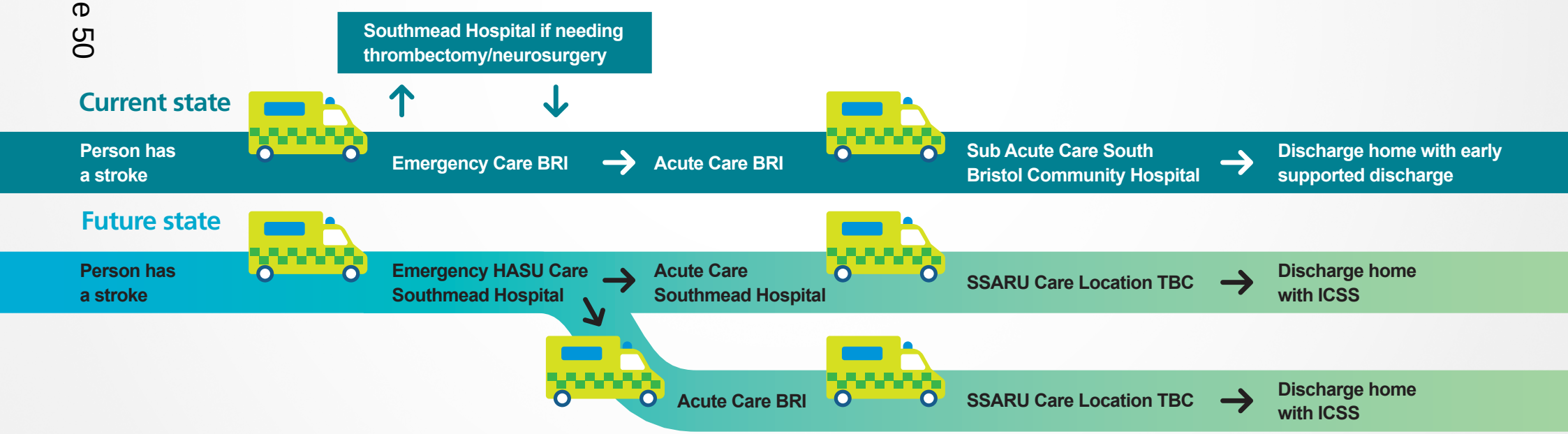
For people in Bristol[11]

1. **Emergency treatment:** The Ambulance Service would take anyone in Bristol suspected of having a stroke directly to the Hyper-Acute Stroke Unit (HASU) at Southmead Hospital for emergency specialist treatment and care.

2. **Ongoing acute hospital treatment:** After treatment on the HASU, people would continue their specialist care on an Acute Stroke Unit (ASU). We're proposing this unit to be at Southmead Hospital.

   If there is a second ASU at Bristol Royal Infirmary, the ambulance would take people[11] there after their treatment on the HASU at Southmead Hospital.

3. **Inpatient Rehabilitation:** People would start rehab as soon as they are ready. Once emergency and acute hospital care had ended, people who needed additional specialist treatment or rehab, and were not ready to return home, would go to the Stroke Sub-Acute Rehabilitation Unit (SSARU) in Bristol or South Gloucestershire.

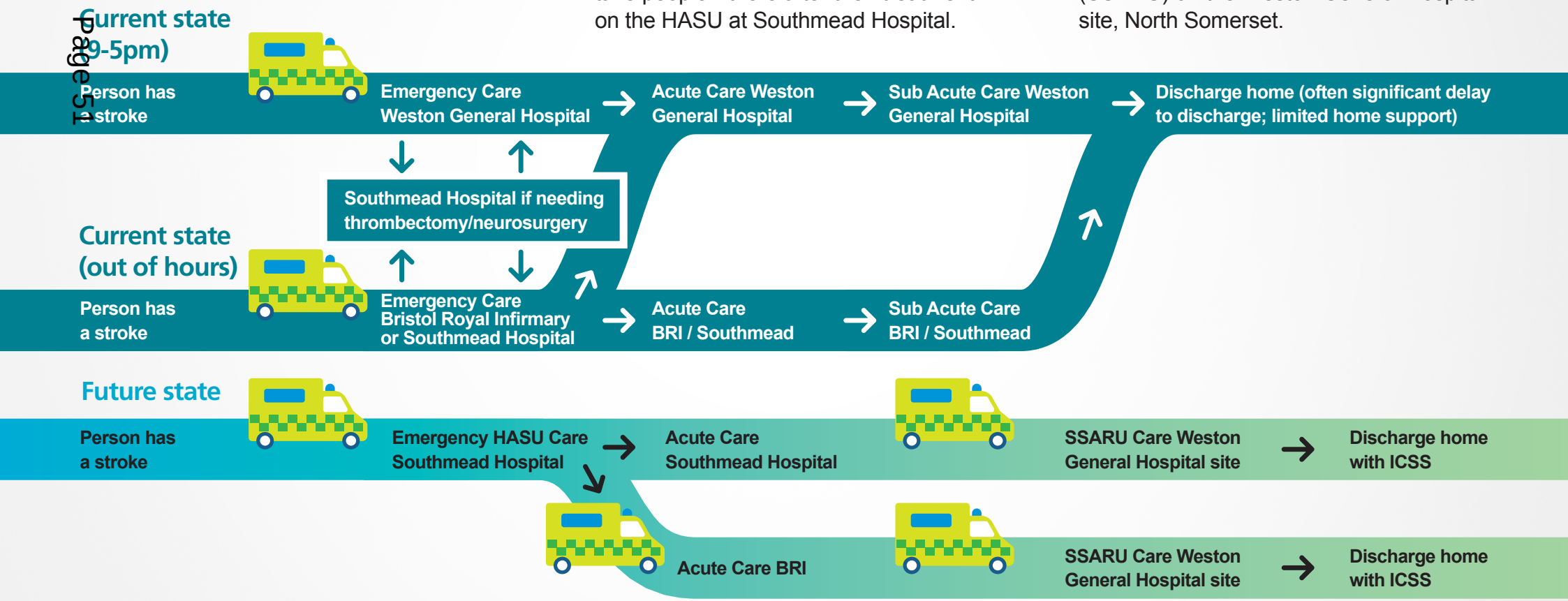


For people in North Somerset[12]

1. **Emergency treatment:** The Ambulance Service would take anyone suspected of having a stroke directly to the Hyper-Acute Stroke Unit (HASU) at Southmead Hospital for emergency specialist treatment and care.

2. **Ongoing acute hospital treatment:** After treatment on the HASU, people would continue their specialist care on an Acute Stroke Unit (ASU). We're proposing this ward to be at Southmead Hospital. If there is a second stroke ward at Bristol Royal Infirmary, the ambulance would take people[12] there after their treatment on the HASU at Southmead Hospital.

3. **Inpatient Rehabilitation:** People would start rehab as soon as they are ready. Once emergency and acute hospital care had ended, people who needed additional specialist treatment or rehab, and were not ready to return home, would go to the Stroke Sub-Acute Rehabilitation Unit (SSARU) on the Weston General Hospital site, North Somerset.



For people in South Gloucestershire[13]

1. **Emergency treatment:** The Ambulance Service would take anyone suspected of having a stroke directly to the Hyper-Acute Stroke Unit (HASU) at Southmead Hospital for emergency specialist treatment and care.
2. **Ongoing acute hospital treatment:** After treatment on the HASU, people would continue their specialist care in an Acute Stroke Unit (ASU). We're proposing this ward to be at Southmead Hospital.
3. **Inpatient Rehabilitation:** People would start rehab as soon as they are ready. Once emergency and acute hospital care has ended, people who needed additional specialist treatment or rehabilitation, and were not ready to return home, would go to a Stroke Sub-Acute Rehabilitation Unit (SSARU) in Bristol or South Gloucestershire.

Current state

Person has a stroke → Emergency Care Southmead Hospital → Acute Care Southmead Hospital → Sub Acute Care Southmead Hospital → Discharge home with early supported discharge

Future state

Person has a stroke → Emergency HASU Care Southmead Hospital → Acute Care Southmead Hospital → SSARU Care Location TBC → Discharge home with ICSS

6 How would the proposed changes improve care?

We've described each of our proposed hospital and rehab changes separately so you know what we propose to do and why. The three main changes are all designed to work together to improve stroke care and integrate with existing prevention and community-based rehab programmes:

1. **More people would survive, live independently and have a better experience.** Evidence shows that survival rates could improve by 1%, meaning 15 fewer deaths and 57 fewer people living permanently in a care home after a stroke each year. People and their families would have a much better experience of care.

2. **We would have enough specialist stroke staff to help everyone having a stroke.** Our specialist doctors and nurses would be able to provide a range of treatments, 24 hours a day, 7 days a week.

3. **People would be able to get the best stroke care, no matter where they live.** We would have a Hyper-Acute Stroke Unit (HASU) for the whole area, alongside everyone would be able to have rehab therapy 7 days a week.

4. **Local people would have care that meets National Standards.** We would have a Hyper-Acute Stroke Unit (HASU) providing the best care. We would be able to consistently support people all the way from having a life-changing event through to a more independent future.

5. **In line with the NHS Long Term Plan, we would make best use of taxpayers' money to serve our whole population.** We spend about £30 million per year on stroke services now. Our proposals would increase this by another £3 million per year to improve care outside of hospital and in the community while improving quality and effectiveness.

"One of the things the stroke programme tries to address is that everybody in Bristol, North Somerset and South Gloucestershire no matter where they are, are all able to access the best stroke care immediately and that stroke care and rehab is offered for as long as they need it."

Claire, Stroke Survivor

7 How can you have your say?

You can take part in our survey here

Have Your Say About Stroke Services Survey (surveymonkey.co.uk)

We want to know what you think before we decide what happens next. Have your say by 12pm on 3 September 2021.

As part of this formal public consultation, we want to know:

- whether you see **why** we think it's a good idea to change stroke services
- what you think about having emergency specialist treatment at **one Hyper-Acute Stroke Unit (HASU)** at Southmead Hospital to support everybody who has a suspected stroke or immediately after a stroke
- what you think of the different options for **ongoing acute treatment in hospital (ASU)** in the first week after a stroke
  - Having our team of expert staff and services across two stroke wards at Southmead Hospital and at Bristol Royal Infirmary
  - Having our team of expert staff and services at one stroke ward at Southmead Hospital
- where you think we should have a **second inpatient rehabilitation unit (SSARU)** for people who aren't ready to return home
  - We know we need one rehab unit on the Weston General Hospital site to meet the needs of the population
  - We'd like to know your thoughts about the location of a second rehab unit.

In addition, we'd like to get your feedback on our wider ideas for stroke services including the Integrated Community Stroke Service.

You can also let us know if you have any alternative proposals or ideas for the delivery of stroke services in our area. Either fill in the survey or contact us directly. See page 36 for details.

Get in touch

Learn more

We have more information on bnssghealthiertogether.org.uk/stroke-services/. You can also email, telephone or post a letter if you have any questions or want to tell us what you think.

- Email us :
  bnssg.strokeprogramme@nhs.net

- Call us:
  0117 900 3432

- Write to us:
  Freepost STROKE CONSULTATION
  You don't need a stamp

We need to hear from you by **12pm on 3 September 2021**.

Invite us to speak with your group

If you belong to a group for people affected by stroke, a community group, support group, charity or staff group, we can attend one of your meetings by video or in person. Use our email or phone number to contact us.

Joint us at an event

We're holding a range of informal events where you can learn more, ask questions and share your thoughts. We can provide extra support at these discussions for people who find it hard to speak, those who have eyesight or hearing difficulties and people who speak various languages.

- Online events:
  16 June - 6pm to 8pm
  24 June – 12pm to 2pm
  30 June – 6pm to 8pm
  07 July – 12pm to 2pm
  26 August – 12pm to 2pm

- Face-to-face events:
  Subject to Government restrictions, we will be holding a number of face-to-face events across Bristol, North Somerset and South Gloucestershire. More information will be available at bnssghealthiertogether.org.uk/stroke-services/ soon.

- Register your interest:
  To register your interest in any of our online or face-to-face events, please email us at bnssg.strokeprogramme@nhs.net. If you're interested in an online event, please provide your name the date of your preferred event. If you're interested in a face-to-face event, please provide your name and let us know if you would prefer to attend an event in Bristol, North Somerset or South Gloucestershire.

What happens next?

Learning from your feedback

We'll be listening to and reading all the ideas you give us. Have your say between 7 June and 3 September 2021.

After the consultation ends, an independent organisation will summarise the main ideas from everyone's feedback and we'll:

- publish the summary on our website
- use the summary as one piece of evidence to help plan next steps
- let you know how we're responding to what we've heard

Deciding on the next steps

Your feedback will be one of the things the BNSSG CCG's Governing Body considers when they decide the next steps.

The purpose of a public consultation is to ensure the views of local people have been considered before a final decision is made on changes to stroke services. The public consultation also seeks to identify any information or evidence that hasn't already been considered and could impact on the proposals. This is not a vote or referendum.

The Governing Body members will meet in early 2022. They will look at all the information and evidence, including the independent summary of consultation feedback.

We'll be listening to and reading all the ideas you give us.

Have your say between 7 June and 3 September 2021.

The Governing Body will make a final decision on the configuration of acute stroke services for the population of Bristol, North Somerset and South Gloucestershire.

Equality: how the proposed changes impact equality of access to treatment and health inequality.

Quality of care: making sure care is safe, effective and good quality.

Access to care: travel time, opening hours and whether people have choices.

Workforce: how changes may affect staff skills, recruitment and retention.

Value for money: how much services will cost to change and run, and the longer term costs and benefits.

Deliverability: how easy it will be to make changes, what else is needed and how services fit with other plans.

If we decide to make changes, new services would begin towards the end of 2022.

8 References

1 Stroke Association, State of the Nation, 2018.

2 Stroke Association

3 https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx

4 https://evidence.nihr.ac.uk/alert/centralising-stroke-services-can-save-lives/

5 https://evidence.nihr.ac.uk/alert/centralising-stroke-services-can-save-lives/

6 https://www.cochrane.org/CD000197/organised-inpatient-stroke-unit-care

7 A type of surgery to remove a blood clot from inside an artery or vein

8 Stroke pathway – Evidence Base Commissioning: An Evidence Review for NHS England and NHS Improvement, March 2020

9 Local assessment based on national evidence of best practice outcomes

10 At home, in a carer's home or in a care home

11 Who would usually go to the Bristol Royal Infirmary or Southmead Hospital for treatment

12 Who would usually go to the Weston General Hospital for treatment

13 Who would usually go to Southmead Hospital for treatment

Healthier **Together**

Improving health and care in Bristol,
North Somerset and South Gloucestershire

NHS

NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

South Plaza, Marlborough Street,
Bristol BS1 3NX.

0117 900 2583
bnssg.strokeprogramme@nhs.net

bnssghealthiertogether.org.uk/stroke-services/

This information is available in Easy Read, Aphasia-friendly or large print formats. In addition, it can be made available in alternative languages for those whom English is a second language.
See page 36 for how to contact us.

CONSULTATION THEMES

IMPROVING STROKE SERVICES IN BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE

KEY MESSAGES

Between 7 June and 3 September 2021 NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) consulted about proposed changes to stroke services on behalf of the health and care organisations in the Healthier Together Integrated Care System.

The CCG received 1,833 responses representing about 2,202 individuals and 4 organisations. These were:

- 1,126 door-to-door interviews with people that represented the age, gender and working profile of the area
- 657 consultation feedback forms from 658 people
- notes from 32 online and in-person meetings with 403 people
- 18 letters, emails and telephone calls from 19 people

People could take part more than once.

About half of the responses that specified a location were from Bristol (46%). 2 in 10 were from North Somerset (23%) and 3 in 10 from South Gloucestershire (30%).

An independent organisation compiled themes from the feedback.

EMERGENCY CARE IN HOSPITAL

The CCG proposes that everyone with a suspected stroke in Bristol, North Somerset and South Gloucestershire should be taken to a single centre of excellence (known as a Hyper-acute Stroke Unit or HASU). The CCG says that people have better outcomes if they receive emergency care at a centre of excellence with the most specialist staff and equipment. This centre would be located at Southmead Hospital in North Bristol.

- **9 out of 10 responses stated that they understood** why the NHS thinks that stroke services need to change (94% of responses that commented about this).

- 6 out of 10 said that if they had a stroke, they would rather be **cared for at a hospital with the most specialist staff and equipment** than a hospital close to home or near to family (69% vs 27%).

