NHS
Gloucestershire Care Services
NHS Trust

Trust Board

Date of Meeting: **30th August 2018**

Report Title: **Specialist Stroke Rehabilitation**

Agenda reference Number	03/0818
Accountable Executive Director (AED)	Candace Plouffe, Chief Operating Officer
Presenter (if not AED)	Candace Plouffe, Chief Operating Officer
Author(s)	Candace Plouffe, Chief Operating Officer
Board action required	
Previously considered by	Gloucestershire Clinical Commissioning Group Governing Body
Appendices	Appendix 1: Community Specialist Stroke Rehabilitation - Appraisal of Ward Options Appendix 2: Community Specialist Stroke Rehabilitation Outcome Report on Targeted Engagement

Executive Summary

As part of the One Gloucestershire Sustainability and Transformation Plan work in reducing clinical variation, a business case has been developed for the development of a Community stroke rehabilitation unit.

This recommendation is based on peer reviewed national evidence that improving the quality and intensity of specialist rehabilitation and care in an appropriate environment improves patient outcomes.

The business case explored possible options to strengthen and improve the provision of specialist stroke rehabilitation in Gloucestershire to meet national recommendations and quality standards, and sits within a more detailed piece of work considering the overall rehabilitation offer for Gloucestershire, including specialist and core requirements for all conditions

This new unit would support specialist stroke provision over the whole stroke pathway and as a result pressure on rehabilitation provision would be reduced in the acute setting resulting in increased therapy provision for the cohort of patients, for whom it is appropriate to remain in the acute hospital, leading to improved outcomes.

Additionally, the community stroke specialist rehabilitation network would be enhanced by additional resource at a community hospital setting, and greater numbers of patients would benefit from this specialist service.

Gloucestershire Care Services NHS Trust was asked to consider how they could deliver this new, community specialist stroke unit, and specifically what premise could this new service be delivered from. An options appraisal was carried out, looking at potential sites in each locality and a report was provided to the Gloucestershire Clinical Commissioning group to consider the investment required to implement this new service.

The expectation from the Commissioners was that the preferred option would require a rebadging of 14 community hospital beds from the Trust's current bed stock of 196. To confirm the viability of this expectation, the Trust secured an independent contractor, 3NN to create a Community hospital bed modelling programme.

This bed modelling has determined that with cohorting existing patients already accessing our Community hospital beds for stroke rehabilitation, the "loss" of local beds would be reduced to 8. With actions to improve patient flow, Operational services are confident that this "loss" can be accommodated, while still achieving bed occupancy of 92%.

The options appraisal and bed model confirmed that the Vale Community Hospital would be the preferred site for the proposed unit. This would create a 14 bed community centre of excellence for stroke in this hospital, with 6 beds remaining for general subacute and rehabilitation care. This proposal is aligned to the previous Community hospital strategic direction agreed at Board in January 2018.

As part of the development of the proposal, a targeted stakeholder engagement with patients who have had a stroke, as well as those third sector providers who support stroke survivors was undertaken. The purpose of this engagement was to understand any concerns from service users in creating a specialist stroke rehabilitation unit in a Community hospital, and in particular their views on whether the benefits of creating a centre of excellence which provides a higher level of specialised rehabilitation outweighs the potential for increased travel for some patients.

The Trust has received formal confirmation from the Gloucestershire clinical commissioning group governing body that they have agreed to proceed with the investment required to implement this new specialist stroke rehabilitation unit at the Vale Hospital.

Recommendation

The Board is asked to

Confirm its intent to be the provider of a Specialist stroke rehabilitation unit;

Agree the recommendation that the specialist stroke rehabilitation unit be sited at the Vale Community hospital;

Recognise the concerns raised in the engagement concerning transport, and the need to work with wider system partners on how to improve transportation to facilitate easier access to health and care services, as this is an issue that impacts on many services delivered in Gloucestershire

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Related Trust Objectives	
Risk Implications	Risk issues are clearly identifed within the report
Quality/Equality Impact Assessment (QEIA)	Implications are clearly referenced in the report
Financial Implications	No finance implications identified
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Community Specialist Stroke Rehabilitation Inpatient Unit – *Improving Life Chances in Gloucestershire following Stroke*

1 Purpose

The Gloucestershire Sustainability and Transformation Plan has, within the "Reducing Clinical Variation" work programme, undertaken a review and redesign of the stroke service model and care pathway.

A previous independent review done in 2014-15, along with the One Gloucestershire work has confirmed that Gloucestershire requires a community inpatient rehabilitation care unit to improve the link between acute inpatient services and general rehabilitation provided by community teams.

This paper sets out the Trust's intention to be the provider of the new community specialist stroke rehabilitation inpatient unit and the work undertaken to determine the preferred option for where this unit will be sited.

2 Background

Stroke is a complex neurological disease, associated with vascular and neuronal functional disturbance. In the UK 7% of all deaths are caused by stroke and it is the 4th single leading cause of death. There are over 1.2 million stroke survivors in the UK. The NHS and social care costs relating to stroke are approximately £1.7 billion per year in England.

There is an anticipation that stroke incidence will increase in Gloucestershire and demand for specialist services will rise. This is due to an increase in the proportion of older people in the total population in the county and increase in presentation for and diagnosis of cardiovascular disease (CVD).

Emergency management of stroke relies upon rapid recognition of symptoms and diagnosis to guide treatment and reduce physiological damage to the patient. Specialist acute stroke care in a discrete unit or acute stroke ward is widely acknowledged as essential in improving patient outcomes resulting in patients more likely to be alive, independent and living at home one year following a stroke.

Following the "hyper-acute" phase of a stroke, rehabilitation should begin as early as possible. Rehabilitation aims to enhance functional activities and participation in society and thus improve quality of life. Early access to rehabilitation is known to help maximise the recovery of a stroke patient.

Where possible, specialist rehabilitation should be carried out in the patient's home with input from an Early Supported Discharge (ESD) team. This has been shown to be particularly effective in promoting rehabilitation and patient recovery for some patients, in addition to shortening stays in acute hospital wards. The ESD team conducts an early assessment in hospital, co-ordinates the patient's discharge home and supports the patient in their own home post-discharge.

For those patients unable to return to their normal residence, rehabilitation may be carried out in a care home, a general rehabilitation unit, a specialist intermediate unit or while they remain in an acute hospital. It is acknowledged that outcomes are improved if patients have access to specialist rehabilitation following a stroke, whether at an inpatient facility or at home.

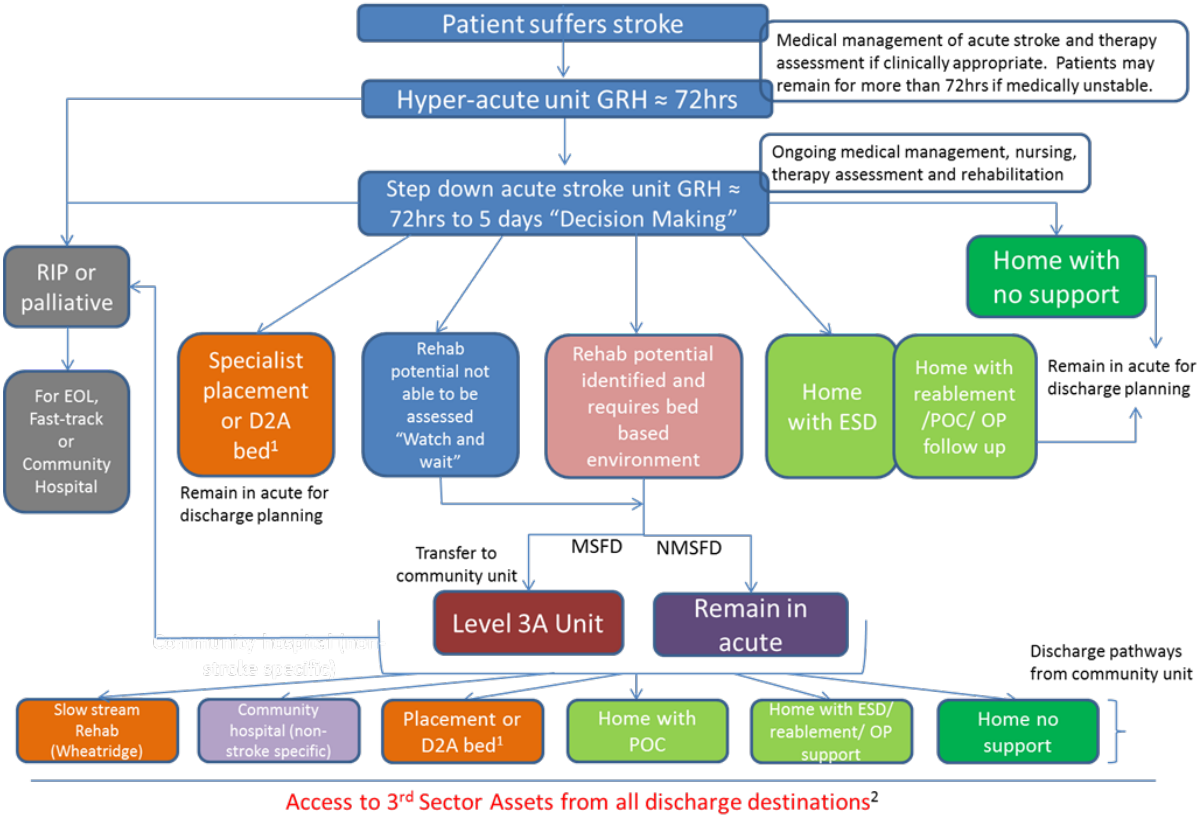
3 Redesigned Gloucestershire Stroke Pathway

As per best practice, the default position for rehabilitation is that it should be provided in outpatient or home based settings once acute medical interventions are no longer required.

