APPENDIX 01

NHS Somerset acute hospital based stroke services consultation activity overview

Introduction

Between Monday 30 January and Monday 24 April 2023, NHS Somerset undertook a public consultation on acute based stroke services in Somerset.

In the development of our consultation plan and process, we considered the feedback from our pre-consultation engagement and worked closely with a range of stakeholders. All methods for consultation were developed in line with best practice and co-designed with local stakeholders alongside guidance from the Consultation Institute and the independent research organisation Opinion Research Services (ORS).

The approach to the public consultation was to use a range of methods and channels to ensure local people, patients, their families and carers, health and care staff, partners and key stakeholders were aware of and able to engage and respond to the consultation.

We sought to reach a broad range of people. This included extensive targeted engagement across our people and communities including people with protected characteristics, deprived communities and other seldom-heard groups to capture and understand a broader range of views as possible on the proposals.

In line with our consultation plan, the public consultation had three main workstreams:

- General public consultation: consultation with the general public through events, the questionnaire and special interest groups.
- Staff consultation: in addition to the consultation documentation and questionnaire we held focused discussion sessions with staff working in stroke services.
- Representative telephone survey: led by the independent research organisation, ORS, we sought to gain the views of a representative sample that was reflective of the geography and demography of Somerset and boarding counties.

We sought feedback on proposals on hyper acute and acute stroke services in Somerset. People could provide feedback in a range of ways including:

- Taking part in a consultation event including online and face to face meetings.
- Coming to see us at one of our pop up or drop in events.
- Providing feedback at one of the community support groups or community organisation meetings we attended.
- Completing a consultation questionnaire online or via post (freepost).
- Providing feedback via email, post, social media or phone.

To ensure we consulted with people who may be impacted by our proposals we:

- Focused on reaching out to people where they are, in their local neighbourhoods and local networks.
- We promoted the consultation and provided opportunities with the aim of covering the geography, demography and diversity of Somerset, and surrounding areas impacted including Dorset.
- We advertised to make sure people were aware of the consultation even if they chose not to participate.

- We produced materials taking into account the differing needs of our communities.
- We worked with partners in surrounding areas, including Dorset, to maximise our engagement and communications reach in surrounding counties where local people may be impacted by any changes.

All the feedback gathered has been shared with Opinion Research Services (ORS) for analysis and theming.

Stakeholder analysis

To make sure our engagement effectively captured the widest possible views and feedback we developed an extensive list of stakeholders who are involved in, affected by, or interested in the future configuration of the service, as well as the wider public.

The Equality Impact Assessment (EIA) was utilised to inform our stakeholder analysis and engagement activities.

A detailed stakeholder analysis was undertaken and informed our engagement and communications activity.

Priority audiences included:

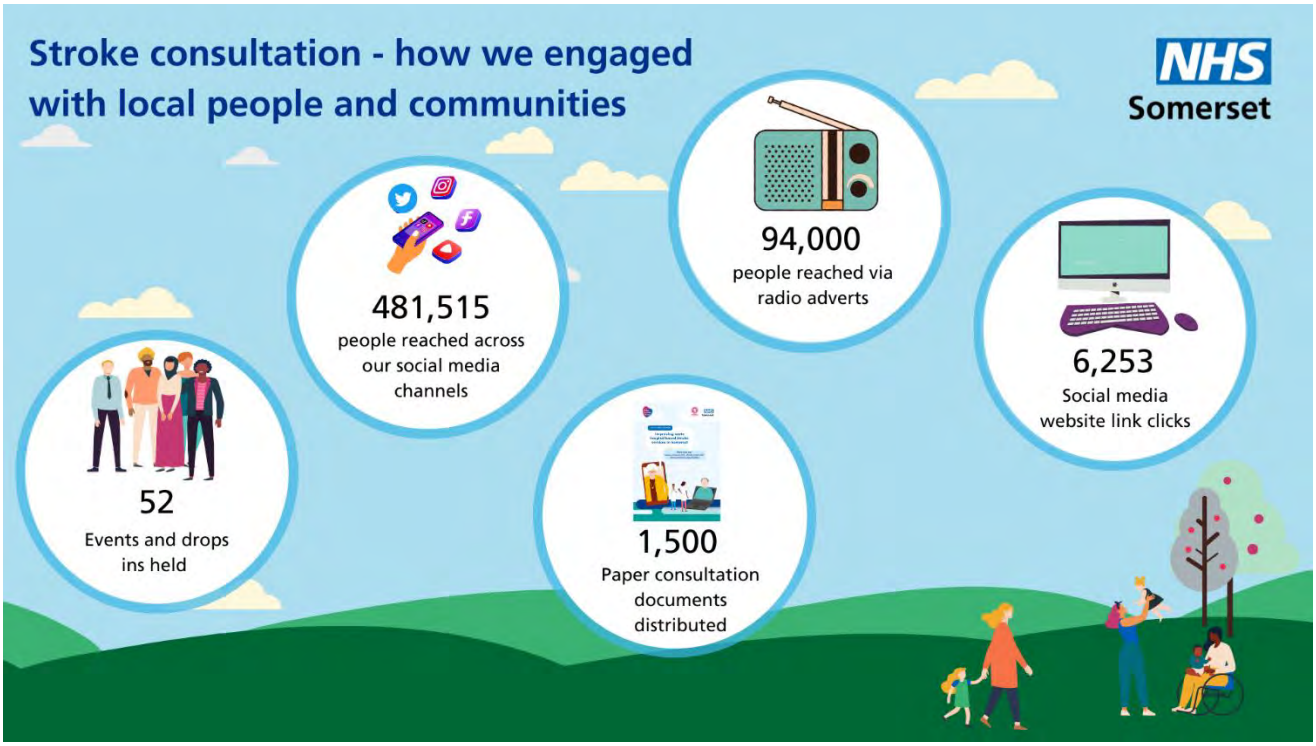
- Patient and carers who have experience of stroke services.
- Key voluntary sector stroke organisations including the Stroke Association.
- Protected characteristics identified in the EIA and HEAT analysis as being at higher risk of stroke.
- NHS and social care staff working in stroke services.

Patient and Public stakeholder reference group

A key part of the consultation preparation has been the establishment of the stroke patient and public reference group. The group consists of key voluntary sector organisations and people with lived experience. The public and patient stakeholder reference group is a time limited group established to provide feedback on our developing solutions and offer their perspectives and insights on how we can inform and engage local people in the hyper acute stroke public consultation.

The reference group is made up of a range of individuals and organisations with direct experience of stroke. The group informed the development of the proposals and supported us to plan the consultation activity and materials.

Activity overview



Public consultation events

Our engagement throughout the public consultation was delivered as a set of activities that were adapted to the location and opportunity. Working with our partners across the Integrated Care System, we were able to put together an engagement programme that worked with existing community events to ensure that we were available across the county (including into Dorset) and reaching diverse audiences with varied needs.

Where appropriate we set up a pop-up stand to showcase and draw attention to the consultation in a public space and we attended existing groups (including support groups for people with lived experience of a stroke and talking cafes across Somerset) at which we presented the information and provided the means for people and communities to take part.

Additionally, we ran a series of public events, these consisted of a presentation and an opportunity to ask questions to our panel of professionals involved in the programme.

All the opportunities to come and meet us were advertised on our website, social media, engagement newsletter, citizens' panel. We also shared with partners and networks to also publicise.

We held and attended 52 events.

Feedback from all events was captured and shared with ORS for inclusion in their analysis.

Date	Venue	Event type	Opportunity
30/01/2023	Yeovil library	Pop-up stand	To engage with people and communities who were using the library. We set up our pop-up stand in the main entrance so we could reach passing footfall to share information on the public consultation; including families with young children, parent and baby, people who use the library, including retired people, those of working age but not working on that day.
31/01/2023	Crewkerne and Chard After Stroke Club	Stroke support group	To reach and engage people in Somerset with lived experience of a stroke having survived a stroke or caring for someone who is there because they survived a stroke. People attending the stroke club had been treated at both acute trusts in the county.
01/02/2023	Westlands Entertainment Centre, Yeovil - café space	Pop-up stand	To engage with people and communities who were meeting up at the entertainment centre as a social venue and/or attending an event being hosted in the main ballroom. We set up our pop-up stand in the main entrance so we could reach passing footfall to share information on the public consultation.
02/02/2023	Yeovil District Hospital - Aspire	Stroke support group	To reach and engage people in Somerset with lived experience of a stroke having survived a stroke or caring for someone who is there because they survived a stroke. People attending the stroke group had recently been discharged from YDH having had a stroke. This was also an opportunity to engage with the staff who work at YDH and run the group.
03/02/2023	Bridgwater, Heather Club	Stroke support group	To reach and engage people in Somerset with lived experience of a stroke having survived a stroke or caring for someone who is there because they survived a stroke. People attending the stroke club had been treated at Taunton (on the occasion they had their stroke in Somerset).

06/02/2023	Crispin Community Hall, Street	Pop-up stand	To engage with people and communities who were meeting up at the centre's community cafe as a social venue. We set up our pop-up stand in the main entrance so we could reach passing footfall to share information on the public consultation
06/02/2023	Martock Information Centre	Pop-up stand	To provide a location for those living in Martock to have access to the public consultation, to reach passing football and to share information on the consultation and to reach.
08/02/2023	Chard, The Guildhall	Talking Café	To ensure that people and communities who attend the local Talking Café as an information hub could have access to information about the public consultation and ask questions.
08/02/2023	Talking Café Live	Live on social media	Presented as part of a Facebook live event version of a Talking Café; recorded and disseminated to people and communities via Facebook.
09/02/2023	Langport library	Talking Café	To ensure that people and communities who attend the local Talking Café as an information hub could have access to information about the public consultation and ask questions.
11/02/2023	Taunton library	Pop-up stand	To engage with people and communities who were using the library because it offered a 'Warm Space', this is a destination for different ages across the life course.
13/02/2023	Yeovil District Hospital - entrance lobby	Pop-up stand	To engage with people and communities who were coming to Yeovil District Hospital for an appointment or to see a relative/loved one. This was also an opportunity for the workforce to engage and colleagues use this thoroughfare. We set up our pop-up stand corridor in view of the Outpatients' Reception to reach passing footfall to share information on the public consultation.
14/02/2023	Yeovil, St Peters Community Centre	Warm space	To ensure that people and communities who attend the local Talking Café as an information hub could have access to information about the public consultation and ask questions.
14/02/2023	Yeovil District Hospital - entrance lobby	Pop-up stand	To engage with people and communities who were coming to Yeovil District Hospital for an appointment or to see a relative/loved one. This was also an opportunity for the workforce to engage and colleagues use this thoroughfare. We set up our pop-up stand corridor in view of the Outpatients' Reception to reach passing footfall to share information on the public consultation.
15/02/2023	South Petherton Hospital	Pop-up stand	To engage with people and communities who were coming to South Petherton Community Hospital for an appointment or to see a relative/loved one. This was also an opportunity for the workforce to engage and colleagues use this thoroughfare. We set up our pop-up stand corridor in view of the main reception to reach passing footfall to share information on the public consultation.
15/02/2023	Ilminster library	Pop-up stand	To engage with people and communities who were using the library. We set up our pop-up stand in the library so we could reach passing footfall to share information on the public consultation.

16/02/2023	Yeovil, St Peters Community Centre	Talking Café	To ensure that people and communities who attend the local Talking Café as an information hub could have access to information about the public consultation and ask questions.
16/02/2023	Yeovil District Hospital - entrance lobby	Pop-up stand	To engage with people and communities who were coming to Yeovil District Hospital for an appointment or to see a relative/loved one. This was also an opportunity for the workforce to engage and colleagues use this thoroughfare. We set up our pop-up stand corridor in view of the Outpatients' Reception to reach passing footfall to share information on the public consultation.
16/02/2023	Thursday teatime check-in - online meeting at 6pm, open to all	Online	To provide an online space for any people and communities who had been unable to attend an in-person session (pop up, talking café or warm space) and any person who had attended and had further questions.
17/02/2023	Crewkerne library	Pop-up stand	To engage with people and communities who were using the library. We set up our pop-up stand in the main entrance to the library so we could reach passing footfall to share information on the public consultation; including families with young children, parent and baby, people who use the library, including retired people, those of working age but not working on that day.
20/02/2023	Wincanton library	Pop-up stand	To engage with people and communities who were using the library. We set up our pop-up stand in the main entrance to the library so we could reach passing footfall to share information on the public consultation; including families with young children, parent and baby, people who use the library, including retired people, those of working age but not working on that day.
20/02/2023	Online	Somerset Engagement Advisory Group, online meeting	Presented the public consultation to this informed group. They meet every 3 months to hear latest from NHS Somerset engagement team. They act as a 'critical friend' function and to take information back to their communities.
20/02/2023	Taunton Musgrove Park Hospital	Pop-up stand	To engage with people and communities who were coming to Taunton Musgrove Park Hospital for an appointment or to see a relative/loved one arriving via the concourse entrance. This was also an opportunity for the workforce to engage and colleagues use this thoroughfare. We set up our pop-up stand in view of the cafe and M&S Foodhall for passing traffic at lunch time/early afternoon.
21/02/2023	Carers Strategic Partnership Board meeting	Presentation - online	This group brings together the main stakeholders working with and on behalf of carers in Somerset. We attended to present the public consultation proposals with guidance on how to take to part.
21/02/2023	Yeovil rugby club	Public event	This was our main panel face to face public event. A presentation on the public consultation was given by Julie Jones (Programme Lead) and Dr Rob Whiting (Clinical Lead) with a Q&A facilitated by NHS Somerset's Chief Nursing Officer, Shelagh Meldrum and Somerset Foundation Trust CEO, Peter Lewis. Provided the

			opportunity for the two options being proposed to be discussed by members of the public.
22/02/2023	Taunton Musgrove Park Hospital	Pop-up stand	To engage with people and communities who were coming to Taunton Musgrove Park Hospital for an appointment or to see a relative/loved one arriving via the concourse entrance. This was also an opportunity for the workforce to engage as colleagues use this thoroughfare. We set up our pop-up stand in view of the cafe and M&S Foodhall for passing traffic at lunch time/early afternoon.
22/02/2023	Williton Community Hospital	Pop-up stand	To engage with people and communities who were coming to Williton Community Hospital for an appointment or to see a relative/loved one. This was also an opportunity for the workforce to engage. We set up our pop-up stand corridor in view of the main reception to reach passing footfall to share information on the public consultation.
23/02/2023	Thursday teatime check-in - online meeting at 6pm, open to all	Online	To provide an online space for people and communities who had been unable to attend an in-person session and any person who had attended and had further questions.
28/02/2023	Burnham on Sea, Methodist Church	Talking Café	To ensure that people and communities who attend the local Talking Café as an information hub could have access to information about the public consultation and ask questions.
28/02/2023	Dorset - Sherborne library	Pop-up stand	To engage with people and communities who were using the library. We set up our pop-up stand in the library so we could reach passing footfall to share information on the public consultation.
28/02/2023	Wellington, St John's Church	Talking Café	To ensure that people and communities who attend the local Talking Café as an information hub could have access to information about the public consultation and ask questions.
02/03/2023	Bridgwater, The Hub, Angel Place	Talking Café	To ensure that people and communities who attend the local Talking Café as an information hub could have access to information about the public consultation and ask questions.
06/03/2023	Taunton, Albemarle Centre	Warm space	To ensure that people and communities who attend the local Talking Café as an information hub could have access to information about the public consultation and ask questions.
07/03/2023	Taunton Stroke Club	Stroke club	To reach and engage people in Somerset with lived experience of a stroke having survived a stroke or caring for someone who is there because they survived a stroke. People attending the stroke club had been treated at Taunton (on the occasion they had their stroke in Somerset).