- **Half of responses fully supported having 1 centre of excellence (Hyper-acute Stroke Unit) at Southmead Hospital** serving all of Bristol, North Somerset and South Gloucestershire (50% of responses that commented fully supported this and 15% partly supported this).

- The organisations that run the hospitals offering emergency stroke care in Bristol, North Somerset and South Gloucestershire all supported this proposal.

The main reasons that responses gave for supporting a single centre of excellence at Southmead Hospital were:

- thinking people would be able to receive the **best care** if specialist staff and equipment were all in one place (15% of 1,538 responses that gave a reason for their views about this)

- thinking that Southmead Hospital is in an **accessible** location, with good parking (11%)

- thinking that Southmead Hospital **already provides** high quality care 24 hours a day, so has all the staff and facilities needed (8%)

The main areas of concern, whether or not responses supported the proposal, were:

- worry that a single unit may not have enough **capacity** to cope with the needs of such a large area (14% questioned capacity, 37% said more than one unit was needed for the large area)

- concern that it may take too long to **travel** to Southmead Hospital from some parts of the area, especially as people said that emergency stroke care needed to begin quickly in order to get the best outcomes for patients (19%)

ONGOING SPECIALIST CARE IN HOSPITAL

After their emergency care, people who have a stroke usually receive ongoing care in hospital. The CCG said that this should be in a specialist stroke ward with staff who are experts in stroke care, not on a general hospital ward. The CCG proposed having 1 specialist stroke ward ('Acute Stroke Unit' or ASU) at Southmead Hospital to serve the whole population of Bristol, North Somerset and South Gloucestershire.

Half of responses supported having 1 specialist stroke ward at Southmead Hospital (50%). Half supported having 2 specialist stroke wards, with the second at Bristol Royal Infirmary (50%).

The main reasons that responses favoured having 1 stroke ward were:

- perception that this would lead to **fewer transfers** and less time in hospital (26% of 1,475 responses that gave a reason for their views)
- thinking that Southmead Hospital is **easy to get to** and park at (14%)

The main reasons that responses favoured 2 stroke wards were:

- believing that 1 stroke ward may not have enough **capacity** to provide services for the large and growing population (28% of 1,475 responses that gave a reason for their views about this proposal)
- thinking that this would give more equal **access** for those in South Bristol and North Somerset (20%)
- thinking that a second unit would spread services out so at least one unit would be closer and more accessible for **visitors** (13%)

SHORT STAY REHABILITATION

The CCG stated that some people who have a stroke are not ready to go home after their hospital-level care ends. They may stay in live-in rehabilitation units for a short time. The CCG proposed to have 2 short stay rehabilitation units ('Stroke Subacute Rehabilitation Units' or SSARU) serving the whole area: one at Weston General Hospital in North Somerset and the other in Bristol or South Gloucestershire.

- 3 out of 10 responses fully supported having 2 short stay rehabilitation units (34% of responses that commented about this)
- **6 out of 10 responses fully supported having 3 or more short stay rehabilitation units (65%)**
- Regardless of how many short stay rehab units there were, 6 out of 10 fully supported having one at Weston General Hospital (58%)

The main reason that responses said they supported having 2 short stay stroke rehabilitation units was that they believed this was a compromise between locating specialist rehabilitation staff together whilst also providing some geographic spread (15% that gave a reason).

The main reasons that responses supported having more than 2 short stay stroke rehabilitation units were:

- thinking that two units would not have enough **capacity** for the large and geographically spread out area (64% that gave a reason)
- concern that it would be difficult for people to **visit** if there were only 2 units, including poor public transport links when visiting (27%)

The CCG invited people and organisations to suggest the location they most preferred for a short stay rehabilitation unit, in addition to Weston General Hospital:

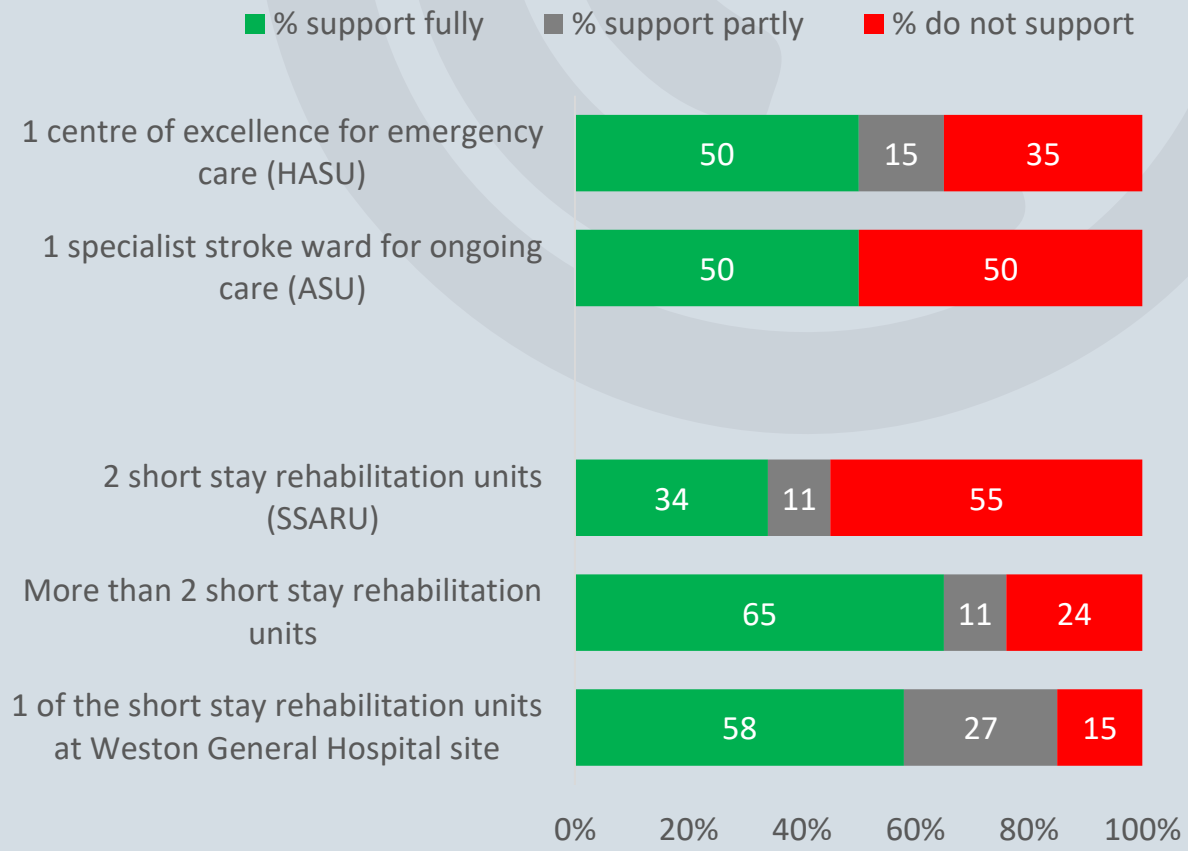
- half chose the Elgar Unit at Southmead Hospital (48% of those that commented about this)
- 1 in 4 chose Frenchay Hospital (25%)
- 1 in 5 chose South Bristol Community Hospital (18%)

The top things that responses wanted the CCG to take into account when deciding on a location for short stay rehabilitation units were:

- **travel time** and cost for families (44% of those that commented about this)
- accessibility by **public transport** (26%)
- sufficient **parking** and free parking (21%)
- **spread** of units across the area (18%)
- **facilities** available at the unit, such as a gym, kitchen, garden and being close to a pool (17%)

The CCG stated that its Governing Body will consider consultation feedback alongside other evidence when it decides on next steps for stroke services. Themes from the consultation feedback will be included in a business case with other information, including data that considers and responds to issues raised during the consultation.

Extent to which consultation responses supported CCG proposals



Note: 1,732 responses provided a view about having a single centre of excellence for emergency hospital care, 1,745 about specialist stroke wards, 1,593 about short stay rehabilitation units and 1.643 about having a short stay rehabilitation unit at Weston General Hospital. A 'response' does not necessarily equal one person. Feedback from an organisation or group was counted as a single response to calculate percentages, as were notes from meetings.

CONTENTS

CONSULTATION PARTICIPANTS

In mid-2021 NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) consulted about proposed changes to help people survive and thrive after stroke. The CCG consulted about three elements of stroke services:

- emergency care in hospital for the first few days after a stroke
- ongoing hospital care in a specialist stroke ward
- short stay rehabilitation for people who are not ready to go home after their hospital-level care ends

The proposals were developed by the Bristol, North Somerset and South Gloucestershire Stroke Programme working with people who had experienced a stroke, their family members, clinicians and voluntary and community groups.

This report summarises themes in the feedback received during the consultation period, which ran between 7 June and 3 September 2021. An independent team compiled the themes.

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WHO TOOK PART?

The CCG received 1,833 responses during the consultation period, representing about 2,202 individuals and 4 organisations. We say 'about 2,202 individuals' because people who provided feedback more than once are counted more than once, such as those who attended a meeting and completed a feedback form.

The appendix to this report describes the methods that the CCG used to promote the consultation and gather feedback. It also describes how this summary of themes was compiled and important things to bear in mind when interpreting the feedback.

Table 1 shows the types of responses received. Nine out of 10 responses were from the public (88%) and the rest from health and care professionals or healthcare organisations.

Table 1: Types of responses

Type of response	Number (%)	People represented
Door-to-door interviews	1,126 (61%)	1,126
Online and posted feedback forms	657 (36%) of which 11 were posted	658
Notes from meetings	32 (2%)	403
Letters, emails and calls	18 (1%)	19
Total	1,833	2,202 individuals and 4 organisations

The CCG and partners kept notes of feedback at 32 meetings:

- 9 meetings with staff
- 7 meetings with stroke support groups or organisations
- 5 public meetings
- 2 targeted meetings with seldom heard groups
- 1 meeting with carers
- 8 other meetings, including visits to stroke services and attending existing meetings with patient and public involvement groups

Each set of meeting notes is counted as one 'response' to the consultation. So throughout this report a response could equate to one person, to a meeting with many people or to a whole organisation.

Additional meetings were held to raise awareness about the consultation, but these were not counted as 'responses' because no record was kept of views shared at those meetings.

CHARACTERISTICS OF RESPONSES

Most responses came from people responding as individuals (1,774 responses). Four responses were from organisations:[1]

- North Bristol NHS Trust
- Sirona Care & Health
- Somerset Clinical Commissioning Group
- University Hospitals Bristol and Weston NHS Foundation Trust

People responding as individuals were asked some background details about themselves when they completed a consultation feedback form or door-to-door interview. This information was usually not available when people responded by letter, email or telephone.

More than 300 responses, or 1 in 6, came from someone who had experienced a stroke (7%, 117 people) or a close family member or carer of someone who had experienced a stroke (10%, 170 people). In addition, the CCG facilitated specific meetings for these groups.

1. The CCG also received feedback forms from the following groups stating that they were responding on behalf of a whole organisation or group: Bristol, North Somerset and South Gloucestershire Local Maternity System; Maternal Medicine Team; North Bristol NHS Trust; St Michael's Hospital; Western Active Stroke Group. The CCG considered that these forms may be from individual members of the group, rather than official organisational responses. They instructed the independent analysts to treat these as individual responses. Notes from meetings were not treated as being an official organisational response. The appendix contains the names of groups that the CCG met with.

About 1 in 5 individual responses were from health and care workers (19%, 337 people). The CCG and partners also facilitated specific meetings with healthcare workers.

Figure 1 shows the geographic location of responses. The CCG reported that the spread of responses broadly matched the proportions of people in the population in each area. Responses received directly by the CCG matched the spread of the population just as well as those collected in door-to-to door interviews. The appendix contains further details about how the interviews were conducted and compares the characteristics of people taking part in interviews versus those who responded directly to the CCG.

Of the 1,687 responses that provided information about their gender, 46% were from men, 54% from women and fewer than 1% from people who defined themselves in another way. The CCG noted that this is representative of the population of the area.

Of the 1,676 responses that provided information about their ethnic group, 4% were from people who identified as Asian or Asian British, 4% Black or Black British, 1% Gypsy or Traveller, 90% White and 1% other ethnic groups. The CCG stated that this is in line with the ethnic groups living in the area.

There was a good spread of age groups (see Figure 2). The CCG reported that the responses received directly by the CCG and the door-to-door interviews were similar to the age distribution of the population. Slightly fewer younger people responded to the CCG directly.

Figure 1: Geographic location of responses

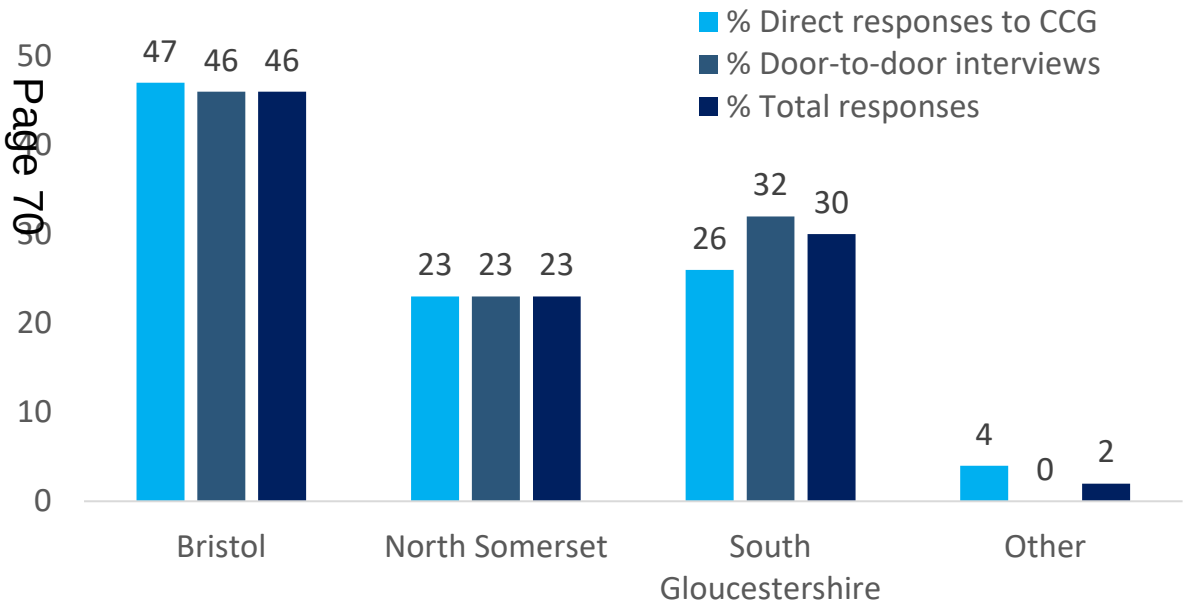
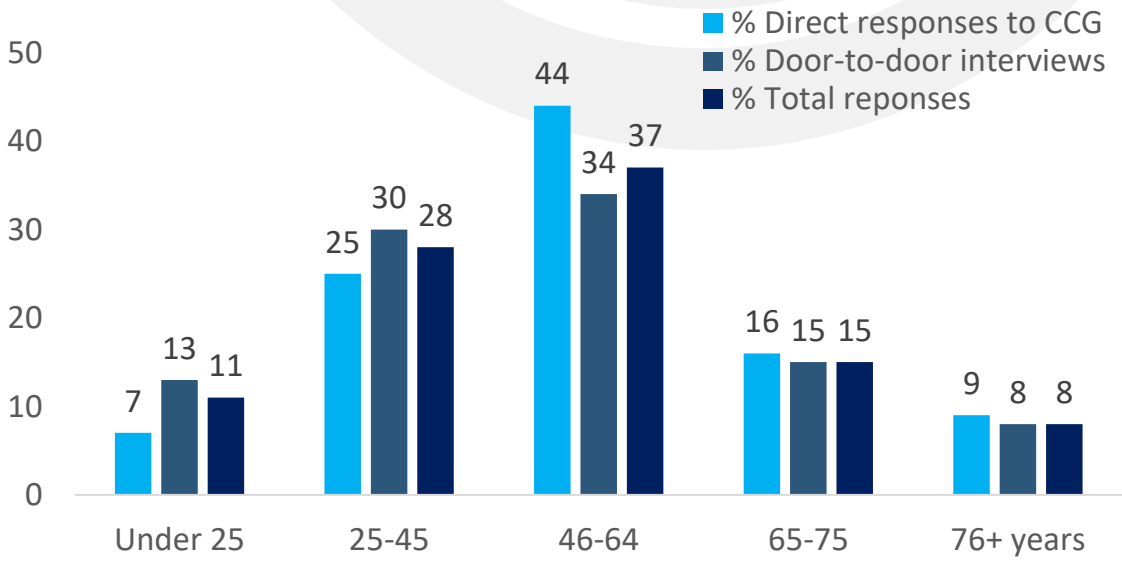


Figure 2: Age groups of individual responses



Note: Based on 1,707 responses that provided a geographic location: 581 were direct responses to the CCG and 1,126 were door-to-door interviews. Some organisational responses and meetings represented people from throughout Bristol, North Somerset and South Gloucestershire and are not included in this figure (<1%).

