# Briefing paper on Hyper Acute Stroke Unit
# Temporary Service change
# Health Overview and Scrutiny Committee

## Document Control

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## Contents

## 1. Purpose of the Document

This paper for the Gloucestershire Health Overview and Scrutiny Committee (HOSC) provides information on the temporary relocation of Gloucestershire Hospitals NHS Foundation Trust's (GHNHSFT) Hyper Acute Stroke Unit (HASU), Transient Ischaemic Attack (TIA) clinics and Outpatient (OP) clinics from Gloucestershire Royal Hospital (GRH) to Cheltenham General Hospital (CGH); co-locating services with the Acute Stroke Unit (ASU) at CGH and the HASU stroke beds to be provided on the Acute Care Unit (ACUC). The change will be implemented as a Temporary Service Change under the Memorandum of Understanding (MOU) in place between Gloucestershire Integrated Care System (ICS) and Gloucestershire HOSC.

## 2. Context

Two elements of Gloucestershire stroke services are already operating under a temporary (emergency) service change. Part of the ICS response to the first wave of COVID-19 involved GHNHSFT Acute Stroke Rehabilitation moving from GRH to CGH and Gloucestershire Health & Care's (GHC) stroke ward at The Vale Community Hospital increasing from 14 to 20 beds. These two changes are due for review at the end of March 2022.

Further information on this can be found in Annex 1.

## 3. Case for Change

The third change to stroke services is necessary as part of the ICS response to increasing winter pressures (emergency attendances and admissions), Stroke Consultant and Stroke Specialist Nurse workforce challenges and in preparation for an anticipated increase in hospital attendances and admissions related to the Omicron variant of COVID-19. Collectively, these elements are impacting the ability to consistently deliver a high-quality stroke service

Increasing demand pressures in GRH Emergency Department (ED) can lead to delays in stroke patients being seen by the correct team impacting the ability to meet national standards for stroke care, for example time to CT scan carrying out thrombolysis and admission to a dedicated stroke ward within 4 hours.

The service is also carrying an Intolerable Risk associated with workforce shortages. Due to a number of planned and unplanned changes, from January 2022 the stroke senior decision-making team will consist of a Stroke Consultant, an Associate Specialist and a locum consultant, to provide medical cover for stroke wards and outpatient clinics across both sites. In addition, the stroke specialist nurse team is down to one member of staff and the Speech and Language Therapists (SALT) team is reduced to two members of staff.

Nationally there is a shortage of stroke doctors. The Trust has attempted to recruit to these posts substantively, but this has been difficult as, across the country, Trusts are chasing a limited workforce pool.

## 4. Temporary Service Change - Hyper Acute Stroke Unit (HASU)

Gloucestershire Hospitals NHS Foundation Trust's (GHNHSFT) Hyper Acute Stroke Unit (HASU), Transient Ischaemic Attack (TIA) clinics and Outpatient (OP) clinics will move from Gloucestershire Royal Hospital (GRH) to Cheltenham General Hospital (CGH); co-locating services with the Acute Stroke Unit at CGH and with the HASU stroke beds to be provided on ACUC.

This second temporary service change will be implemented w/c 10th January 2022 and will be reviewed at the end of March 2022 to determine if the changes are reverted or retained for a further temporary period. Should evidence show there would be sustainable patient and staff benefits of the temporary change becoming permanent, this would be secured through the Fit for The Future programme and subject to required level of public and staff involvement.

The previous Temporary Service Changes (Acute Stroke Rehabilitation moving from GRH to CGH and stroke beds at The Vale Community Hospital) are part of the stroke pathway review and will also to be updated in March 2022.

This move will be enabled by implementing a stroke direct admission pathway to CGH, therefore by-passing ED. There will also be training for the acute medical team (i.e. the acute medical take and ACUC staff), to provide support to the stroke service.

The Trust has discussed the proposal with the national Getting It Right First Time (GIRFT) clinical lead for stroke services and has been advised that a similar model is currently being used at East Kent Hospitals with direct admissions to a planned care site. Feedback on the proposed model has been positive and supportive.