However, a community inpatient rehabilitation care unit will improve the link between acute inpatient services and general rehabilitation provided by community teams. This unit will have the dual benefit of ensuring patients are cared for in the most appropriate environment, supported by specialist professionals at every point of the pathway and will help to free up acute hospital beds, ensuring that stroke patients in the hyper-acute phase have sufficient access to acute hospital care on a specialist ward.

Therefore a business case has been considered by the Gloucestershire Clinical commissioning group and approved by the governing body to develop a specialist rehabilitation unit, in line with the recommendations set out by the NHSE Commissioning Guidance for Rehabilitation.

The diagram below details the new care pathway, with the community unit identified as a "Level 3A unit", with clear guidance developed on which patients would benefit from bed based specialist rehabilitation vs specialist rehabilitation provided in the home setting by the Trust's early supported discharge (ESD) service.



4 Proposal for creation of Community Specialist Stroke Rehabilitation unit using existing Community bed stock

The business case developed by GCCG details a preferred option to "rebadge" 14 existing community hospital beds, with an intention to centralise stroke rehabilitation and cohort patients transferring to Community hospitals with stroke to improve access to specialist staff. The evidence indicates this will improve outcomes for stroke survivors who are currently receiving general rehabilitation in our 7 community hospitals.

Modelling indicated that there was already between 6-8 patients at any one time in a Community hospital bed across the county that would meet the criteria for the new unit, so the maximum "loss" of local, general community hospital beds would be 8.

To understand the operational impact of this proposal on bed stock, an independent contractor (3NN) was secured to create a community hospital bed model tool to understand the utilisation of our bed stock over the last 2 years, and to determine how any changes in services (for example reducing length of stay) would impact on bed stock requirements.

This bed modelling has been used to consider how the Trust could accommodate both the of "loss" of beds as part of the creation of the new community specialist stroke rehabilitation unit.

The bed model has identified an opportunity to reduce our bed requirements by focussing on the cohort of patients whose length of stays are currently greater than 50 days. This is work we have already begun as part of the NHS Improvement Emergency care improvement programme and the focus on "stranded" and "super-stranded" patients. The aim is to ensure prolonged inpatient stays are minimised, unnecessary waits for services are minimised and care is provided in the most appropriate setting.

If we are successful with 80% of this group of patients this would release the equivalent of 11-15 beds and therefore accommodate the 8 bed loss for the creation of the new specialist stroke rehabilitation unit.

5 Options Appraisal for Location of the Unit

As the current provider of community rehabilitation services, the commissioners have identified the Trust as the preferred provider for this new unit.

To support the Commissioner's business case development, an options appraisal was completed by the Trust to determine what would be required to support the implementation of this new unit, and more importantly where this unit could be sited. Appendix 1 details the option appraisal completed.

The appraisal reviewed all potential sites in each locality (including Cheltenham) and was further reduced to 4 potential options

- Cirencester Hospital – Coln, Thames and Windrush Wards; and
- The Vale Hospital – Peak View Ward

The essential and desirable criteria were determined by senior clinicians and the four options were evaluated against the following 6 areas

- Capacity Planning;
- Internal Environment;
- External Environment;
- Clinical Staffing;
- Medical Resilience / Sustainability;
- Strategic Fit

The Peakview ward at the Vale Hospital was the preferred option, based on the following factors:

- Modern, well designed and resourced building with very flexible internal configuration. Accommodation configured in the preferred configuration of single rooms;
- Fully meets all capacity planning criteria – now and in future
- More generous bedroom dimensions for sanctuary/privacy, could readily accommodate sofa-bed, and all en-suite
- Relocation of current MSK services to Stroud would liberate well over 200 sqm. of very good, multi-functional Social and Therapy Spaces.
- Nice external aspects with easy and safe access to a range of external social/therapeutic spaces
- Would provide a strategically meaningful purpose for The Vale as a Neurological Rehab Centre of Excellence
- Costs/complexity of conversion
- Could be made operational very quickly – by far the lowest conversion lead time

Two areas of potential concern related to perceived isolation of this ward setting with longer distances for patients and families to travel, and potential lower medical and diagnostics resilience.

It is important to note that car journey times from the urban centres to Cirencester and Vale Hospitals are broadly equal and public transport (bus and train) links to The Vale are better.

In addition, to support the understanding of the potential issues with designating a community hospital as a specialist unit, the GCCG has undertaken a targeted stakeholder engagement with patients who have had a stroke, as well as those third sector providers who support stroke survivors.

The purpose of this engagement was to understand any concerns from service users in creating a specialist stroke rehabilitation unit in a Community hospital, and in particular their views on whether the benefits of creating a centre of excellence which provides a higher level of specialised rehabilitation outweighs the potential for increased travel for some patients. Appendix 2 details the outcome of this engagement.

In terms of medical and diagnostics resilience, it is important to recognise the previous challenges in securing stable medical coverage for the Vale inpatient unit. However there is also a view from the specialists working in this area that by creating a specialist Centre of Excellence for stroke, this will attract colleagues who specifically want to work in this type of centre, rather than providing input into a general community hospital setting.

6 Proposed Level of Investment

Additional investment has been confirmed by GCCG as detailed in the table below.

	Recurrent	Non Recurrent	Total
Revenue Investment	*488,000*	*51,296*	*539,296*
Therapy Workforce (Physiotherapy,Occupational Therapy, Speech and Language Therapy)	316,329		316,329
Nursing Workforce	19,433		19,433
Other Specialist roles (including Medical, Psychology, etc)	98,204		98,204
Other Revenue Costs	54,034	51,296	105,330
Capital Investment		115,000	115,000
Total Investment	**488,000**		**654,296**

The investment detailed above does not include the existing workforce that currently is allocated to Peakview ward and would remain, but rather a significant enhancement to the current staffing levels which will ensure adequate provision for not just the 14 beds providing stroke specialist rehabilitation but also the 6 core rehabilitation beds.

It is important to note the current proposal and investment for specialist roles are likely to be commissioned directly from Gloucestershire Hospitals Foundation NHS Trust.

The capital investment is indicative, and assumes no structural changes required to the ward environment. Following Board approval, detailed costings will be sought via a tender process.

7 Conclusion and Proposed Next Steps

The addition of a Community specialist stroke rehabilitation inpatient unit is an exciting opportunity for the Trust in supporting the delivery of a strengthened care pathway for the people of Gloucestershire who experience a stroke.

This new service offer supports the Community hospital strategic direction of travel agreed by the Board in January 2018, and should the unit be located at the Vale provides a sustainable future for this community hospital, while still ensuring that there are sufficient community inpatient beds to accommodate the residents of Stroud and Berkley Vale locality.

8 Recommendations for the Board

The Board is asked to;

Confirm its intent to be the provider of a Specialist stroke rehabilitation unit;

Agree the recommendation that the specialist stroke rehabilitation unit be sited at the Vale Community hospital;

Recognise the concerns raised in the engagement concerning transport, and the need to work with wider system partners on how to improve transportation to facilitate easier access to health and care services, as this is an issue that impacts on many services delivered in Gloucestershire

Community Specialist Stroke Rehabilitation Service

Appraisal of Options for Hosting of Specialist Stroke Rehabilitation Ward

To: Executive Board Members, GCS

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Gavin Rowcraft, Project Manager, GCS Estates
Sian Thomas, Deputy Chief Operating Officer, GCS
Steven Wainwright, Commercial Manager, GCS

From: John Hurst, Hurst Consulting Ltd.

Date: February, 2018

1 INTRODUCTION

1.1 Few stakeholders in this project would question the level of effort and commitment that has to date gone into the proposal for a Specialist Stroke Rehabilitation (SSR) Service in Gloucestershire, nor would they question the benefits this service will provide. Although some considerable time has elapsed since work on the SSR Service business case commenced, Q4 of 2017/18 is seen as an ideal time to bring all stakeholders involved to a place of common understanding and confirm the way forward for deployment of the service as soon as possible in 2018/19.

1.2 John Hurst has been engaged by Gloucestershire Care Services (GCS) to work with the key stakeholders within GCS, at NHS Gloucestershire CCG (NHSG) and Gloucester Hospitals Foundation NHS Trust (GHFT) to review existing resources and take a fresh look at the options to enable stakeholder consensus on the recommended deployment approach.

1.3 The purposes of this paper therefore are:

- Summarise briefly the background work leading the current milestone requiring choice of SSR Ward option;
- Outline an approach to re-appraisal of the options, following a meeting of a key stakeholders group on 31st January 2018;
- Document the reappraisal and highlight key findings and implications; and
- Make recommendations for a preferred option.

2 KEY CONTEXT

2.1 NHSG commenced work on the business case for the SSR Service towards the close of the 2015/16 financial year. Considerable background work has gone into the underlying investigation of local clinical benefit, and an appraisal of strategic options for delivery of SSR services in 2016/17 held convincingly in favour of a dedicated SSR Service to be hosted within a Community Hospital setting.