Note: Based on responses from 1,675 individuals: 549 direct responses to the CCG and 1,126 door-to-door interviews. The door-to-door interviews used a quota approach to ensure that responses represented the age groups in the area.

REASONS FOR CHANGE

The CCG set out reasons why it believes that stroke services need to change.

9 out of 10 responses said that they partly or fully understood why the NHS thinks stroke services need to change:

- 75% of 1,808 responses that commented about this said that they fully understood why the NHS thinks stroke services need to change
- 19% partly understood
- 6% said they did not understand

This does not mean that responses agreed with the proposed changes, but that they understood the reasoning set out by the CCG.

No area, age, gender or ethnic group was more likely than others to say that they did not understand the reasons for change put forward by the NHS. People who took part in a door-to-door interview were just as likely to say they understood as those who provided feedback direct to the CCG.

EMERGENCY CARE IN HOSPITAL

PRIORITIES FOR EMERGENCY CARE

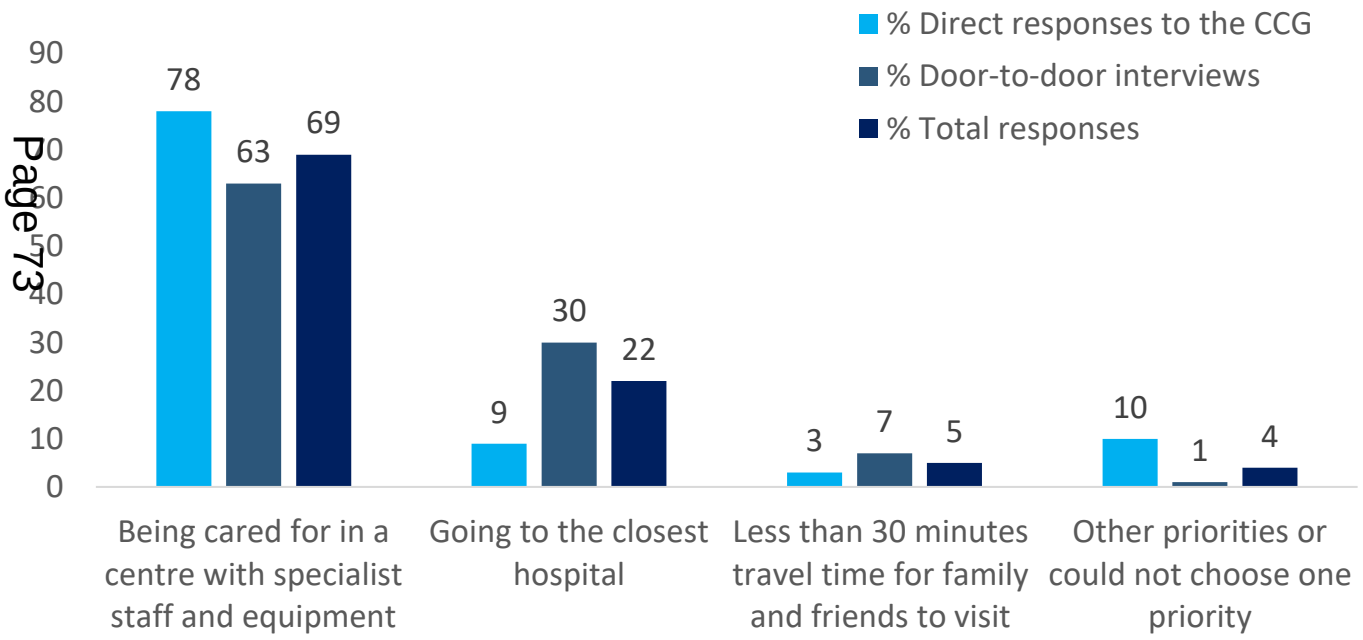
Most people who have a stroke go to hospital to be assessed and start treatment. The CCG wanted to understand whether it was a higher priority for people to receive treatment at the closest hospital or whether it was more important to receive care from the most specialist staff and equipment.

The CCG invited people and organisations to select their top priority from a list.

- 7 out of 10 responses that commented about this said that their **highest priority was to be cared for at a hospital with specialist staff and equipment** (69%)
- 3 out of 10 responses said their top priority was to be at the closest hospital (22%) or somewhere that visitors could travel within 30 minutes (5%)

Individual responses prioritised having the most specialist staff and equipment over a close location no matter where they lived, or their age. People from minority ethnic groups also prioritised the most specialist staff and equipment, but a significant proportion prioritised care close to home. Exact numbers are listed in the appendix.

Figure 3: Extent to which responses prioritised being close to home vs specialist care



Note: Responses were asked 'Which ONE of these things would be most important for your first few days of hospital care if you had a stroke?' 1,750 responses considered this: 635 direct responses to the CCG and 1,115 door-to-door interviews. Direct responses more likely to prioritise the most specialist staff and equipment than door-to-door interviews (78% vs 63%)

Area	No difference in trends between areas
Age	No difference in trends between age groups
Ethnicity	White people were more likely to prioritise having the most specialist staff and equipment compared to minority ethnic groups (70% vs 60%)
Gender	Women were more likely to prioritise having more specialist staff and equipment (68% vs 59% men)
People who had experienced a stroke	No difference from total responses
Carer of someone who had a stroke	No difference from total responses

CENTRE OF EXCELLENCE FOR EMERGENCY STROKE CARE (HASU)

People suspected of having a stroke in Bristol, North Somerset and South Gloucestershire are currently taken to the closest hospital with an emergency department for assessment and then admitted or transferred to a more specialist team if needed. The CCG proposed the following change:

- Everyone who has a stroke or a suspected stroke would be taken directly to one stroke centre of excellence at Southmead Hospital. This 'Hyper-acute Stroke Unit' (HASU) would have the best equipment and specialist staff and be open 24 hours a day, 7 days a week.
- People living in Sedgemoor district (Northern Somerset) would be taken to their nearest Hyper-acute Stroke Unit at Musgrove Park Hospital.

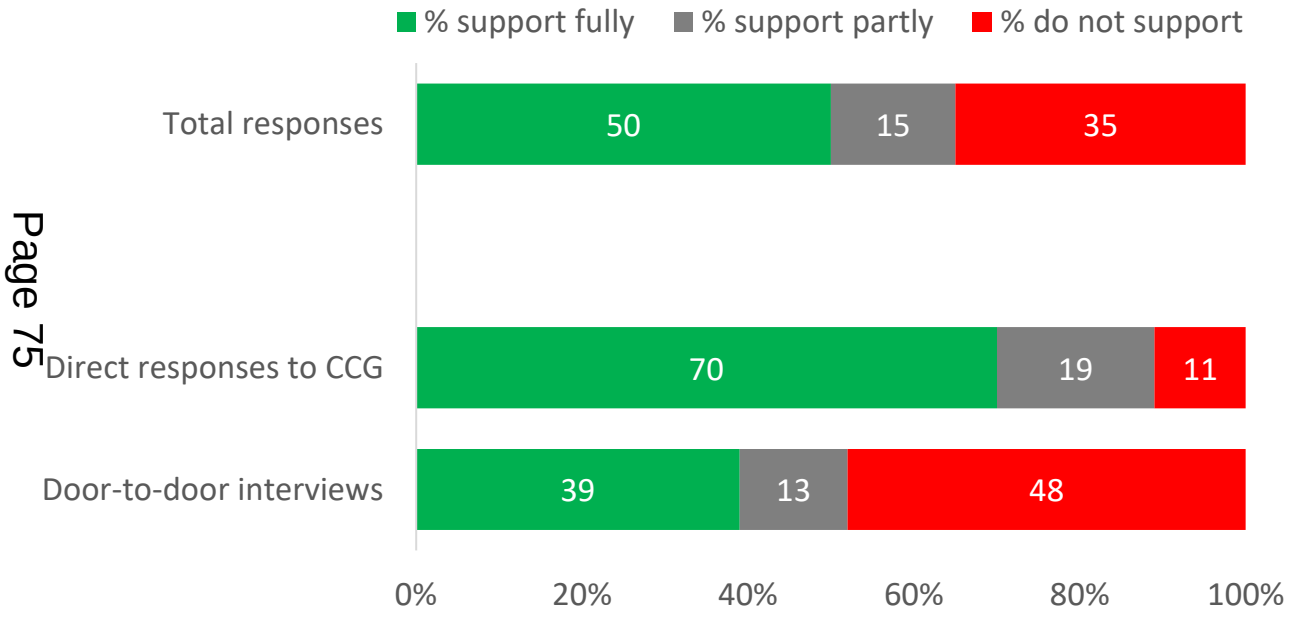
1,732 responses stated whether they supported this proposal (see Figure 4).

Overall half of responses fully supported the CCG's proposal, but there was a significant difference in direct responses to the consultation and door-to-door interviews.

7 out of 10 direct responses to the CCG fully supported having one centre of excellence at Southmead Hospital compared to 4 in 10 door-to-door interviews. Part of this difference may be because the door-to-door interviews asked slightly different questions. The appendix explains the wording used and how feedback was combined. The difference in feedback may also be because people taking part in door-to-door interviews did not have background information about the reasons that the NHS thinks that one centre of excellence would be beneficial. The immediate reaction may be 'more is better', whereas people who took part in consultation meetings or read or watched materials may have had more information to inform their views.

Individual responses had similar views about this proposal regardless of their area, age or ethnicity. People in North Somerset were just as likely to support having a single centre of excellence at Southmead Hospital as people in Bristol and South Gloucestershire. People who had experienced a stroke and health and care professionals were more supportive than other responses. The appendix contains more breakdowns.

Figure 4: Support for single centre of excellence at Southmead Hospital



Note: 1,732 responses provided a view about a single centre of excellence (Hyper-acute Stroke Unit) for emergency stroke care at Southmead Hospital: 626 direct responses and 1,106 door-to-door interviews. At meetings and in the consultation feedback form, people and organisations were asked the extent to which they supported having one Hyper-acute Stroke Unit at Southmead Hospital serving the whole area. The door-to-door interviews asked people whether they preferred a single unit at Southmead or somewhere else. The appendix describes how the different question wording was combined.

Area	No difference between areas
Age	No difference between age groups
Ethnicity	No difference between ethnic groups
Gender	Women were more likely to support a single centre of excellence than men (68% vs 59% men)
People who had experienced a stroke	People who had experienced a stroke were more likely to support a single centre of excellence compared to other responses (85% vs 65% total responses fully or partly supporting)
Carer of someone who had a stroke	No difference from total responses
Health and care professionals	Health and care professionals were more likely to support this proposal compared to total responses (60% fully supported and 17% partly supported)

The two organisations that run the hospitals providing emergency stroke care in Bristol, North Somerset and South Gloucestershire both stated that they supported the proposal to have one centre of excellence at Southmead Hospital serving the whole region.

> **"The proposed changes are evidence-based, and we know that where similar changes have been implemented in other health systems, they make a huge difference for the outcomes of people who suffer a stroke. We are proud that we already offer highly specialised stroke services to many patients each year, including through our stroke thrombectomy service. However, not all BNSSG[2] patients can access these services due to capacity constraints and variations in service provision across our health system. The proposed changes will ensure that we are able to offer all our patients across BNSSG the very best stroke services, 24 hours / 7 days per week."** (Letter from North Bristol NHS Hospitals Trust)

> **"There is strong evidence that immediate transfer of patients to a specialist Hyper-Acute Stroke Unit staffed by highly specialist teams improves patient outcomes. Consolidating our expertise into one HASU will help us to achieve this and the recommendation is supported."** (Letter from University Hospitals Bristol and Weston NHS Foundation Trust)

2. Responses quoted in this report sometimes used the abbreviation BNSSG to refer to Bristol, North Somerset and South Gloucestershire.

The neighbouring Somerset Clinical Commissioning Group said they were eager to work with the CCG to support next steps. They were concerned that ambulances may take more people from North Somerset to a hospital in Somerset, rather than to Southmead Hospital.

> **"We have some concerns that the ambulance service would take more patients to Musgrove Park Hospital than Southmead than the modelling suggests as the crews won't want to be caught up in the traffic in the city… Given that patients from the Sedgemoor area (and possibly from North Somerset) will likely receive their hyperacute stroke care at Musgrove Park Hospital, can assurance be given that patients will be able to transfer in a timely way to Sub Acute Rehab Unit at Weston General Hospital to be closer to home and their relatives? Currently, there are constant challenges with repatriating patients to Weston Hospital so what will be different with this arrangement?... The HASU capacity at Musgrove Park Hospital is four beds and therefore any delay will have an impact on ability to provide care to other patients."** (Letter from Somerset Clinical Commissioning Group)

Only 5 people from the Sedgemoor area responded directly to the consultation so there is not enough feedback to get a sense of what people from this area thought.[3]

3. The CCG reported that people in Sedgemoor currently use stroke services in Bristol, North Somerset and South Gloucestershire, but Sedgemoor is in the Somerset local authority area so was not included in from interviews. Sedgemoor District Council, the Sedgemoor equalities group and Morland community hub reportedly promoted the consultation to Sedgemoor residents.

REASONS FOR SUPPORTING A SINGLE CENTRE OF EXCELLENCE

1,538 responses made 2,276 comments about the reasons why they did or did not support the CCG's proposal for a single centre of excellence for emergency hospital stroke care. Responses could provide more than one reason for their view, so percentages add to more than 100%. The main reasons for supporting this proposal were:

- thinking that a single centre would provide the **best care** because it was perceived that specialist staff and equipment would be available in one place and other advanced hospital services would be on the same site if needed (15% of 1,538 responses that gave a reason)
- perception that Southmead Hospital is **accessible**, including being in a central location with motorway access and sufficient parking (11%)
- feeling that Southmead Hospital **already provides** high quality care 24 hours a day (8%)
- thinking that this would result in **better outcomes** for patients including increased survival, less disability, shorter stays in hospital and more continuity of care (7%)
- thinking that it is better to have one centre of excellence than none at all (6%)
- believing this is a better use of **resources** and would be less costly if funds are all directed into one centre (5%)
- thinking this would **avoid delays**, provide more timely and streamlined care, involve fewer transfers and make sure care is available 7 days a week (5%)
- concern that there would not be enough **workforce** to spread across more than one centre. Some also thought that this proposal would allow staff to develop and maintain their specialist skills because would be seeing the right range of people. They thought this may in turn attract and retain staff and build teamwork (3%)
- perceived **parity** and fairness of access to good care across all of Bristol, North Somerset and South Gloucestershire (2%)

"The hours following a stroke, along with the quality of care provided, are crucial to the outcome so it makes sense to centralise expertise. Accessibility of location is the main factor for location and access to Southmead is better than to Bristol Royal Infirmary." (Feedback form provided by Asian man aged 76+ in South Gloucestershire)

"Southmead is modern and caters for everything. Going to Southmead allows everything to be done under 1 roof. Staff at the individual hospitals such as Weston currently get frustrated because they aren't necessarily seeing the type of acute stroke patients they are trained to care for. Centralised care and therapies would be better for staff and patients. Care can be concentrated on the stroke patients and will allow access to all the equipment needed. Generally the group wouldn't mind travelling further if it meant better care and outcomes." (Notes from meeting with North Somerset Casual Stroke Survivors Group)

"After my father suffered a stroke on a Saturday morning, being told that treatment was unavailable due to being out of hours was the most devastating news… Dad had a stent fitted into his brain, just in time. 1 hour longer he would have died. Today you wouldn't know he had ever suffered a stroke. No family should have to go through what I did just because it's the weekend. Surely everyone should be entitled to treatment every day of the week no matter what time of the day/night." (Feedback form provided by 25-40 year old woman in South Gloucestershire who cares for someone who had a stroke)

REASONS FOR NOT SUPPORTING A SINGLE CENTRE OF EXCELLENCE

Concerns about the proposal, whether people supported it or not, were:

- concerns about **capacity**: responses worried that a single centre of excellence may not be able to cope with the number of people having strokes or said that they needed more information to be confident that there was enough capacity. They believed that more than one unit was needed for the large area, with a growing elderly population. They said that the CCG's modelling was too optimistic and that it did not account for delays getting people into the community or staff shortages (51% of 1,538 responses that gave a reason for their view said this. 14% of these primarily spoke about capacity of a single centre. 37% primarily spoke about needing more than one unit for a large or widespread area. Many said both things)
- taking **longer to get to emergency care**, which responses thought may lead to greater rates of death or disability. Responses emphasised the need to act 'FAST' with stroke to get the best outcome. They did not believe the CCG's claim that everyone would be able to be transported to a single centre of excellence within 45-60 minutes and they thought this would lead to poorer clinical outcomes. They felt that more hospitals should offer emergency stroke care because they thought this would let more people get treatment quickly. Some said that the CCG had not accounted for the time it takes an ambulance to get to a patient and unload at the hospital. They were also concerned about ambulance capacity (19%)
- concerns about accessibility for **families** and visitors. Responses said Southmead Hospital would be further for visitors from North Somerset and South Bristol to travel. They aid that there are not good public transport links and that visitors may be elderly and not drive (10%)
- not wanting to lose **existing facilities** and specialist staff at Bristol Royal Infirmary. There was concern that this would leave cardiac and maternity patients without access to specialist stroke care and may deskill staff in other hospitals (3%)
- feeling that there would be better **continuity of care** and better quality of care if there was more than one unit or it was located somewhere else (2%)

"With the increasing traffic and congestion it's a bit of a concern that if we only have one unit journey times could potentially be an hour or more. As stroke is time critical I would worry that some patients far away from Southmead may struggle to get there in time for treatment." (Door-to-door interview with White 65-75 year old man in South Gloucestershire)

"If my husband had another stroke and was taken to Southmead, I could not visit him as I don't drive. Better transport is needed before any more services are centralised in Bristol. I'm petrified of getting poorly or having to have tests as I can't get to Bristol hospitals." (Feedback form from 41-64 year old White woman in North Somerset who cares for someone who had a stroke)

"I think we can and should have 2 hyperacute stroke areas. It would lose far too many skilled staff across the two sites, not everyone will be able to, or want to move areas to work in this specialist field. Looking at amalgamation of one service is very short sighted. Nursing staffing and its workforce is in crisis. To lessen one amazing specialist area is extremely unfair. We need to retain nurses in an area they chose, are good at and can logistically get to on a daily basis." (Feedback form provided by White female healthcare worker aged 41-64 in North Somerset)

ONGOING HOSPITAL CARE

After the first few days of emergency treatment, people may stay in hospital for ongoing stroke care. In Bristol, North Somerset and South Gloucestershire, people usually stay at the hospital they are admitted to. They may be cared for on a specialist ward devoted to stroke care or on a general hospital ward with other patients.

The CCG proposed caring for everyone who has a stroke on a specialist stroke ward (called an 'Acute Stroke Unit' or ASU).

- The CCG proposed having 1 specialist stroke ward at Southmead Hospital serving everyone in Bristol, North Somerset and South Gloucestershire.
- The CCG also wanted to know what people thought of having 2 specialist stroke wards, one at Southmead Hospital and one at Bristol Royal Infirmary. With this approach, everyone would be admitted to Southmead Hospital for their emergency care for the first few days. Some would then be transferred to Bristol Royal Infirmary for ongoing care.

1,745 consultation responses stated whether they supported this proposal. **Half supported having one specialist stroke ward (50%) and half supported having two specialist stroke wards (50%).**

People had similar views about the proposal regardless of their age, gender, ethnicity, whether they had experienced a stroke and whether they provided feedback direct to the CCG or through a door-to-door interview. People from Bristol and North Somerset were slightly more likely to support 2 wards, as were carers of people who had experienced a stroke (see appendix).

There is currently a specialist stroke ward at Bristol Royal Infirmary. This would close under the CCG's preferred proposal. University Hospitals Bristol and Weston NHS Foundation Trust, which runs this hospital, stated that it **supported** the CCG's preferred proposal. It also highlighted a risk that the University Hospitals Bristol and Weston workforce may lose the clinical skills to manage stroke patients who are not able to be transferred to Southmead Hospital and patients on non-stroke pathways (e.g. acquired brain injury).

> **"As a cautionary note, given the scale of workforce changes we already face across the system, we will collectively need to ensure focus on the recruitment and retention of staff across the whole stroke pathway."** (Letter from University Hospitals Bristol and Weston NHS Foundation Trust)

North Bristol NHS Hospitals Trust, which runs Southmead Hospital, did not express a preference related to this proposal.

The neighbouring Somerset Clinical Commissioning Group stated that it was keen to work with the CCG to consider next steps. It raised questions about how transfers would be handled for people from Sedgemoor, who it is proposed would receive their immediate emergency care in Somerset.

> **"If a Somerset patient was taken to a HASU at Southmead would they continue their care in the ASU at Southmead or need to be transferred back into Somerset? If a Somerset patient is taken to the HASU at Southmead, what provision will be made for patients living in Somerset? It has to be appreciated that Southmead Hospital is 40 miles from some areas of Sedgemoor, resulting in an 80 mile round trip, with little public transport provision for visiting relatives."** (Letter from Somerset Clinical Commissioning Group)

Responses from South Gloucestershire were slightly more likely to support having 1 specialist stroke ward at Southmead Hospital and responses from North Somerset were slightly more likely to support having another specialist stroke ward at Bristol Royal Infirmary. However, in all geographic areas, preferences were almost equally split between having 1 or 2 specialist stroke wards.

REASONS FOR SUPPORTING 1 STROKE WARD

1,475 responses made 1,988 comments about why they supported having 1 or 2 specialist stroke wards. Responses could provide more than one reason for their view.

The main reasons for supporting a single specialist stroke ward were:

- perceived smoother **patient journey** including the potential for fewer transfers, more continuity when people are unwell, fewer delays, less time in hospital and less burden on the ambulance service (26% of 1,475 responses that gave a reason said this)
- responses thought the **location** of Southmead Hospital was accessible, with parking space that is not available elsewhere (14%)
- thinking that **better care** may be available if all resources are in 1 ward, rather than diluting into 2 wards (5%)
- perceived better use of **resources** and less cost (4%)
- perception that Southmead Hospital **already** provides a good service (3%)
- believing that 1 ward would consolidate **staff skills**, as it was thought that staffing was too stretched to cover 2 wards (2%)
- perceived better **patient outcomes** and possibility of equitable treatment for all, no matter where people live (2%)
- suggestion that the area may not not need a second unit so **close** (3 miles apart) (1%)

"Keeping services on one site means patients can go back to the emergency bit if needed and also good to have less ambulance transfers for patients." (Feedback form provided by White 25-40 year old man in Bristol)

"All in one place was preferred for the hyperacute and acute phases of stroke care. Everyone agreed that patients should not be transferred during this time." (Notes from online public meeting)

"Keeping patients in one place would be better as patients can be quite frightened and disruptive. Public transport is not great in terms of getting to Bristol Royal Infirmary. There are better services available to Southmead." (Notes from meeting with Virtual Carers Group)

"A single ASU reduces the number of patient transfers and team handovers for the patients which would result in poorer patient experience for the majority of patients and delays. It also consolidates the specialist stroke capacity, enabling a more resilient service. However, it is essential that all parts of the proposed pathway changes are fully implemented to ensure that patients do not spend more time in acute setting than is necessary." (Feedback form from a healthcare professional in Bristol)

There was positive feedback about having one ASU at Southmead, with comments that it would reduce costs and … people would receive the best treatment. There were comments about the financial implications in having two ASU sites, with questions about the level of care if there were to be two sites… They would be concerned that the same services would not be offered at both sites." (Notes from Bristol After Stroke meeting)

REASONS FOR SUPPORTING 2 STROKE WARDS

Reasons that people gave for supporting 2 specialist stroke wards were:

- **capacity**: responses thought that 1 ward may not be able to provide services for an area as large as Bristol, North Somerset and South Gloucestershire (28% of 1,475 responses that gave a reason)
- responses thought there would be more **equal access** for those in North Somerset and southern parts of Bristol. They also said more older people live in North Somerset (20%)
- perception that having an extra ward would mean that it would be easier and more accessible for **families** visiting. Responses stated that visitors were essential for providing support and that Southmead Hospital was difficult to get to by public transport (13%)
- perception that 2 wards would better support other **service pathways**, including for people who have a stroke while at Bristol Royal Infirmary and heart patients who cannot transfer. Responses said that there was already a good stroke ward at Bristol Royal Infirmary that should not be closed (7%)
- perceived improved **patient outcomes** such as more choice about where to receiving ongoing care, perceived better clinical outcomes and more personalised and individualised care (5%)
- perceived increased flexibility and **resilience** of the service since 1 stroke ward may not be able to cope with contingencies (3%)
- perceived negative **impacts on staff** if closing a stroke ward at Bristol Royal Infirmary, such as possibly deskilling staff and reducing training opportunities, which may reduce staff retention (1%)

"Support for having 2 as it's a big area to cover and distance to travel. Bristol Royal Infirmary is hard to get to and no parking though so hard for families to visit. Wanted assurance that the second unit would be the same standard as the one at Southmead." (Notes from meeting with Thornbury and District Stroke Support Group)

"Bristol Hospital is a very well located hospital to offer the specialist treatment." (Door-to-door interview with Asian female aged 41-64 years in South Gloucestershire who had experienced a stroke)

"I'm afraid might get overwhelmed if there are a lot of cases so better to have 2. More choice for patients." (Door-to-door interview with Black male health and care worker aged 25-40 in Bristol)

"Having a cardiac hospital at Bristol Royal Infirmary needs stroke services on site, not moving cardiac patients away from specialist cardiac care because they have had a stroke. Also not fair on relatives to visit from Bristol or North Somerset to Southmead - family contact has a massive positive impact on recovery." (Feedback form provided by 25-40 year old ethnic minority female healthcare worker in South Gloucestershire)

"Issues with overcrowding so 2 sites is good to maintain flow but perhaps better at a site further away from Southmead." (Feedback form provided by 25-40 year old White man, area unknown)

SHORT STAY REHABILITATION

Some people who have a stroke are not ready to go home after their hospital-level care ends. Currently these people may stay in hospital longer, go to a live-in rehabilitation unit or be discharged home or to a care home.

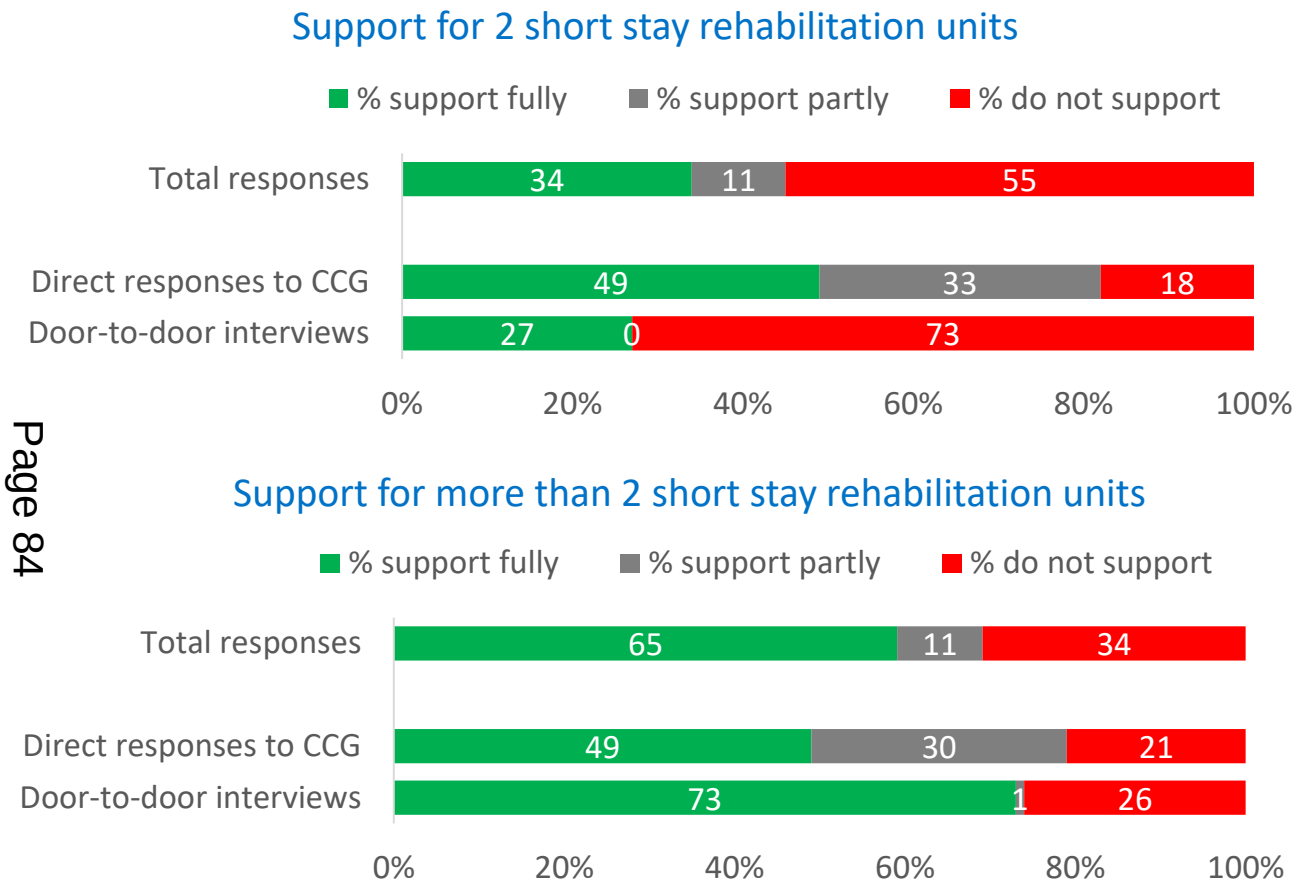
The CCG proposed setting up 2 short stay rehabilitation units (called 'Stroke Subacute Rehabilitation Units' or SSARU) to serve everyone in Bristol, North Somerset and South Gloucestershire.

- The CCG proposed that 1 of these units would be on the Weston General Hospital site.
- The CCG sought feedback about the location of a second short stay rehabilitation unit.

Of 1,592 consultation responses that commented on this, **one third fully supported 2 short stay rehabilitation units (34%) and two thirds fully supported having 3 units or more (65%).**

Those taking part in door-to-door interviews were more likely to want 3 or more short stay rehabilitation units (see Figure 5). People who had experienced a stroke were more likely to support having 2 units, whereas carers wanted more than 2 units. The appendix contains further demographic differences.

Figure 5: Support for 2 or more short stay rehabilitation units



Note: 1,593 responses stated whether they supported having 2 short stay rehabilitation units. Direct responses to the CCG could express partial support for both options. The door-to-door interviews asked people to choose between them. Open-ended feedback showed that there was sometimes a lack of understanding about what a short stay rehabilitation unit was, particularly in door-to-door interviews. Some confused this with care after discharge or emergency care. Some did not understand the term 'stroke subacute rehabilitation unit' or 'SSARU'. Direct responses were more likely to support 2 units than door-to-door interviews (82% vs 27% interviews partly or fully)

Area — No meaningful differences as all areas preferred 3 or more rehab units, but North Somerset responses also liked the idea of 2 units because one would be at Weston General Hospital

Age — No difference between age groups

Ethnicity — No meaningful difference between ethnic groups

Gender — A larger proportion of people supporting 2 units were women, but the majority of women, men and non-binary people preferred more than 2 units

People who had experienced a stroke — People who had experienced a stroke were more likely to favour 2 units (61% vs 45% total responses partly or fully supporting)

Carer of someone who had a stroke — Carers were more likely to support 3 or more rehab units (77% vs 65% total responses)

Health or care professional — Health and care professionals were more likely than other responses to support 3 or more rehab units

REASONS FOR SUPPORTING 2 SHORT STAY REHABILITATION UNITS

2

1,462 responses made 1,846 comments about the reasons why they did or did not support the CCG's proposals about short stay rehabilitation units. Responses could provide more than one reason for their view.