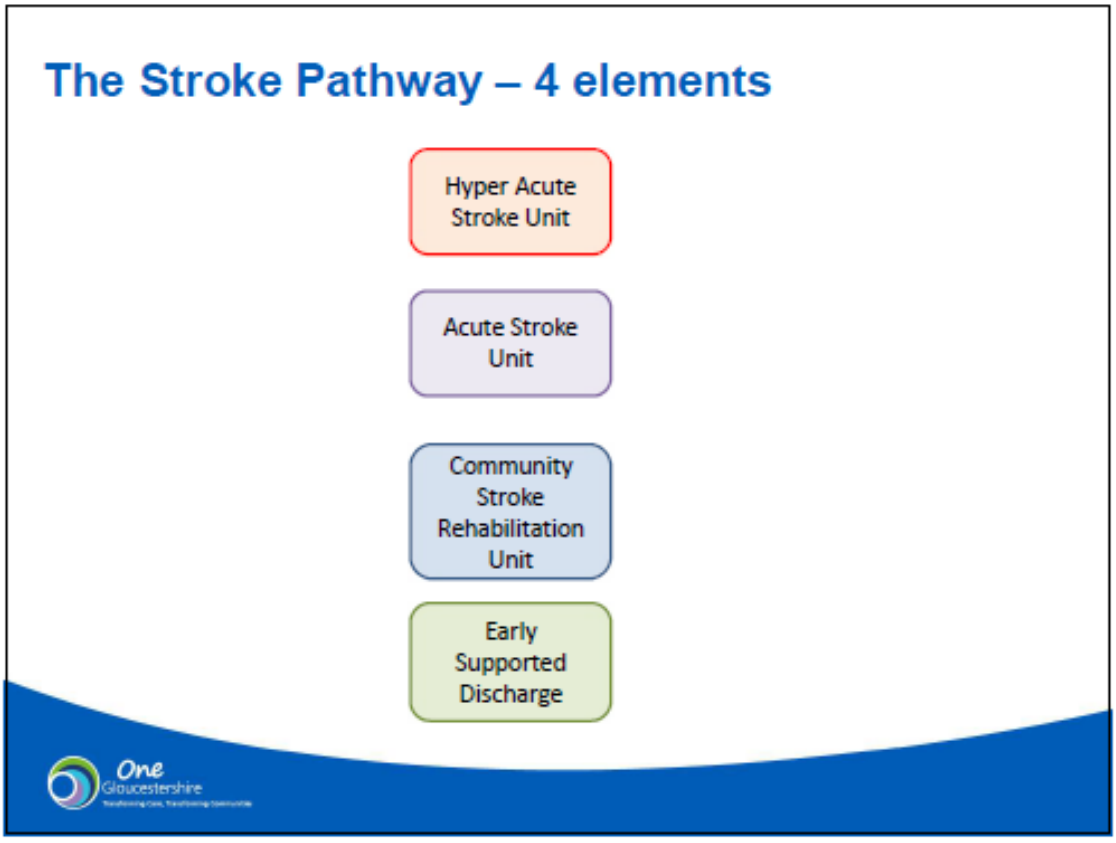
This change will be implemented as a temporary (emergency) service change under the Memorandum of Understanding (MoU) the ICS has in place with Gloucestershire Health Overview and Scrutiny Committee (HOSC).

*Memorandum of Understanding (MoU) Pro-forma* is provided in Annex 2.

## 5. Conclusion

HOSC are requested to note the temporary relocation of HASU from GRH to CGH and, in accordance with the MOU protocols, further updates will be provided on the impact of this in due course.