08/03/2023	Online Public Event	Public meeting - online	This was our main panel online public event, repeated online for access by those unable to attend in person session 21st February. A presentation on the public consultation was given by Julie Jones (Programme Lead) and Dr Rob Whiting (Clinical Lead) with a Q&A facilitated by NHS Somerset's Chief Nursing Officer, Shelagh Meldrum and Somerset Foundation Trust CEO, Peter Lewis. Provided the opportunity for the two options being proposed to be discussed and challenged by members of the public.
09/03/2023	Thursday teatime check-in - online meeting at 6pm, open to all	Online	To provide an online space for any people and communities who had been unable to attend an in-person session any person who had attended and had further questions.
09/03/2023	Wells, Bishop's Palace Talking Café	Talking Café	To ensure that people and communities who attend the local Talking Café as an information hub could have access to information about the public consultation and ask questions.
10/03/2023	Heather Club, Bridgwater	Stroke Club	Returned with hard copies of the public consultation document.
11/03/2023	Chard Together, Guildhall Chard	Public event	Community event that took place at the Guildhall in Chard. We were invited to attend with a pop up stand by Diverse Communities team, Community Council Somerset.
13/03/2023	Online meeting targeting members of public who are resident on/near the border between Somerset and Dorset	Public meeting - online	Presentation of the public consultation proposals and case for change was given by Julie Jones, Programme Lead with Maria Smith as representative of NHS Dorset in attendance. There was also an opportunity to ask questions.
16/03/2023	Thursday teatime check-in - online meeting at 6pm, open to all	Online	To provide an online space for any people and communities who had been unable to attend an in-person session or had attended and had further questions.
18/03/2023	Veterans breakfast, Yeovil Rugby Club	Pop up stand	Attended this event hosted for veterans living in Somerset (and into Dorset) to present the public consultation proposals and be available to share information on how to take part. Following brief presentation we were available for any person attending the breakfast to find out more.
22/03/2023	Frome stroke group	Stroke support group	To reach and engage people in Somerset with lived experience of a stroke having survived a stroke or caring for someone who is there because they survived a stroke. People attending the stroke club had been treated at Royal United Hospital in Bath and Yeovil District Hospital (as people who lived in Somerset at time of stroke).
23/03/2023	Thursday teatime check-in - online meeting at 6pm, open to all	Online	To provide an online space for any people and communities who had been unable to attend an in-person session and any person who had attended and had further questions.

30/03/2023	Thursday teatime check-in - online meeting at 6pm, open to all	Online	To provide an online space for any people and communities who had been unable to attend an in-person session and any person who had attended and had further questions.
05/04/2023	Shepton Mallet, The Art Bank	Talking Café	To ensure that people and communities who attend the local Talking Café as an information hub could have access to information about the public consultation and ask questions.
11/04/2023	Dorset - Sturminster Newton Country Market	Pop up stand	To engage with people and communities who attended the market. We set up our pop-up stand so we could reach passing footfall to share information on the public consultation.
12/04/2023	Dorset - Sherborne town centre	Pop up stand	To engage with people and communities in Sherborne. We set up our pop-up stand in a central location so we could reach passing footfall to share information on the public consultation.
13/04/2023	Morrisons, Glastonbury	Pop up stand	To engage with people and communities in Glastonbury. We set up our pop-up stand in a central location so we could reach passing footfall to share information on the public consultation.
13/04/2023	Teatime drop in	online	To provide an online space for any people and communities who had been unable to attend an in-person session and any person who had attended and had further questions.
14/04/2023	Dorset - Gillingham library	Pop up stand	To engage with people and communities who were using the library. We set up our pop-up stand in the library so we could reach passing footfall to share information on the public consultation.
20/04/2023	Online meeting with councillors in Somerset	Online meeting	An online meeting was specifically set up to present the proposals to councillors in Somerset. A presentation on the public consultation was given by Julie Jones (Programme Lead) and Dr Rob Whiting (Clinical Lead) with a Q&A facilitated by NHS Somerset's CEO, Jonathan Higman, and attended by Maria Smith as a representative of NHS Dorset.

Telephone and emails

The Engagement team managed and responded to email and telephone queries. Feedback provided on the proposals was logged. This feedback was reported to and analysed by Opinions Research Services as part of their themed consultation feedback report.

Staff engagement

Programme Lead, Julie Jones spent time prior to the start of the public consultation engaging with staff to inform staff on the stroke units at both hospitals. Feedback and insights from staff helped to inform the proposals. Stroke staff were members of the stroke steering group and informed the development of the proposals.

During the consultation, the engagement team visited Aspire, the support group for people recently discharged from Yeovil District Hospital after having a stroke. We also ran a number of pop-up stands in public facing areas of the two acute hospitals and South Petherton Community Hospital and Williton Community Hospital, liaison and facilitation of these opportunity was done with staff at each hospital. Staff could also had the opportunity to visit the pop up

stands. Visits to the stroke units were also completed, giving staff the opportunity to go through the proposals and timelines.

For specific engagement with the staff most likely to be impacted by any changes, the engagement team facilitated the offer of confidential interviews with ORS to ensure that staff who wished to speak, could do so freely. This opportunity was taken up by 4 staff.

Communication activity

We created a variety of communication materials to make sure we met the needs of local people. Public facing materials used information contained within our Pre-consultation Business Case (PCBC). The PCBC was signed off by the stroke steering group, Fit for my Future Programme Board and the NHS Somerset Board.

We tested our communication materials with members of our public and patient stakeholder group and Healthwatch Somerset readers' panel.

Materials included:

- A public facing consultation document
- A summary consultation document
- Easy read summary consultation document
- Aphasia friendly summary consultation document
- Case for change summary
- The first 72 hours of stroke care explainer document
- Patient story examples
- Events list
- Consultation questionnaire (online and hard copy)
- FAQs which were updated throughout the consultation
- Summaries of questions asked at public events were shared on our website
- Videos explaining the proposals and case for change
- Social media infographics
- Launch toolkit for stakeholders
- Stakeholder launch briefing
- MP briefing
- News releases
- A4 Posters
- A5 leaflets
- Pull up banner.

All materials were made available on our website and were available in printed form on request. We also provided printed copies of the consultation document, questionnaire and other key documents at events we held and attended. Materials were also available in different formats on request.

Consultation materials distribution

Printed copies of the leaflet and summary consultation document were distributed to key stakeholder organisations at the start of the consultation and made available at all public listening and pop up events. Paper copies of the consultation documentation were available and promoted at all engagement events.

We shared materials with partners and stakeholders and asked them to share across their channels and networks.

During the consultation, online and hard copies of consultation materials were distributed to key stakeholders.

In recognition of the broad range of people who might be impacted by any changes to hospital-based acute stroke services, we sent copies of the public consultation document and questionnaire to complete (and send to FREEPOST address) to 100 residential homes in Somerset with a view to reaching both residents and workforce. Additionally,

we sent copies of the consultation document and form to complete to 26 organisations who represented a broader view of the population in Somerset with a view to reaching people engaging with these organisations including workforce.

These included:

Name of organisation	Type of organisation
Somerset Care	Company, employer in Somerset
Home Care Taunton	Company, employer in Somerset
Somerset Chamber	Business community
Somerset Energy Innovation Centre	VCFSE
Somerset Wildlife Trust	VCFSE
Creative Innovative Centre CIC	VCFSE
Tacchi Morris Arts Centre	VCFSE
Ilminster Arts Centre	VCFSE
Bridgwater Arts Centre	VCFSE
Wellington Arts Association	VCFSE
Taunton Brewhouse	VCFSE
The SPACE (thespacesomerset.co.uk)	VCFSE
The Princess Theatre and Arts Centre	VCFSE
ACE arts	VCFSE
Black Swan Arts	VCFSE
Halsway Manor	VCFSE
Clayhill Arts	VCFSE
Compass Wellbeing Centre	VCFSE
Courtyard Natural Health	Health and wellbeing company
Nine Springs	Health and wellbeing company
Taunton Chamber	Business community
Company, employer in Somerset	Business community
Yeovil Chamber	Business community
SBA CIC	Company, employer in Somerset
Outsourced HR	Company, employer in Somerset
100 Residential Care homes across Somerset	Care homes

Website

Information on the stroke consultation was shared on the Somerset Integrated care System / Fit for my Future website. The web pages were updated as the consultation progressed. Links to the website were shared across all communications channels promoting the consultation including social media, newsletters, media and radio. The aforementioned materials were published on the website alongside the Pre-Consultation Business Case.

Unfortunately, we do not have any metrics software on the website so are unable to see page views or visits to the site.

Media releases and radio advert

We issued various press releases to raise awareness of engagement opportunities during the public consultation, disseminate information and signpost local people to different ways in which they can find out more about and respond to the consultation.

We also ran a radio advert campaign to raise awareness of the consultation. The 30 second advert ran from 13 February 2023 until 12 March 2023, with 93 spots across the month. The advert ran across Heart West Country, with a reach of 94,000 covering a population of around 433,000.

Social media

NHS Somerset and the Fit for my Future programme both have established social media profiles. We proactively used these channels to promote the consultation and share key messages. We targeted posts to our key demographics including cross border areas. We also posted in individual groups as well as posting organic and paid for content across our channels. We shared a social media toolkit with our partners to support and amplify our reach and encouraged stakeholders to share across their social media channels.

Our social media channels include: Facebook, Instagram, Twitter and NextDoor.

Below is an overview of our posts. In addition to this, we also posted directly to a number of relevant community groups.

	Reach	Engagement	Link clicks
Paid for social media	248,325	2922	2365
Organic social media	233,190	5355	3888
Total	**481,515**	**8277**	**6253**

Our main social media messages encouraged residents to visit our website, attend an event and complete the consultation questionnaire.

The messaging and assets used were adapted during the consultation to encourage engagement with a wider range of people and communities.

Adaptation to our approach following mid-point review

Following the mid-point review of the consultation survey responses at the mid-point of the consultation, we evaluated and adapted our consultation engagement and communication activity. This included:

At mid-point review, proportion of responses: Men 28% Women 72%	To address the gap in the proportion of men to women, we reviewed our existing engagement locations for the remainder of the public consultation and looked for specific opportunities to adapt our approach to reach a greater proportion of men: • Targeted men specific engagement opportunities including veterans social/support groups and Men's Sheds association. We were successful in engaging with a nearly all-male audience at a Veterans Breakfast event in Yeovil. • Targeted organic and paid for digital posts to online groups and individuals (for instance, making use of male focused imagery, identifying male-specific community and community support groups in Somerset e.g. Men's Sheds and sports groups). • Faith-based community engagement working with our Equalities and Diversity Lead Officer, Lee Reed. • Business-led groups in Somerset, including Chambers of Commerce. • Staff and students over 18 at schools and colleges (with imagery to represent/create emotional connection with the need).
At mid-point review, responses from people aged 18 - 25 were 2% compared to 10% of population of Somerset who are under 25	• To encourage greater representation of younger audiences, we maximised our existing contacts and shared targeted creative assets with partners including Somerset County Council for socialising with Young Peoples Forum and Parliament and leading youth charity, Young Somerset. • We also shared the collateral with schools and colleges bearing in mind staff and students may wish to participate. • We reached out to Somerset Activity and Sport Partnership who work with multiple audiences including different life stages and those living more deprived areas (who are impacted by health inequalities).

	• We ran targeted organic and paid for digital posts to raise profile of intergenerational aspects of stroke as well as highlighting stroke as a condition that affects all people.
Deprived areas – engagement measured through responses to the consultation at the mid-point of the consultation showed greater engagement in areas with lower IMDs	• Targeted paid for and organic digital adverts aimed at increasing engagement with people living in Somerset's most deprived areas. • Indices of Multiple Deprivation (IMD) data for Somerset highlight some areas of the most urban parts of Somerset as being the most deprived in Somerset. A significant amount of the engagement activity was delivered in areas where there are Talking Cafes and these sessions were in areas that are high on the IMD scale. • One way we adapted our engagement plan was to deliver pop ups in low priced supermarkets in the county to give greater visibility to the public consultation; Morrisons in Glastonbury, Asda in Frome, Asda in Taunton (we were unable to do the same in Yeovil due to a packed agenda in one supermarket and a very hard to reach community function in a second supermarket). • Working with our Equality and Diversity Lead Officer, we reached out to specific groups identified in the EIA including homeless people and Gypsy Roma Traveller communities. These were in the plan already but engagement with these communities had not been completed at the mid-point review stage of the process.
Dorset residents	• To ensure that we reached those potentially impacted by changes to Yeovil District Hospital we also delivered on site engagement in three specific areas of Dorset (as guided to by NHS Dorset) – Sherborne, Sturminster Newton and Gillingham. These areas have variations in deprivation but significantly are not likely to have increased representation among deprived areas but may have contributed to proportions of men and younger audiences. • To encourage greater representation from Dorset residents, we also shared further targeted creative assets with partners in Dorset. • We ran targeted organic digital posts to raise profile of the potential impact on Dorset residents and targeted these to the bordering areas of Dorset.

Analysis of consultation responses

All the feedback from the public consultation has been shared with ORS for analysis. The feedback report will be shared on our website and shared across our channels.

Hearing the views of people throughout the consultation process is an important part of the decision making and will be taken into account alongside other essential factors such as clinical, financial and practical considerations. Any decision to proceed with the proposals will be informed by the feedback from the consultation.

APPENDIX 02

Opinion Research Services

Excellent research for the public, voluntary and private sectors

NHS Somerset

Improving hospital-based stroke services in Somerset

Public consultation feedback report

Opinion Research Services

September 2023

NHS Somerset

Improving hospital-based stroke services in Somerset

Public consultation feedback report

Opinion Research Services

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This study was conducted in accordance with ISO 20252:2019, ISO 9001:2015, and ISO 27001:2013.

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Contents

Key Findings

Summary of main findings

The key findings below are expanded upon in the executive summary and covered in comprehensive detail in the main body of the report.