The main reasons given for supporting having 2 short stay rehabilitation units serving the area were:

- Perceiving this as a good **compromise** that brings staff together at a manageable number of units but also has 1 unit in the north and 1 in south of the area to give easier access (15% of 1,462 responses that gave a reason for their view)
- thinking that there may be **better quality care**, including more continuity and less reduction in standards of care across a greater number of units (3%)
- perceived good use of **resources** (3%)
- thinking that 2 units provide enough **capacity** to cope with the number of strokes (2%)
- thinking that this would boost **Weston General Hospital** (2%)
- potential for improved **staff** recruitment and retention with perceived attractive jobs such as rotational posts (1%)

Reasons that responses supported having 3 or more short stay rehabilitation units were:

- **capacity**: some responses said the area is geographically spread and the population is large so they thought 2 units would not provide sufficient capacity or enough redundancy for contingencies. Responses said that rehabilitation can take a long time so units may get full and create a bottleneck for discharges from hospital (64% of 1,462 responses that gave a reason)
- belief that the more units there are, the closer and easier it will be for **family** to visit, especially given reported limited public transport. Responses said that family visits could be an important part of recovery, and that family should not be expected to travel long distances for an extended period whilst people stay in a rehabilitation unit (27%)
- thinking that it may be better to have rehabilitation locally to support discharge planning, continuity of onward care and perceived **smoother transitions** to the home environment (3%)
- desire to keep **existing services** open, including to reduce the need for staff to move (2%)
- perceived that this would provide more patient **choice** (1%)

3+

REASONS FOR SUPPORTING 3 OR MORE SHORT STAY REHABILITATION UNITS

EXAMPLES OF SUPPORTING 2 REHAB UNITS

"(In addition to Weston), Bristol/South Gloucester needs a dedicated unit to cater for the number of stroke patients. One unit in this area would enable a robust specialist team that can support and develop each other, facilitate cover 7 days a week and promote staffing levels for this thus providing a patient centred service. Working in a smaller rehab unit with a handful of stroke beds is difficult as this has to be juggled with remaining non-stroke patients thus affecting the intensity of rehab required as per national stroke guidelines." (Feedback form from disabled White woman aged 41-64 in South Gloucestershire)

"I think rehab in an inpatient unit should be in a location that is close to a service user's home, to allow links with family and friends and community. However, I understand how financially this may not make sense and to consolidate resources into 2 units would be appropriate." (Feedback form from White female aged 41-64 in Bristol who had experienced a stroke)

"Group felt that is was good that there will be a service in Weston as travel and accessibility for North Somerset residents going to Bristol-based hospitals can be difficult. One attendee mentioned that they have had positive experiences with Weston stroke services previously, so was pleased that part of the pathway could be continued here." (Notes from meeting with North Somerset Patient Participation Group)

"Makes sense to allow specialism in the 2 units rather than spreading staff and beds across multiple locations." (Notes from staff meeting at healthcare organisation)

EXAMPLES OF SUPPORTING 3 OR MORE REHAB UNITS

"I think the whole of the BNSSG area is too big for 2 units. Should definitely have one in Weston for North Somerset, one in South Gloucestershire and South Bristol. A majority of patients with stroke will require a reasonable period of inpatient stroke rehab prior to discharge and 3 units will enable patients to be nearer their home and families while receiving this." (Feedback form provided by White female healthcare worker aged 41-64 years in Bristol)

"Better to have more. Need to keep services more local so it is easier for family to visit." (Notes from visit to people receiving stroke care at Weston General Hospital)

"There should be one in each location so relatives can get there and you are closer to home." (Door-to-door interview with White female aged 41-64 in Bristol who had experienced a stroke)

"Part of the rehabilitation is reengaging with friends and family. Also friends and family need to learn how best to support when the patient returns home. This means that the family and friends support network need to have easy access to the rehab unit - as I did. They can provide the knowledge of the home background and bring stories of past events / photos etc to assist with memory loss and communication." (Feedback form from White female stroke carer aged 25-40 in South Gloucestershire)

LOCATION OF SHORT STAY REHABILITATION UNITS

The CCG proposed to have one short stay rehabilitation unit on the site of Weston General Hospital.

Regardless of the total number of short stay rehabilitation units, **6 out of 10 responses fully supported having one of the units on the Weston General Hospital site**. Only 15% did not support this partly or fully.

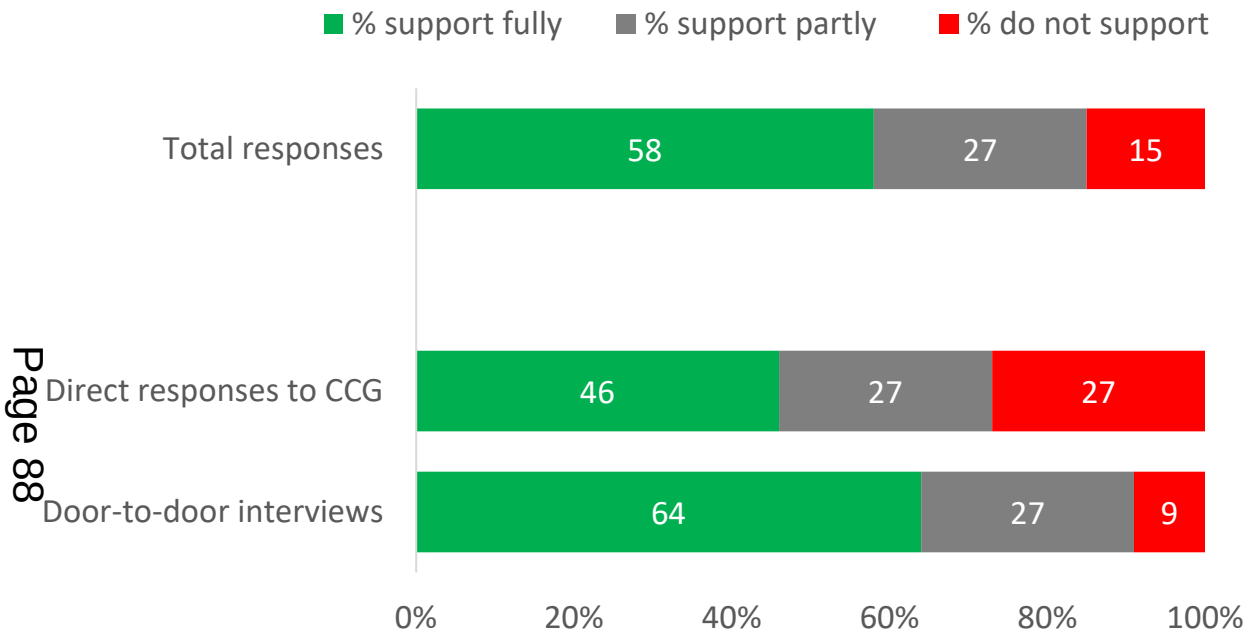
Although there was a high level of support overall, more door-to-door interviews supported this than direct responses to the CCG (see Figure 6).

In open ended feedback over 50 responses (around 5%) said they did not support having a unit on the site of Weston General Hospital because they perceived there to be concerns about the quality of care and staffing at that site. The perceived reputation of the hospital influenced how confident these people were about the level of care that might be provided in a new rehabilitation unit there. It is important to stress that this was a very small proportion of all responses.

Responses had similar views about this proposal regardless of their age, gender or ethnicity. Responses from North Somerset were slightly more likely to favour this, but there was a high level of support from other areas too.

People who had experienced a stroke, their carers and health and care professionals were less likely to support this than others, though there was still a high level of support.

Figure 6: Support for short stay rehabilitation unit at Weston General Hospital



Note: 1,643 responses stated whether they supported a short stay rehabilitation unit at the Weston General Hospital site. Direct responses were less likely to support this than door-to-door interviews (73% vs 91% fully or partly)

Area — Responses from North Somerset were most likely to support this, but all areas were supportive

Age — No difference between age groups

Ethnicity — No difference between ethnic groups

Gender — No difference between gender groups

People who had experienced a stroke — People who had experienced a stroke were less likely to support this than others, but were still largely favourable (79% vs 85% total responses partly or fully)

Carer of someone who had a stroke — Carers were less likely to support this than others but were still largely favourable (78% vs 85% total responses)

Health or care professional — A higher proportion of health and care staff did not support this compared to total responses (24% vs 15% total), though 52% of health and care professionals did fully support it

LOCATION OF ANOTHER UNIT

Responses were invited to suggest a location for a short stay rehabilitation unit somewhere in Bristol or South Gloucestershire, using a prespecified list or adding their own ideas. There were 1,424 responses about this.

Preferences were:

- Elgar Unit at Southmead Hospital (48%)
- Frenchay Hospital (25%)
- South Bristol Community Hospital (18%)
- Skylark Unit in South Gloucestershire (5%)
- Other (4%), in order of frequency stated: Bristol Royal Infirmary, Cosham Hospital, Thornbury, Emerson Green, Bath, Keynsham, Yate

THINGS TO CONSIDER WHEN SELECTING REHAB UNIT LOCATIONS

Responses wanted the CCG to think about the following things when deciding on the location of a short stay rehabilitation unit:

- **travel time** and cost for families and staff e.g. proximity to motorways (44% of 361 responses that commented about this)
- accessibility by **public transport** or having transport provided (26%)
- sufficient **parking** and free parking (21%)
- **spread** of units across the area (18%)
- the **facilities** available such as gardens, social activities, kitchen, rehabilitation gym, individual rooms to support good sleep and having a swimming pool nearby (17%)
- availability of **staff** specialising in stroke, from many disciplines (11%)
- proximity to **hospital** and other services and support groups in case people need them (8%)
- population **demographics**: focusing on where people most at risk of having a stroke live (7%)
- how long it will take to set up or build the unit, or the ability to use **existing facilities** (5%)
- **capacity** and flexibility of facilities (5%)
- facilities being **purpose built** for stroke (3%)
- not in a care home so as to remain appropriate for younger patients and not restrict visiting hours (3%)
- **cost** to establish and maintain (1%)

CARE IN THE COMMUNITY

The CCG's vision for stroke care involves setting up an 'Integrated Community Stroke Service' working across Bristol, North Somerset and South Gloucestershire.

The CCG did not formally consult about this approach, but invited people and organisations to share any feedback about this idea. 267 responses provided 345 comments about plans for the Integrated Community Stroke Service.

1 in 3 said positive things about the idea of an Integrated Community Stroke Service, including the planned mix of roles (36% of 267 responses commenting about this).

- 1 in 5 commented that there was not enough support available currently or reported poor existing services (21%). Although not explicit, the sentiment was that the planned new service may help to alleviate some of these issues.
- About 1 in 5 said they were not convinced that the service would be resourced or implemented as planned, especially not as quickly as stated. Responses said that this service needed to be in place before changes to hospital stroke care (17%).

The rest of the comments about the Integrated Community Stroke Service suggested things that responses would like to see prioritised as part of the service, including:

- good **coordination** and communication across services, including sharing data, reducing duplicated assessments and linking to GPs and the voluntary sector (20% of responses that commented about care in the community)
- **personalisation**, such as providing a list of available services for people to choose between (7%)
- more **staff** capacity and training (7%)
- having a wider **range** of rehabilitation available 7 days a week (6%)
- making support available for a **longer** period (5%)
- **equity** of access to the proposed service (5%)
- involving **family** in ongoing support (4%)
- suggestions for **other services** or roles to include in the team e.g. bladder/bowel support (3%)

"I feel so pleased with what your aims are, we need to do this. When I had my stroke almost six years ago the hospital saved my life, but there is nothing when you come out and we need the continuity of rehabilitation if we are ever going to get better."
(Feedback form from White female aged 76+ in South Gloucestershire who had experienced a stroke)

OTHER THINGS TO CONSIDER

176 direct responses to the CCG provided 213 other comments about things for the CCG to consider when developing stroke services:

- **workforce requirement**s: perceived need to support, value, recruit and train staff (12% of those commenting)
- **communicating what is already available** for people who have a stroke and their families (11%)
- **joining up care** and communication between services (10%)
- developing **stroke support for specific groups** such as younger people, pregnant people, people who do not speak English as a first language and those using the cardiac unit at Bristol Royal Infirmary (7%)
- improving **prevention** and diagnosis (7%)
- providing follow on care for a **longer duration** (3%)
- impacts on people near the **boundaries** of the area (3%)

2 in 10 responses that provided additional comments worried that the proposed changes to stroke services would not happen as described, be well funded or be delivered in a timely manner (21%).

1 in 10 did not think the estimates used were accurate and realistic, such as the estimated travel times or the number of beds needed (10%).

A small number of responses suggested that before making decisions the CCG should hear from a wider range of people such as more people who had experienced a stroke and their carers, cardiac patients and stroke services staff (6%). Some felt that the consultation was not advertised widely.

EXAMPLES OF ADDITIONAL COMMENTS

"We are very supportive of the proposed model for the following reasons: We know that current services are fragmented and inequitable across BNSSG which means that stroke survivors we support have different treatment and rehabilitation depending on where they live before they transfer to community services. The changes support a significant shift to treatment out of hospital, which we believe will deliver better, more cost effective outcomes as well as improving quality of life for stroke survivors. The changes include additional investment across the system to support enhanced treatment and rehabilitation of people who have had a stroke which will contribute significantly to enabling a better outcome and quality of life for individuals and their families." (Letter from Sirona Care & Health)

"General idea seems fine BUT deeply unimpressed by overall reduction of 15 beds. I'm sceptical of the modelling. It assumes a performance improvement which may or may not be achieved. I'd only support bed reduction after improvements clearly demonstrated. Does it take account of growing population adequately?" (Feedback form provided by White man aged 76+ in South Gloucestershire)

"A single HASU for BNSSG is a good idea because it will have the depth of specialist capabilities to provide the very best model of acute care 24 hours per day, 7 days per week - this consistency of specialist service is crucial for giving everyone in BNSSG the best care possible if they have stroke and will significantly improve patient outcomes with reduced mortality and reduced disabilities. However, this model will only work if there is sufficient capacity on the Southmead site to accommodate the additional stroke patients and stroke mimics ... Therefore, it is essential that all parts of the proposed pathway changes including rapid transfer of care to community and social care are achieved for this single site model to work. The volume of additional stroke mimics likely to be routed to Southmead needs to be understood and mitigations agreed to minimise the impact with effective triage protocols applied and rapid repatriation to local hospitals." (Feedback form from healthcare professional in Bristol)

It's great and long overdue. There are pockets of excellence but the system is mostly hugely fragmented and under resourced. After my mum's stroke she refused to eat - but stroke doctors didn't understand mental health issues and she starved …It's been a constant battle for answers so any solutions are welcome, but don't underestimate the extent of the current problem and don't over promise." (Feedback form from White 41-64 year old female carer in Bristol)

SUMMARY

More than 2,000 people and organisations shared their views during Bristol, North Somerset and South Gloucestershire's stroke services consultation. Responses generally supported the CCG's broad goals for stroke services, though often responses did not think that the proposals adequately took into account the geography and demographics of the area or had built in enough capacity and continency to cope with the future demand for stroke services.

The trends in opinions were relatively similar regardless of people's area, age, gender, ethnicity or whether they had had a stroke or cared for someone who had. There were some differences, with people from North Somerset, people who had experience of a stroke, carers and health and care workers more likely to suggest that greater numbers of stroke centres, wards or rehabilitation units were needed.

Overall, people providing feedback through door-to-door interviews were less positive about two out of three of the CCG's proposals compared to those that responded to the consultation directly through meetings, feedback forms, letters, emails and telephone calls. This may be because they had less information about the proposals.

- **Half of responses fully supported the CCG's proposal to have a single centre of excellence for immediate hospital care** (Hyper-acute Stroke Unit) serving everyone suspected of a stroke in Bristol, North Somerset and South Gloucestershire (65% supported partly or fully).

- **Half of responses supported the CCG's proposal to have 1 specialist stroke ward for ongoing hospital care** (Acute Stroke Unit) at Southmead Hospital serving everyone in Bristol, North Somerset and South Gloucestershire. The other half wanted 2 specialist stroke wards, one at Southmead Hospital and one at Bristol Royal Infirmary.

- **One third of responses fully supported the CCG's proposal to have 2 short stay stroke rehabilitation units** serving the area (Stroke Subacute Rehabilitation Units) (45% partly or fully supported this). The majority would prefer to have three or more short stay rehabilitation units (76% partly or fully supported this).

- **Regardless of the number of short stay rehabilitation units, over half of responses fully supported having one of these at Weston General Hospital** (85% partly or fully supported this). The most commonly suggested location for another unit was the Elgar Unit at Southmead Hospital (48%).