2.2 A Stroke Clinical Reference Group (SCRG), comprising clinical and operational leads from GCS, GHFT and NHSG was established in 2016 and a series of key evaluation criteria for the SSR Service were agreed. Two cross-border community hospital reference sites were visited in 2016/17, findings from which helped further shape the essential and desirable criteria. In early 2017, the SCRG undertook a desk-based evaluation of all community hospital settings and included the Woodmancote Ward at Cheltenham General Hospital. Key outcomes from that appraisal exercise are summarised in Figure 1:

Figure 1: High Level Appraisal of Countywide Stroke Ward Options		
Site Option		Key Points from Appraisal
1	Cheltenham General Hospital (Woodmancote Ward)	Ward well situated, equipped, and medically resilient, but significant infection control concerns from inability to ring-fence SSR Beds.
2	Cirencester Hospital	Potential to meet all key evaluation criteria with appropriate estates work and workforce enhancement.
3	Dilke Memorial & Lydney Hospitals	Geographically remote from eastern and southern extremities of county, and community hospital configuration likely to change in Forest of Dean.
4	North Cotswold Hospital	Geographically remote from some the western and southern localities, and reduction in inpatient capacity considered too extensive for the locality.
5	Stroud Hospital	Layout of hospital, ward configuration, and limited capacity for expansion all likely to make estate costs prohibitive.
6	Tewkesbury Hospital	Specialisation of bed capacity would result in too great a reduction in community inpatient provision for the locality itself and wider locality provision for both Cheltenham and Gloucester who do not have community hospitals.
7	The Vale Hospital	Potentially good alternative use of a high quality but underutilised Hospital, and lowest impact on inpatient bed capacity for its locality. However, concerns over ward isolation and medical resilience would need to be addressed with credible solutions.

2.3 From this work four potentially viable options emerged across two of the Community Hospitals:

- **Cirencester Hospital** – Coln, Thames and Windrush Wards; and
- **The Vale Hospital** – Peak View Ward.

3 APPROACH TO OPTION EVALUATION

Key Evaluation Criteria

3.1 At 31st January meeting a number of factors affecting the option evaluation criteria were clarified and which have been built into the appraisal framework in this document. All essential and desirable criteria have been allocated across six themes as follows:

- Capacity Planning;
- Internal Environment;
- External Environment;
- Clinical Staffing;
- Medical Resilience / Sustainability; and
- Strategic Fit.

Capacity Planning

3.2 Modelling of required SSR bed capacity was presented by NHSG in detail on 31st January and the justification for an initial baseline of 14 beds was accepted. Although new forms of early-intervention treatment for cardiovascular and neurological disorders are emerging and could potentially curtail the demand trend for SSR, Gloucestershire has an aging population and it is considered by NHSG highly likely that commissioning intentions will in the near future favour expansion of rehabilitation services across a broader range of neurological pathways. Consequently, NHSG have recommended the SSR Ward be expandable to at least 20 specialist beds, and potentially more if the service is successful.

3.3 It was further agreed that:

- The chosen ward option needs to minimise net loss of current community inpatient bed capacity: the pathway model assumes a net reduction of 8 beds for general community inpatient use and an assumed zero loss to the system of the current actual community hospital stock of 196 beds. Consequently, any reduction arising from conversion to the SSR Ward would need to be found in other community inpatient settings; and
- Any surplus capacity in the chosen ward beyond the baseline 14 specialist beds would be devoted to Core Rehabilitation in one designated area within the ward.

Internal Environment

Capital Costs of Conversion

3.4 At this stage, NHSG have set no absolute threshold for capital conversion costs, but for costs to be contained as far a reasonably possible. Until the choice of SSR Ward is decided, it was agreed indicative range estimates would be produced by the GCS Estates Department (Estates). It was acknowledged these estimates would vary significantly depending on the chosen configuration for bed accommodation.

Patient Accommodation

3.5 The following critical aspects of the internal environment were clarified and agreed at the 31st January meeting:

- A clear preference for single-occupancy en-suite rooms rather than communal bays, the justifications for which included:
    - Clear support within national guidance;
    - Better infection control;
    - Emphasis on bed accommodation to be for purposeful rest and recovery as part of a structured rehabilitation programme;
    - Privacy/sanctuary; and
    - Easier for carers/relatives to stay overnight using a sofa-bed.
- A good level of space to provide an engaging environment for social interaction and active rehabilitation, thereby complementing the single-occupancy accommodation and mitigating risk of social isolation among more vulnerable patients; and
- A minimum provision of 2 bariatric beds featuring overhead tracking.

Other Key Features of the Internal Environment

3.6 Other requirements from the internal environment were clarified and the evaluation criteria in this document now reflect the key features of the *DoH Health Building Note (HBN) 00-01 (2014):* general design guidance for a healing/therapeutic environment. Each of the key internal environment criteria are explained in Figure 2 and they cross-reference to the Options Evaluation Matrix presented at Appendix 1 (see also Section 4):

Figure 2: Evaluation Criteria for the Internal Environment

Matrix Ref.	Internal Environment Criteria	Essential & Desirable Features
9	Kitchen for rehab purposes	Essential: Basic kitchen working area for the basic activities of independent living, e.g. making hot drink; preparing very basic food. Desirable: None yet stipulated, but there is potential for collocation within a well-equipped social space.
10/15f	Social Space	Essential: Suitable area that encourages social interaction among patients / visitors, provision for personal technology. Desirable: Large enough space to feature dining / coffee space and potentially some indoor recreational activities..?
11	Therapy / Gym Room	Essential: Room to accommodate at least 3 patients and 3 therapists, and essential equipment. Desirable: Room large enough to accommodate essential features and other desirable equipment.
12/15d	Internal Sanctuary	Essential: Pleasant, naturally-lit environment with calm, open spaces. Desirable: Quiet room for patients and/or relatives/carers to use when a little personal space is needed for calm composure and/or counselling.
13	MDT Meeting Space	Meeting room needed for up to 6 people on site, not necessarily collocated on the SSR Ward.
14	Equipment Store	Most therapy equipment will be situated in the Therapy Gym Room, but sufficient space to accommodate other items, e.g. mobile hoist, wheelchairs, etc. is considered essential.
15e	Sanitary	Essential: minimal sharing of bath/shower facilities. Desirable: all accommodation to have en-suite facilities; optional access to a bath and for its use to be incorporated into rehabilitation where appropriate.

External Environment

3.7 The potential to extend active, therapeutic rehabilitation to outdoor areas of the site was considered an important factor, given the predicted average patient lengths of stay of circa. 2-4 weeks. Adequacy of transport links and site access must also be considered.

Clinical Staffing

3.8 Affordability, calibre and resilience of SSR Ward staffing were considered essential for success and work on the staffing model has continued since 31st January – see Section 4.18.

Medical Resilience / Sustainability

3.9 Robust medical cover was considered a fundamental criterion that has to be fully met to ensure 24/7/365 availability of the SSR Service.

3.10 To achieve both the necessary medical cover and clinical staffing requirements, robust arrangements for recruitment, retention and contractual engagement of medical services was considered necessary for a specialist service of this type.

3.11 Provision of basic diagnostics was also considered necessary from the outset but would be more critical if the service was to expand into other neurological disorders. The options appraisal should therefore explore technology links to ensure availability of digitally-transmissible X-Ray images and remote access to medical diagnoses when on-site medical provision was unavailable.

Strategic Fit

3.12 Until such time there is an agreed countywide Centres of Excellence Strategy, some consideration must still be given to the relative strategic and tactical advantages each option provides. There will inevitably be differing opportunity costs of ring-fencing bed capacity and hospital space at the different sites. These factors are discussed in Section 4.

4 OPTIONS EVALUATION OUTCOMES

4.1 Methodology for weighting and scoring each of the 28 criteria assessed in Appendix 1 is straightforward, as shown in Figure 2. None of those criteria is considered anything less than highly desirable in terms of their relative importance weighting.

Figure 3: Options Evaluation Scoring Method

Weighting		Score of Fit	
5	Essential to success of the service and to be fully met	5	Total fit
4	Necessary, but not a 'show-stopper' if not fully met	4	Highly suitable
3	Highly desirable	3	Moderately suitable
2	Desirable	2	Some compatibility issues
1	Nice-to-have but not material	1	Poor fit
0	—	0	Does not fit at all, not appropriate

4.2 Capital works implications of full and partial provision of single-occupancy accommodation have been explored and broadly estimated by Estates in terms of costs and viability of actual construction.

4.3 A summary of scored outcomes against each evaluation theme for the four SSR Ward options is given in Figure 4:

Figure 4: Summary Outcomes from Options Evaluation				
Evaluation Criteria Categories	**Category Score Totals**			
	Coln	**Thames**	**Windrush**	**Vale**
Capacity Planning	82	47	69	116
Internal Environment	221	191	220	339
External Environment	92	95	92	132
Clinical Staffing	56	46	56	42
Medical Resilience / Sustainability	67	67	67	52
Strategic Fit	30	23	30	38
OVERALL EVALUATION SCORES	**548**	**469**	**534**	**719**

4.4 Significant findings in favour and against each option are summarised in Figure 5:

Figure 5: Principal Advantages and Disadvantages of Each Option	
Advantages	**Disadvantages**
POINTS COMMON TO ALL CIRENCESTER WARDS	
• Based within a thriving Community Hospital, earmarked for Urgent Treatment Centre (UTC): o Potentially greater staffing resilience. o Potentially closer proximity to more on-site medical cover. o Closer proximity to more diagnostics.	• Hospital buildings are dated and contain asbestos - expensive to convert into fully fit for purpose SSR Ward. • To achieve required capacity, room dimensions will be smaller, not as easy to accommodate specialist seating and manual handling equipment. • Potentially limited space for sanctuary, meeting and storage space – very limited if converted to single occupancy. • Pleasant external surroundings but access to them not considered easy/safe for stroke patients. • Loss of general inpatient beds may impact South Cotswold more than Stroud & Berkeley Vale. • Long construction lead times required to convert to necessary internal specification.