**Annex 1: Stroke Services: scope and context**

## The Stroke Pathway – HASU

Hyper Acute Stroke Unit

- Suspected stroke and TIA patients
- Patients assessed if suitable for thrombolysis and thrombectomy)
- 850 patients per year
- Length of Stay (< 3 days)
- Transferred to Acute Stroke Unit (50%) or usual place of residence
- Gloucestershire Hospitals NHS FT
- Currently located at Gloucestershire Royal Hospital

Acute Stroke Unit

Community Stroke Rehabilitation Unit

Early Supported Discharge

One Gloucestershire

## The Stroke Pathway – ASU

Hyper Acute Stroke Unit

Acute Stroke Unit

- Stroke Rehabilitation
- 500 patients per year
- Length of Stay (Median average 12 days)
- Transferred to Community Stroke Rehabilitation or usual place of residence
- Gloucestershire Hospitals NHS FT
- Pre-COVID 19 located at Gloucestershire Royal Hospital
- Currently located at Cheltenham General Hospital

Community Stroke Rehabilitation Unit

Early Supported Discharge

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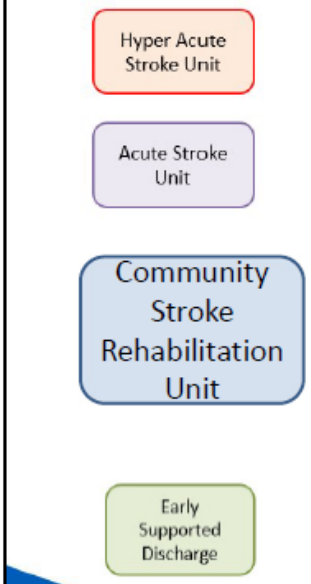
3

## The Stroke Pathway – Community Rehabilitation




- Stroke Rehabilitation
- 200 patients per year
- LoS (Median average 34 days)
- Discharged to usual place of residence (74%), new Care Home (16%) or specialist unit (1%)
- Gloucestershire Health & Care NHS FT
- Located at The Vale Community Hospital
- Pre-COVID 19 capacity = 14 beds
- Current (temporary) capacity = 20 beds

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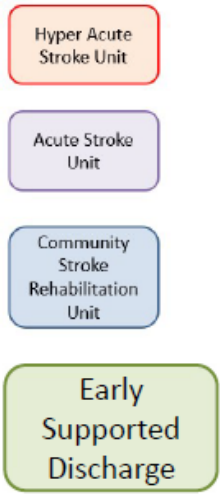
4

## The Stroke Pathway – Early Supported Discharge




- A therapy led outreach community 'step down' service delivered at usual place of residence
- Up to 6 weeks
- 474 patients per year
- Supporting improved flow from acute and rehabilitation stroke unit beds
- Gloucestershire Health & Care NHS FT

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5

## Stroke Pathway Service Review 2021/22


- To maintain and enhance outcomes for patients as measured by SSNAP* performance
- To determine the optimal number of beds across the pathway (including at The Vale)
- To determine the preferred location of Acute Stroke Unit (CGH or GRH)
- Longer term preferred staffing models for each element of the pathway
- Opportunity presented by enhancing the Early Supported Discharge service
- To update in March 2022 including temporary changes

* Sentinel Stroke National Audit Programme https://www.strokeaudit.org/About-SSNAP.aspx

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6

## *Second Stroke Service Temporary Change*
## Relocation of HASU from GRH to CGH

Hyper Acute Stroke Unit

- The change is necessary as part of the Integrated Care System (ICS) response to increasing winter pressures (emergency attendances and admissions) and Stroke Consultant and Stroke Specialist Nurse workforce shortages.
- Move the HASU from GRH to beds within the Acute Care Unit at CGH
- Centralise stroke inpatient beds onto one site at CGH
- Implement in Jan 2022 as an emergency (temporary) service change in line with the agreed MOU


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7

## Annex 2: Memorandum of Understanding (MoU) Pro-forma
## Consideration of a temporary (emergency) service change:
## Hyper Acute Stroke Unit

### Name of NHS Trust/ Name of NHS Commissioning Organisation

**Gloucestershire Clinical Commissioning Group (CCG)**

**Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)**

### Lead Manager and contact details

Simon Lanceley, Director of Strategy & Transformation, GHNHSFT

Dave Cooper, General Manager for Care of the Elderly, Neurology and Stroke, GHNHSFT

### Details of the current service

This paper focuses on the proposal to move the Hyper Acute Stroke Unit (HASU) element of the acute hospital stroke service temporarily to Cheltenham General Hospital.