"At last a really comprehensive plan for the future of stroke! This is so needed. It should be put in place as swiftly as possible." (Feedback form provided by 41-64 year old White woman in Bristol)

The reasons that responses did not always fully support the CCG's proposals tended to be similar for each of the proposals. These were the issues that responses wanted the CCG to consider when planning next steps:

- **Transport issues** including whether it would have a negative impact on outcomes to travel longer to hospital, the perceived inconvenience and cost of travel for family and visitors, the environmental impact of increased longer ambulance and car journeys, the reported lack of public transport to and from services and concerns about the capacity of ambulance services to cope with longer journeys

- **Capacity** of services to cope, specifically whether one or two centres or units would be sufficient for the number of people having a stroke in future and whether centralising services across a large area would account for contingencies in the event of unexpected infections, pandemics or similar

- **Population demographics**, including the size, level of growth, age profile, and rural location of the population and the number of holiday makers that visit the area

The CCG's consultation materials set out that most people having a stroke could be transported to a centre of excellence for emergency care within 30-45 minutes, but responses questioned whether this was accurate. They also emphasised poor transport infrastructure, including public transport and parking, that they said would make it difficult to visit loved ones.

Responses highlighted the need to concentrate on recruitment and retention of the workforce to bring these proposals to fruition. They also said that community services needed to be strengthened to reduce bottlenecks before making changes to hospital care.

The CCG stated that consultation feedback will be considered alongside other evidence when its Governing Body decides on next steps. Themes from the consultation feedback will be included in a business case with other data, including material that considers and addresses issues raised during the consultation.

"Really happy that after many, many years we are in a place for this to be consulted upon and moved forwards. Well done to all for getting this far!"
(Feedback form from 41-64 year old White female in South Gloucestershire who had experienced a stroke)

APPENDICES

CONSULTATION APPROACH

HOW WERE PEOPLE INVITED TO TAKE PART?

This section summarises information provided by the CCG about the consultation approach.

Between 7 June and 3 September 2021, the CCG and Healthier Together partners sought feedback about the proposals from the public, staff and local organisations. People could give feedback by:

- taking part in a consultation meeting (see details over the page)
- sharing views at an information stand
- completing a consultation feedback form online or via post (freepost)
- providing feedback by post, email, social media or telephone
- taking part in a door-to-door survey if invited
- providing feedback as part of the Healthier Together Citizen's Panel if invited

The CCG promoted the consultation with:

- consultation booklets, factsheets, a video animation and other material placed on the Healthier Together website (https://bnssghealthiertogether.org.uk/)
- 43 engagement events and meetings
- newspaper advertisements, including North Somerset Life magazine (distributed to every household in the North Somerset Council area)
- 56 social media posts
- paid social media advertising on Facebook and Instagram
- paid online content on Bristol Live, Somerset Live, Gloucestershire Live platforms and 'in my area' app
- posters and leaflets
- mail drops in targeted areas of Bristol (about 4,800 homes)
- information stands at COVID-19 vaccination centres
- information shared with Healthier Together partners to distribute, including hospitals, general practices, community services and voluntary and community organisations. The information included wording and images to place on websites, in newsletters and on social media
- materials given to councils to disseminate to elected representatives
- requests to clinical leaders and local authorities to gather feedback from vulnerable groups and people receiving care for stroke in hospital, in the community and at home
- hiring Healthwatch to use their contacts to raise awareness through talks, distributing consultation materials and supporting outreach events

The consultation took place during the COVID-19 pandemic so infection prevention and control requirements meant that materials like leaflets could not always be given out in healthcare settings.

The CCG provided specific materials for areas and groups that may be affected by the proposals in different ways, including people living in the Sedgemoor area and pregnant people.

The CCG also prepared an easy read version of the consultation booklet and a version for people with aphasia. About 1 in 3 people who have a stroke experience aphasia, which affects people's ability to speak, understand what others say, read and write.

Translated materials were available on request, including information in Arabic, Albanian, Bengali, Cantonese, Farsi, Gujrati, Mandarin, Pashto, Punjabi, Somali, Sorani, Turkish and Urdu. An animation about the proposals was also translated into Urdu and Punjabi.

ENGAGEMENT EVENTS AND MEETINGS

The CCG and Healthier Together partners hosted consultation meetings and attended existing meetings to share the proposals and gather feedback. This included events for the public, meetings with healthcare staff and targeted events for older people, people from minority ethnic groups, those living in areas of higher deprivation, men, pregnant people and carers. The meetings also included visits to hospital stroke wards, visits to a traveller site and pop-up engagement stands at COVID-19 vaccination clinics.

The following pages list the meetings.

Most events were held online due to COVID-19 restrictions. When restrictions eased during late-July and August, the CCG began face-to-face activities, adhering to the relevant government guidelines.

The CCG provided the following list of consultation engagement activities. Some of these meetings were used to promote the consultation, not to collect feedback. Notes were taken at the meetings marked with asterisks, and these notes were each counted as a consultation response.

DATE	GROUP / MEETING	PARTICIPANTS	TARGET GROUP
14/06/21	North Somerset casual stroke survivors group*	11	Lived experience
15/06/21	Thornbury and District stroke support group*	12	Lived experience
16/06/21	North Somerset communication support group*	5	Lived experience
16/06/21	Public meeting (online)*	3	Public
17/06/21	4 healthcare staff meetings: one at North Bristol Healthcare Trust, one at Bristol Royal Infirmary, one at Weston General Hospital and one at Sirona (community services)	73	Staff
17/06/21	Bristol After Stroke meeting*	25	Lived experience
24/06/21	Public meeting (online)*	8	Public
25/06/21	Young stroke survivors*	8	Lived experience
30/06/21	Multi-organisational staff event*	15	Staff
30/06/21	Public meeting (online)*	4	Public
06/07/21	South Gloucestershire Patient Participation Group*	22	Public
07/07/21	Public meeting (online)*	7	Public
07/07/21	Carers group (online)*	3	Carers
08/07/21	One Weston Locality Board*	18	Staff
08/07/21	Age UK support hub*	22	Older people
13/07/21	Voluntary Action North Somerset forum*	14	Voluntary sector
14/07/21	Woodspring GP Locality Group*	20	Staff
14/07/21	South Gloucestershire GP membership meeting*	24	Staff
15/07/21	Woodspring integrated primary care group*	20	Staff
21/07/21	Public meeting (face-to-face in Bristol)	0	Public
26/07/21	Social Prescribing Development Group*	20	Voluntary sector

DATE	GROUP / MEETING	PARTICIPANTS	TARGET GROUP
28/07/21	Independent Living Services occupational therapy forum*	19	Staff
29/07/21	Public meeting (face-to-face in North Somerset)*	10	Public
29/07/21	Independent Living Services occupational therapy services meeting*	29	Staff
31/07/21	Pop up event at vaccination clinic	12	Areas of higher deprivation, younger people, minority ethnic groups
04/08/21	Public meeting (face-to-face in South Gloucestershire)*	3	Public
04/08/21	Sirona staff meeting*	22	Staff
11/08/21	North Somerset People First meeting*	12	Disabled people
11/08/21	Pop up event in Easton	50	Areas of higher deprivation, younger people, minority ethnic groups
18/08/21	South Bristol Rehabilitation Unit visit	7	Staff, people with lived experience
19/08/21	Weston General Hospital stroke ward visit (4)*	11	Staff, people with lived experience
20/08/21	Stroke service user group	3	Lived experience
24/08/2021	Weston Active Stroke Group (face-to-face)	35	Lived experience
24/08/2021	Thornbury Aphasia Group (face-to-face)*	6	Lived experience
24/08/2021	North Somerset Patient and Public Involvement Group*	9	Public
25/08/21	Bristol Aphasia Group*	9	Lived experience
25/8/21	Bristol Traveller – three site visits	7	Minority ethnic group
26/08/21	Public meeting (online)*	4	Public
31/08/21	Dhek Bhal meeting*	23	Minority ethnic groups
02/09/21	Multi-organisational staff event	20	Staff

DOOR-TO-DOOR INTERVIEWS

The CCG encouraged people and organisations to share their views online, in writing or at meetings. In addition, the CCG hired a market research organisation to conduct structured face-to-face interviews with people from randomly selected parts of the area. The CCG stated that this was to collect feedback from people of a similar age, ethnic group and socio-economic status to the population overall and so the opinions of those who may be less engaged were included. The questions were designed by the CCG to be similar to those used in the consultation feedback form.

The market research organisation randomly selected geographic areas (streets or blocks) to target, taking into account the size of the area and levels of deprivation. Interviewers knocked on doors in those areas and invited people aged over 16 to take part. The interviewers had quota targets to get feedback from people who matched the age, gender, ethnicity and work status profile of the local population. Interviewers left at least 3 houses between interviews. Interviews were conducted during the day, evening and at weekends.

There were a larger number of door-to-door interviews than direct responses to the CCG through meetings, emails and feedback forms. However it is important that the views of people canvassed door-to-door are not seen as more important than other views, just because of the numbers. We must be careful when interpreting the feedback from the door-to-door interviews because:

- People were not given any material to read or watch in advance so were commenting about proposals that they may not know anything about. This means people responded based on their immediate instincts, rather than an informed reflection. Less than 5% of people interviewed said they had heard anything about potential changes to stroke services before the interviewer knocked on their door, and fewer than 2% said they knew much about the proposals. In contrast, people submitting a feedback form or taking part in a meeting had usually had an opportunity to look at consultation material, see a video or hear a presentation, so they may have more informed opinions, or stronger views, than those who answered questions from an unannounced interviewer.
- Interviews took place between 5 July and 12 August 2021. Some of the interviews happened when England remained under COVID-19 lockdown restrictions so some people may not have felt comfortable opening their door. It is uncertain what proportion of households visited declined to take part or did not answer the door.
- The questions asked by the interviewers were not exactly the same as the consultation feedback form or meeting prompts. The CCG reported that changes were made to give more flow during an interview, but this changed the meaning of some questions and asked about different concepts, particularly related to having a single centre of excellence for emergency stroke care at Southmead Hospital. It appears that these wording changes influenced the feedback.
- The interviewers typed people's responses as they spoke. There was a difference in the quality and quantity of information that interviewers captured. Some interviewers typed people's responses word for word, whereas other interviewers typed only a few words to represent the main things that people said. There was a lot less detail collected about people's reasons in door-to-door interviews compared to other responses.

More people who had experienced a stroke, carers and health and care workers responded directly to the CCG than took part in the door-to-door interviews.

The CCG's consultation activities partly aimed to seek feedback from those most likely to be affected or who may have informed opinions about the proposals.

Characteristics of people responding directly to the CCG versus in door-to-door interviews

Characteristic	% of individual responses received	% of door-to-door interviews	% of all responses
Total number	644	1,126	1,770 responses from individuals
People who had experienced a stroke	14%	2%	7%
Carer of someone who had a stroke	19%	5%	10%
Long term physical or mental health condition other than stroke	9%	9%	9%
Carer of someone with condition other than stroke	8%	5%	6%
Disabled	7%	3%	5%
Health or social care workforce	42%	6%	19%

Note: People could have more than one of these characteristics

COMPILING THEMES

The CCG logged all responses received in a spreadsheet and passed on the responses to an independent team to compile. The independent team read all of the feedback and numerically coded each open comment. The independent team then analysed the themes using a software package (the Statistical Package for the Social Sciences). The team drew out quotes as examples to illustrate common themes.

The independent team looked at whether people had different opinions depending on their age, gender, ethnicity, area, whether they had experienced a stroke, were a carer or health professional and whether they gave feedback directly to the CCG or via a door-to-door interview. The independent team used statistical tests to see whether there were any differences between groups (Chi-squared test based on 95% level of confidence). In this report, anywhere a 'difference' between groups is mentioned, this refers to a significant difference based on these statistical tests. This means the difference is not likely to have happened by chance.

It is important to bear in mind the following things when interpreting the feedback.

- The independent summary of themes aimed to compile **common points**, not to describe the detail within each response. The summary of themes is not a substitute for reading each of the responses individually.
- The feedback presented represents people's **opinions**, rather than objective facts. Views from a wide range of people were included and not every person who provided feedback will agree with all of the points raised.
- The summary shows what people and organisations that provided feedback said. It **does not generalise** to represent the opinions of all people in Bristol, North Somerset and South Gloucestershire. The report lists the proportion of responses that mentioned each theme to illustrate how often points were raised, but this does not show the proportion of the population who share this view.
- One 'response' does not necessarily equate to one person. Pieces of feedback varied in size and scale, with some comprising a short email from an individual, others a letter representing an entire organisation and others being notes from meetings with many participants, for example. The theme summary **did not weight** the responses in any way because all feedback was important to the CCG.
- If someone provided feedback in multiple ways, they would be counted more than once. For example, someone who took part in a meeting and also submitted a feedback form would be counted as part of two responses. This is why it is important to use the percentages as a guide to show which opinions were **most common**, but not to focus too much on the exact numbers.
- The consultation is **not a referendum** or 'vote'. The CCG wanted to understand the reasons for people's views so it could consider these opinions when planning next steps. The CCG's Governing Body will consider the consultation feedback alongside other evidence when making decisions.

RESPONSES RECEIVED COMPARED TO TARGETS

The CCG set itself a target of encouraging 1,500 individual responses to the consultation. It achieved this target, with 1,774 individual responses, plus meetings. The table below sets out the targets that the CCG set itself for reaching specific population groups and the extent to which it achieved these. No formal target was set for responses from people with lived experience of stroke but more than 300 responses, or 1 in 6, came from someone who had experienced a stroke (117 people) or a close family member or carer of someone who had a stroke (170 people). In addition, the CCG facilitated meetings with people who had experienced a stroke and their carers.

GROUP	CATEGORIES	MINIMUM TARGET NUMBER OF PEOPLE	NUMBER OF INDIVIDUALS RESPONDING
Age	Under 25 years	150	188
	25-40 years	300	475
	41-64 years	340	628
	65+ years	200	386
Disability, impairment or long-term condition	People with a disability or impairment (including due to stroke) or a long-term condition other than stroke	95 disability	85 disability or impairment 152 long-term condition (193 disability and/or long-term condition)
Ethnicity	Ethnic minority groups	100	155
Sex	Males	490	780
	Females	510	906
Areas of higher deprivation	Multiple deprivation indices 1-2	160	295 (in door to door survey where this information was known)
Geography	Bristol	480	782
	North Somerset	230	387
	South Gloucestershire	290	513
Carers	Those with caring responsibilities	94	170 carers or close family of people who had a stroke; 112 carers of people with other long-term physical or mental health conditions

PRIORITIES FOR EMERGENCY STROKE CARE

CHARACTERISTICS	NUMBER RESPONDING	% PRIORITISED THE MOST SPECIALIST STAFF AND EQUIPMENT	% PRIORITISED HOSPITAL CLOSE TO HOME
All responses	1,750	69%	22%
Area	1,681	70% Bristol 68% North Somerset 67% South Gloucestershire	21% Bristol 23% North Somerset 25% South Gloucestershire
Age	1,662	68% under 25 67% 25-40 73% 41-64 64% 65-75 65% 76+	25% under 25 24% 25-40 20% 41-64 26% 65-75 23% 76+
Ethnicity*	1,662	60% Asian 63% Black 56% Gypsy / Traveller 70% White 39% Other	34% Asian 29% Black 37% Gypsy / Traveller 22% White 33% Other
Gender	1,666	69% women 68% men	23% women 23% men
Person who had experienced a stroke	109	73%	14%
Carer of someone who had a stroke	168	76%	13%
Direct responses to CCG	635	78%	9%
Door-to door interviews*	1,115	63%	30%

Note: * indicates a statistically significant difference between groups.

IMPACT OF DIFFERENCES IN QUESTIONS

The CCG used different questions to ask people about its proposal for a single centre of excellence for emergency stroke care at Southmead Hospital.

In consultation feedback forms and meetings, the CCG asked people the extent to which they supported having a single Hyper-acute Stroke Unit at Southmead Hospital serving the whole area. The door-to-door interviews used two different questions to ask people about this proposal, one about the preferred location of a Hyper-acute Stroke Unit and one about whether people supported having one unit to serve the whole area, regardless of where it was located.

To be able to combine the feedback from the two different types of questions, the analysis used the CCG's official consultation form as the primary question. The analysis then drew out feedback from the door-to-door interviews to match that question. The analysis team first considered whether people interviewed said they supported a single unit at Southmead Hospital if there could be only one unit. Then they looked at people's stated reasons why in order to judge whether they partly or fully supported the proposal. This was cross checked with another interview question about whether or not people supported having one unit serving the whole area.

