FAQ's

Please can you provide a detailed update on progress in the development of the stage 1, and especially stage 2, provision at DCH HASU, outlining the active milestones achieved and those yet to be achieved?
Dorset County Hospital (DCH) stage 1 business case to develop a hyper-acute stroke unit (HASU) within their existing stroke unit has been completed and the HASU is now open. They continue to recruit stroke physicians, with the remainder of the additional staffing required for the stage 1 business case now complete with successful recruitment to new additional multi-disciplinary roles.

The Stage 2 active milestones are still to be completed, and NHS Somerset will consider how to keep interested parties updated on the progress of the development of the DCH HASU as this moves forward.

Please clarify the arrangements for the YDH stroke service while the implementation phase is going on and how the ICB will be assured and make the decision to Go Live.
The current service at Yeovil District Hospital (YDH) does not a dedicated HASU and is part of the coronary care unit. The intent laid out at the time of approving the DMBC was that the current service at YDH would continue as it is while this period of change is ongoing. As SFT is a merged organisation and working towards a one team, two site stroke service, support will be provided across both Musgrove Park and Yeovil District Hospitals.

The Go/No-Go criteria for stroke are yet to be agreed however to proceed with the service change would mean being satisfied that the new service provides safe, high-quality care that presents an improvement to the existing service.

The specific criteria for stroke will be developed by the implementation group. SFT, DCH, SWASFT and NHS Somerset will be part of recommending to the ICB Board that the criteria have been satisfied.

The HASU at YDH will remain open until NHS Somerset are satisfied that the DCH HASU will deliver the outcomes and improvements to hyper acute stroke care.

Why was there a delay in getting the Joint Stroke Consultation Board set up to oversee the decision making for the implementation phase.
The ICB board approved recommendations at the January 2024 board meeting to improve stroke services in Somerset however, the Board requested that the ICB finance committee review the financial case in terms of maximising value for money for the investment and seeking assurance around the affordability of the capital case.

At the March 2024 ICB Board they unanimously approved the Somerset acute hospital-based stroke services reconfiguration – review of the financial case report and approved the move to implementation.

Since then, the transfer of responsibility for implementation to SFT and DCH has been completed and the ICB Board will retain oversight of the implementation process through the Joint Stroke Coordination Board.

Time has been given to SFT and DCH to plan for delivery of the implementation plan and for them to develop more detailed plans and governance arrangement.

Several requests were made to the Secretary of State to review the decision taken in March 2024 to implement a new model of hyper acute stoke services for the population of

Somerset. NHS Somerset welcomed the decision by the Secretary of State that the call-in requests did does not meet the criteria for ministerial intervention and the Minister's view that NHS Somerset is best placed to determine the needs of our local population.

Progress on implementation was made more difficult while the potential request for a review by the Secretary of State hung over the project. This is because, if the decision had been referred for investigation and the Secretary of State had subsequently overturned NHS Somerset's decision, we would not have been able to carry out service reconfiguration.

Dr Whiting indicated previously that at MPH, they will need six to eight consultant stroke physicians for the enhanced unit however it says that DCH will require two stroke consultants. This does not seem like the equivalent level of staffing and expertise as that proposed for MPH.
Dorset County Hospital NHS Foundation Trust (DCH) is wholly committed to providing a high quality hyper-acute stroke unit (HASU) for the expanded population it will serve across North Dorset and South Somerset from 2025.

The Trust has recently expanded capacity as a result of the outcome of the Dorset Clinical Services Review and benchmarks favourably against national standards of care.
The central aim of the DMBC for Stroke services in Somerset was to ensure compliance with the national standards of care. These can be met in several ways depending on local service configuration and complementary staffing across specialties. This will often be different in different hospitals because of the way services develop and the fact that individual specialists often have different skills and experience in clinical teams
All organisations are now working together through the Implementation Group to align their respective care models and timelines for implementation.