COLN WARD	
• Can meet all capacity and key internal environment criteria. • Could collocate therapy and social space in one purposeful area at one end of ward. • Capital opportunity cost somewhat mitigated by Coln Ward being overdue an estimated £200,000 refurbishment.	• Communal bed capacity unavoidable if SSR Service expanded beyond Phase 1. • At least 6 beds lost to the system. • Major works needed: more complex to convert than Windrush due to rerouting of waste services through solid concrete flooring. • Therapy and social space acceptable, but limited to approx. 130 sqm. • Ward would have to close for 6-8 months, significant impact on inpatient movements (partially mitigated by use of Thames for decant).
THAMES WARD	
• Minimises loss of other current inpatient capacity.	• Barely meets minimum Phase 1 bed capacity with all communal Bays, single occupancy configuration would not meet Phase 1 capacity without major loss of Social Space. • Therapy/Gym and Social Space compromised if single-occupancy bedrooms required. • Expensive, complicated capital works required to convert to full fitness for purpose. • Very close to Plant Room and GHFT Theatre, making construction more challenging. • Therefore, longest lead time to making SSR Service operational. • GCS loses a key tactical decant space that facilitates other capital refurbishments. • Already refurbished for different purpose and has potentially better alternative uses, e.g. overnight rehab. from minor theatre activity. • Overall opportunity costs therefore the highest.
WINDRUSH WARD	
• As Coln: can collocate therapy and social space nicely at one end of ward. • Capital opportunity cost somewhat mitigated by Windrush Ward also being due a circa £200,000 refurbishment. • Construction costs potentially lower due to easier access to first floor void spaces.	• Not fully expandable beyond Phase 1, barely meeting the baseline capacity, even with a mix of single-occupancy and bays. • At least 4 beds lost to the system. • Therapy and social space acceptable, but limited to approx. 110 sqm. • Ward would have to close for circa. 6 months, significant impact on inpatient movements (partially mitigated by use of Thames for decant).
VALE PEAK VIEW WARD	
• Modern, well designed and resourced building with very flexible internal configuration. • Fully meets all capacity planning criteria – now and in future. • More generous bedroom dimensions for sanctuary/privacy, could readily accommodate sofa-bed, and all en-suite. • Relocation of current MSK services would liberate well over 200 sqm. of very good,	• Isolation of Ward setting. • Potentially lower medical and diagnostics resilience in a non-UTC Community Hospital.

multi-functional Social and Therapy Spaces. • Nice external aspects with easy and safe access to a range of external social/therapeutic spaces. • Would provide a strategically meaningful purpose for The Vale as a Neurological Rehab Centre of Excellence. • Could be made operational very quickly – by far the lowest conversion lead time.	

4.5 Each of the key evaluation themes are explored further as follows:

Capacity Planning

Specialist Bed Numbers

4.6 The four wards offer very different potential for specialist bed capacity, the actual bed numbers differing significantly depending on overall configuration of the SSR Ward. Figure 6 shows the current and potential bed capacities; the latter being based on Estates' assessment of current floor plans:

Figure 6: Bed Capacities from Ward Configurations

Specialist Bed Configurations	Coln	Thames	Windrush	Vale
Current Capacity	28	13*	21	20
Max. possible specialist bed capacity if all single occupancy and collocated	15-17**	12*	12**	26
Maximising Specialist bed capacity if mix of single occupancy and Bay, comprising:	22***	18*	17***	30
• Bay Beds	10	16*	9	8
• Single Rooms	12	2*	8	22

* Capacity includes space available in Thames Ward and the Churn Suite.
** Single occupancy for Coln and Windrush wards assumes some sharing of sanitary facilities in a 2:1 ratio.
*** Current 4 bed wards would reduce to 3-bed to allow on-ward en-suite.

Estimated Capital Conversion Costs	Coln £000	Thames £000	Windrush £000	Vale £000
Conversion to all single bedded specialist ward	600-900	700-1000+	500-800	50-100
Costs to achieve maximum occupancy of Rooms and Bays	400-600	400-750	350-500	100-200

Capital Conversion Costs

4.7 Of the three Cirencester wards, Thames is thought to be the most expensive to convert to single-occupancy, and in any event, the resultant capacity would not be fit for purpose. To increase bed space, the main corridor would need to be moved sideways into some of the Healthy Market Place area, reducing some of the social and Therapy/Gym space. As both the Ward and the Churn Suite are fully bay-based, provision of any single occupancy en-suite accommodation is major configuration change in an old building with various health and safety risks.

4.8 Coln and Windrush Wards are very similar in layout, the latter situated on the first floor immediately above Coln. Conversion costs for Windrush would be lower than for Coln, mainly due to reduced floor area: Windrush forfeits further communal ward space to the Endoscopy Suite, but also because first floor conversion works would be easier. To accommodate the required number of specialist beds, both Coln and Windrush would need to be configured with a blend of Bays and single-occupancy rooms. Coln could accommodate capacity expansion beyond the Phase 1 baseline of 14 beds, but Windrush would be very cramped to achieve a potential total capacity of 20 beds. Even with the mix of single-occupancy and bays, some loss of total bed capacity at all Cirencester wards would be unavoidable to allow for extra sanitary provision and some bariatric facilities.

4.9 As a strong preference for single-occupancy accommodation was agreed on 31st January, Thames and Windrush become the least feasible of the options and not viable as single-occupancy wards.

4.10 Peak View Ward at The Vale Hospital is, in purely design and construction terms, by far the most configurable accommodation for a specialist inpatient service. All of the capacity criteria are fully met and future-proof. Costs of conversion are therefore substantially lower, and potentially would include:

- Segregation of one end of the ward for Core Rehabilitation;
- Fitment of high quality therapy, rehab and social spaces; and
- Minor works necessary to re-home MSK Services onto the ground floor.

Internal Environment

Room & Ward Dimensions

4.11 Single room dimensions at The Vale are quite generous at approx. 15 sqm plus the en-suite. Two of the rooms at The Vale already incorporate full bariatric tracking. Single room dimensions in all the Cirencester Wards would be smaller, between 11 and 12 sqm, and they would therefore be less accommodating manual handling equipment/seating or a Parker-Knoll style sofa-bed for relatives/carers. Outlooks from rooms at Coln and Windrush wards feature the courtyard on one side and the woods on the other, with window dimensions being similar across all three wards. Outlooks from patient rooms at The Vale are consistently more open, with larger windows and more natural light.

4.12 The largest working floor area for all internal spaces would be available at The Vale, which has the most open feel with wider, better-lit corridors and larger rooms generally. Corridors on Coln, Thames and Windrush are generally narrower and the working floor areas smaller.

Therapy & Social Spaces

4.13 For Thames Ward, use of the Healthy Marketplace would be necessary, but it features all internal walls and so lacks any external aspect. For Windrush and Coln, the wing of the ward currently occupied by the Day Room could be converted into reasonable therapy and social spaces, but at the cost of some potential bed capacity.

4.14 There are numerous options for provision of therapy and social space at The Vale. The current Day Room is on the ward and large enough for therapy, and if MSK services were relocated to the ground floor, this large, bright and multi-purpose area could open up numerous creative possibilities for integrated rehab kitchen-dining, social and recreational activity. There are short and longer-term options for rehoming The Vale's MSK services on the ground floor: utilisation of the current Meeting Room and some Outpatient rooms until such time (and subject to consultation) UTCs become operational and the MIIUs are decommissioned. At that point, straightforward conversion of the Vale's MIIU would offer an ideal, spacious area of the ground floor for MSK and potentially other services.

External Environment

4.15 Both Cirencester and Vale Hospitals are situated in pleasant grounds with generally attractive outlooks. Being the much larger site, access to the wooded area at Cirencester would mean a good walk through along a main roadway and via the services area at the Undercroft. This is considered potentially risky for patients with physical and/or cognitive limitations. Conversely, the grounds at The Vale are very close to the periphery of the hospital building with secured garden/shrub space and benches, and there is an allotment area to the front aspect. These facilities, commissioned as a result of charitable funding and local GP support, are considered both safe and appropriate for therapeutic use.

4.16 Both Hospitals feature pleasant central courtyards with shrubs and benches. However, Cirencester's courtyard is more exposed to unmonitored public access than that at The Vale, which is accessed through the main Waiting Area, past Reception.

4.17 Car journey times to Cirencester and Vale Hospitals are broadly equivocal, but for differing reasons, and public transport (bus and train) links to The Vale are better.

Staffing Model

4.18 Various iterations of the staffing model have to date been shared between GCS and NHSG and the required composition of nursing and therapy staffing co-developed. The latest model, costed in detail for The Vale Hospital, has been reviewed by GCS Executives and shared with NHSG on 23rd February. Dialogue between the respective CEOs on staffing requirements for the SSR Service is in progress.

4.19 Note, GCS staffing costs exclude provision for Speciality Medicine input, Dietetics, Psychology and Social Worker resource. These are being commissioned and costed by NSHG.