- There was broad recognition of the **need for change** to address challenges in delivering acute stroke services in Somerset. Moreover, many respondents said they had not previously been aware that 24/7 consultant-led stroke care is not already in place at both current stroke units.
- Overall views on the proposal to deliver ***hyper* acute stroke services** from a single hyper acute stroke unit (HASU) at one Somerset hospital were more negative, with a majority of residents (via the telephone survey) and respondents to the open consultation questionnaire disagreeing. Agreement varied based on geography however: questionnaire respondents living nearest to Musgrove Park Hospital (MPH) in Taunton were much more likely to agree with the proposal than those living nearest to Yeovil District Hospital (YDH).
- When asked if hyper acute stroke services were to be delivered from one hospital in future, whether this should be from MPH, agreement was stronger among residents (via the telephone survey) than it was among respondents to the consultation questionnaire. Similar geographical variations to those outlined above were observed via both methodologies.
- Focus group/interview participants, some written submissions and many attendees at the NHS Somerset-run events were more positive about the proposed model for hyper acute stroke services, seeing it as having potential to improve efficiency and quality of care, and make the service more attractive to new recruits. There were, though, concerns about ambulance waiting times, the impact of having to travel further to hospital on patient journey times and outcomes, and the possibility that consolidating hyper acute services would impact visiting.
- Most questionnaire respondents and residents thought **acute stroke care** should be provided at both MPH and YDH if *hyper* acute stroke services were to be delivered from only one hospital. This was also echoed across the other consultation strands. The reasoning for most was wanting to keep services local and the potential impacts of increased journey times to reach an acute stroke unit on patients, visitors and staff members.
- The majority of concerns about the **potential impacts** of proposals referred again to concerns about travel and access. Several groups were highlighted as being particularly vulnerable to these impacts, including: vulnerable and older people; those with disabilities; people on lower incomes and/or without access to private transport; and people with co-morbidities or additional/complex needs.
- Some **mitigations** were suggested, such as better patient or community transport; shuttle buses between hospitals; providing accommodation for visitors; offering parking passes or tokens to reduce the cost of parking; and offering follow-up care, rehabilitation, and proper stroke support networks locally.

1. Executive summary

Introduction

1.1 The consultation reported here was led by NHS Somerset, which agrees the strategic priorities and resource allocation for all NHS organisations in Somerset. Somerset NHS Foundation Trust provides acute hospital and community NHS services for people living in Somerset, as well as some patients travelling from neighbouring areas in Devon, Dorset and part of Wiltshire, among others. This includes acute and hyper acute stroke services, which are currently delivered from two Somerset Hospital hospitals: Musgrove Park Hospital (MPH) in Taunton, and Yeovil District Hospital (YDH). Somerset NHS Foundation Trust also provides recovery and rehabilitation services for people who have experienced a stroke.

1.2 NHS Somerset is proud of the care its stroke staff provide but feels that its acute hospital-based stroke services are not set up in the best way having identified the following challenges:

- Somerset's ageing population means demand for stroke care will increase;
- The specialist stroke workforce available to provide care is limited. There is a shortage of the specialist workforce, locally and nationally, needed to deliver hyper acute stroke care, leading to problems with medical cover in local hospitals;
- NHS Somerset cannot provide 24/7 specialist stroke care. Neither hyper acute stroke unit in Somerset has the number of specialist staff needed to provide consultant cover 24 hours a day, 7 days a week. This means that both hyper acute stroke units have different hours when a stroke consultant and specialist stroke staff are available;
- Services are not set up to maximise the skills and experience of staff. Currently, Yeovil District Hospital does not see the minimum recommended number of stroke patients (500–600 per year) for staff to maintain their skills and build expertise; and
- Treatments are not always provided fast enough. Increasingly, there are new and specialised treatments to reduce brain damage and disability after a stroke. These require highly skilled staff, and the latest technology and services. Expertise is currently spread over two sites, and NHS Somerset is unable to offer this level of service at both acute hospitals all of the time.

1.3 Following a period of options development and appraisal, NHS Somerset has proposed a model of care for how and where *hyper* acute stroke services (the first 72-hours after a stroke) might be delivered in Somerset: the provision of a single hyper acute stroke unit (HASU) at one hospital. MPH in Taunton was identified as the 'preferred site' for the HASU, because:

- It has access to a wider range of scans required to help doctors make quick treatment decisions;
- Centralising the hyper acute stroke unit would increase the number of stroke patients arriving in the Emergency Department at one hospital. By utilising the existing direct admission pathways to the stroke unit and increased specialist stroke staff, MPH would be in a better position to manage this;

- It has an onsite neurology service which can respond to inpatient referrals to the neurology service. This helps with prompt diagnosis and treatment for patients with a stroke mimic condition. YDH does not offer the same service; and
- It has a vascular surgery team which assists in rapid assessment by vascular surgeons. YDH patients wait until a vascular surgeon from MPH attends Yeovil, patients then need to be transferred to MPH if surgery is needed.

1.4 NHS Somerset has also identified possible options for delivery of *acute* stroke services (post 72-hours after stroke):

- Two acute stroke units (ASUs) at both MPH and YDH; or
- A single ASU, co-located with the proposed HASU at MPH.

The public consultation

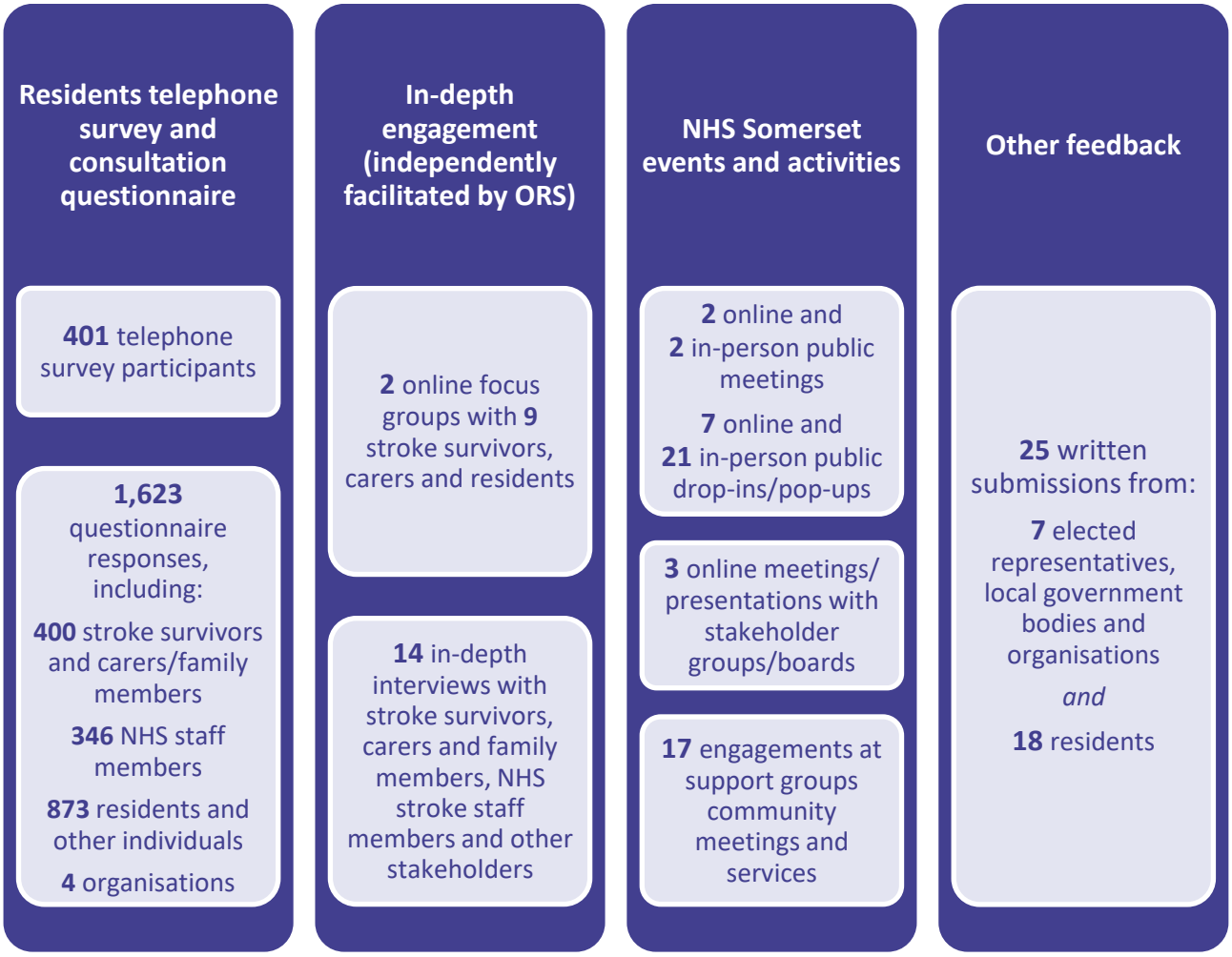
1.5 Between 30th January 2023 and 24th April 2023, NHS Somerset undertook a 12-week period of consultation in which service users, members of the public, NHS staff members, organisations and other stakeholders were invited to give feedback on both the proposed model of care and location for HASU, and possible options for delivery of *acute* stroke service at either one or two ASUs in Somerset.

1.6 Opinion Research Services (ORS), a spin-out company from Swansea University, now with a UK-wide reputation for social research and major statutory consultations, was appointed in October 2022 to support, analyse and report the outcomes of the public consultation programme.

1.7 During the consultation period, residents and other stakeholders were invited to provide feedback on the stroke proposals through a wide range of methods, including all of the following:

- A consultation questionnaire for all residents, staff members, stakeholders and organisations: the questionnaire was available online (hosted by ORS) and paper questionnaires were circulated widely and available on request. Easy read, an aphasia-friendly version, and other accessible and translated were also available.
- Independently facilitated in-depth engagement designed and conducted by ORS:
  - Online focus groups and one-to-one in-depth online or telephone interviews with stroke survivors, carers and local residents;
  - A workshop and in-depth interviews with representatives of stakeholder organisations.
- Engagement activities undertaken by NHS Somerset and , including:
  - Face-to-face and online public meetings;
  - Meetings with NHS Somerset staff members;
  - Attendance at existing community events and groups, and service user/carer meetings; and
  - ‘Pop-up events’ and other engagement activities in public spaces across Somerset.
- Written or email submissions from residents, stakeholders and organisations.

1.8 The consultation response from the different research strands is summarised in the figure overleaf.



1.9 This executive summary brings together the feedback received through each of the different feedback channels above and concisely reviews the full range of feedback received, bringing together the common themes that have emerged. The full report covers public, professional and stakeholder opinions and feelings in considerable detail to achieve a more comprehensive understanding; this can at times be repetitive given that similar issues emerged across the different strands – but it is important that an accurate reflection of all of the feedback received is available.

1.10 With this in mind, ORS strongly recommends that this executive summary and the full report be read together. It is the journey, as well as the destination, that will matter to those wishing to understand stakeholders' views, assumptions, arguments and conclusions around current and future stroke services in the area. We trust that both this executive summary and full report will be helpful to all concerned.

Summary of views from consultation feedback

The need for change

1.11 There was general recognition of the need for change across all consultation strands. In the ORS-run qualitative activities in particular, Somerset's ageing population was recognised as placing increasing strain on services that are already restricted due to a limited specialist stroke workforce, and everyone considered the lack of 24/7 cover to be a challenge that should be remedied as a priority so that treatment can be provided quickly. On this note, there was evidence that many members of the public were not aware that 24/7 specialist consultant-led stroke care is not currently available in Somerset.

The proposed model of care: hyper acute stroke services

1.12 Levels of support for the proposal to deliver hyper acute stroke services from only one hospital in future were lower than those for the need for change in the two quantitative consultation strands.

1.13 In the residents' survey, just over three-in-ten residents (31%) agreed with the proposal, but nearly six-in-ten (58%) disagreed. In the consultation questionnaire, less than a third of NHS staff who responded (32%) and an even lower proportion (23%) of other individual respondents (including stroke survivors, carers and family members and residents) agreed. It should be noted, however, that views were more balanced among NHS staff working in stroke services, with nearly half (47%), agreeing while a marginally greater proportion (49%) disagreed.

1.14 Levels of agreement varied considerably based on geography in the consultation questionnaire: around half (51%) of respondents living nearest to Musgrove Park Hospital (MPH) in Taunton agreed with the proposal to deliver hyper acute stroke services from only one hospital site in future, whereas only around one-in-six (17%) living nearest to Yeovil District Hospital (YDH) agreed.

1.15 When asked to provide a view on if hyper acute stroke services were to be delivered from one hospital in future, whether this should be from MPH, nearly six-in-ten (58%) residents agreed, and nearly three-in-ten (29%) disagreed. There was again variation in views by geography: over seven-in-ten (72%) of those living nearest to MPH were in agreement, but only 44% of those nearest to YDH were.

1.16 In the consultation questionnaire, over two-fifths (43%) of NHS staff and less than a third (32%) of other individuals agreed that if hyper acute stroke services were to be delivered from only one hospital in future, this should be MPH, while almost half (48%) of NHS staff and nearly three fifths of (58%) other individuals disagreed. Again, there was some geographical variation: four fifths (80%) of respondents living nearest to MPH agreed with the proposed location for a single hyper acute stroke unit (HASU) in Somerset, whereas only one fifth (20%) of those living nearest to YDH did so.

1.17 Focus group/interview participants, some written submissions and many attendees at the NHS Somerset-run events were more positive about the proposed model for hyper acute stroke services, seeing it as having potential to improve efficiency and quality of care, and make the service more attractive to new recruits. The prospect of 24/7 hyper acute care from specialist staff was viewed especially positively. However, YDH staff members, while generally agreeing that having one HASU providing 24/7 consultant-led specialist care was positive, did raise some concerns, including: the possible 'de-skilling' of stroke staff at YDH; national challenges around staffing, including potential difficulties recruiting new consultants; and that not delivering hyper acute stroke care at YDH could have negative impacts on surrounding hospitals such as Dorset County Hospital in Dorchester.

1.18 Ambulance waiting times and the impact of having to travel further to hospital on patient journey times and outcomes was the main criticism of this aspect of the proposed model of care across all consultation strands. It was felt that the proposed changes would preclude people from being seen within an acceptable amount of time after having a stroke.

1.19 Furthermore, visits from family and friends were consistently noted as a key aspect of stroke recovery, and there was concern that consolidating hyper acute services would impact visitors (especially older visitors) from Yeovil and the surrounding area, especially if they are reliant on public transport. Potential detrimental impacts on the work/life balance of staff as a result of longer commutes were also raised.

1.20 Despite the possibility of longer travel time to a single HASU however, many respondents and participants recognised the issues caused by lack of 24/7 specialist care, and that consolidating hyper acute stroke services could bring benefits in terms of clinical care and patient outcomes. Others were able to recognise both sides of the argument; they understood the rationale for the proposed model of care, while also understanding concerns around its impact on journey times.