The change is necessary as part of the Integrated Care System (ICS) response to increasing winter pressures (emergency attendances and admissions), Stroke Consultant and Stroke Specialist Nurse workforce challenges and in preparation for an anticipated increase in hospital attendances and admissions related to the Omicron variant of COVID-19. Collectively, these elements are impacting the ability to consistently deliver a high-quality stroke service.

This change would be implemented as an emergency (temporary) service change in line with the agreed MOU and is in addition to the existing emergency (temporary) service change that resulted in the Acute Stroke Unit (ASU) moving to Cheltenham General as part of the ICS response to the first wave of COVID-19.

The HASU is currently located on a shared ward with Cardiology on the Gloucestershire Royal Hospital (GRH) site. The majority of stroke patients are admitted directly to HASU for up to 3 days. After this period, patients who require ongoing inpatient care are transferred to the ASU, which is currently on Woodmancote ward at Cheltenham General Hospital (CGH) site.

| | Hyper Acute Stroke Unit (HASU) | Acute Stroke Unit (ASU) |
|---|---|---|
| **Current temporary service model** | 8 beds that can be flexed up to 12 beds shared ward with Cardiology at GRH | 32 beds on Woodmancote ward at CGH. |

### Details of the proposed change to service

**Proposal:** To move the HASU from GRH to CGH. This move will centralise all acute stroke beds onto one site at CGH. A stroke consultation service will be provided on the GRH site, to manage inpatient referrals from other specialties.

**Proposed patient pathway:**

- SWASFT/GP call via CINAPSIS
- The patient is accepted by the stroke team
- The patient arrives at CGH and is taken directly for a CT scan (no contact with the Emergency Department at CGH)
- The patient is swabbed for COVID 19.
- If negative the patient is admitted to a bed on ACUC.
- If positive the patient is admitted to Knightsbridge ward.
- All patients requiring specialist stroke care (COVID and non COVID) will be managed at CGH, similar to the oncology pathway.

If patients require ongoing inpatient care, following their stay on HASU, they will be transferred to the Acute Stroke Unit, also at CGH. There will be an agreed protocol with South West Ambulance Services Foundation Trust (SWASFT) to take all stroke/query stroke patients direct to CGH.

Any patient arriving at GRH would be assessed in GRH ED. Experience of other centres that operate this proposed model suggests that these numbers are likely to be low and their symptoms are likely to be mild – and rarely would need intervention i.e. thrombolysis or thrombectomy. If required, patients would be transferred to CGH for admission or referred to the Trans Ischaemic Attack (TIA) Clinic.

The Trust has discussed the proposal with the national Getting It Right First Time (GIRFT) clinical lead for stroke services and has been advised that a similar model is currently being used at East Kent Hospitals with direct admissions to a planned care site. Feedback on the proposed model has been positive and supportive.

It is also proposed to transfer TIA clinic and stroke outpatient clinics to CGH.

**The benefits of this proposal include:**

- Reduced pressure in GRH ED and GRH cardiology ward/medical bed base in anticipation of increased COVID-19 (Omicron) attendances and admissions from January 2022
- Direct patient pathway to acute medical/stroke team avoiding ED – reducing pressure in GRH and CGH ED
- Same site for HASU and ASU – benefits for staff covering all stroke areas (stroke doctors, nurses and therapists).
- Stroke Consultants/Associate Specialists on same site, so more able to cross cover each other.
- Faster training of on-call medical take team, ACUC nurses by Stroke team.
- Better training of stroke ward juniors
- TIA clinic could be run from Ambulatory Emergency Care Unit (AEC) at CGH – enabling faster access to specialist opinion, ability to train acute medical juniors in stroke.
- Reduced pressure on GRH CT/MRI.