What is NHS Somerset doing about the category two ambulance handover waits which are over the 18-minute national target.

NHS Somerset completely understand the concerns people have with regards to long ambulance response times. The speed of ambulance response is a complex issue which is predicated on a range of factors such as:

• What alternative support is available for people.
• Whether ambulances can hand patients over quickly at hospitals.
• Whether the support to patients on a ward is timely.
• Whether discharge is well planned and delivered.
• Whether people can move out of hospital to home or their place of residence.

All these things play a part in ambulance availability and responsiveness and steps are being taken right across our system and with other ICBs at regional level, to improve the responsiveness of ambulances.

Why is it not possible to run a trial rather than immediately close Yeovil District Hospital's HASU, where the HASU at YDH is kept open for five days a week, as it is currently. For two days a week patients could be sent to Musgrove Park Hospital in Taunton or Dorchester County Hospital in Dorchester. Clinical staff from Yeovil HASU could remain on-call during this period to support Musgrove Park or Dorchester County Hospital if needed.

An option to maintain a 5 day a week service at Yeovil was considered in the development of the Business Case. This option was not supported by the Clinical Senate on the grounds

that it would be operationally difficult to implement for the Ambulance Service in having different dispositions on certain days of the week.

The option was also felt not to address an underlying challenge at YDH which is that on-site clinical review at the weekends is not in place. We are keen to address the fact that a patient admitted for hyper-acute intervention at YDH on a Friday (as an example) does not receive the level of support required under national standards over the following 72 hours (weekend period). If we were to rectify that under this pilot proposal, then stroke patients could only be admitted at YDH on a Monday and Tuesday – to allow for 72 hours of on-site clinical support given the Unit will effectively close at the weekend.

What clinical evidence is there that longer travel times can be more than offset by consistent and efficient diagnostic and clinical care on arrival at hospital.

There is evidence that services with higher volumes of stroke patients and thus performing higher volumes of stroke thrombolysis (clot busting treatment), perform this more quickly. This is because their systems and pathways are more organised and efficient, enabling a shorter “door-to-needle” time, which is the time taken from arrival in hospital to receiving the thrombolysis treatment.

There is also evidence from London, Greater Manchester, and Northumbria that reorganising stroke services can improve the front door processes and increase the chance of timely evidence-based clinical interventions, including early CT brain scanning, intravenous thrombolysis, admission to stroke unit, and specialist multidisciplinary assessment.

The reorganisation of stroke services in Northumbria, a more rural population than the London and Greater Manchester models, again showed an improvement in the front-door processes, including time to CT scan, earlier stroke consultant reviews and multidisciplinary goal setting.

As stated above, the evidence suggests that reorganisation of stroke services can improve front-door processes, and it is realistic to expect a similar level of improvement in the door-to-needle times for stroke thrombolysis as was seen in Northumbria.

We do not believe that anyone has implied or stated that longer ambulance journeys are of no consequence. The aim is that the improvements in care from having an organised, well-staffed unit that provides 7-day care as a HASU should, will mitigate against the consequences of longer ambulance journeys for some patients. Thus, at a population level in Somerset, when applying an expected, evidence-based improvement in stroke thrombolysis door-to-needle times that can be derived from the service reorganisation, this does more than mitigate the increase in ambulance journey times.

Can you please explain the role of the Stroke Stakeholder Reference Group and who are the members of that group.

The Stroke Stakeholder Reference Group has been in existence since 2022 when the programme of work started and has continued into the implementation phase.

The format of the group was a joint decision between Somerset ICB and the leads for the work using a stakeholder mapping process alongside the engagement team.

Since the start of the implementation phase the group had been independently chaired by Healthwatch Somerset however due to changes in roles the chair has been taken over by the Stroke Association. This forum provides a two-way flow of information with the Joint Stroke Coordination Board and is one way in which project leaders hear the voice of service users and local people.