1.21 Those who objected to the proposed model of care for hyper acute stroke services also raised some concerns around clinical sustainability, including that: consultant recruitment would continue to be challenging given national shortages; some YDH staff might refuse to transfer to MPH, further exacerbating shortages; and that undue pressure would be placed on MPH should services be consolidated there. There was also significant concern at the NHS Somerset-run events about the potential for further services to be lost from YDH and that Yeovil *"will end up with a second-rate hospital."*

The proposed model of care: acute stroke services

1.22 Most questionnaire respondents and just over seven-in-ten residents (71%) thought ACUTE stroke care should be provided at both MPH and YDH if HYPER acute stroke services were to be delivered from only one hospital in future. Again, there was significant geographical variation among the latter; two-thirds (66%) of those living nearest to MPH thought acute stroke care should be provided at both hospitals (significantly lower than the overall result), while over three-quarters (76%) of those living nearest to YDH chose this option (significantly higher than the overall result).

1.23 Support for providing acute stroke care at both hospitals was also echoed across the other consultation strands. The reasoning for most was wanting to keep services local and the potential impacts of increased journey times to reach an acute stroke unit on patients, visitors and staff members. In particular, early transfer back to their local area would allow carers/relatives to be more easily involved in patients' ongoing care. Retaining staff expertise in stroke services at both hospitals was also important to focus group/interview participants, as was the potential for an acute stroke unit at YDH easing pressure on MPH, which is already busy due to having other specialist centres.

1.24 There was some support in the focus groups/interviews and the NHS Somerset events to co-locate one ASU in Somerset alongside the proposed HASU at MPH. Those who felt it would be beneficial to have both units in one place considered it an opportunity to streamline and therefore improve the quality of services whilst making the best use of specialist stroke staff. There was more disagreement however, for the reasons outlined above.

The proposed model of care: overall comments

1.25 As for other key reasons to disagree with the model of care as a whole, there was some concern (especially at the focus groups and NHS Somerset-run events) that the proposals may be driven by cost savings and the need to address internal challenges, rather than being in the best interests of patients.

Equalities impacts and mitigations

1.26 The majority of concerns about the potential impacts of proposals referred again to concerns about travel and access, focusing on the speed with which stroke patients might receive the specialist care they need, as well on those who might wish to visit stroke survivors during their time in hospital.

1.27 Several groups were highlighted as being particularly vulnerable to these impacts, including: vulnerable and older people; those with disabilities; people on lower incomes and/or without access to private transport; and people with co-morbidities or additional/complex needs (like neurodivergence, learning disabilities and cognitive impairment).

1.28 There were also concerns about the impact of the proposals on outcomes for people in different geographies. It was acknowledged that the speed and quality of care, and outcomes, would be different depending on where people live, and there were particular access concerns for those living in Yeovil and surrounding areas. The proposals were also said to put people from rural areas and small villages at a disadvantage, in particular those who are reliant on public transport, or isolated individuals without a support network of family and friends who are able and willing to drive them to appointments, and to visit them whilst in hospital.

1.29 Some mitigations were suggested (especially in relation to travel inequalities), such as better patient or community transport; shuttle buses between hospitals for staff and visitors; providing accommodation for visitors; offering parking passes or tokens to reduce the cost of parking at MPH; and offering follow-up care, rehabilitation, and proper stroke support networks locally – especially in remote rural areas where transport can be problematic.

2. Consultation overview

Introduction

2.1 NHS Somerset is the statutory NHS organisation responsible for implementing Somerset's health and care strategy. Working collaboratively with primary care partners, foundation trusts, local councils, voluntary sector organisations and other partner organisations, it oversees the planning, performance, financial management and transformation of local NHS services. All partners working together form the Somerset Integrated Care System (ICS).

2.2 Somerset NHS Foundation Trust provides acute hospital and community NHS services for people living in Somerset, as well as some patients travelling from neighbouring areas in Devon, Dorset and parts of Wiltshire, among others. This includes acute and hyper acute stroke services, which are currently delivered from two Somerset hospitals: Musgrove Park Hospital (MPH) in Taunton, and Yeovil District Hospital (YDH). Somerset NHS Foundation Trust also provides recovery and rehabilitation services for people who have experienced a stroke.

The challenges facing stroke services in Somerset

2.3 NHS Somerset is proud of the care its stroke staff provide but feels that its acute hospital-based stroke services are not set up in the best way having identified the following challenges.

- Somerset's ageing population means demand for stroke care will increase;
- The specialist stroke workforce available to provide care is limited. There is a shortage of the specialist workforce, locally and nationally, needed to deliver hyper acute stroke care, leading to problems with medical cover in local hospitals;
- NHS Somerset cannot provide 24/7 specialist stroke care. Neither hyper acute stroke unit in Somerset has the number of specialist staff needed to provide consultant cover 24 hours a day, 7 days a week. This means that both hyper acute stroke units have different hours when a stroke consultant and specialist stroke staff are available;
- Services are not set up to maximise the skills and experience of staff. Currently, Yeovil District Hospital does not see the minimum recommended number of stroke patients (500–600 per year) for staff to maintain their skills and build expertise; and
- Treatments are not always provided fast enough. Increasingly, there are new and specialised treatments to reduce brain damage and disability after a stroke. These require highly skilled staff, and the latest technology and services. Expertise is currently spread over two sites, and NHS Somerset is unable to offer this level of service at both acute hospitals all of the time.

Developing the options

2.4 Insights and feedback have been gathered from a range of people, including people with lived experience of stroke, to inform and develop proposals for transforming acute hospital-based stroke services in Somerset.

2.5 A series of workshops were held with people working in stroke services, other key stakeholders including the Stroke Association, and people with lived experience of a stroke. These sessions were used to develop a long

list, then a short list, of potential solutions for the future. These were assessed to decide how they would meet the following criteria:

- Quality of care – impact on patient outcomes;
- Quality of care – impact on patient experience and on carer experience;
- Deliverability;
- Workforce sustainability;
- Affordability;
- Travel times for patients and their carers and visitors; and
- Impact on equalities.

2.6 The four solutions shortlisted were examined further and following insights from the public and patient group, were refined and reduced to two potential options. The potential pros and cons of each of the shortlisted options were discussed through the following perspectives:

- Patients;
- Clinical outcomes;
- Workforce;
- Inequalities;
- Finance;
- Family and carers.

2.7 The detail of this process is described in the NHS Somerset pre-consultation business case (PCBC) which was available throughout the consultation along with other key documents.

The proposed model of care and location of *hyper* acute stroke services

2.8 Following the options development and appraisal stages, NHS Somerset finalised their proposed model of care for *hyper* acute stroke services and a preferred location from which they would be delivered. In summary, the proposal is:

A single hyper acute stroke unit (HASU) at Musgrove Park Hospital (MPH), Taunton

2.9 This would mean that most people in Somerset would receive their first 72 hours of stroke care at MPH, Taunton. People who live closer to hyper acute stroke units out of Somerset would be taken to their closest unit, for example at Dorset County Hospital, Dorchester. NHS Somerset says that by creating one centralised hyper acute stroke unit, it could increase the number of patients receiving high-quality specialist care and meet the standards for providing stroke care in line with national clinical guidelines, seven days a week.

2.10 To make the changes, YDH would no longer deliver *hyper* acute stroke services, meaning some people who have a stroke would be taken to a hospital further away than the one they might be taken to currently for their emergency stroke care. NHS Somerset believes that better outcomes for hyper acute stroke patients (reduced deaths and better long-term outcomes) would outweigh these impacts.

2.11 MPH in Taunton was identified as the 'preferred site' for the HASU, because:

- It has access to a wider range of scans required to help doctors make quick treatment decisions;
- Centralising the hyper acute stroke unit would increase the number of stroke patients arriving in the Emergency Department at one hospital. By utilising the existing direct admission pathways to the stroke unit and increased specialist stroke staff, MPH would be in a better position to manage this;
- It has an onsite neurology service which can respond to inpatient referrals to the neurology service. This helps with prompt diagnosis and treatment for patients with a stroke mimic condition. YDH does not offer the same service; and
- It has a vascular surgery team which assists in rapid assessment by vascular surgeons. YDH patients wait until a vascular surgeon from MPH attends Yeovil, patients then need to be transferred to MPH if surgery is needed.

2.12 Dorset County Hospital NHS Foundation Trust has been involved throughout the process of options development and appraisal, is supportive of the proposed changes, and has given assurance that the DCH HASU is able to manage any increased demand if the proposed changes go ahead.

Possible approaches to delivery and locations of *acute* stroke services

2.13 In terms of acute services, these are currently provided from both MPH and YDH. If the proposal for a single HASU went ahead, then for *acute* stroke care, there would be two possible approaches:

A. An acute stroke unit at both MPH and YDH

B. A single acute stroke unit at Musgrove Park Hospital, Taunton

2.14 Under both options, rehabilitation services for people who have had a stroke would still be available across Somerset, either in their home or in a healthcare setting.

2.15 Both approaches to *acute* stroke service delivery have advantages and disadvantages:

- Under A, staff expertise in acute stroke care would be retained across both hospitals, and there would be less impact on hospitals in neighbouring counties as Somerset residents could transfer to their closest acute stroke unit; but more patient transfers may be needed to transfer patients closer to home at YDH, and the number of beds needed in the hyper acute unit at Musgrove Park Hospital would need to increase.
- Under B, Patients would receive their acute stroke care at the same hospital they received their hyper acute stroke care, resulting in better continuity of care; there would be a reduced number of handovers of care for patients; and specialist stroke staff would all be on one site. However, patients would remain at the hospital where they received their hyper acute stroke care resulting in lengthier journeys for family and friends for longer; the number of beds needed at the proposed hyper acute unit at MPH would need to increase; new patient pathways for acute care would need to be put in place, including for Dorset County Hospital; there would be more impact on Dorset County Hospital as it would need to ensure enough acute stroke beds (as Somerset patients would remain there for their acute stroke care rather

than being transferred back to Somerset); and there would be a greater impact on staff as more staff would move to MPH.

2.16 Overall, by changing the way stroke services are organised, NHS Somerset believes it can ensure everyone has access to specialist teams and treatments 24 hours a day, 7 days a week; meet national standards for stroke care; support staff better, and attract and retain the specialist staff needed; make the best use of resources to create a service fit for the future; and save more lives and help more people live well after stroke.

The public consultation

2.17 The 12-week public consultation period began on 30th January 2023 and ended on 24th April 2023, during which time service users, members of the public, NHS staff members, organisations and other stakeholders were invited to give feedback on both the proposed model of care and location for acute stroke services in Somerset.

2.18 Throughout the consultation, stakeholders were provided with paper documentation or signposted to the Somerset ICS website: www.somersetICS.org.uk/stroke. A range of information and resources were available, including the full consultation document and separate summary versions, the pre-consultation business case (PCBC) and equality impact assessment (EIA).

2.19 Paper copies of documentation and the consultation questionnaire were also available, including accessible and other languages versions, and were distributed at face-to-face meetings and other engagement events, as well as being available on request via telephone or email. In all, 1,500+ paper copies of consultation documents were distributed.

2.20 NHS Somerset also worked with local organisations and community groups including local stroke clubs and support groups, among others, to promote the consultation and encourage feedback.

2.21 In summary, the communications programme undertaken by NHS Somerset included:

- Initial briefings and updates for local MPs and councillors;
- Invitations to participate and promote the consultation sent to stakeholder organisations, including 26 VCFSE organisations, care and health and wellbeing providers and business groups, and 100 individual care homes across the county;
- Press and publicity activity, including a local radio campaign of 90+ 30-second radio spots during the 12-week consultation period; and
- Extensive promotion via the Somerset ICS and 'Fit for my Future' websites and social media channels, including paid for and organic social media posts reaching more than 480,000 users and generating 8,200 engagements with posts and 6,200 link clicks.

2.22 NHS Somerset also undertook a comprehensive programme of public engagement and consultation activities which are summarised in the methodology section below and in Appendix II of this report, and in NHS Somerset's Stroke Consultation Activity Report.

The nature of public consultation

2.23 Public consultation promotes accountability and assists decision making; public bodies give an account of their plans or proposals and listen to feedback. Consultation has therefore been described as a dialogue, based on a genuine and purposeful exchange of views.

2.24 It should be noted, however, that consultations are not referenda or 'votes' in which the loudest voices or the greatest numbers automatically determine the outcome. The feedback received often reflects widely varied and sometimes polarised views, and it is important to report these concerns and contrary views robustly, in order for decision-makers to be able to conscientiously take into account the issues raised.

Consultation methodology and response

2.25 Each chapter in this report provides detailed information about the consultation activities from which feedback has been reported; the following section provides a brief overview.

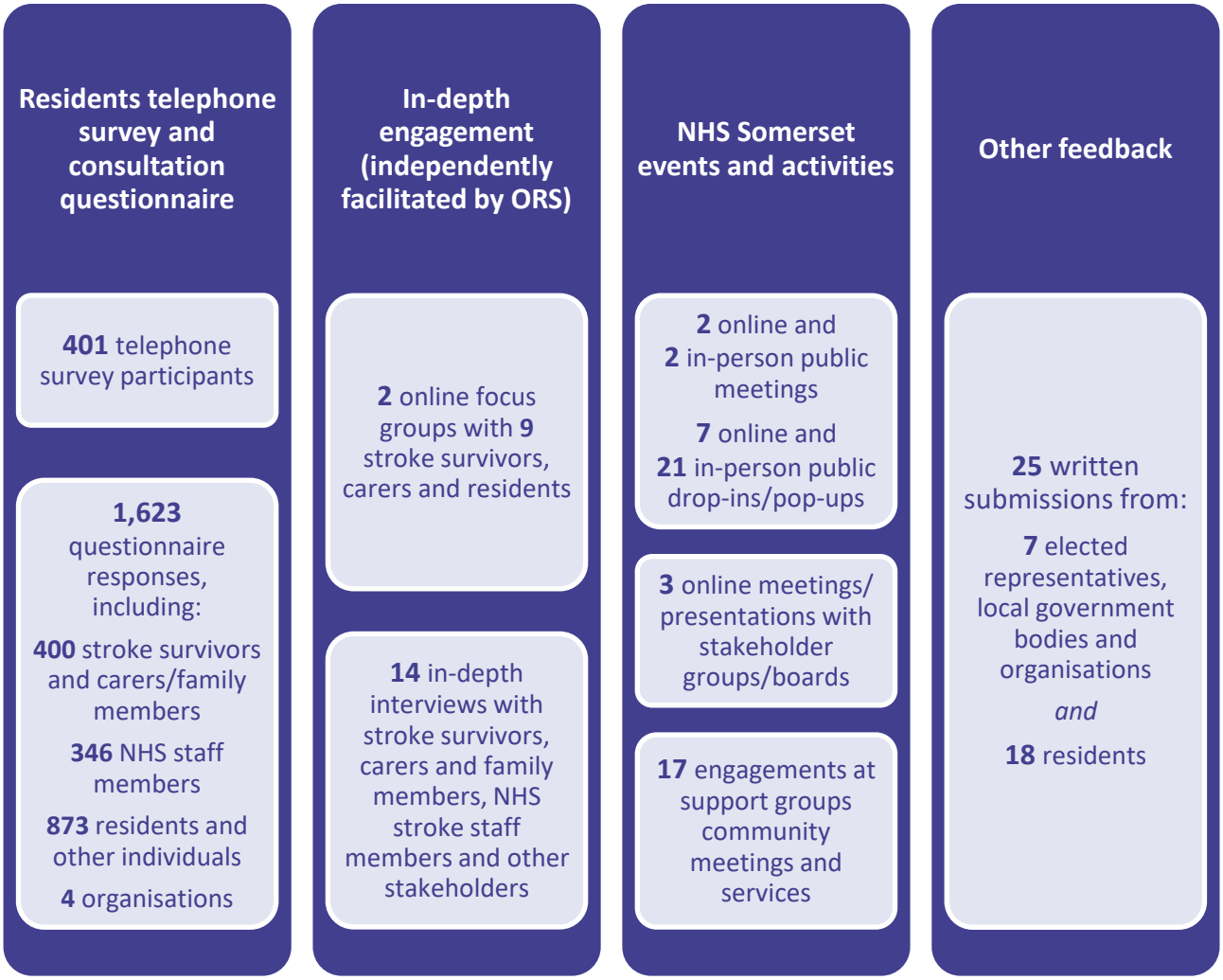
2.26 To provide relevant information that might inform respondents' view, information about the proposals and the preferred location of a single hyper acute stroke unit in Somerset was included in a consultation document (in summary form) and in the detailed pre-consultation business case (PCBC) and equality and health inequalities impact assessment (EHIA). This information included background information including travel time analysis, data regarding patient flows within Somerset and the impact of shortlisted options and the final proposal on neighbouring stroke services providers (e.g., Dorset County Hospital in Dorchester).

