Appendix 9: Stakeholder appraisal and assessment of the shortlist

Stakeholder assessments (whether staff, clinicians, commissioners, carers or stroke survivors) are clearly based on individual judgements.

They enable us to understand the perceived potential implications of different options on different groups of people.

They also ensure that the evidence we present to these groups is clear, accurate and unbiased.

The sole purpose of stakeholder assessment is to capture the views of the attendees – each of whom may have placed different importance on different factors and taken account of different evidence – which will then help to ensure we have a rounded understanding of the implications of the options.

This will in turn inform our processes and decision making.

Date	Venue	Stakeholders	Event outcome
23/06/22	North Petherton Workshop	Clinical Reference Group – Taunton	• Options appraisal • Mapping the pathways for each shortlisted option • Challenged the validity and viability of option B • Overlaying of TIA longlist onto preferred stroke option • **Emerging preferred option C**
23/06/22	Email Feedback	SWASFT	• Option A is not feasible given the fragility of the set up. • Having been involved in a number of stroke redesigns both clinically and from a senate perspective a split HASU/ ASU across sites generally does not mitigate the workforce challenges as staff are still split across sites, even where the sites are closer than YDH & MGPH. Therefore, I don't think Option B and C are feasible. • Option B I don't think would work in reality as it would still require additional staff to be recruited which is a national challenge and the additional journey/ travel time may impact recruitment. • Option C is not feasible in my view due to the staffing challenges. • Option D would have an impact on SWASFT & Dorset and would need to be modelled.

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			• **Emerging preferred option D**
29/06/22	Zoom Workshop	Public and patient stakeholder group	• See detailed feedback below • Discussed pros and cons of each option • Group asked questions and presented opinions, based on their own experiences • Challenged the validity and viability of option B • Option D felt more challenging from an equalities and carer perspective • Consensus that expertise in hyperacute phase outweighed the potential impact on additional travel time • **Emerging preferred option C**
07/07/22 1-2-1 interviews	Dunkery Ward	Taunton Stroke Team	• Met with staff of a range of grades and roles on an individual basis to discuss options • Option A not viable • Option B issues with workforce and staff travel, responsiveness, and continuity of care • Option C negative impact on carers, increased workload for Taunton, staffing and bed capacity issues, increased patient transfers of care • Option D better patient experience and outcomes, negative impact on carers, staffing considerations, impact on relationship between YDH and MPH • **Emerging preferred option B**
21/07/22 1-2-1 interviews	YDH	Yeovil Stroke Team	• Met with staff of a range of grades and roles on an individual basis to discuss options • Option A does not resolve any issues • Option B does not resolve workforce issues or current performance issues, continuity of care concerns, delays to treatment plans • Option C potential to improve outcomes, would resolve medical staffing issues, worse for carers, more transfers of care, requires telemedicine • Option D impact on MPH staffing levels as YDH staff unlikely to travel to Taunton, worse for carers, less transfers of care, better outcomes for patients “We need to accept that we cannot continue to provide HASU care here.” “I would be devastated if we lost the HASU.” “Although I love stroke and neuro I would not travel to Taunton to work”

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			• **Emerging preferred option C**
20/07/22 1-2-1 interviews	MPH	Therapies Team	• Met with staff of a range of grades and roles on an individual basis to discuss options – followed up with email feedback • Option A would be preferred option, but accept it is not viable • Option B not viable due to lack of medical care and risk of diluting further across both sites • Option C Needs robust repatriation process in place to minimise delayed transfers of care, impact on carers, would need increased investment for beds, equipment and staffing • Option D best option for patients, would need significant increase in capacity and staffing, worse for carers • **Emerging preferred option C**
03/08/22 Meeting	MS Teams	Dorset Stroke Team	Staff Engagement
09/08/22 Workshop	Yeovil	Clinical Reference Group - Yeovil and Dorset	• Options appraisal • Mapping the pathways for each shortlisted option • Overlaying of TIA longlist onto preferred stroke option • **Emerging preferred option**
25/08/22 Workshop	MS Teams	Patient and public stakeholder reference group	• Review shortlisted options with modelling • Identify preferred options for consultation • **Emerging preferred option C**

The table below is the detailed staff feedback:

Staff Group / Team	**Option A** **No change**	**Option B** **Shared Medical Delivery Team**	**Option C** **Single HASU at MPH (ASU at MPH and YDH)**	**Option D** **Single HASU and ASU at MPH**
MPH Stroke Team *07/07/22*	0 votes Comments: • Would not be a viable option	**PREFERRED OPTION** 4 Votes Comments: • Implementation concerns • Continuity of care • Responsiveness and timeliness of medical input • Lack of adequate workforce • Staff travel issues	2 votes Comments: • Parking an issue for relatives • Better having staff in one place. • Patients closer to home for the ASU part of their stay. • Impact on relatives' ability to visit • Impact on workload of wider stroke team • Need more beds • Need more staff • Ambulance travel times	2 votes Comments: • Better patient experience • Staff all in one place. • Ward capacity • Open visiting would be required • Specialist unit may give more confidence • Would be easier to get patients to the community stroke units • No repatriation

			• Increased number of patient transfers.	• Potential impact on relationship with YDH • Not patient and carer friendly • Increased carer travel and cost implications • Public transport not good. • Better continuity of care than C • Staffing challenges • Additional equipment • Impact on patients if carers cannot visit
YDH Stroke Team 21/07/22	0 votes Comments: • Does not resolve the medical staffing issues • Need minimum of two consultants to deliver service • Weekends and OOH would continue to be a problem • Could have shared learning • Does not fix the SSNAP performance issues • Increasing numbers from Dorset • Would continue with stroke patients being priority 3 for rehab as ward based and currently not meeting daily rehab SSNAP goals • No rehab facilities on ward • Care of stroke patients during pandemic has been terrible	1 vote Comments: • Does not solve recruitment issues • Good for patients having one team • Lack of continuity of care and negative impact • Need consultant on site to develop relationships • Would need consultants for long periods and not changing every day/week. • Increased phone calls • Harder to develop trust in clinicians if you are not working with then all the time • Delays in treatment plans • Building relationships can be difficult e.g., Neurology Would not be happy with a neuro type service • Location and travel would be difficult and take time away from clinical work	**PREFERRED OPTION** 3 votes Comments: • Need a consultant based in YDH 5 days a week. • Would need team working across both sites to trust assessments • Increased travelling for relatives • Repatriation may be difficult • Would need telemedicine • Would need to ring fence beds • May resolve the delayed discharges from Dorset • Potential to improve staffing – e.g. Could rotate staff • Relatives are important to be able to work with them and help orientate patients • Loss of skills • Impact on delayed stroke diagnosis? • Continuity and trust in HASU assessment • May increase duplication. • Opportunity to get ASU right • Need to resolve the anxieties of the clinicians. • Need rehab facilities kitchen, gym etc "Thought we had agreed that we would go with this option in 2020." "We need to accept that we cannot continue to provide HASU care here."	0 votes Comments: • Staff would not travel to work at Taunton • Increased travel for patients and relatives • Catastrophic for Yeovil patients • Musgrove could not cope • Impact on IP and walk-ins? • Impact on mimics? • Impact on delayed stroke diagnosis? • Impact on neuro patients? • Impact on Dorset? • Impact on SSNAP? • Would need ESD service • Does not fit with the clinical strategy • Not happy makes me nervous • Do not agree with this option "Although I love stroke and neuro I would not travel to Taunton to work"

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			"I am delaying retirement until we know what we are doing." "I would be devastated if we lost the HASU as we have a good rapport with ED and radiology."	
MPH Therapists 26/07/22	**PREFERRED OPTION** Comments: • Best option for patients. • Accept it is unsustainable • will there continue to be a thrombolysis service AT YDH? Obviously, this would need resourcing adequately which it isn't currently.	Comments: • There is insufficient medical staffing resource at present to do this • Patients still get to be treated in a unit geographically nearer to home. • Diluted medical care in both units • High likelihood of medical staff leaving	**PREFERRED OPTION IF ROBUST REPAT PROCESS** Comments: • Increased risk of communication errors. • Risk of patients not being transferred back to YDH in timely way • There would need to be a strict/clear 24/7 pathway to return patients to YDH with no option for them to decline patients • Impact on stroke mimics? • Increased travelling time for carers • May make timely communication difficult for gaining consent for time critical decisions e.g. thrombolysis / thrombectomy Increased demand on all diagnostic depts. • Would need adequate space/environment for additional HASU bed and additional staffing resource including for 7/7 working. • Admission numbers will increase thus increased need for all staffing to meet the national standard ratios – is this achievable?	Comments: • Best option for patients. • Potential delay in thrombolysis / thrombectomy for patients • Would need large increase in all areas of stroke care e.g. beds, staff, therapy treatment areas, equipment, • Would need increased therapy treatment area as likely higher therapy need for those patients post 72hour to enable discharge home with ESD or awaiting transfer to SRU • Note it says 'will receive stroke care post-acute phase nearer home' – is this the case as they might have to go to Williton for rehab. • Will there be any re-location of staff from YDH?

