NHS
Bedfordshire
Clinical Commissioning Group

Central Bedfordshire Health Overview and Scrutiny Committee

Date: 12 November 2018
Subject: Stroke Services

Summary

Bedfordshire Clinical Commissioning Group is committed to improving outcomes for patients in Bedfordshire, who have experienced stroke. This paper provides Members with an outline of the direction in which the CCG would like to take stroke services and provides an update on current progress, to ensure that Members are informed in a timely fashion about potential service changes, which would affect residents in Central Bedfordshire.

Options

The Committee is asked to consider, if so minded, whether it has any recommendations to make to Bedfordshire Clinical Commissioning Group on:

- Future plans for stroke services,
- The impact this will have on patients.
- Whether continued engagement with patients and the public in the coming months is a reasonable way forward for the project progression.

Background

The National Stroke Strategy (2007) provides the foundation for defining stroke services and outlines what is needed to create the most effective stroke services in England. The strategy identifies major stages in the stroke patient's pathway and stresses a need to reorganise the way in which stroke services are delivered, from prevention through to support for those who have experienced a stroke.

A whole pathway approach to the provision of stroke services is crucial to maximising the clinical outcomes for patients, the resultant quality of life and their experience of stroke services. The first 72 hours of care is vital to ensure the optimum clinical outcome for stroke survivors. This needs to be underpinned by an effective whole system pathway for assessment, discharge and repatriation to local stroke services, subsequent rehabilitation and longer term support.

The stroke pathway is broken down in different phases below:

A. Primary prevention - lifestyle causes, risk factors, prevention and symptoms
B. Pre-hospital - A fast response to stroke reduces the risk of mortality and disability – "Time is Brain". The identification of potential stroke and TIA patients and their timely admission to an appropriate stroke centre is a critical stage of the care pathway
C. Acute phase
i. Hyper Acute Stroke care
ii. Acute Stroke care (including in-hospital rehabilitation services)
iii. Transient Ischaemic Attack (TIA) services
iv. Tertiary care services (e.g. neuro and vascular surgery referrals)
D. Community rehabilitation
i. Early Supported Discharge (ESD)
ii. Stroke specialist community rehabilitation
E. Long term care and support - Stroke survivors and their carers should be enabled to live a full life in the community over the medium and long term (>3 months)
F. Secondary prevention - Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke
G. End of life
Improving outcomes in stroke services is core to the NHS Bedfordshire's ambitions to provide access to the highest quality services

In 2012, a comprehensive review of Stroke Services was undertaken, which set out that across the Midlands and East NHS area the number of Stroke Hyper Acute Units should be reduced from 4 to 3 with units remaining at the Lister Hospital, Luton and Dunstable Hospital and Watford General.

This recommendation was based on evidence which demonstrated that units with at least 600 stroke admissions a year have sufficient volume to make a 24/7 hyper acute stroke unit (HASU) service clinically sustainable and able to maintain the expertise required to ensure good outcomes for patients.

This meant that the Stroke Unit at Bedford Hospital would no longer provide assessment, diagnosis and treatment of stroke in the first 72 hours following a stroke which included thrombolysis treatment. Patients from the Bedford Hospital catchment area would be taken to the nearest 24/7 Hyper Acute Stroke Unit. After 72 hours patients would be repatriated back to Bedford Hospital Stroke Unit if further medical and/or nursing stroke care was required. This ensured a safe, high quality patient pathway, ensuring that patients would receive the best possible clinical care in a 24/7 unit and moving back to their local hospital once stabilised.

Change under emergency measures

In 2016, Bedfordshire CCG developed commissioning plans for stroke, which moved the Hyper Acute Stroke Unit (HASU) from Bedford Hospital to the Luton and Dunstable Hospital, under emergency measures, as a result of a lack of stroke consultants at Bedford Hospital (BHT). This arose following the resignation of the stroke consultant at Bedford Hospital, who resigned in September 2016.

The new pathway would ensure that inpatient and community stroke rehabilitation was delivered safely and meet our four priorities for stroke, which Are:

- Prevention initiatives to reduce the incidence of stroke;
- Reduce mortality from stroke;
- Minimise disability as a result of stroke;
- Commission best practice care pathways.