A validity check combined the proportions from two quantitative interview questions without looking at people's comments. Here all the people were identified who supported BOTH a single unit serving the whole area AND who supported the unit being located in Southmead Hospital. Using this approach, 26% fully supported and 22% partly supported having a single Hyper-acute Stroke Unit at Southmead serving the whole area (48% overall, compared to 52% using the method which took people's open-ended comments into account).

Thus whichever analysis method was used, the trend was about the same: half of people who took part in door-to-door interviews partly or fully supported a single Hyper-acute Stroke Unit at Southmead.

One of the door-to-door interview questions asked "which one of the TWO options do you most prefer?" People were asked to choose between a single Hyper-acute Stroke Unit at Southmead Hospital or a single Hyper-acute Stroke Unit at another hospital. Some people suggested another possibility or said they did not know.

This is forced choice question asking where a unit would be located if there could only be **one** unit. 77% of people interviewed said that if there could only be one unit, they would prefer it at Southmead Hospital. This does **not** mean that 77% preferred only one unit though. In fact, when combined with answers to another question about whether people agreed with having only one unit, the results showed that 26% fully supported having a single unit located at Southmead Hospital.

SUPPORT FOR SINGLE CENTRE OF EXCELLENCE (HASU)

CHARACTERISTICS	NUMBER RESPONDING	% FULLY OR PARTLY SUPPORT	% DO NOT SUPPORT
All responses	1,732	65%	35%
Area	1,681	65% Bristol 61% North Somerset 64% South Gloucestershire	35% Bristol 39% North Somerset 36% South Gloucestershire
Age	1,662	58% under 25 66% 25-40 65% 41-64 60% 65-75 65% 76+	42% under 25 34% 25-40 35% 41-64 40% 65-75 35% 76+
Ethnicity	1,662	64% Asian 61% Black 64% Gypsy / Traveller 64% White 76% Other	36% Asian 39% Black 36% Gypsy / Traveller 36% White 24% Other
Gender*	1,666	68% women 59% men	32% women 41% men
Person who had experienced a stroke*	109	85%	15%
Carer of someone who had a stroke	168	72%	28%
Health or care professional*	254	79%	21%
Direct responses to CCG	626	89%	11%
Door-to door interviews*	1,106	52%	48%

Note: * indicates a statistically significant difference between groups or compared to the overall average.

SUPPORT FOR 1 OR 2 SPECIALIST STROKE WARDS (ASU)

CHARACTERISTICS	NUMBER RESPONDING	% SUPPORT 1 STROKE WARD	% SUPPORT 2 STROKE WARDS
All responses	1,745	50%	50%
Area*	1,688	47% Bristol 46% North Somerset 54% South Gloucestershire	49% Bristol 52% North Somerset 44% South Gloucestershire
Age	1,671	45% under 25 46% 25-40 51% 41-64 53% 65-75 47% 76+	52% under 25 49% 25-40 47% 41-64 46% 65-75 52% 76+
Ethnicity	1,671	52% Asian 40% Black 44% Gypsy / Traveller 49% White 33% Other	45% Asian 56% Black 56% Gypsy / Traveller 48% White 56% Other
Gender	1,673	48% women 49% men	49% women 48% men
Person who had experienced a stroke	109	49%	46%
Carer of someone who had a stroke*	167	39%	56%
Health or care professional	240	47%	53%
Direct responses to CCG	619	48%	52%
Door-to door interviews	1,126	51%	49%

Note: * indicates a statistically significant difference between groups or compared to the overall average. 9% of direct responses said they had ‘no preference’ and are excluded from the figures above. If those responses are taken into account, 44% of direct responses supported 1 specialist stroke ward and 47% supported 2..

SUPPORT FOR 2 OR 3 SHORT STAY REHAB UNITS (SSARU)

CHARACTERISTICS	NUMBER RESPONDING	% PARTLY OR FULLY SUPPORT 2 STOKE REHAB UNITS	% PARTLY OR FULLY SUPPORT 3 OR MORE REHAB UNITS
All responses	1,593	45%	65%
Area*	1,565	43% Bristol 50% North Somerset 41% South Gloucestershire	80% Bristol 79% North Somerset 74% South Gloucestershire
Age	1,533	35% under 25 46% 25-40 45% 41-64 45% 65-75 44% 76+	80% under 25 73% 25-40 75% 41-64 75% 65-75 78% 76+
Ethnicity*	1,671	41% Asian 42% Black 67% Gypsy / Traveller 44% White 60% Other	73% Asian 82% Black 43% Gypsy / Traveller 76% White 93% Other
Gender*	1,673	50% women 37% men	75% women 77% men
Person who had experienced a stroke*	109	74%	69%
Carer of someone who had a stroke*	167	61%	77%
Health or care professional*	233	64%	74%
Direct responses to CCG*	520	82%	79%
Door-to door interviews*	1,073	27%	74%

Note: * indicates a statistically significant difference between groups or compared to the overall average. Percentages add to more than 100% because responses could support both options and some people party supported both.

SUPPORT FOR STROKE REHAB UNIT AT WESTON HOSPITAL

CHARACTERISTICS	NUMBER RESPONDING	% FULLY OR PARTLY SUPPORT	% DO NOT SUPPORT
All responses	1,643	85%	15%
Area*	1,613	82% Bristol 91% North Somerset 86% South Gloucestershire	18% Bristol 9% North Somerset 14% South Gloucestershire
Age	1,598	88% under 25 84% 25-40 86% 41-64 84% 65-75 84% 76+	12% under 25 16% 25-40 14% 41-64 16% 65-75 16% 76+
Ethnicity	1,595	87% Asian 96% Black 87% Gypsy / Traveller 485 White 77% Other	13% Asian 4% Black 13% Gypsy / Traveller 15% White 23% Other
Gender	1,599	83% women 86% men	17% women 14% men
Person who had experienced a stroke*	92	79%	21%
Carer of someone who had a stroke*	151	78%	22%
Health or care professional*	235	76%	24%
Direct responses to CCG	517	73%	27%
Door-to door interviews*	1,126	91%	9%

Note: * indicates a statistically significant difference between groups or compared to the overall average.

This independent compilation of themes was produced by

THE Evidence Centre

Healthier Together

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Integrated Care System (ICS) Update

For Discussion with JHOSC

15th November 2021

For discussion

1. How Healthier Together partners are working together today
2. Principles and ways of working – our ICS MOU (*full documents attached)*
3. Legislative change and national guidance to-date
4. ICS development priorities and plans

1. How partners are working together today

Healthier Together

An overview of our ICS

- **Population: 1m**
- **Place: 6**
- **CCGs: 1**
- **Providers: 5**
- **Local authorities: 3**
- **PCNs: 18**

The 10 *Healthier Together* ICS partners are:

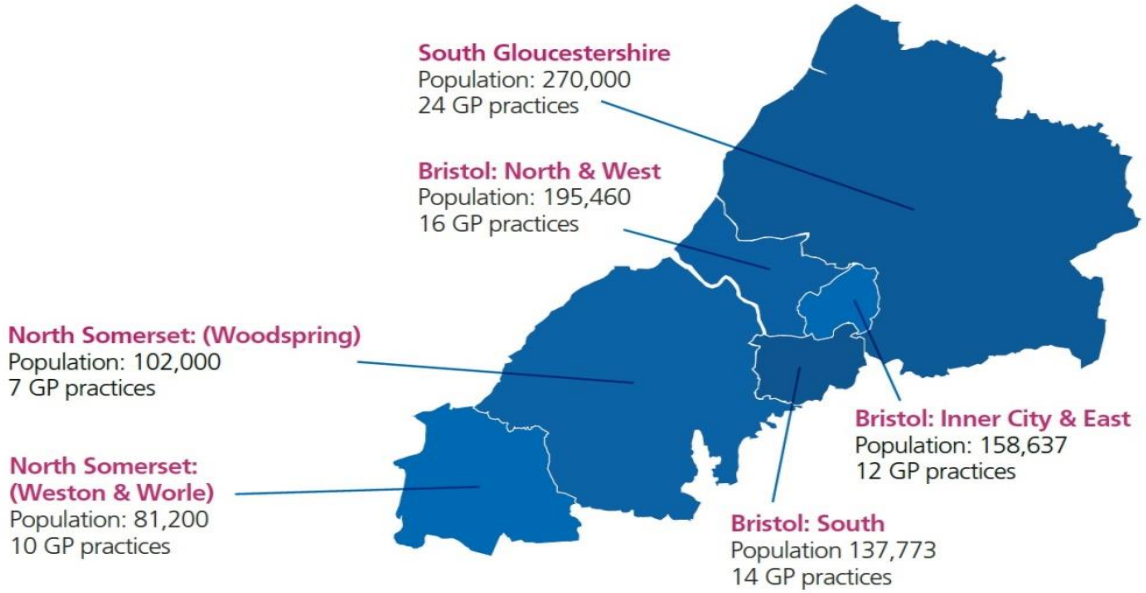
Clinical Commissioning Group:
- BNSSG CCG

Local Authorities:
- Bristol City Council
- North Somerset Council
- South Gloucestershire Council

Healthcare Providers:
- Avon & Wiltshire Mental Health Partnership NHS Trust
- North Bristol NHS Trust
- Sirona Care and Health
- South Western Ambulance Service NHS Foundation Trust
- University Hospitals Bristol and Weston NHS Foundation Trust

GP Federation:
- One Care (BNSSG) Ltd

We are developing integrated care partnerships (ICPs) in six localities:



We were designated as a 'maturing' Integrated Care System in December 2020, in recognition of what we have achieved together….
The next phase of journey involves transition to a new statutory form by April 2022

2016	2019	2020	Feb 2021	Oct 2021	April 2022
Partnership formed	Long term plan	ICS designation	White Paper published	ICS Memorandum of Understanding	ICSs operating in new statutory form

Healthier Together

Our shared vision for the people of BNSSG

Healthier Together is the health and care partnership for people in Bristol, North Somerset and South Gloucestershire. We work together to improve the health of our population and make sure services work for everyone.

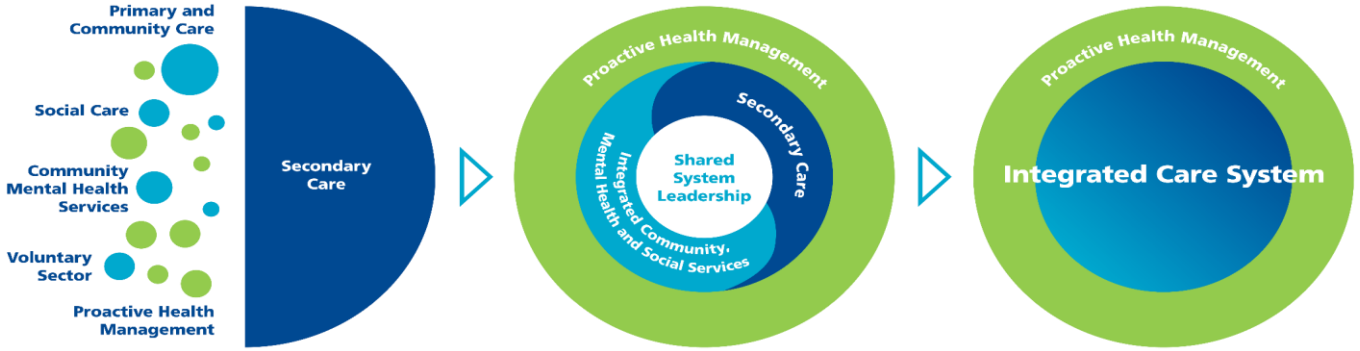
Our vision is for people in Bristol, North Somerset and South Gloucestershire to have the best start in life, and for the places where we live to be healthy and safe.

Everyone will have the opportunity to live longer in good health. When people need support from our services, they will be high quality and easy to access.

People will be better supported to take control of their own health and wellbeing, and become equal partners in care. Working alongside our communities, we'll build on strengths and tackle inequalities together.

We'll make it simple for health and care staff to work better together for the benefit of the people we care for – nurturing talent, removing barriers and acting on views and concerns.

Our vision for delivering our ambitions is to join up care at locality level and across our hospital systems to respond to what people with complex needs tell us matters to them