2.27 NHS Somerset acknowledged that, if the proposal were to go ahead, some Somerset residents would have to travel further to reach a HASU or ASU. Particular effort was made during the consultation, therefore, to facilitate feedback on concerns around travel and access and potential mitigation measure for patients, carers and staff members.

2.28 During the consultation period, residents and other stakeholders were invited to provide feedback on the stroke proposal through a wide range of methods, including all of the following:

- A consultation questionnaire for all residents, staff members, stakeholders and organisations: the questionnaire was available online (hosted by ORS) and paper questionnaires were circulated widely and available on request. Easy read and aphasia-friendly, translated documents and other formats were also available;
- Independently facilitated in-depth engagement designed and conducted by ORS (described below);
- Engagement activities undertaken by NHS Somerset, including:
  - Staff engagement activities;
  - Online and face-to-face public meetings;
  - Pop-up and drop-in activities in public and community spaces; and
  - Attendance at existing community group and services users meetings.
- Written and email submissions from residents, stakeholders and organisations.

2.29 The consultation response from the different research strands is summarised below:



Quantitative consultation activity

'Open' consultation questionnaire

2.30 An open consultation questionnaire was available for anyone to complete either via the dedicated consultation website or by completing a paper version. The questionnaire was designed to be completed on the basis of the issues presented in the consultation document, with questions about the need for change, the proposed model of care, the preferred location for a single *hyper* acute stroke unit (HASU) in Somerset, options for the location or locations of *acute* stroke units (ASUs) and potential equalities and health inequalities issues. Respondents were given the opportunity to raise concerns, as well as to suggest alternative solutions to the current challenges.

2.31 Open questionnaires are important, being inclusive and giving opportunity to express and explain views, including disagreement with proposals; they are not random sample surveys of a given population however, and cannot necessarily be expected to be representative of the general balance of opinion. For example, younger people and those living in deprived area are usually under-represented, while older people and residents living in more affluent areas tend to be over-represented.

2.32 Furthermore, respondents from groups or geographic areas which feel most affected by the proposals - and therefore where there may be more press coverage or campaigning - are more likely to respond; for example, the number of respondents living near to Yeovil were proportionally greater than those from other areas.

Deliberative consultation activities

2.33 The deliberative consultation activities with stroke survivors, carers, NHS stroke staff, representatives and local residents undertaken by ORS, comprised focus groups and in-depth interviews. Designed to complement the other consultation strands covered in this report, the activities were used as an opportunity to explore in more depth the themes arising in feedback from the open consultation questionnaire, as well as to discuss any additional considerations around the proposed changes based on the experience of those with existing connections to stroke services in Somerset.

2.34 Participants were invited to the deliberative activities via a recontact question in the telephone survey and open questionnaire, via Somerset NHS Foundation Trust and with the support of local stakeholder organisations. The nine members of the public (residents, carers and volunteers) who participated were offered 'reward and recognition' payments in acknowledgement of the time required to take part.

Public meetings and other engagement activities

2.35 During the consultation period, NHS Somerset also undertook a number of engagement activities for members of the public and other stakeholders. These activities focused predominantly on promoting the consultation and signposting people to the questionnaire and other feedback channels, although there was also opportunity for people to give feedback at the time.

2.36 Two face-to-face and online public meetings took place, hosted by NHS Somerset. Following short presentations about the proposals, attendees were invited to ask questions and give feedback on the proposed changes. Attendees were again signposted to online resources and the questionnaire, and paper copies of the consultation document and questionnaire were available.

2.37 'Pop-up' events took place in which members of the NHS Somerset consultation team visited public locations such as supermarkets and shopping centres to speak to members of the public and promote the consultation. Flyers providing information and links to the consultation website were distributed, as well as paper copies of consultation documents and the questionnaire on request. In some cases, members of the public shared their views at the time which were noted and passed to ORS and are summarised in Appendix II of this report.

2.38 Members of the NHS Somerset consultation team also attended, online or in person, a number of pre-existing community and support group meetings to promote the consultation, answer questions, hear views on the proposals, and signpost attendees and participants to other ways to provide feedback.

Written submissions and petitions

2.39 During the formal consultation process, 25 written submissions were received, all of which have been read and summarised by ORS. These included seven submissions from representatives or members of organisations, and 18 from individual respondents. No petitions were submitted as part of this consultation.

The consultation report

2.40 In contrast to the more thematic approach in the executive summary, the full report considers the feedback from each element of the consultation in turn because it is important that the overall report provides a full evidence-base for those considering the consultation and its findings.

2.41 All types of consultation responses are important, and this report presents an independent analysis so that all of them may be taken into account. Some contributions have been highlighted based on at least one of the following aspects:

- Relevant to and/or having implications for the proposal under consideration;
- Well-evidenced – for example, submissions from professional bodies, staff and concerned people or local groups that point to evidence to support their perspective;
- Deliberative – based on thoughtful discussion in public meetings and other group settings;
- Representative of the general population or particular localities, groups or points of view;
- Focused on the views from under-represented people or equality groups; or
- 'Novel' – in the sense of raising 'different' issues from those being repeated by a number of respondents or arising from a different perspective.

2.42 The report also identifies where strength of feeling may be particularly intense, either in relation to specific themes or possible outcomes, or coming from specific groups of respondents. Those with strong concerns or objections are more likely to provide these views robustly and in detail; furthermore, ORS has an obligation to comprehensively report these concerns and contrary views, in order for decision-makers to be able to conscientiously consider the issues raised (Gunning Principle 4). It should be noted, however, that this can mean that the feedback can appear more 'negative' than was actually the case.

2.43 Finally, it is not ORS' role to 'make a case' for or against the proposals, nor to make any recommendations as to how decision makers should use the reported results. It is for the appropriate bodies to take decisions based on all of the evidence available, of which consultation feedback is one part. To this end, ORS trusts that both the executive summary and full report will be helpful to all concerned.

3. Telephone residents' survey

Introduction

3.1 The purpose of the telephone survey was to achieve a broadly representative set of views on the proposals from residents in the hospitals' catchment area (Somerset and neighbouring eligible wards in the surrounding counties of Dorset, Devon and Wiltshire) aged 18 and over. The survey was conducted using a quota sampling approach with targets set on the numbers of interviews required by age, gender, area and working status.

3.2 ORS completed 401 interviews between 16th February and 13th April 2023 using a Computer Assisted Telephone Interviewing (CATI) methodology, with interviews undertaken by ORS's social research call centre. The sample source for the survey was a combination of random-digit dialling (RDD) and purchased mobile phone numbers to ensure inclusion of those less likely to have or use landline telephones.

3.3 A short summary of background information was included to be 'read out' for each question within the survey, for the benefit of allowing respondents to answer them from an informed perspective.

Respondent profile

3.4 The extent to which results can be generalised from a sample depends on how well the sample represents the population from which it is drawn, as different types of people may be more or less likely to take part. Such 'response bias' is corrected by statistical weighting based on a comparison of the demographic characteristics of the respondents with data for the whole population.

3.5 The achieved sample was compared against secondary data for electoral ward, age and gender, and subsequently weighted by ward, age and gender. As a result of this process, the survey results can be seen as broadly representative of Somerset and surrounding wards (within hospitals' catchment) to within around +/- 5 percentage points at a 95% confidence level. This means that if the survey estimated that 50% of respondents agreed with a proposal, 19 times out of 20 the actual result for the entire population would be between 45% and 55%. Results based on smaller subgroups of the achieved sample will have a greater confidence interval.

3.6 The table overleaf shows both the unweighted and weighted demographic profile of respondents to the survey, compared with the population aged 18+ (based on Mid-Year Population Estimates 2020).

Table 1: Demographic response profile to the residents survey, compared with the Somerset and surrounding wards population aged 18+

Characteristic	Unweighted Count	Unweighted Valid %	Weighted Valid %	Resident Population 18+ %
BY AGE				
18 to 24	25	6%	6%	8%
25 to 34	65	16%	15%	13%
35 to 54	143	36%	31%	30%
55 or over	168	42%	48%	50%
Total valid responses	**401**	**100%**	**100%**	**100%**
BY GENDER				
Male	202	50%	48%	48%
Female	199	50%	52%	52%
Total valid responses	**401**	**100%**	**100%**	**100%**
BY WORKING STATUS				
Working	236	59%	54%	56%
Retired	126	31%	36%	29%
Otherwise not working	39	10%	10%	15%
Total valid responses	**401**	**100%**	**100%**	**100%**
BY TENURE				
Owned outright	159	43%	47%	40%
Owned with a mortgage or loan (including shared ownership)	121	33%	30%	32%
Social rent	41	11%	10%	12%
Private rent	47	13%	13%	16%
Total valid responses	**368**	**100%**	**100%**	**100%**
Not known	*33*	-	-	-
BY DISABILITY				
Yes	75	19%	20%	21%
No	316	81%	80%	79%
Total valid responses	**391**	**100%**	**100%**	**100%**
Not known	*10*	-	-	-
BY ETHNIC GROUP				
White British	372	96%	96%	92%
Other ethnic groups	17	4%	4%	8%
Total valid responses	**389**	**100%**	**100%**	**100%**
Not known	*12*	-	-	-

3.7 The following table shows the area profile of responses to the survey (based on ward, nearest stroke unit and nearest proposed HASU), again presented as both unweighted and weighted.

Table 2: Response profile to the residents survey by area compared with the Somerset and surrounding wards population aged 18+

Characteristic	Unweighted Count	Unweighted Valid %	Weighted Valid %	Resident Population 18+ %
BY WARD GROUP				
Taunton	189	47%	47%	47%
Yeovil	157	39%	40%	39%
Dorset (Neighbouring Dorset wards plus Mere)	42	10%	10%	11%
Devon	13	3%	3%	3%
Total valid responses	**401**	**100%**	**100%**	**100%**
BY NEAREST STROKE UNIT				
Musgrove Park Hospital	204	51%	50%	54%
Yeovil District Hospital	197	49%	50%	46%
Total valid responses	**401**	**100%**	**100%**	**100%**
BY NEAREST PROPOSED HASU				
Musgrove Park Hospital	278	69%	69%	79%
Dorset County Hospital	123	31%	31%	21%
Total valid responses	**401**	**100%**	**100%**	**100%**

Interpretation of the data

3.8 The results of the residents survey are presented in a largely graphical format. The pie and bar charts (and other graphics) show the proportions (percentages) of residents making responses. Where possible, the colours of the charts have been standardised with a 'traffic light' system in which:

- Green shades represent positive responses;
- Yellow shades represent neither positive nor negative responses;
- Red shades represent negative responses;
- Bolder shades highlight responses at the 'extremes', for example, strongly agree or strongly disagree.

3.9 Where percentages do not sum to 100, this may be due to computer rounding, the exclusion of 'don't know' categories, or multiple answers. Throughout the chapter an asterisk (*) denotes any value less than half of one per cent. The number of valid responses recorded for each question (base size), are reported throughout. As not all respondents answered every question, these base sizes vary between questions.

3.10 It should be remembered that a sample, and not the entire population of Somerset and surrounding wards, has been interviewed. In consequence, all results are subject to sampling tolerances, which means that not all differences are statistically significant. Differences between results that are not said to be statistically significant are indicative only. Statistical significance has been calculated at a 95% level of confidence.

Differences in views by demographic sub-groups

3.11 Some of the charts in each section below provide a summary of the weighted results by demographic sub-groups.

3.12 For these charts, each bar represents the proportion agreeing with the proposal; results showing levels of agreement that are significantly higher than the overall result are highlighted in green and significantly lower levels of agreement are highlighted in red. Statistical significance is calculated at a 95% level of confidence. Occasionally results may need to be interpreted with caution due to lower base sizes.

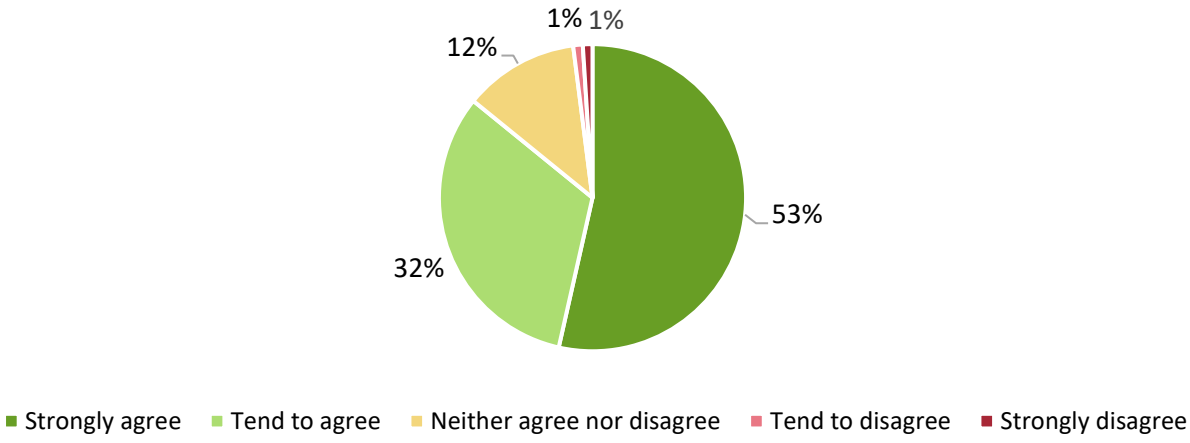
Residents survey results

Residents' views on the need for change

3.13 Overall, nearly nine-in-ten residents (86%) agreed with making changes to respond to these challenges, and only 2% disagreed.