Since then Bedford Hospital Trust has appointed a stroke consultant under a long term locum arrangement. However, there is not currently, a dedicated stroke ward and stroke patients are now spread across the hospital site, sharing a ward with Fracture Neck of Femur patients. This is not in line with national guidelines.

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What's our vision?

Our vision is to provide a dedicated 20 bedded unit for stroke rehabilitation survivors as set out in the *National Stroke Strategy* which is:

'For those who have had a stroke and their relatives and carers, whether at home or in care homes, to achieve a good quality of life and maximise independence, well-being and choices'.

This was derived from a recent clinical needs assessment. This will provide additional capacity for 173 patients per year into the system which will reduce the need to spend on spot purchasing beds.

This will enable people to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels.

Rehabilitation provides stroke survivors with the tools they need to attain independence and self-determination. This is built on the premise that rehabilitation should begin as soon as possible after a person has a stroke, and continue for as long as is clinically appropriate, to ensure the best possible recovery whilst also allowing our health and social care teams to use resources effectively and prevent patients from being placed out of area. We believe that by developing the stroke rehabilitation service, we will deliver improved outcomes in the following areas:

- Reduced levels of disability following a stroke;
- Reduced lengths of stay in bed based services;
- Improved patient experience through access to long term support and follow up;
- Improved value for money through the most effective use of resources;
- More equitable service provision across the region;
- We meet NICE guidelines and the service standards and specifications for rehabilitation, set by the Royal College of Physicians.

We've listened to our patients

As part of the work we've undertaken to review stroke services, we have taken the opportunity to speak to patients and listen to their views on the care they want after they have had a stroke.

We undertook two workshops in September and November 2017, which included Healthwatch, the Stroke Association, Bedford Borough Council, Central Bedfordshire Council, patient representatives, voluntary organisations and clinicians from across the pathway, and we also started to hold monthly stroke meetings with a number of stakeholders and patient representatives, so that they could start to influence and co-design the stroke pathway.

Patients told us they wanted

- To receive rehabilitation care closer to home – so the families of patients can visit and be part of their rehabilitation;
- To be looked after in an appropriate clinical setting when they are acutely poorly, but able to leave that level of care when well enough.
- Continuity of care – with therapists rotating from the acute setting into rehabilitation and then into the community, to ensure that patients can build up a relationship and trust with their clinicians.

How have we responded?

Having listened to our patients and given our commitment to delivering optimum stroke care in Bedfordshire, the aim of the CCG is to develop a new rehabilitation centre in Bedford. This means that central Bedfordshire residents will be able to receive optimum rehabilitation care closer to home, regardless of whether they live in the north or south of the Local Authority area and flow into either the L&D or Bedford Hospital.

What have we done to progress this?

Suitable premises are being sought with one potential site being John Bunyan House, at the Archer Unit, on the north wing of Bedford Hospital, as it provides the right space, layout and location to meet the specification of a stroke rehabilitation unit, and also the requirements identified by patients.

The premises are currently occupied by Headway which supports patient in an outpatient setting. Headway is a voluntary organisation which support brain injury patients and supports life after stroke which is part of the stipulated national pathway. They provide longer-term rehabilitation for patients following discharge from the Acquired Brain Injury, Neuro-Rehab Teams or other health professional services, allowing patients to achieve

their potential. This could be a return to employment, accessing work, education, or volunteering, accessing social support or transferring to day care more appropriate to the patients need.

Our impact assessment shows that 100 patients a year use the service, receiving 6 sessions usually delivered over 6 weeks. The core hours of operation for attending patients are from 11am -3pm Mondays to Thursdays. The services provided by Headway is an important component of the pathway for those who have had a stroke or other acquired brain injuries.

How have we taken this forward?
Since undertaking the workshops and listening to patient views, we have been working closely with partners, including NHS Property Services, Bedford Hospital and Community Therapy teams to better integrate care and look for opportunities to develop a rehabilitation Centre.

We have also undertaken further engagement with residents, Stroke survivors and carers with the help of Stroke Association, staff engagement and undertaken meetings with Headway.

Before we progress further with this work, the CCG wanted to take the opportunity to share this proposal with the Central Bedfordshire Overview and Scrutiny Committee to understand if there were any comments or recommendations from Members that should be considered and factored into our engagement programme and plan.