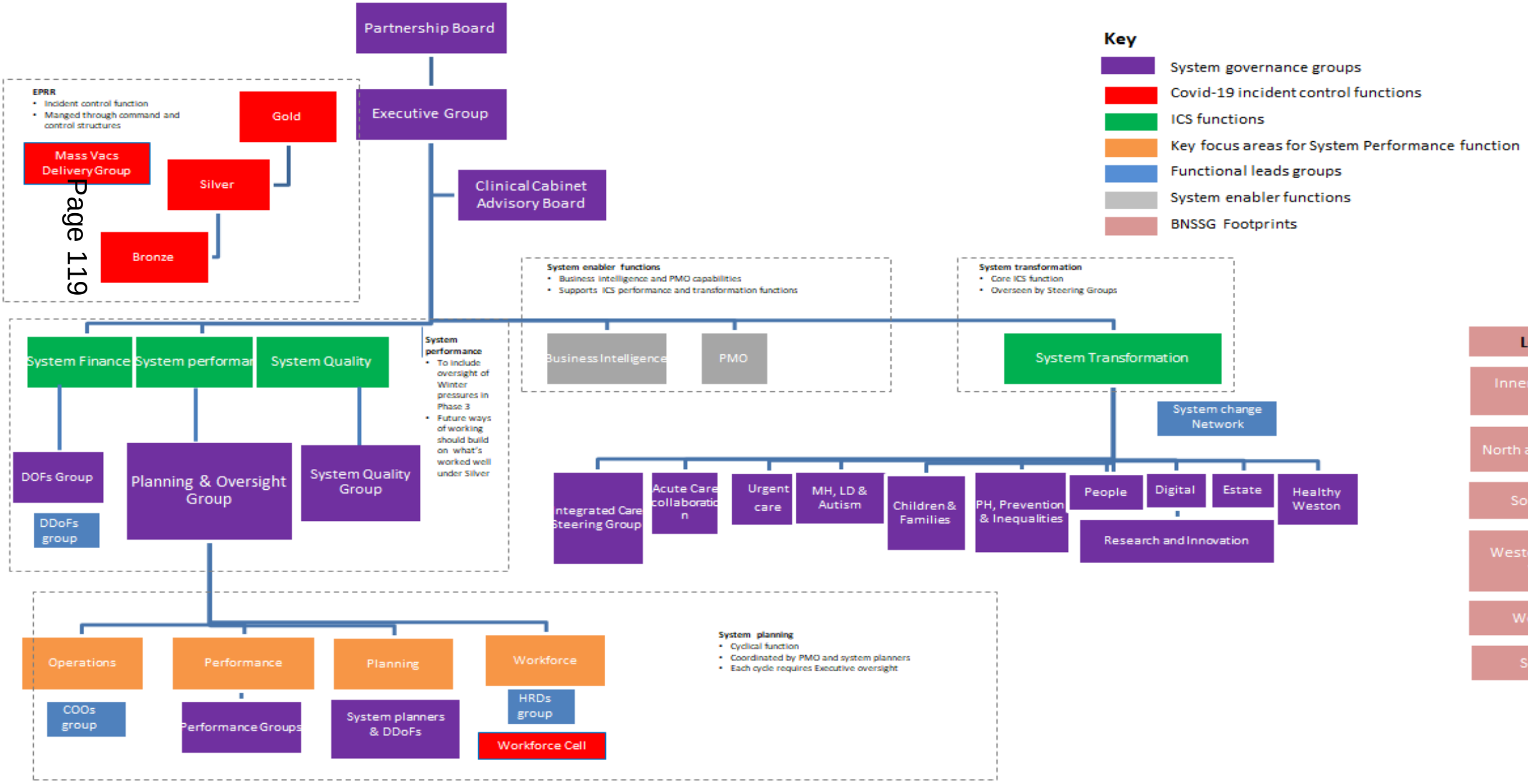


Healthier Together

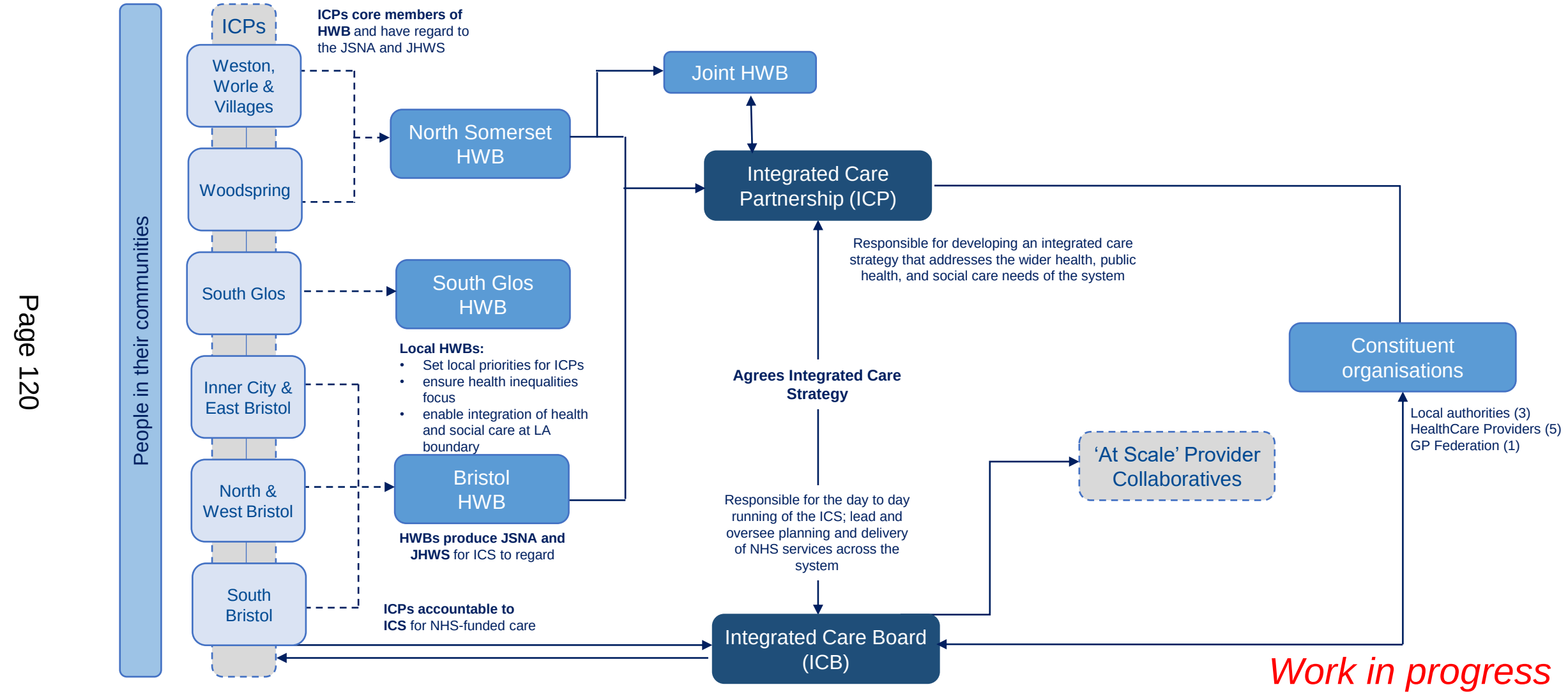
Our BNSSG system goals

Healthier Together

Current Healthier Together Governance Structure



Emerging concept of what our ICS will look like from April 2022



Healthier Together

Acronyms:
- HWB: Health and Wellbeing Board
- JSNA: Joint Strategic Needs Assessments
- JHWS: Joint Health and Wellbeing Strategies

Work in progress **– does not currently include key functions, such as:**
- Clinical and professional leadership
- System planning and performance oversight
- Quality improvement and oversight
- Health and wellbeing transformation and enabling programmes
- Statutory functions for all sovereign bodies

2. Principles and ways of working

Healthier Together

The HT Partnership Board and constituent organisations have signed off an ICS MOU, focusing on *principles* for how we work in partnership for the benefit of the people of BNSSG

ICS MOU scope:

- **How we work together** as Healthier Together partners **and with the people and communities** we serve
- Our **shared vision, values, and principles**
- How we intend to **evolve and build on the work we do in partnership** to achieve our system ambition
- How we want to **make decisions in partnership, resolve disagreements, manage risk, and manage conflicts**

Supporting annexes

- *Outcomes Framework*
- *Outcomes-Driven Performance & Quality*
- *Strategic Commissioning*
- *Financial Framework*
- *Communications and Engagement*
- *Organisational Development Plan*
- *Clinical and Care Professional Leadership Principles*

Principles for how we work together as an ICS

People @ the Centre	1. We work to achieve **our vision** to meet our citizens' needs by working together within our joint resources, as one health and care system. We will develop a model of care and wellbeing that **places the individual at its heart**, using the combined strengths of health and social care. **2. Citizens** are integral to the design, co-production and delivery of services 3. We involve people, communities, clinicians and professionals in all decision-making processes. 4. We will take collective, considered risks to cease specific activity to release funds for **prevention, earlier intervention and for the reduction of health inequalities.** 5. We will focus on the causes of inequality and not just the symptoms, ensuring **equalities is embedded** in all that we do.
Subsidiarity	**6. Decisions taken closer to the communities** they affect are likely to lead to better outcomes. The default expectation should be for decisions to be taken as close to communities as possible, except where there are clear and agreed benefits to working at greater scale**.**
Collaboration	**7. Collaboration between partners in a place** across health, care services, public health, and the voluntary sector can overcome competing objectives and separate funding flows to help address health and social inequalities, improve outcomes, transform people's experience, and improve value for the tax payer. **8. Collaboration between providers** across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity. 9. Through **collaboration as a system** we will be better placed to ensure the system, places, and individual organisations are able to make best use of resources 10. We **prioritise investments based on value**, ensuring equitable and efficient resource allocation, and we take shared ownership in achieving this.
Mutual Accountability & Equality	11. We are coming together under a distributed leadership model and we are committed to working together as an **equal partnership.** 12. We have a **common understanding** of the challenges to be addressed collectively and the impact organisations can have across other parts of the system. We engage in honest, respectful, and open dialogue, seeking to understand all perspectives and recognising individual organisations agendas and priorities. We accept that diverse perspectives may create dissonance, and we seek to understand and work through any disharmony, and move to conclusions and action in service of our citizens. We strive to **bring the best of each organisation** to the partnership. 13. We adhere to a **collective model of accountability**, where we hold each other mutually accountable for our respective contributions to shared objectives. 14. We develop a **shared approach to risk management taking collective responsibility** for driving necessary change while mitigating the risks of that change for individual organisations.
Transparency	15. We **pool information** openly, transparently, early, and as accurately and completely as practical to ensure one version of the truth 16. We work in an open way and establish **clear and transparent accountability for decisions.**

Evolving our ways of working together – what's new/different?

Examples from our ICS MOU:

- Focus on **working in partnership with people and communities** to ensure we deliver what matters to people in BNSSG
- New approach to improve BNSSG population health by delivering **value**: the outcomes that matter and services that work for people and are culturally appropriate, while making best use of resources
- Shift in how we manage **system performance and quality** to be more outcomes-driven, person-centred, proactively improvement-focussed, self-regulating, and with a learning culture utilising peer review
- Plan to develop a **system culture** where we seamlessly work together across sectors and teams
- Approach to establish **place-based partnerships** (also known as integrated care partnerships) to design and deliver fully integrated preventive, proactive, and personalised services focussed on local people's health and wellbeing needs
- Intent to build **'at scale' provider collaboratives** to improve outcomes and consistency of care and optimise use of resources

3. Legislative changes and national guidance to-date

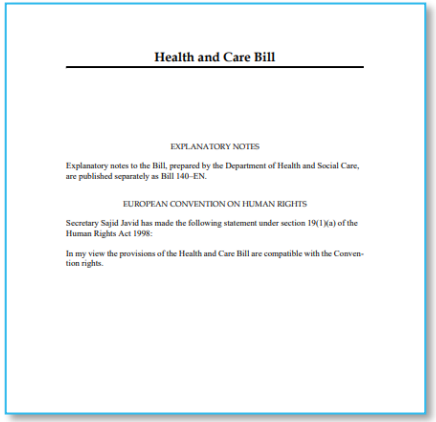
Overall timeline

Feb 2021:

White paper published with legislative proposals for a Health and Care Bill

July 2021:

Health and Care Bill introduced in parliament



July-Oct 2021:

LGA and NHSEI publish guidance documents on ICS implementation

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The draft legislation / Health and Care Bill outlines two structures at the system level. This legislation is still going through Parliament.

Integrated Care Partnership
(locally: Partnership Board)

- **A statutory committee (not a statutory body), formed by the NHS and local government as equal partners**
- Operates as a **forum for joint action** to improve health and care services and influence wider determinants of health and broader social and economic development
- Develops an **"integrated care strategy" for the whole population,** based on local needs assessments

Integrated Care Board:

- **A new statutory organisation**, which will take on all statutory functions of CCGs
- **Responsible for NHS planning and resources**, including development of a five-year forward plan,
- **Establishes joint working and governance** to support system delivery and performance; arranges for the provision of health services and major service transformation programmes

Key points from guidance to-date

- **Flexibility** for Partnership Boards to design and operate in a way to best serve people in their area
- Each ICS to agree how the Partnership / Integrated Care Board work together and be **held to account through the different accountability mechanisms** for local government and the NHS
- **Integrated Care Boards will take on CCG responsibilities** in relation to local authority overview and scrutiny committees
- Integrated Care Boards will be required to work closely with HWBs and **have regard to the joint strategic needs assessments and the joint health and wellbeing strategies**
- Integrated care boards will take on commissioning functions of CCGs, and will be able to delegate commissioning and functions to **place-based partnerships,** building on local delivery partnerships

4. ICS development priorities and transition plans

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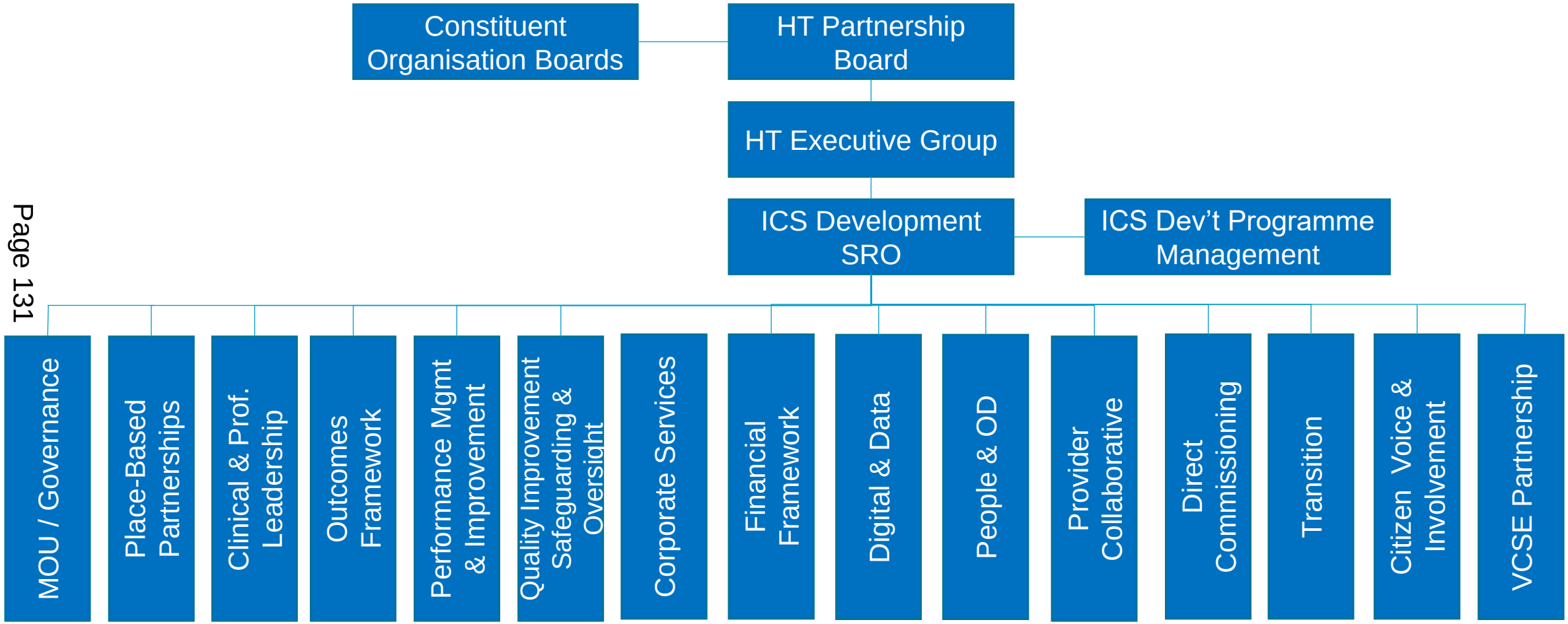
Our strategic development priorities

1	**Developing our partnership and transitioning to a statutory ICS:** evolving our ways of working as an ICS to ensure our system is fit for purpose to achieve our goals for the people we serve and support our staff in the transition
2	**Developing ICPs (x6):** transform experience of health and care (starting with community mental health) through fully integrated preventative, proactive/ anticipatory and personalised services: • Focused on people's health and wellbeing • Building on the asset base of individuals and communities • Embedding the voluntary sector and working with community and faith groups… • …to make community the default setting of care 24/7, 365 days a year
3	**Adopting a new value-based health and care approach** to meet the aims of population health by focusing on achieving the outcomes that matter to people, services that work for them and are culturally appropriate, and making the best use of resources • Working with the community to optimise access to services and prevention/ early intervention • Promoting wellbeing for the whole population, and not just those who present to services • Ensure equitable and efficient resource allocation • Progressing to long-term financial stability
4	**Redesigning pathways to transforming health and care services for the people we serve** (e.g. stroke, mental health, learning disabilities, autism, children's health)
5	**Recovering from the covid pandemic:** increasing access to our services through online, telephone, and face-to-face appointments; reducing waiting lists and supporting our staff…while managing ongoing impact of covid and vaccination campaign
6	**Improving our performance:** driven by the outcomes we want to see for our population; raising standards, e.g. faster diagnosis and treatment for cancer and improved access to physical healthcare for people living with learning disabilities and serious mental illness
7	**Provider** collaboration across the sector to improve outcomes and consistency of care, transform patient experience, and delegate and optimise use of resource, including: • Acute care reconfiguration • Community provider collaboration • Mental health collaboration
8	**Developing our People:** collaborating on recruitment, retention, and learning and development and increasing diversity to make BNSSG the best place to work
9	**Developing our role as an anchor organisation:** investing in and working with communities to impact the wider factors that make us healthy, addressing root causes of health inequalities and promoting social and economic development
10	**Harnessing the power of data and digital technology** to deliver more proactive, person-centred, efficient and effective care

Our ICS development programme structure



The Healthier Together Partnership Board will participate in development sessions this Autumn to address key questions

- What does ‘equal partnership’ mean to us and how do we create it together?
- What is the role and functionality of the Partnership Board in the ICS?
- Would we review our membership in any way?
- How should the Partnership Board and the (NHS) ICB interact?
- How will the interface work between constituent bodies and the Partnership Board?
- How will the Partnership Board relate to place-based partnerships?
- How will the interface work between the Partnership Board and Health and Wellbeing Boards?
- How will we ensure that we are ‘rooted in the people, communities and places we serve’ and how will we interface with them?
- How do we want to develop our Partnership over time?

Key BNSSG ICS development next steps

Q3 2021/22
Design governance and operations

- **Sign off ICS MOU** to agree system principles and ways of working
- **Complete design of ICS governance arrangements** (ICS Partnership Board and Integrated Care Board)
- Begin **long term plan** updates

Q4 2021/22
*Complete transition**

- Begin operating under new governance in **shadow form**
- **Update ICS MOU** in line with national policy and local agreements
- Complete governing documents and **transfer staff and assets to Integrated Care Board**

***Subject to Health & Care Bill passage through parliament; expected timeline:**

6 July 21	14 July 21	Sept/ Oct 21	2 Nov 21	Q3/ Q4	Q4	1 April 22
1st reading – House of Commons	*2nd reading – House of Commons*	Committee stage – House of Commons	Report stage – House of Commons	Bill passes through House of Lords	Royal assent	Bill becomes law

Healthier Together

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Contact us:

Healthier Together Office, Level 4, South Plaza, Marlborough Street, Bristol, BS1 3NX

0117 900 2583

Bnssg.healthier.together@nhs.net

www.bnssghealthiertogether.org.uk

@HTBNSSG