4.20 The rationale behind key aspects of the staffing model is as follows:

- **Band 8A Therapist Lead** – reflecting Clinical Senate feedback, this post-holder will take a significant role in audit, evaluation, and ensuring the SSR Service delivers against best practice and national standards;

- **Band 7 Ward Manager** – this role will continue as it already exists within the current ward structure. Working alongside the Band 6 nurses, the Ward Manager will continue to ensure effective patient flow through the ward;
- **Richer clinical skills-mix** – there is increased presence of Band 6 nursing to ensure strong input to senior clinical leadership 7 days per week as there will be no qualified therapy presence at weekends; and
- **More overnight HCA clinical cover** – to ensure the core duties are discharged across the 24/7 period and provide additional support for a higher dependency of patients for night nursing needs.

Medical Resilience / Sustainability

4.21 The single inpatient ward at The Vale Hospital, and possible loss of its MIIU services, are potential risks to sustainable resilience of a SSR Service. Cirencester Hospital is a dynamic health campus with two principal wards, Theatre/Endoscopy suite, and a larger clinical staffing complement. However, there is no material difference in medical cover across any of the Community Hospital Wards, and as a specialist Centre of Excellence, the SSR Service should attract the necessary staffing and medical cover – whether at Cirencester or The Vale.

4.22 Critical to ensuring resilience of the SSR Service, irrespective of where it is situated, will be two other key factors:

1. **A necessary cascade of skills and training from GHFT** – to ensure the service can thrive independently in a Locality setting. The nature and timing of that skills cascade will be considered further within a detailed deployment plan, once the SSR Ward option is agreed; and
2. **Collaborative in-reach support from the multidisciplinary ESD Team** – to ensure seamless continuity of stroke patient management along the whole care pathway.

4.23 If the SSR Service expands beyond the first phase, X-Ray diagnostics would be necessary. Modern X-Ray equipment is already available at The Vale. Digital transmission of images to any other site would be viable if clinical staff on the SSR Ward were trained to use the machinery and suitable arrangements put in place with the UTCs / Acute Hospital centres for review of the images and provision of diagnoses. All Community Hospital sites feature robust IT infrastructure, with the Vale having the most modern internal networking technology. Establishing telemedicine links of any kind will not therefore be a problem.

Medical Cover – Contractual Arrangements

4.24 GCS has in place an agreement with GDOC for provision of medical cover 6 days per week. Any new requirements arising for the SSR Service could be met through structured change to current contractual arrangements. Recent dialogue between NHSG and GDOC has been positive and it is considered that resilient medical cover should be available for whichever option is chosen. Similarly, feedback from the Stroke Consultant to NHSG also suggests that sufficient 7-day medical cover for the SSR Service would be viable.

Strategic Fit

Estate Utilisation

4.25 The four ward options offer differing strategic and tactical advantages in an environment where the longer-term clinical and operational models for Acute, Community, Mental Health and Centres of Excellence are all currently under development. Tactically, Thames Ward now serves as a useful decant space for temporary inpatient accommodation, and its suitability for this was proven during the refurbishment of the first floor of Tewkesbury Hospital in 2017. Numerous other GCS wards are due refurbishments in 2018 and beyond, and so Thames Ward could potentially be used productively for this purpose over the next few years. There are potentially other suitable applications for Thames as an overnight rehabilitation centre, given its close proximity to Cirencester Theatre. However, whilst this could be advantageous to GHFT, it is purely aspirational at this time. Real or aspirational, for a number of reasons, deployment of Thames Ward for SSR would generate the highest opportunity costs, as well as construction costs.

4.26 Deployment of the SSR Service into Coln or Windrush Wards would further enhance Cirencester Hospital as a thriving clinical hub within the south of the county. Strategically, this could be advantageous over time, potentially supporting repatriation strategies, for example. However, the roadmap for consolidation and specialism of this type remains to date uncertain.

4.27 Use of The Vale as a SSR centre of excellence generates a number of other arguments. The facility is excellent in many ways, but very underutilised in all but the inpatient services. Consolidation of the Community Hospitals estate is neither politically nor strategically justifiable at this time, and so conversion of The Vale into a neurological rehab centre of excellence for the foreseeable future could give the Hospital a very worthy identity, and stimulate much more productive use of the ground floor for other planned care activity. Even in its current internal configuration, The Vale is more or less 'ready-to-go' as a facility and there would be minimal ward downtime. Aspirations to launch the SSR Service as soon as possible in 2018/19 are also most easily realised through this option.

Skills Enrichment

4.28 As a centre of excellence the SSR Service will provide positive opportunities for both Occupational Therapy and Physiotherapy for undergraduate and postgraduate placements from the University of West of England. The staffing model will enable GCS to incorporate postgraduate rotation into the already well-established programme. This will be a highly attractive rotation and will enhance recruitment into the Therapies. The SSR Service should also provide attractive opportunities for apprenticeships, again expanding on programmes already in place.

5 CONCLUSION

5.1 A main purpose of 31st January meeting was to explore the viability of The Vale Hospital as a preferred option for deployment of the SSR Service. Given the current strategic context, and acknowledging the need for a number of mitigating actions to address the isolation of the ward and ensure clinical resilience, there is very clear evidence to confirm The Vale as a suitable site option, on grounds of:

- Accommodation configured in the preferred configuration of single rooms;
- Quality, volume and flexibility of other internal areas;
- Scalability;
- Costs/complexity of conversion;
- Availability of internal and external environmental features that could provide therapeutic benefit; and
- Lead times to full operability.

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Improving Specialist Rehabilitation after a Stroke

Outcome of Engagement Report: August 2018

Foreword

During the six weeks of the public engagement, Gloucestershire Care Services NHS Trust (GCS) and NHS Gloucestershire Clinical Commissioning Group (CCG) have sought the views of local people who have experience of stroke services in the county.

In this Outcome of Engagement Report we have sought to present the views shared with us respectfully, taking care to record the comments and suggestions received accurately.

This report provides information about the engagement process and activities and summarises the feedback received from members of the public, stakeholders and health and care staff.

We are grateful to everyone who has taken the opportunity to get involved with the engagement.

Further copies of this Report, and copies of the Report in other formats, are available from:
The engagement team: glccg.consultation@nhs.net

or by writing to:

Improving Specialist Rehabilitation after a Stroke
Engagement and Experience Team
5220 Valiant Court
Gloucester Business Park
Brockworth, GL3 4FE

To discuss receiving this information in large print or Braille please ring **0800 0151 548.**

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Introduction

This Report provides a detailed overview of the engagement activity and feedback received, which will inform the decision making of NHS Gloucestershire Clinical Commissioning Group and Gloucestershire Care Services NHS Trust regarding investment in the development of a new Stroke Rehabilitation service in Gloucestershire.

Thank you to all those individuals, groups and organisations who shared their views with us.

Background

Specialist rehabilitation is widely recognised as an essential part of recovery after stroke – providing significant health and social care benefits for patients over the longer term.

Currently the patient's journey through care can be disjointed and in Gloucestershire there is a gap in provision. This happens when a patient no longer needs specialist medical care in Gloucestershire Royal Hospital (GRH), still requires significant rehabilitation, but is not ready to return home with support.

We believe we can improve services and support in Gloucestershire for stroke patients, provide the right care in the right environment for all patients and ensure recovery and health benefits are improved. This includes supporting people to achieve as much independence as possible.

We are committed to meeting the highest quality standards of care for patients in line with National Institute for Health and Care Excellence (NICE) recommendations and Royal College of Physicians (RCP) guidelines.

How could services be provided in the future?

Our ambition is to develop a 'centre of excellence' approach to specialist stroke rehabilitation care.

- By providing a dedicated therapy led rehabilitation service in the right environment, we can:
- Improve health benefits for patients and improve levels of recovery and independence
- Benefit healthcare professionals, and the patients they treat, by providing an improved environment for a therapy based approach
- Improve arrangements for on-going learning and development and;
- Raise the profile and appeal of specialist stroke rehabilitation in the county so specialist staff will want to come and live and work in Gloucestershire adding to our already skilled team.

The Options

Clinicians and managers carried out a detailed Options Appraisal, to help develop a preferred option. They looked at four options, summarised below:

Option 1: Do Nothing

Stroke patients who are unable to return home once medical treatment is complete would continue to have their stroke rehabilitation at GRH.

Option 2: Expand therapy provision and improve the therapy facilities at GRH

The staffing levels on the stroke ward are increased to meet national guidelines and therapy space is increased. Patients would remain in GRH for rehabilitation until they are able to go home or show no further improvement.

Option 3: Expand the Early Supported Discharge Team (ESD) and provide 'in-reach' care (specialist therapy) with the team travelling to multiple community hospital locations

The ESD Team would provide specialist and intense rehabilitation to an increased number of stroke patients – a maximum of 14 beds would be available across Gloucestershire's community hospitals. This would be for patients who no longer need medical treatment in a large acute hospital, but are unable to go home.

Option 4: Stroke Rehabilitation Unit in a single community setting

Use 14 beds in a single community hospital to create a dedicated unit for stroke specialist rehabilitation. A team of stroke specialist staff would provide rehabilitation, 7 days a week. This would be for patients who no longer require medical treatment in a large acute hospital, but are unable to go home.

Location of Stroke Rehabilitation Unit in a single community setting

Gloucestershire Care Services NHS Trust, in partnership with NHS Gloucestershire Clinical Commissioning Group, undertook a review of all community hospital sites benchmarking (reviewing) them against a number of criteria identified by expert clinical staff, with the support of a lay (patient) champion.