Figure 1: To what extent do you agree or disagree that NHS Somerset need to make changes to respond to these challenges?

OVERALL

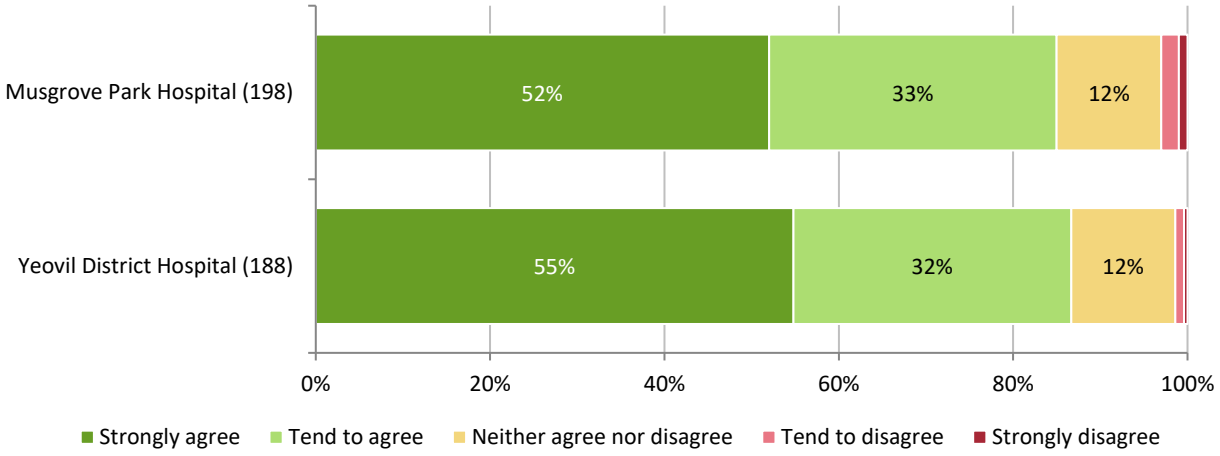


Base: All residents (386)

3.14 Figure 2 presents results to the question about the case for change broken down by residents' nearest stroke unit and it shows that there was, in general, a high level of agreement across the areas with only limited differences in views: 84% in agreement for those living nearest to Musgrove Park Hospital, and 87% for those nearest to Yeovil District Hospital.

Figure 2: To what extent do you agree or disagree that NHS Somerset need to make changes to respond to these challenges?

BY NEAREST STROKE UNIT



Base: All residents (numbers shown in brackets)

Residents' views on the need for change by demographic sub-groups

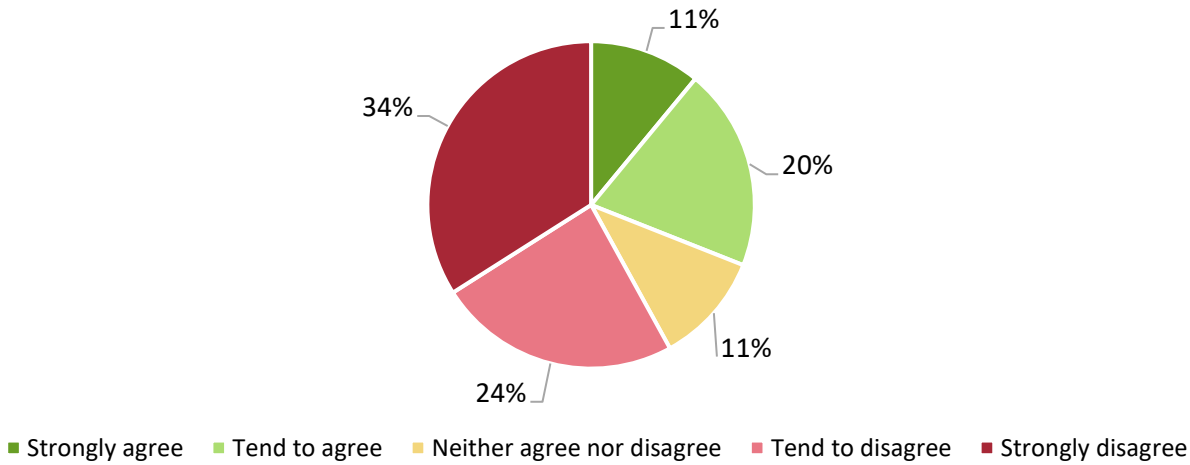
3.15 In relation to the question about whether there is a need to make changes, there were no significant differences to note by demographic sub-group.

Residents' views on the proposal to deliver hyper acute stroke services from only one hospital site in future

3.16 Just over three-in-ten residents (31%) agreed with the proposal to deliver hyper acute stroke services from only one hospital site in future. However, nearly six-in-ten (58%) disagreed.

Figure 3: To what extent do you agree or disagree with the proposal to deliver hyper acute stroke services from only one hospital site in future?

OVERALL



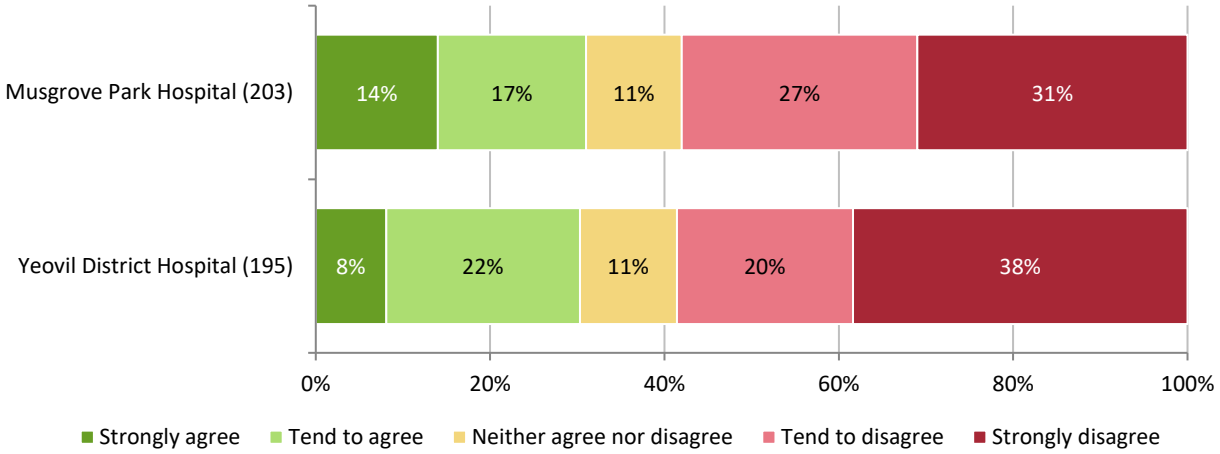
3.17 Base: All residents (398)

3.18 Figure 4 below presents results to the question about the proposal to deliver hyper acute stroke services from only one hospital site in future broken down by residents' nearest stroke unit. This shows similar levels

of acceptance to the proposal compared to the overall figure, with 32% in agreement for those living nearest to Musgrove Park Hospital, and 30% for those nearest to Yeovil District Hospital. Nearly six in ten disagreed whichever hospital was their closest (57% and 59% respectively).

Figure 4: To what extent do you agree or disagree with the proposal to deliver hyper acute stroke services from only one hospital site in future?

BY NEAREST STROKE UNIT

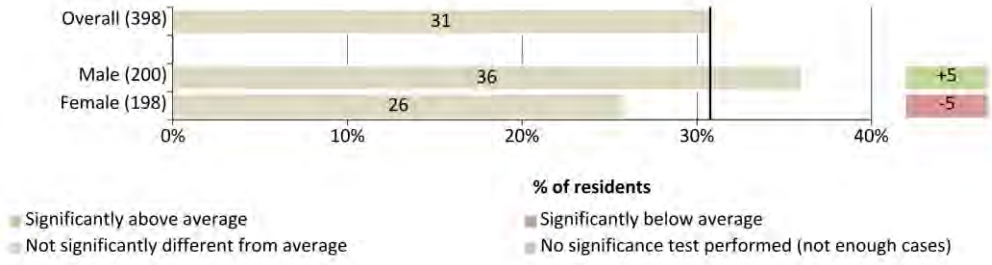


Base: All residents (numbers shown in brackets)

Residents' views on the need for change by demographic sub-groups

3.19 In relation to the question about the proposal to deliver hyper acute stroke services from only one hospital site in future, male residents were significantly more likely to agree whereas female residents were significantly less likely to agree.

Figure 5: Level of agreement with the proposal to deliver hyper acute stroke services from only one hospital site in future
BY POPULATION CHARACTERISTICS



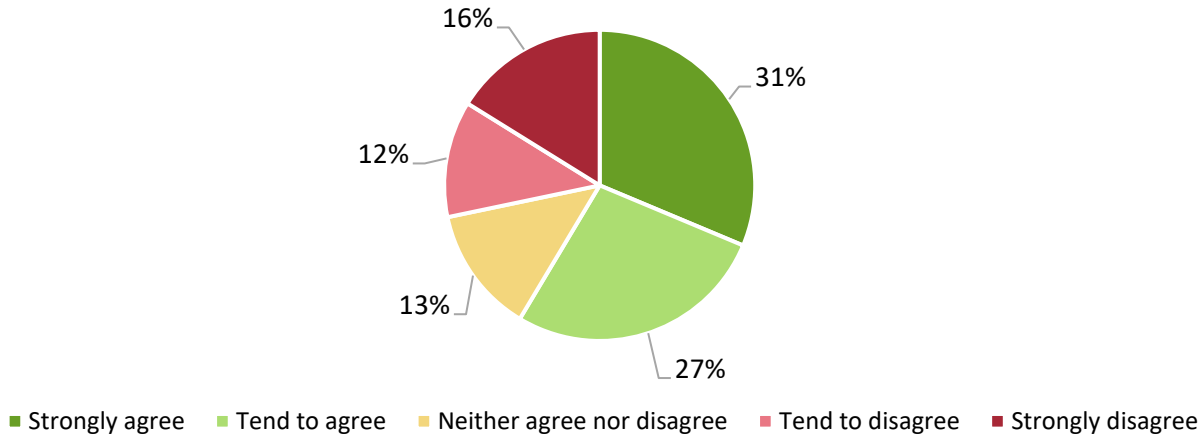
Base: All Respondents (number of respondents shown in brackets)

Residents' views on the proposed location of a HASU in Somerset

3.20 When asked to provide a view on if hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton, nearly six-in-ten (58%) agreed. However, nearly three-in-ten (29%) disagreed (see Figure 6 below).

Figure 6: If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton?

OVERALL

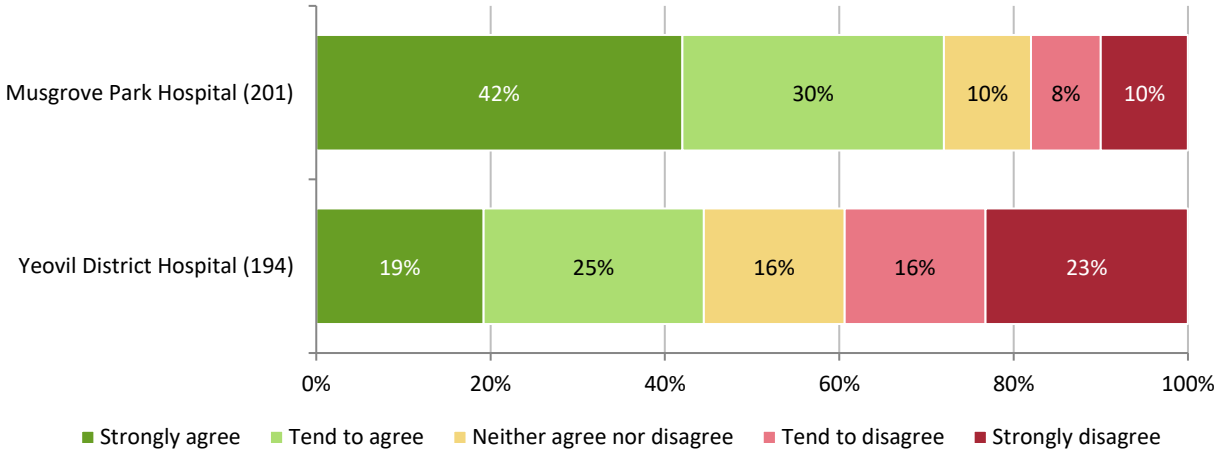


Base: All residents (395)

3.21 Figure 7 below presents results to the question about if hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton, broken down by residents' nearest stroke unit. This shows there was a significant variation in views around this proposal, with over seven-in-ten (72%) in agreement for those living nearest to Musgrove Park Hospital, but only 44% in agreement for those nearest to Yeovil District Hospital. Less than one-in-five (18%) disagreed for those living nearest to Musgrove Park Hospital whereas two-in-five (40%) disagreed for those living nearest to Yeovil District Hospital.

Figure 7: If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton?

BY NEAREST STROKE UNIT



Base: All residents (numbers shown in brackets)

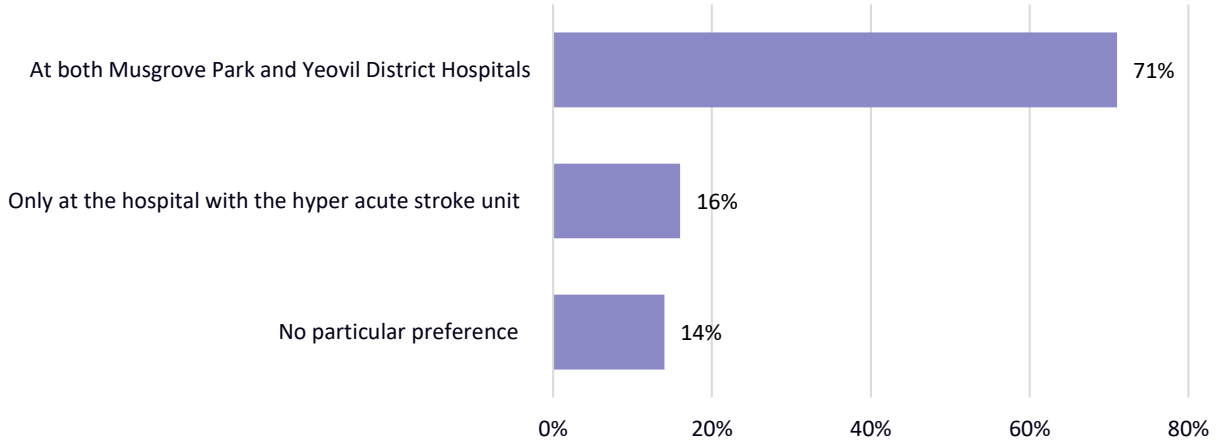
Residents' views on the proposed location of a HASU in Somerset by demographic sub-groups

3.22 In relation to the question about if hyper acute stroke services were to be delivered from only one hospital in future whether this should be from Musgrove Park Hospital in Taunton, there were no significant differences to note by demographic sub-group.