**The following options were considered and discounted:**

**Do nothing** – this would not address the immediate staffing challenge of a reduced workforce – one stroke Consultant, an Associate Specialist and a locum consultant - covering HASU and Acute Stroke Rehabilitation across two sites. Further deterioration in the time to review by a senior clinician in ED departments for stroke patients.

**Move ASU back to GRH:** This would enable stroke services to be provided on one site, but this would return 32 beds to the GRH site, displacing another service (with no spare capacity available) and further increasing the level of bed occupancy at GRH.

## Timescales involved

To undertake the transfer of HASU to CGH in the week commencing 10th January 2022 for a period of no less than 3 months and will be reviewed at the end of March 2022 to determine if the changes are reverted or retained for a further temporary period. Should evidence show there would be sustainable patient and staff benefits of the temporary change becoming permanent, this would be secured through the Fit for The Future programme and subject to required level of public and staff involvement.

Please note that the previous Temporary Service Changes (Acute Stroke Rehabilitation moving from GRH to CGH and stroke beds at The Vale Community Hospital) are part of the stroke pathway review and will also to be updated in March 2022.

## What is the reason for the proposed service change?

***Emergency Care Demand***:

GRH and CGH Emergency Departments (EDs) are facing increasing demand due to delayed presentations from the pandemic, continued COVID 19 demand, difficulties in patients accessing other services and the normal increase over winter. This can lead to delays in stroke patients being seen by the correct team impacting the ability to meet national standards for stroke care, for example time to CT scan carrying out thrombolysis and admission to a dedicated stroke ward within 4 hours.

In addition, a combination of planned and unplanned staff changes means the number of stroke medical and nursing staff will substantially reduce. This position will make it difficult to provide safe and sustainable staffing levels on stroke wards at GRH and CGH and to continue to provide outpatient services on both sites.

***Workforce:***

Due to a number of planned and unplanned changes, from January 2022 the stroke senior decision-making team will consist of a Stroke Consultant, an Associate Specialist and a locum consultant, to provide medical cover for stroke wards and outpatient clinics across both sites. In addition, the stroke specialist nurse team is down to one member of staff and the Speech and Language Therapists (SALT) team is reduced to two members of staff.

Nationally there is a shortage of stroke doctors. The Trust has attempted to recruit to these posts substantively, but this has been difficult as, across the country, Trusts are chasing a limited workforce pool. Strenuous efforts have also been made to backfill these posts, including locum/off framework agency staff. Despite these efforts it has proved difficult to cover these vacancies in sufficient time. The Trust is hopeful that it can recruit an additional locum Stroke Consultant in January 2022.

Given the above position the Trust has identified the stroke staffing levels as an intolerable risk (number *ID 3706)* and has been exploring options to reconfigure the service to make the best use of available staff. Centralising stroke services onto one site will help mitigate this risk.

## Has any consultation or engagement/ involvement taken place to date?

There has been engagement with staff involved in the delivery of stroke services and with those staff who will be impacted by the proposed changes. There have also been ongoing discussions with SWASFT to design the proposed pathway.

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| Given the pace of the proposed service change there will not be sufficient time for public engagement to be conducted at the point of instigation of these temporary changes. This is in line with accepted practice when change is required as an 'emergency' response to an intolerable risk.<br>We will continue to work through the Stroke Task and Finish Group to develop a longer-term proposal for Stroke care in Gloucestershire and this will include engagement with patients and stakeholders. | |
| **Expected impact of change and what is being done to address this** | |
| **Changes in accessibility**<br><br>(i.e. transport issues/ opening hours etc) | The temporary re-location of HASU from GRH to CGH will impact some patient and carer travel times; either positively (for patients in the east of the county) or negatively (for patients in the west).<br>An initial analysis of the impact of moving ASU to CGH has shown the there is a relatively even distribution of patients admitted to the stroke service from the east and the west of the county.<br>Full travel analysis will be completed by the Stroke Task and Finish Group as part of the work-up of long-term options. |
| **Patients/ carers affected**<br><br>(demographic assumptions that have been made) | A full Integrated Impact Assessment would be developed if this temporary change is to be considered in the long-term option.<br>Previous impact assessment has identified the following that would need to be considered:<br>**Age**<br>The age of an individual combined with additional factors including other 'protected characteristics' may affect their health and social care needs. Individuals may also experience discrimination and inequalities because of their age.<br>Analysis of previous stroke patients has identified that 60% are >75 years, 20% are 65-74 years and 20% 18-64 years.<br>**Gender**<br>There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely on the basis of a person's gender. Analysis of previous stroke patients has identified that 53% are male and 47% female.<br>**Race / Ethnicity**<br>Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission.<br>The district with the highest proportion of ethnic diversity is Gloucester city meaning that a geographical distribution of services away from GRH might have a greater impact on these communities.<br>**Disability**<br>Forest of Dean is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. People with disabilities may have an increased risk of developing secondary conditions that are more likely to result in the need for acute care. This geographical clustering means that geographical |