The criteria that were reviewed included:

- The internal and external care environment
- The ease of adapting the building
- How 'future proof' the unit would be if located at the site
- The safety of the site.

These criteria suggest that the Vale Community Hospital, Dursley would provide the best opportunity to deliver this proposal for the following reasons:

- It's a newly built community hospital with single rooms which are en suite
- It offers both physical and psychological benefits e.g. accessible outside space and a suitably large therapy space
- Minimal building work would be required to provide a good rehabilitation environment
- It's accessible with easy and free parking
- It's sited within the same locality as another community hospital with additional general community hospital beds available to local residents.

Engagement: June/July 2018

During June and July 2018, a range of engagement activity was undertaken to gather feedback from local people who have lived experience of local stroke services, either as a patient, carer, patient representative or service provider.

The focus of the engagement was Option 4 above. Respondents were invited to share their views on the preferred option by answering the following questions:

- What are your initial thoughts about our proposals?
- What do you think are the positive aspects of the proposals?
- Do you have any suggestions for improvements to the proposals, if yes please tell us?
- Do you have any concerns?
- Are there any other things you would like us to consider?

Engagement Activity

The engagement was promoted through the local media, online via the GCCG website https://www.gloucestershireccg.nhs.uk/wp-content/uploads/2018/06/Stroke-Rehab-Engagement-Booklet-June2018.pdf , a printed public engagement booklet including a freepost feedback form, a targeted stakeholder workshop and a number of targeted group meetings, including the League of Friends of the Vale Community Hospital. We are grateful to the local branch of the Stroke Association and to local Stroke Clubs and others for promoting the engagement to their members, inviting us to meet with them and for providing valuable feedback.

Staff engagement
The engagement was promoted to staff, and engagement materials made available by GCS.

Engagement Feedback

The engagement gathered feedback in two ways: targeted face-to-face events and a survey. One letter was also received.

Engagement Events

Face-to-face discussions with the following groups (A-Z):

- Circulatory Clinical Programme Board CPG Lay Members (attended Stroke Workshop)
- Cirencester Stroke Club (attended Stroke Workshop)
- Clinical Programme Board
- Countywide Patient Participation Group Network, followed by Stroke Workshop
- Countywide Stroke Strategy Group
- Gloucestershire Care Services (GCS) NHS Trust Board
- GCS staff
- Gloucester Stroke Club
- Health and Care Overview and Scrutiny Committee (HCOSC)
- Healthwatch Gloucestershire (attended Stroke Workshop)
- Integrated Locality Board - Stroud and Berkley Vale
- New Models of Care Board
- NHS Reference Group
- Painswick Stroke Club
- Patient Representatives
- Patient Participation Group (PPG) Cluster
- Priorities Committee at NHS Gloucestershire Clinical Commissioning Group (GCCG)
- Rehabilitation Steering Group
- South West Clinical Senate
- Vale League of Friends (Member attended Stroke Workshop)
- Vale League of Friends meeting with GCS

Community Partner Workshop

A Community Partner Workshop was held on 8 June 2018. Presentations were made by representatives of NHS Gloucestershire Clinical Commissioning Group, Gloucestershire Care Services NHS Trust and Gloucestershire Hospitals NHS Foundation Trust. These were followed by facilitated round table discussions.

Below is a summary of the main themes from feedback collected at the workshop.

Initial thoughts

- General support from all respondents – but worry about what happens after the unit.

- *“It’s obvious, it’s specialist care at a specialist location – families cope”*
- *“Sounds like a stroke boot camp”*
- *“It’s the right thing to do”*

Positive aspects of the proposals

- Calmer environment with the whole day-to-day business more responsive to needs of people with stroke – respondents were particularly enthusiastic about the time for staff to understand some of the limitations stroke survivors have in terms of meeting basic needs (e.g. ability to reach/see a buzzer or glass of water)
- You get the right care at the right time 7 days a week
- Psychology becomes a key component
- Good for staff morale
- Ability for family to be more involved with therapy
- Led by an enthusiastic team
- Feeling of moving on / making progress for patient (less institutionalised care)
- Good opportunity for rest in single rooms after demanding/ tiring therapy
- Reassured that the proposal has considered transport and mitigation of single site access issues, including use of IT.
- Easy access to the outside.

Suggestions for improvements to the proposals

- What happens after the unit? In particular: Access to stroke specialist nurse support, easily accessible information (paper and electronic), supporting local and regional networks, Linking to stroke clubs (and advertise them in the unit), Possible in-reach of stroke clubs to unit, Use the booklet (currently given at discharge from GHFT), More engagement with VCS and GPs particularly around discharge.
- To reduce social inequality and problems with relatives visiting, ensure that this is identified and managed before transfer to the unit (i.e. as part of discharge planning at GRH).

Concerns

- Patients are aware they can’t have specialist therapy forever, but many felt that there is little or no support for the transition into community services.
- Home visits from the unit need to be available wherever they are resident in the county.

- Vale Hospital is perceived as “not easy to find” and may be more inaccessible during adverse weather.
- Although transport links were said to be good, where is the bus stop, and how regularly does the service run. In particular, the transport links may be good, but are they as good as for GRH?
- What is happening to support younger stroke patients and their young families when they leave the unit?
- Follow up from specialist services is currently not long enough and doesn’t have all of the right professionals (e.g. psychology, nutrition, speech and language) – will this change?
- Health inequalities are wider than transport and access – how will this be addressed?
- Could the unit create dependency/ is this a better service than going home with ESD?

Any other things to consider

- Query over how food is prepared and served to meet different patient needs
- What translation provisions will be made?
- How would the unit deal with large families visiting?
- Representatives heard and acknowledged the proposal would include social space, but wanted to emphasise the importance of it because of single room accommodation.
- “Glimmer of hope for Community Hospitals to be revitalised”
- Staff rotation through the unit to create network feel felt to be very positive.

Other Group feedback

Stroke Clubs

The Engagement Team were invited to attend two Stroke Clubs to talk about the proposed new development. The following is a summary of the main themes from the feedback from both groups:

Painswick Stroke Club

The Painswick Stroke club were enthusiastic about the prospect of improved rehabilitation services albeit in a time of the pathway that would not benefit “historic” stroke survivors. In general, people were supportive of the idea that a specialist centre would be available when needed, and that most people would be happy to travel to ensure the best/ most appropriate therapy was provided. Some concerns were:

There is an information overload at the point of discharge, and then very little support later once people feel able to try and access some of the things that were previously mentioned.

There is a feeling of abandonment for stroke survivors after the initial “intense” rehabilitation period.

One couple felt that the introduction of “another handoff” would be detrimental and questioned why it was not possible to have the unit at the acute hospital.

Gloucester Stroke Club

Welcomed the further work underway to improve stroke services

If there was a Community specialist stroke rehabilitation unit available following their stroke they would have used it

Recognised the environmental issues in the Tower block

No comment was made related to the location but overall Transport is a significant issue to access all services including the Stroke Club

Need for more support to Stroke clubs and the volunteers who run these (I gather a number of locality Stroke clubs have recently ceased due to lack of support)

Strong support for a change in service model that focuses on supporting individuals and carers who have had a stroke across their whole lifespan and not just post incident (many spoke of limited support given by Early Supported Discharge (ESD) Team - only 6 weeks – then not having any information on what was available. Recognise that this is not only the health and social care sector that has a role in providing this.

Many are accessing private therapists due to lack of services

Comments on lack of proactive follow-up and limited/no engagement from primary care

Limited understanding of what supports are available for Carers – no awareness of Carers Gloucestershire

Frustration with shift to information online, many who are not IT literature are disadvantaged by this

The ReConnect Peer Support Group at Dundry, Cheltenham, the majority of members have had a stroke or are carers of stroke survivors, met together to discuss the proposed service development. Below is a summary of the feedback from their discussion:

- All agreed that Option 4 was the best option.
- Wards at GRH cramped and unsuitable for effective rehabilitation. One member stated that *“it did not fill you with hope when someone in the bed next to you was very poorly. You need to have positivity around you”.*
- There were varying experiences (good and not so good) of Early Support Discharge (ESD) and all stated that six weeks of support was not enough. Carers said that they were expected to cope at home with very little knowledge about how to manage someone with e.g. physical

disability, no speech etc. as well as dealing with all the emotional stress associated with a sudden lifestyle change.

- Like the fact that all the specialist/therapists would be in one place. You would get to know them well and them you. There would be continuity in the advice/treatment received.

The Site:

- Free parking close to hospital a bonus. Able to make use of Train station at Cam if good bus link.
- *"Distance is not a problem if you are going to get better care and support"*
- Outside space available to sit with family away from the ward/get some fresh air, is good.
- Good to have single rooms but also need communal area so patients can meet others going through the same thing/give encouragement/feel less isolated.
- Other suggestions:
- Have a Resource Library on site so that items may be borrowed to help in their recovery afterwards- Carers said that they had to source their own materials, equipment to help with e.g. strengthening , speech improvement, writing tools, games, etc.
- Sessions provided for Carers (as part of the rehab and before the patient goes home) – Understanding Stroke / Moving and Handling/ Emotional Support. Hear about other support in the community.
- Need to provide a café area so that relatives have somewhere to take stroke patient, meet informally with other support providers etc.
- Could there be a Drop-In facility or telephone help line for people who have been discharged but may be having a problem and need some advice?
- In more difficult cases could a respite bed be provided to give Carers a break?
- Would it be open visiting times? It is very restricted at GRH at the moment. Relatives would get to know more about how to support the person once they are discharged?