Residents' views on the delivery of *acute* stroke services in Somerset

3.23 Just over seven-in-ten residents (71%) thought ACUTE stroke care should be provided at both Musgrove Park and Yeovil District Hospitals if HYPER acute stroke services were to be delivered from only one hospital in future. A much smaller proportion (16%) thought they should be provided only at the hospital with the hyper acute stroke unit and around one-in-seven (14%) had no particular preference.

Figure 8: IF HYPER acute stroke services were to be delivered from only one hospital in future, do you think ACUTE stroke care should be provided…? OVERALL

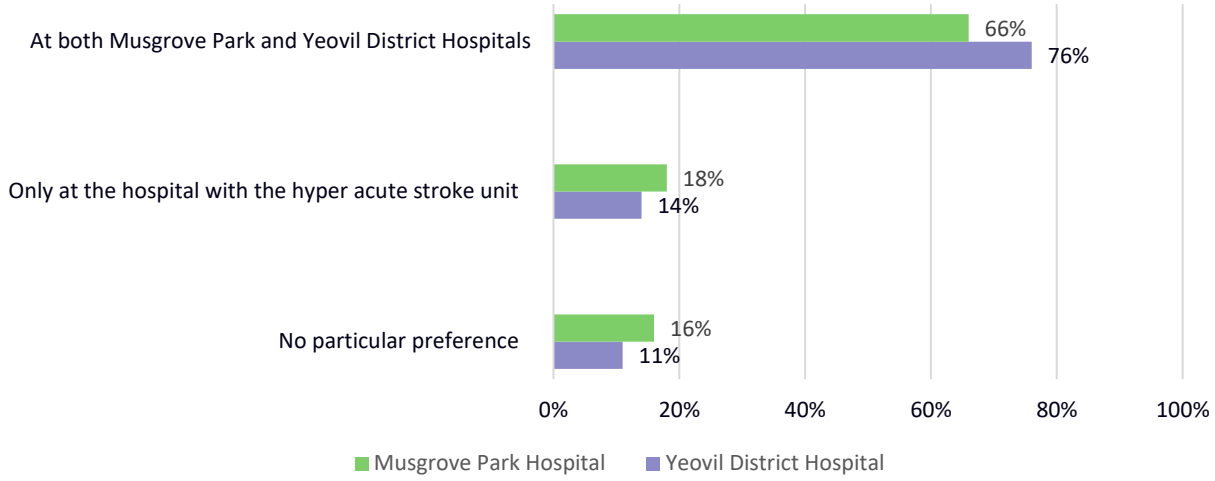


Base: All residents (394)

3.24 Figure 9 below presents results to the question about if hyper acute stroke services were to be delivered from only one hospital in future where ACUTE stroke care should be provided, broken down by residents' nearest stroke unit. This shows there was a significant variation in those thinking that acute stroke care should be provided at both Musgrove Park and Yeovil District Hospitals with two-thirds (66%) giving this option for those living nearest to Musgrove Park Hospital (significantly lower than the overall result) but over three-quarters (76%) of those living nearest to Yeovil District Hospital chose this option (significantly higher than the overall result). Those living nearest to Musgrove Park Hospital were more likely to state no particular preference (16%, compared to just over one-in-ten (11%) of those living nearest to Yeovil District Hospital).

Figure 9: IF HYPER acute stroke services were to be delivered from only one hospital in future, do you think ACUTE stroke care should be provided…?

BY NEAREST STROKE UNIT



Base: Nearest Stroke Unit - Musgrove Park Hospital (201), Yeovil District Hospital (193)

Feedback comments in the residents survey

3.25 In addition to being asked to indicate whether they agreed or disagreed with each proposal, respondents were given an opportunity to share any final views by making additional comments.

3.26 Less than half of participants chose to make further comments. Of those who did, most made general comments rather than focusing on a particular aspect of the proposal or service. Those who expressed concern tended to focus on transport and travel times. For example:[1]

> *"All this stuff being centralised is enough to make you ill, an hour's journey for people who are extremely sick anyway is unacceptable."*
>
> *"I would like to know who came up with this idea. Geographically, it is not an easy route from Yeovil to Taunton, there are a lot of narrow B roads, and it would put patients at risk. This should never be contemplated."*

3.27 Some expressed concerns about the potential impact on visitors ability to travel to see loved ones, and the effect that might have on patients' well-being:

> *"Father was in hospital for 7 months after a stroke. If you have someone in hospital for a long time after a stroke, it would be a long way to visit for family, and the cost of visiting would be a lot. Better provision needs to be provided across Somerset. All hospitals need to have the right provision. It's a problem across the NHS, strokes affect the person and their family, it's a sticking plaster."*
>
> *"It might be good for the patients' medical needs but not for their social or emotional needs. Not everyone can get to Taunton. Centralization might be good for this or that, but you have to look after mental health as well. Family won't be able to visit every day, petrol is getting expensive. Got to look at the holistic aspect too."*

[1] Quotes are edited using ellipses and square brackets [...] to ensure anonymity.

3.28 While some participants recognised the issues caused by lack of 24/7 specialist care, and that consolidating hyper-acute stroke services could bring benefits in terms of clinical care and patient outcomes, they still expressed concern about the increase in travel time and distance for those living further away from Taunton.

> *"I don't think it's good enough that there is not 24-hour support for acute stroke services. I would worry about time as with a stroke the travel would be time sensitive."*
>
> *"Consolidating would have benefits but also drawbacks. e.g., distance."*

3.29 Others were concerned that the proposed changes add pressure to health services, particularly if the number of stroke patients were to increase in future.

> *"I think you will put too much pressure on one hospital [...] Parking will also be a problem in regard to the hospital…"*
>
> *"… the NHS expect a rise in people needing stroke services so I think they should be putting money into both of the hospitals..."*

3.30 One participant expressed concern about what they saw as a pattern of service being lost from Yeovil Hospital, while another expressed specific concerns on the impacts of the proposed changes on service users who might require additional support or find it difficult to cope with changes.

> *"Yeovil Hospital is always shrinking down, soon it will be like a small cottage hospital. Taunton takes everything. Our community raised money to open a hospice in the area, it opened and then they said they couldn't afford to keep it open and moved it to Taunton."*
>
> *"Thinking about the patient having to travel will put pressure on them, especially concerning the elderly. Also, they could have other ailments, Parkinson, Huntington's, they could have a language barrier which only creates more pressure, e.g., concerning traveling. Older people sometimes have never left their own town, allocating them to another town will create more pressure. Financially you will also be creating an issue in regard to petrol for those having to travel."*

4. Consultation questionnaire

Introduction

4.1 Throughout the 12-week public consultation (which began on 30 January 2023 and ended on 24 April 2023), stakeholders were signposted to the Somerset Integrated Care System website or provided with paper documentation. A range of information and resources were available, including the full consultation document and separate summary versions.

4.2 A structured consultation questionnaire was designed to allow stakeholders to provide feedback in a consistent format. Appropriate summary information was included for each question, with additional signposting to more detailed information; feedback was invited around any concerns or alternative solutions, and potential equalities impacts. Finally, a profiling section gathered stakeholder type and demographics.

Summary of main findings

The need for changes to address challenges

4.3 There was general recognition of **the need for change** from all stakeholder groups responding to the consultation questionnaire. 77% of NHS staff and 61% of other individuals who responded agreed with the need for changes to be made in response to challenges facing NHS hospital services in Somerset.

The proposed model of care for hyper acute stroke services

4.4 However, levels of support with **the proposal to deliver hyper acute stroke services from only one hospital site in future** was much lower. Less than a third of NHS staff who responded (32%) and a lower proportion (23%) of other individual respondents agreed with this proposed change.

4.5 Among NHS staff working in stroke services, views were more balanced compared to all other respondent groups, with nearly half, 47% agreeing with the proposed model of care and a marginally greater proportion (49%) disagreeing.

The proposed location for a single HASU in Somerset

4.6 Support was slightly higher for the proposal that, if *hyper* acute stroke services were to be delivered from only one hospital in future, that **it should be from Musgrove Park Hospital in Taunton**, with over two-fifths (43%) of NHS staff and less than a third (32%) of other individuals in agreement, while almost half (48%) of NHS staff and nearly three fifths (58%) other individuals disagreed.

4.7 Views among NHS staff members working in stroke services in particular were more positive with nearly three fifths (58%) agreeing, however, just under one third (32%) of NHS stroke services staff respondents disagreed with the proposed location.

4.8 Levels of agreement with the proposals varied considerably based on geography, i.e., by respondents' closest Somerset hospital currently delivering acute stroke services:

» Around half (51%) of respondents living nearest to Musgrove Park Hospital agreed with **the proposal to deliver hyper acute stroke services from only one hospital site in future**. Whereas only around one-in-six (17%) living nearest to Yeovil District Hospital agreed.

» Four fifths (80%) of respondents living nearest to Musgrove Park Hospital agreed with the proposed location for a single HASU in Somerset, whereas only one-fifth (20%) of those living nearest to Yeovil District Hospital agreed with the proposed location.

Views on potential approaches to delivery of *acute* stroke services

4.9 The majority of respondents thought that, if HYPER acute stroke services were to be delivered from only one hospital in future, **that *acute* stroke care should continue to be provided at both Musgrove Park and Yeovil District Hospitals**.

Methodology and questionnaire response

4.10 The questionnaire was available online (hosted by ORS), and paper questionnaires were distributed at events and in public locations, and available on request (including an easy read version and in different languages). All questionnaire responses submitted by the closing date, and subsequently received by ORS or NHS Somerset, in which at least one of the consultation questions was answered, were included in the analysis, regardless of whether or not any profile questions were answered. A total of 1,623 questionnaires were completed, which included 1,553 online responses and 70 paper copies.

4.11 ORS routinely monitors cookies and IP addresses to ensure that multiple completions by a small number of individuals are not submitted in an attempt to deliberately affect the outcomes. After detailed analysis of the raw dataset, ORS did not find any multiple responses attempting to systematically skew results.

4.12 It is important to reiterate that while open questionnaires are inclusive and give people an opportunity to express and explain any views, the results are not generally expected to be representative of the general balance of opinion in the wider population. The results in this chapter should be interpreted in this context.

Respondents connections to stroke services

4.13 The first question asked respondents about their connection with stroke services in Somerset. It should be noted the question was voluntary (i.e., respondents could choose not to answer and still complete the survey). Furthermore, it was a multiple response question so that those taking part could identify more than one connection (e.g., as an NHS staff member *and* a local resident).

4.14 For the purpose of succinct analysis and reporting, individual respondents who provided *multiple connections* have been grouped with those who identified as having a single connection according in the following order:

Stroke survivors	107 responses in total
NHS *stroke services* staff members	73 responses
Other NHS staff members	273 responses
Family members/carers of stroke survivors	293 responses
Residents and other respondents	873 responses, including 14 unknown

4.15 Among the respondents who specifically stated an ‘other connection’ to stroke services, 19 said that they had lost a family member as a result of a fatal stroke or complications arising afterwards.

4.16 Those respondents who said that they were completing the questionnaire on behalf of organisations were asked to provide further details about the group or capacity in which they were responding. Four responses from respondents identifying as representatives of named organisations were submitted (Table 3).

Table 3: Named organisations responding via the consultation questionnaire

Dunster & Porlock Patient Participation Group
Probation Service
Stalbridge Community Volunteer Car Scheme (available for registered patients to assist with transport to medical and hospital appointments)
Dorset Council's People and Health Scrutiny Committee working group

Demographic profile of respondents

4.17 All other individuals were asked to provide some basic demographic information. Table 4 summarises the demographic information for those who were asked to provide this information. Mid-year population estimate 2020 data of the NHS Somerset area (Somerset and a number of neighbouring wards in surrounding Dorset, Devon and Wiltshire from which patients might travel to use NHS Somerset hospital services) is used as a comparator where available, to give some general indication of how well the response profile of the questionnaire matches the wider population that might be affected by the proposed changes.

4.18 An asterisk has been used to denote percentages greater than zero, but less than half of one percent. There was a very small proportion (less than 1%) of questionnaire responses received from people who provided a postcode lying outside the NHS Somerset catchment area; nonetheless, those responses have also been included in the demographic profile tables below for completeness.

Table 4: Demographic response profile to the consultation questionnaire for those who were asked to provide this information: age, gender, disability, ethnic group – compared with the Somerset and surrounding wards population aged 18+

Characteristic		Questionnaire Responses		'Catchment' population aged 18+
		Number of Respondents	%	
BY AGE	Under 25	28	2%	8%
	25 to 34	95	7%	13%
	35 to 54	382	29%	30%
	55 or over	819	62%	50%
	Total valid responses	**1,324**	**100%**	**100%**
	Not known	*295*	-	-
BY GENDER	Male	332	26%	48%
	Female	968	74%	52%
	Total valid responses	**1,300**	**100%**	**100%**
	Not known	*319*	-	-
BY DISABILITY	Has a disability	288	23%	21%
	No disability	990	77%	79%
	Total valid responses	**1,278**	**100%**	**100%**
	Not known	*341*	-	-

Characteristic		Questionnaire Responses		'Catchment' population aged 18+
		Number of Respondents	%	
BY ETHNIC GROUP	White British	1,212	95%	92%
	Other ethnic group	60	5%	8%
	Total valid responses	**1,272**	**100%**	**100%**
	Not known	*347*	-	-
BY WHETHER RESPONDENT PROVIDES HELP / SUPPORT TO OTHERS[2]	Yes	526	41%	11%
	No	747	59%	89%
	Total valid responses	**1,273**	**100%**	**100%**
	Not known	*346*	-	-
BY WHETHER GENDER IS THE SAME AS ASSIGNED AT BIRTH[3]	Yes	1,277	100%	100%
	No	3	*%	*%
	Total valid responses	**1,280**	**100%**	**100%**
	Not known	*339*	-	-

4.19 Table 5 summarises the number of responses received by district/county and by relative levels of deprivation (based on postcodes, where this information was provided as part of the questionnaire response). The locations of around a quarter of respondents (407) are unknown, but it is reasonable to assume that the distribution of those responses is similar to those where postcodes are provided.

Table 5: Distribution of questionnaire responses received, by (grouped) district or county and by deprivation (calculated using Indices of Multiple Deprivation (IMD)) for those who provided postcodes – compared with the NHS Somerset 'catchment' (Somerset and neighbouring electoral wards in surrounding counties) population aged 18+

Characteristic		Questionnaire Responses		'Catchment' population aged 18+
		Number of Responses	%	
BY DEPRIVATION (IMD QUINTILE)	1 – most deprived	161	13%	19%
	2	226	19%	20%
	3	212	18%	21%
	4	312	26%	20%
	5 – least deprived	284	24%	20%
	Total valid responses	**1,195**	**100%**	**100%**
	Not known	*424*	-	-

4.20 Table 6 summarises the number of responses received by nearest Somerset stroke unit and nearest proposed HASU (based on postcodes, where this information was provided as part of the questionnaire response). The locations of around a quarter of respondents (407) are unknown, but it is reasonable to assume that the distribution of those responses is similar to those where postcodes are provided.