Detailed feedback: Public and patient stakeholder engagement event 29th June 2022

For those with lived experience of stroke, as a patient or carer, to provide feedback on the options.

The attendees had seen all four options before invited to feedback on each option.

Thoughts captured in the table below:

Option A (1)	Option B (2)	Option C (5b)	Option D (6b)
If it was recognised that the service was not fit for the future then would this be an option?	This seems the worst of all worlds. Spreading the resource thinly. Medical staff between 2 sites.	I like this option, some faults with it, with transport etc. Other options on how you get relatives to hospital. Addresses the employment issue.	Advantages can outweigh disadvantages. So similar to last option. Disadvantage having to get to Yeovil or Taunton
Recently had a relative admitted, had CT scan but no other services available until the Monday. The impact is already there. It needs to be addressed. And the available services.	About to move into ICS - shared services	(there is) an aspect of how it affects Dorset patients	Support that carers and families can give, emotionally and mentally should be considered
Specialised equipment needed in different sites?	Proposed merger of the 2 foundation trusts shortly. So surely sharing more than the hyper acute stroke services?	Concerned about the workforce. Acute stroke unit. Is there enough medics to support 2 sites?	Comes back to capacity. Patient transport can be addressed etc. Bus services don't run all the time to Taunton. You could get there and then be stuck as services finish at 17.30 ish
Do nothing is not a right choice- best of care is not available for stroke survivors. Not ideal to share staff	People who have a medical condition need support.	Live in Mendip. Not discussed the RUH. Patients who live in Frome would go to RUH	Areas of deprivation in Yeovil. Need to be mindful
4 options divide into 2. Important thing is if it 1 or 2 sites	(My) Mum was in BRI. If no car would not have been able to go and visit. Cost of living, no buses. Can't afford taxi	Carers need to be informed at all times	
Outcome of the potential stroke was that it wasn't a stroke. Workforce and supportiveness of staff. Shortage of staff	Don't think you can substitute a hands on examination with a patient. Something that happens face to face (rather) than on screens.	Re workforce. Not having enough staff in Musgrove Park Hospital. Will then be creating a problem at MPH? Shifting a problem?	
Current model is not effective as it could be why we are looking at the change. Workforce is a challenge - concern	Would be a downward spiral and cost to NHS in long run	SWAST - their ability to be part of this? Implications on them as a service	
		Time waiting for ambulance and then ambulance moving across the county	
		Door to door treatment time frame - elevation of stroke, needs to have a different priority. Needs to be balanced	
		Capacity - need to be mindful to address all these areas	

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Public and Patient Stakeholder Reference Group engagement event 25th August 2022

The aim of this session was to undertake ranking of the four shortlisted options, having had access to additional information such as modelling and workforce, from their least preferred to most preferred.

The higher the score the preferable the option. Maximum score of 70. The outcomes are detailed below:

	Ranking			
Lived experience	**Option A** Previously Option 1	**Option B** Previously Option 2	**Option C** Previously Option 5B	**Option D** Previously Option 6B
Person who survived a stroke	1	1	5	9
Carer	1	2	9	5
Carer	2	4	9	3
Person who survived a stroke	1	2	9	9
Healthwatch colleague #1	1	5	5	4
Healthwatch colleague #2	1	3	5	5
Patient Engagement and Experience Manager, Yeovil District Hospital	3	5	5	3
Total	10	22	47	38
Average	1.42	3.14	6.71	5.42

Scale: 1 - least preferred, 10 - most preferred

Average: total / number of people 7

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