PPG Cluster

The PPG Cluster agreed that: *"Gloucestershire needs a dedicated stroke unit. The argument for this is well made, clearly summarised, and supported by a wide range of evidence and specialist judgement."* However, the group expressed concerns and questions regarding the proposed location.

Questions focussed on transport planning, impact on bed numbers at the Vale Hospital if the new Specialist Stroke Rehabilitation Unit was established there and the impact on other services provided

at the Vale Hospital such as outpatient services and future investment in services at the Vale Hospital. The preference of this group was that the *"proposed stroke unit should be somewhere on the GRH campus, allowing for the practicalities of bus travel from most parts of the county, as well as parking, even though this is charged for and insufficient at present".*

Survey Questionnaire

The survey questionnaire was created using survey software which supports analysis of both quantitative (number and %) responses as well as qualitative (free text) responses.

The survey questionnaire was made available to the public, staff and stakeholders for a six week period in either print form or online. The engagement was targeted as previously mentioned towards people with lived experience of local stroke services. However, the survey was open to anyone wishing to provide feedback during the engagement period, resulting in a self-selecting, random sample of respondents to the engagement.

Characteristics of open surveys

In considering the open survey questionnaire analysis it should be noted that:

- Anyone can respond
- It is not a controlled statistical sample
- There is self-selection bias (just those who want to respond do respond)
- There are no controls on:
    - One person responding multiple times
    - People misrepresenting facts (e.g. their postcode)
    - Demographics of those who respond
    - Therefore we cannot say: "this reflects the views of population X"
    - We can say: "the people who chose to respond said Y"

The engagement team can confirm that <u>all</u> survey questionnaires received between were included in the analysis in this Report (receipt of postal questionnaires was extended beyond the 31 July deadline to enable one of the local stroke clubs to meet and discuss the engagement at a meeting on 4 August 2018).

Where it was clear that the same hand had been used to complete a postal survey questionnaire, or identical phrases had been used to answer free text questions, it was assumed by the engagement team that the questionnaire had been completed on behalf of another individual.

Survey Questionnaire Responses

A total of 65 surveys were completed. Survey questionnaires were either completed on line or by hand using the tear-out freepost survey questionnaire printed in the engagement booklets Questionnaires received by freepost were entered into the online survey by the engagement team using exactly the same words as were used originally. Where, in some cases handwriting was very difficult to read a series of '?????' were entered. This engagement focussed on qualitative feedback. Therefore, all responses were read by members of the engagement team and grouped according to key themes.

Who responded?

The survey questionnaire provided the opportunity, optional, for respondents to provide information about themselves. This information is helpful in identifying whether a good range of local people have taken the opportunity to provide feedback. Demographic information is summarised in Appendix 1.

How did people respond using the survey questionnaire?

People were asked to consider five questions

- What are your initial thoughts about our proposals?
- What do you think are the positive aspects of the proposals?
- Do you have any suggestions for improvements to the proposals, if yes please tell us?
- Do you have any concerns?
- Are there any other things you would like us to consider?

People were also asked how they would like to stay involved and be kept informed and included "by email", "hospital meetings", "my PPG", "local media" and the website on which the consultation documents were placed.

Survey questionnaire feedback

Overall there was very positive support for the concept of delivering stroke specialist skilled rehabilitation in a dedicated unit.

> *"An excellent proposal and I endorse it wholeheartedly. There are so many stroke patients who would benefit. The patients' long term outcomes and lifestyle would see so much improvement"*
>
> *"Sounds really positive. Pleased that my local area will have such a specialist service"*
>
> "*Good to have it in a single community hospital, better chance of recovery and saves journeys to Gloucester. It's a new building and has single rooms, good parking not like Gloucester"*
>
> *"Providing specialist, state of the art, care and rehab for stroke patients is long overdue in Gloucestershire…and on balance I can see that putting this care onto a single site makes sense, despite the reservations expressed earlier"*

In terms of the location 3 key themes emerged from responses to the engagement questions above;

1. Transport

Comments regarding transport fell into two parts; concerns regarding the distances people would have to travel to see relatives who were receiving specialist rehabilitation on the unit in The Vale and concerns regarding travel that Vale residents may have to undertake should their relative be unable to access a bed locally.

> *"It would leave very few beds for local people and that the transport into Dursley is not ideal for a countywide service"*
>
> *"My concern is the patient could become more withdrawn and lack confidence with no families/friends available on a regular basis"*
>
> "…*rural community where travel to other hospitals is very difficult for many. I am not sure what other available community facility is referred to, but the nearest are either Stroud (already oversubscribed) or Tetbury (no public transport from the Dursley/Cam area)*

2. Reduced access to community hospital beds at The Vale for local residents.

Whilst there were no responses disputing the need for a specialist rehabilitation unit there was a high level of anxiety regarding the reduction in beds available for the local population. Some respondents queried the impact of new housing developments in the area.

> *"I believe that the proposed changes are essentially a good idea but also have concerns as to the loss of community beds for patients living in and around the Dursley area."*
>
> *"The Vale Community Hospital was set up to provide services for local people. It has had full bed occupancy and local GP's have not always been able to get access for their own patients. There is no spare capacity and it will be to the detriment of local people if 14 of its 20 beds are allocated for stroke patients. "*
>
> *"With an increased local housing programme these beds are needed for local patients, after all it was built as a community hospital not a county facility."*

3. Staffing and other services

There were a number of comments regarding the employment of staff and effect on services not related to the in-patient beds but based at the site. The feedback fell into two areas; the impact of the unit on peoples jobs and the future of other services within the hospital such as out-patient physiotherapy.

> *"It worries me that I currently work in The Vale and will be moved if this site is selected"*
>
> *"What will be the effect on the Physio Department?"*

"The jobs and location of the people who currently work in the Vale hospital and inform us of plans for where our service will go if the stroke unit takes over."

Suggestions for improving the proposal

Although there was overwhelming support for a single site stroke specialist rehabilitation facility, due to concerns regarding transport and local bed availability, a number of alternative suggestions were made for improving the proposal which primarily focussed around the location and current building

"A new unit should be built."

"..The unit needs to be centrally placed in the county to enable all Gloucestershire residents' equal access."

"By definition the Dursley Community Hospital is a justifiable/viable facility and if the requirement is for a stroke unit then the option is to extend the building to accommodate the Stroke unit."

"Make this facility an add-on at an existing facility or convert an underused building to accommodate it."

Areas for consideration

Positively, respondents made valuable contributions in terms of things that should be considered.

"*Transport is always a problem- how about a group to consider it across Gloucestershire regarding the NHS"*

"Good IT so families and carers far away can Skype /keep in touch without having to make a long journey every day.
A therapy pool might be good?"

"Can the transport problems be offset by some measures to make travel and visiting easier? E.g. flexible visiting times, shuttle bus from Cam & Dursley station."

"*..good links with social care for discharge planning"*

"How will the nurses at the community hospital gain stroke specialism – will any nurses go over from GRH stroke team?"

"*.. access to orthoptics and orthotic services – for visual assessments – splints etc. as at GRH"*

A number of questions were raised and suggestions made in the feedback received. These have been grouped by themes and the responses to these can be found in Appendix 2.

Next steps

Presentation and publication of Outcome of Engagement Report

Online
This report and Appendices will be published online at https://www.gloucestershireccg.nhs.uk/stroke-rehab/

NHS Gloucestershire Clinical Commissioning Group (CCG)
Before making their decisions regarding the proposed service development the CCG Governing Body will consider the Outcome of Engagement.

The information included within the Outcome of Engagement Report will be given due regard by members of the Governing Body of Gloucestershire Clinical Commissioning Group, when they meet in public on 30 August 2018. The GCCG Governing Body will receive a Report setting out recommendations; this Outcome of Engagement Report will be an appendix to the Main Report.

List of Appendices

Appendix 1: Demographic information about survey respondents.

I am:

		Response Percent	Response Total
1	A member of the public	75.76%	50
2	A community partner	0.00%	0
3	A health or care professional	24.24%	16
		answered	66
		skipped	1

I am:

		Response Percent	Response Total
1	Male	28.79%	19
2	Female	66.67%	44
3	Prefer not to say	4.55%	3
		answered	66
		skipped	1

My age group is:

		Response Percent	Response Total
1	Under 18	0.00%	0
2	18 – 25	1.49%	1
3	26 – 45	17.91%	12
4	46 – 65	35.82%	24
5	over 65	37.31%	25
6	Prefer not to say	7.46%	5
		answered	67
		skipped	0

Are you?