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| | changes to where services are delivered may have a disproportionate impact on those with disabilities in terms of access. A travel impact assessment will be needed to fully assess this impact.<br>Providing services from a planned care site, with a shorter overall length of stay, may well benefit those with disabilities as they may be more affected by such factors than the general population. |
| **Changes in methods of delivery**<br><br>(venue / practitioner) | Emergency patient pathway will change from GRH to CGH. There will be a direct admit pathway to HASU. via:<br>a) Emergency Department presentation<br>b) Outpatients via attendance at a TIA clinic<br>c) From an inpatient ward where a patient has suffered a stroke that was not predicted and therefore the patient is not already under active stroke inpatient treatment.<br>Care will be delivered through the stroke specialist medical and nursing team supported by the acute medical physicians (via the acute medical take) and ACUC team.<br><br>The following essential support services have adjusted work patterns to provide cover, ensuring minimal service disruption as a result of the temporary service move:<br>• Physical Therapy<br>• Cognitive Therapy<br>• Psychological Support<br>• Dietitian<br>• Speech & Language Therapy<br>• Radiology<br>• Vascular Laboratory |
| **Impact upon other service delivery** | Whilst the temporary service change remains in place, support services, such as those noted above, will continue to adjust work patterns in order to facilitate patient support at CGH.<br>Other services such as health records, portering, catering and pharmacy would not be affected as these are all currently provided across both Cheltenham and Gloucester sites.<br><br>Experience will be monitored using Friends and Family Test patient survey. |
| **Wider implications** | It is not envisaged that there will be any negative implications on the wider community or health economy whilst the temporary service change remains in place. |
| **Equality/ Inequality issues** | A full Integrated Impact Assessment would be developed if this temporary change is to be considered in the long-term option.<br>Previous impact assessment has identified the following that would need to be considered:<br>**Deprivation** |

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| | Gloucester city has the highest proportion of its population living in the most deprived areas<br>**Homelessness**<br>On average 2.37 per 1000 households are homeless in Gloucestershire with highest levels in Cheltenham and Gloucester city.<br>**Substance Misuse**<br>The age standardised hospital admissions due to substance misuse in Gloucestershire is among the lowest in the South West region at 38 per 100,000 persons; lower than both regional and national rates; however mortality rates suggest that the district of Gloucester City has the highest rates of deaths due to substance misuse, significantly higher than county and national averages.<br>**Mental Health**<br>The prevalence of mental health disease within the GP practice registered population within Gloucestershire is among the lowest in the South West region at 0.8%; significantly lower than both regional and national averages<br>GHFT admission data demonstrates that more people attend GRH than CGH with mental health related issues.<br>The specialist stroke rehabilitation service at the Vale is a county wide service and is open to the whole population based on clinical need.<br>The remaining community hospitals will all continue to offer general rehabilitation for all residents across the county |
| **Name of person completing this pro-forma** | David Cooper - General Manager – Care of the Elderly, Neurology, Stroke<br>Kate Hellier – Clinical Lead for Stroke Services<br>Clare Stephenson – Strategy and Transformation Programme Manager |
| **Date proforma completed** | December 2021 |
| **Outcome (HOSC Comments)** | |