Membership includes staff representatives from Somerset FT and DCH, and patient and carer representatives alongside NHS engagement and project managers.

The group has an advisory role but does not have any decision-making responsibilities.

What do the changes mean for Somerset now the decision has been made to reconfigure stroke services in the county?

- Hyper acute stroke services, with the establishment of a single Hyper Acute Stroke Unit (HASU) at Musgrove Park Hospital in Taunton, providing 24/7 emergency treatment. Research shows that more people survive stroke and can live independently when specialised stroke services are located in one place.
- Ongoing hospital treatment, with Acute Stroke Units (ASU) at both Musgrove Park Hospital, Taunton, and Yeovil District Hospital, Yeovil. Maintaining two Acute Stroke Units would mean that following their emergency stroke treatment, patients could move to Yeovil District Hospital if this were closer to where they live.
- Where patients would be taken to their nearest Hyper Acute Stroke Unit. This could be out of Somerset if it were closer, such as Dorset County Hospital, Dorchester.

The plans were developed by clinicians, people working in stroke services, key stakeholders, and people with lived experience of stroke.

People who are suspected of having a stroke are taken to the nearest HASU to be cared for and treated for the first 72 hours. Therefore, when stroke services are reconfigured, people in Somerset who are suspected of having a stroke will be taken to the nearest HASU which could be Musgrove Park Hospital in Taunton or Dorset County Hospital in Dorchester.

After approximately 72 hours, patients who need ongoing hospital care are transferred to an ASU. For patients who live closer to Yeovil, they will be repatriated to Yeovil District Hospital to receive their treatment in the ASU there. Those who live closer to Musgrove Park Hospital, will be treated in the ASU there after the first 72 hours.

Patients who are suspected of having a TIA (transient ischemic attack) or “mini stroke” will be referred to a seven-day clinic at Musgrove Park Hospital or five-day clinic at Yeovil District Hospital, both with appropriate access to diagnostics and an on-site stroke consultant, within 24 hours of referral, in line with national guidance.

What is the difference between a HASU and an ASU?

HASU – Musgrove Park Hospital, Taunton, and Dorset County Hospital Dorchester

A Hyper Acute Stroke Unit brings experts and equipment under one roof to provide world-class treatment 24 hours a day, reducing death rates and long-term disability.

A HASU is for the initial diagnosis and specialist intensive care for stroke patients for up to first 72 hours of being diagnosed with a stroke.

A HASU includes:

- Rapid assessment – patients arrive at the Emergency Stroke Unit and are rapidly assessed by the specialist team at the earliest opportunity.
- Early treatment – using clot-busting drugs (thrombolysis), if the scan shows they are needed and world class procedures such as Mechanical Thrombectomy (available via referral to Southmead).
- 24 hours a day, 7 days a week monitoring and physiological intervention in a high-dependency bed
- A multidisciplinary specialist team on call 24 hours a day and providing specialist ward rounds seven days a week. This includes consultant stroke physicians, specialist nurses and therapists.

ASU – at Yeovil Hospital and Musgrove Park Hospital, Taunton

An Acute Stroke Unit (ASU) is for stroke patients requiring further medical, nursing and therapy support after the initial 72 hours. The unit brings together experts from a range of disciplines who provide a specialised multi-disciplinary team approach to stroke treatment.

If you need to stay in hospital beyond a few days, you may move from the Hyper Acute Stroke Unit (HASU) to the Acute Stroke Unit (ASU).

The service provides diagnosis and medical intervention to manage and minimise the impact of the stroke. Once therapy assessments have been completed, the ASU team works with patients and their families to identify the most suitable way of discharging patients from hospital. These could include inpatient rehabilitation within a community stroke rehabilitation unit, home with therapy support from the early supported discharge team, community stroke service or a follow-up with a member of the living well after stroke team.

The team knows that people with stroke make a better recovery while getting specialist rehabilitation at home, so our teams work hard to promote early discharge from our inpatient units whenever possible.