		Response Percent	Response Total
1	A patient who has experience of stroke services	9.30%	4
2	A carer of someone who has experience of stroke services	9.30%	4
3	A family member or friend of someone who has experience of stroke services	81.40%	35
		answered	43
		skipped	24

Do you consider yourself to have a disability? (Tick all that apply)

		Response Percent	Response Total
1	No	75.76%	50
2	Mental health problem	0.00%	0
3	Visual Impairment	4.55%	3
4	Learning difficulties	1.52%	1
5	Hearing impairment	7.58%	5
6	Long term condition	6.06%	4
7	Physical disability	6.06%	4
8	Prefer not to say	9.09%	6
		answered	66
		skipped	1

To which of these ethnic groups would you say you belong? (Please tick one)

		Response Percent	Response Total
1	White British	86.57%	58
2	White other	0.00%	0
3	Mixed	0.00%	0
4	Asian or Asian British	0.00%	0
5	Black or Black British	0.00%	0
6	Chinese	1.49%	1
7	Prefer not to say	10.45%	7
8	Other (please specify):	1.49%	1
		answered	67

Appendix 2

Specific questions or suggestions raised in the engagement feedback and responses

Question/Suggestion	Response
Theme: Location	
There should be a ward in each area of the county, not just one place.	**To deliver the level of highly specialised rehabilitation intended by this proposal a 24 hour approach by staff with expert skills is required. Spreading this across multiple wards alongside other patients with a variety of conditions will dilute the effectiveness of the environment and specialist approach and reduce the positive benefits delivered by a single site.** **To provide the level of intensity of rehabilitation required over a number of sites would be unaffordable as small specialised team of staff would need to travel to multiple locations resulting in significant travelling time. The relatively small numbers of patients do not indicate a specialised team would be appropriately utilised if based at more than one site.** **As part of the initial review we looked at national, clinical and academic evidence and all universally recommend that a single site delivers the best quality of rehabilitation for people.**
Use 2 community hospitals for the new service.	**The same response as above – our modelling tells us we need 14 beds. 7 beds on two sites make it an unaffordable proposal being inefficient in terms of staffing and covering for absence of staff.** **There would be insufficient critical mass of beds for clinical staff to be dedicated to stroke -again reducing the anticipated benefits to people's recovery.**
Site the specialist stroke rehabilitation unit at Gloucestershire Royal Hospital – it is more central.	**Both Gloucestershire Royal (GRH) and Cheltenham General (CGH) Hospitals were reviewed as potential sites as part of the site options appraisal.** **GRH is a busy acute hospital and stroke patients at the point of their recovery when longer term (post 2 weeks) intensive rehabilitation is required do not need acute care beds. The physical environment in the tower block is not conducive to rehabilitation and cannot easily be modified. The cost to build a new unit anywhere at GRH would**

	prohibitive.
A unit for stroke victims is needed but possibly use a hospital which is about to be closed like the one in the Forest of Dean.	**The two existing hospitals in the Forest of Dean are not conducive for effective specialist stroke rehabilitation due to a number of factors e.g. the age of the buildings and cost to upgrade**
Theme: staff	
Who will run the service?	**There will be therapy led provision with key leadership offered from senior stroke skilled therapists and nursing staff. The majority of the staff will be employed by Gloucestershire Care Services NHS Trust who will have overall management of the service with a small number of the team (stroke consultant, psychologist and social worker) being employed by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and Gloucestershire County Council (GCC).The multidisciplinary set up of the unit would offer improvements to the whole stroke pathway by adopting a cross-organisational approach reducing barriers to ongoing care.**
Staffing structure - it would be really beneficial to be able to offer both a band 5 physiotherapy and occupational therapy post.	**The staffing follows national recommendations for the number of beds and we have sought to balance the specialist nature of the posts against a desire to support opportunities for more junior staff to work in a specialist unit and facilitate succession planning. There is a band 5 Physio post but not OT at this stage. As this is a new development there will be the opportunity to review staffing at appropriate intervals whilst maintaining the need to comply with national best practice guidance.**
Staff need to feel confident in looking after these patients and receive appropriate training before they arrive.	**New stroke specialist staff will be employed and will support existing (particularly nursing) staff to gain additional skills required. For the first 6 months there would be funding for a stroke skilled nurse to work on a supernumerary basis alongside staff to train "on the job"** **It is also expected that there would be a transitional period to allow staff to build confidence and skills and learn to work together in a new way while the unit reaches full capacity at 14 beds.**
Where will the specialist staff be recruited from?	**The site of the unit near to an M5 Motorway junction may potentially attract therapy staff from out of county and there may be some internal opportunities for staff already working within the county.**

Theme: transport and access	
Transport is always a problem - how about a group to consider it across Gloucestershire regarding the NHS	**That is a good point and will be taken forward as a suggestion.**
Vale hospital is not easy to reach if you do not have transport. I would recommend there is a regular transport system in place for relatives to access so that family contact can be maintained an important part of helping recovery	**As part of discharge planning relatives and friends would be asked whether they need advice on how to travel to The Vale.** **We would have information readily available regarding transport options.**
Patients could become more withdrawn and lack confidence with no family/friends available on a regular basis.	**We appreciate the geography in Gloucestershire always makes travelling to a specialist unit challenging e.g. to Bristol or Birmingham for those who require out of county beds for more complex care. Friends and family already have to travel to see their loved ones in GRH as this is the specialist site for when people require specialist stroke care.** **There are a number of things that will be positively different in the unit to support the identified issues regarding travel:** • **People will have full daily rehabilitation programmes – including weekends focussed on getting home ASAP with less time to feel unoccupied.** • **There is open visiting at The Vale Hospital and therapy programmes can be adapted to accommodate visitors- relatives would be actively encouraged to join in therapy sessions to continue the ethos of a 24 hour approach to recovery not just in therapy sessions.** • **We would be investing in technology solutions such as 'Skype' to allow remote face-to-face contact** • **There will be reclining chairs available so that should a relative need to stay overnight this can be accommodated.** **Finally we appreciate the challenges that the geography brings however our data shows us that just under 70% of those who have a stroke will follow the current pathway and either die or return home from GRH within 2 weeks of their stroke. The specialist rehabilitation unit is likely to impact only 25% of those who experience stroke who at present are not able to achieve their full**

	potential. **Around 150 patients will require the specialist longer term rehabilitation for a relatively short period of time that the unit would offer. We feel for most people this timeframe would be acceptable given that the benefits may make the difference in terms of a person being able to return home/return to work etc. People would only stay in the unit whilst they require specialist rehabilitation. They would then go home where they can have their onward rehabilitation by either our Early Supported Discharge (ESD) team or community teams.**
Theme: services/amenities	
Increase therapy provision to national standards throughout the Stroke pathway to achieve best outcomes in the (long term) most cost effective way	**The staffing for the unit has been guided by national recommended staffing levels and the impact of the unit would support the acute stroke teams to reach those levels too. Our ESD team was also modelled on national evidence. The next phase of the rehabilitation review which instigated this development is to look at community specialist rehabilitation outside the period offered by ESD which is reinforced by feedback from this engagement**
Will there be a detrimental effect on the home support currently offered or will this be replaced by patients attending the specialist unit?	**The home based support offered by our countywide stroke specialist ESD team for stroke or our non-stroke specialist community teams would not be reduced as a result of the unit.**
More input on discharge for stroke patients, and more involvement of family members needed.	**Excellent discharge planning for stroke patients into community services would be a central theme as it is important to ensure people continue to feel supported once they are at home living in their own community.**
Peer support is important - will patients get opportunity to mix with other stroke survivors i.e. activities, meals together?	**There would be a social space which people would be actively encouraged to use with relatives or during rest breaks from therapy. In addition the unit would foster strong links with locality stroke groups to support people and families on the unit and beyond.**
Essential that on discharge from the unit, there is proper community based Physio/OT follow up in the patient's own home or in residential or nursing care facilities until the patient has recovered sufficiently to carry out activities of daily living without continued support.	**Discharge care planning with the person would assess individual ongoing needs. If ongoing rehabilitation is required there would be a number of options available ranging from specialist home based rehabilitation to advice and guidance from our Community Wellbeing Coordinators.**
Theme: beds	
There is no mention in the proposals of any under-use of the existing beds to justify reducing	**Reviewing the use of community hospital beds in general in the light of new**

their number. The acceptable way can only be to build an extension to The Vale.	**developments indicates the way we use our resource needs to change to meet patient need and improve the flow of patients through the whole system. We recognise long lengths of stay are often detrimental to recovery and home and community based support is more beneficial. By reducing unnecessary lengths of stay and ensuring people use community hospital beds where they will actively benefit there will be confidence in the numbers of available beds across the county. Over the past 10 years it has been recognised that home is best for a wide range of people, supporting reduction in the risk of loss of independence associated with longer stays in hospital.**
Will the beds be ring-fenced for stroke patients?	**The 14 beds will be ring fenced for stroke patients. This will be reviewed at agreed periods**
How will this affect the accessibility of general care in the Dursley area with the loss of 14 beds at The Vale Hospital?	**Our data analysis consistently showed that fewer than 50% of the people using the community hospital were local to The Vale Hospital. The community bed modelling undertaken indicated that the remaining beds at the Vale hospital along with beds at Stroud hospital are sufficient for the population of the Stroud and Berkeley Vale locality**
Why are 14 beds required for Stroke Rehabilitation?	**As part of the business case we modelled the number of beds required based on national recommendations, local data for 2 years and clinical review of 98 real-time case studies. For the cohort of patients who would benefit from longer term intensive specialist rehabilitation, 14 beds was the required number.**
Theme: information	
Information available to family and friends on how to help the stroke patient, e.g. exercises, forming words, picture cards etc., memory loss etc.? Could this be made available on line?	**This would be an integral part of the approach. There are also a number of very useful online resources and APPs which would be fully utilised to maximise the ability to self-support rehabilitation.**
Good IT so families and carers far away can Skype /keep in touch without having to make a long journey every day.	**IT at The Vale is excellent and tablets/iPads etc. are being considered to enable as many people as possible to communicate remotely whenever they wish e.g. to say goodnight.**