[2] Defined as being any help or support provided to family members, friends, neighbours or others because of long-term physical or mental ill-health/disability or problems relating to old age

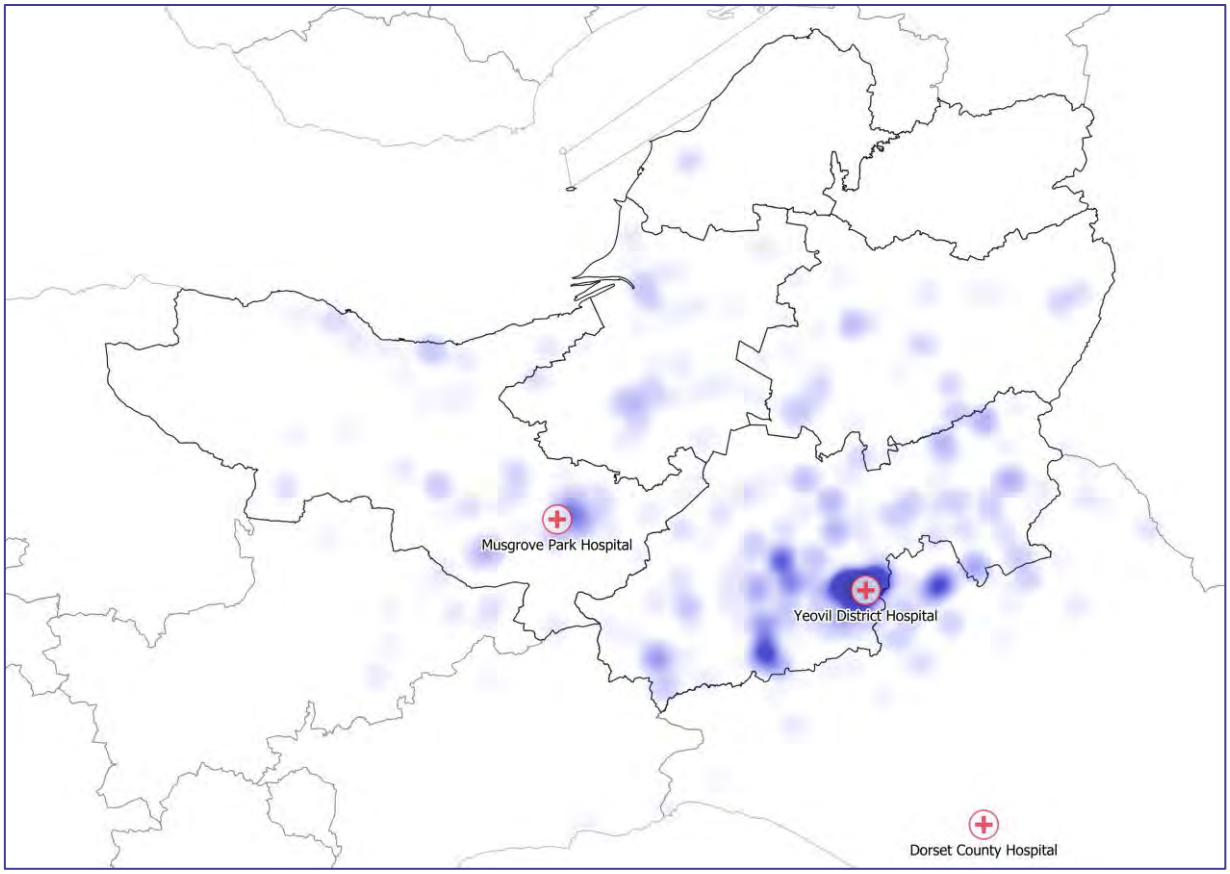
[3] National ONS Census 2021 population data for Somerset, Devon and Dorset

Table 6: Distribution of questionnaire responses received, by nearest current Somerset stroke unit and nearest proposed HASU for those who provided postcodes – compared with the NHS Somerset 'catchment' (Somerset and neighbouring electoral wards in surrounding counties) population aged 18+

Characteristic		Questionnaire Responses		Population aged 18+
		Number of Responses	%	
BY DISTRICT/ COUNTY	Sedgemoor, Mendip and North Somerset	135	11%	36%
	Somerset West and Taunton	149	12%	24%
	South Somerset	800	66%	26%
	Dorset and Wiltshire	105	8%	11%
	Devon	17	1%	3%
	Total valid responses	**1,212**	**100%**	**100%**
	Other areas	*6*	-	-
	Not known	*407*	-	-
BY NEAREST STROKE UNIT	Musgrove Park Hospital	293	24%	54%
	Yeovil District Hospital	919	76%	46%
	Total valid responses	**1,212**	**100%**	**100%**
	Not known	*407*	-	-
BY NEAREST PROPOSED HASU	Musgrove Park Hospital	590	49%	79%
	Dorset County Hospital	622	51%	21%
	Total valid responses	**1,212**	**100%**	**100%**
	Not known	*407*	-	-

4.21 As indicated in the table above and Figure 10 overleaf, the open questionnaire response was greatest from areas nearest to the current stroke unit at Yeovil District Hospital (76% Table 6) compared to just under a quarter (24%) from respondents living nearest to Musgrove Park Hospital.

Figure 10: Map showing distribution of responses (for questionnaire responses where a postcode was provided)



Interpretation of the data

4.22 Data from the consultation questionnaire has not been combined to produce "overall" findings across the different stakeholder groups, because the size of the stakeholder groups, and the numbers of their respective responses, are very different; moreover, they have distinctive views and feedback cannot simply be merged.

4.23 With this in mind, the views of different respondent groups have, in some key places, been reported separately, as their perspective may be informed by their experience of working within the NHS. In these cases, for convenience of reporting and to provide clarity, the views of NHS staff are generally reported first. This is in no way intended to suggest that views from NHS staff are considered as any more or less important than those from residents and other individuals.

4.24 For simplicity and ease of access, the results of the consultation questionnaire are presented in a largely graphical format. Where possible, the colours used on the charts have been standardised with a 'traffic light' system in which:

- Green shades represent positive responses;
- Yellow shades represent neutral responses;
- Red shades represent negative responses; and
- Bolder shades highlight responses at the 'extremes', for example, strongly agree or strongly disagree.

4.25 The numbers on pie charts are percentages indicating the proportions of respondents giving a particular view. It should be noted that, when reporting combined percentages of poor and very poor, or good and very good, responses in the text commentary, the figure may sum differently (+/- 1%) to the figures shown on stacked bar charts due to rounding of decimal places.

4.26 The number of valid responses recorded for each question (base size) are reported throughout. As not all respondents answered every question, the valid responses vary between questions. Every response to every question has been taken into consideration.

4.27 Where percentages do not sum to 100, this may be due to computer rounding, the exclusion of "don't know" categories, or multiple answers. Throughout the report an asterisk (*) denotes any value greater than zero, but less than half of one per cent. In some cases, figures of 2% or below have been excluded from graphs for presentational reasons.

4.28 Finally, feedback from organisations is reported separately at the end of the chapter.

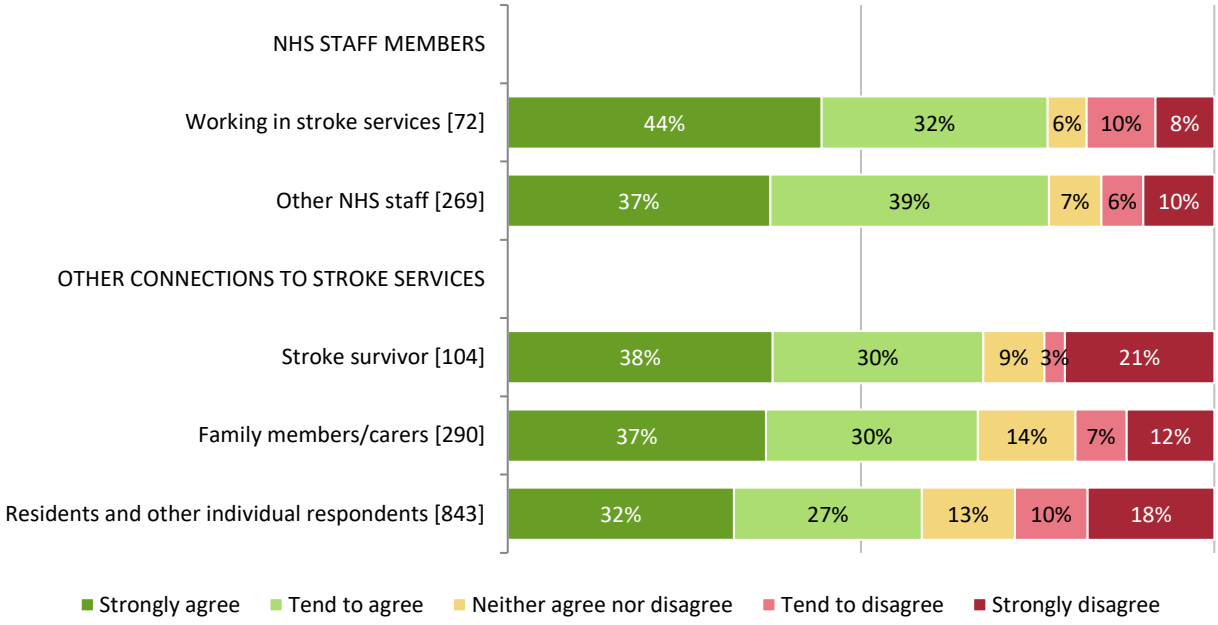
Questionnaire feedback

Respondents' views on the need for change

4.29 Just over three-quarters of respondents who identified themselves as NHS stroke services staff (76%) and other NHS staff members (77%) either tended to agree or strongly agreed that NHS Somerset needs to make changes to respond to challenges facing acute stroke services in Somerset. Around two-thirds of those who identified as stroke survivors (67%) and carers and family members of stroke survivors (67%) also agreed, while nearly three fifths (59%) of other individual respondents agreed (Figure 11).

Figure 11: To what extent do you agree or disagree that NHS Somerset need to make changes to respond to these challenges?

BY STAKEHOLDER TYPE (individual questionnaire respondents only)



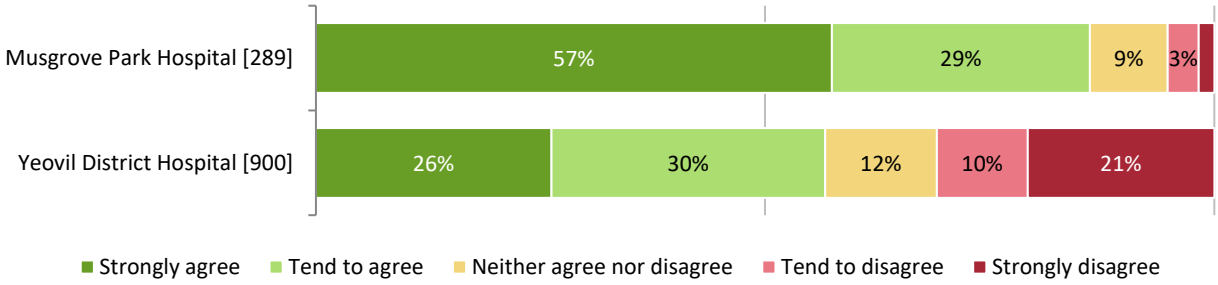
Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.30 While an overall majority of respondents from all geographic areas agreed that there is a need to make changes to current acute stroke services, there was some evidence of variation in the strength of that agreement.

4.31 More than four fifths (86%) of respondents living closest to Musgrove Park Hospital in Taunton agreed with the need for change (Figure 12 overleaf), while only one-in-twenty (5%) disagreed. Views were more mixed, however, among those living nearest to Yeovil District Hospital; just under three fifths (57%) agreed with the need for change, while nearly a third (31%) either tended to agree or strongly disagreed.

Figure 12: To what extent do you agree or disagree that NHS Somerset need to make changes to respond to these challenges?

BY NEAREST STROKE UNIT (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

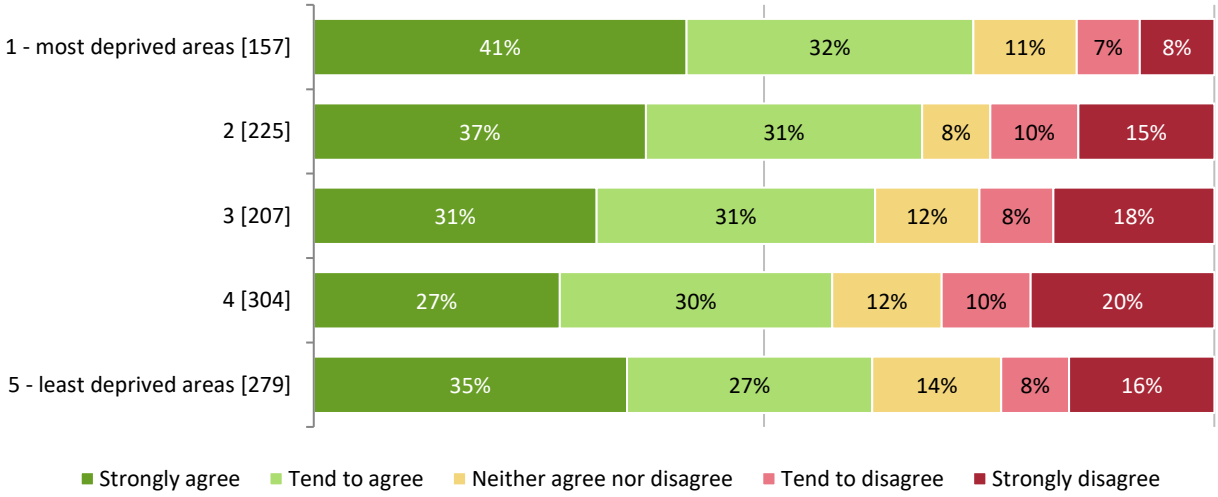
Views on the proposed model of care by demographics

4.32 In the Equality Impact Assessment (EIA) prepared ahead of consultation, NHS Somerset identified some demographic groups that might be particularly affected by or vulnerable to changes to health services, including groups with protected characteristics under the Equality Act 2010 (e.g., Age, Disability, Ethnicity) as well as those living in more deprived areas. This section breaks down the views of respondents who complete some or all of the *voluntary* equalities profiling section of the questionnaire.

4.33 Figure 13 presents all individual questionnaire respondents views on the need for change, broken down by IMD quintiles (1 being the most deprived areas within Somerset and surrounding wards, 5 being the least deprived). It indicates some small variations in views, with a greater proportion of those living in the least deprived areas disagreeing (around three-in-ten or 30% in the fourth quartile) than in other, more deprived areas.

Figure 13: To what extent do you agree or disagree that NHS Somerset need to make changes to respond to these challenges?

BY INDICES OF MULTIPLE DEPRIVATION (IMD) (individual respondents only, where postcodes are provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

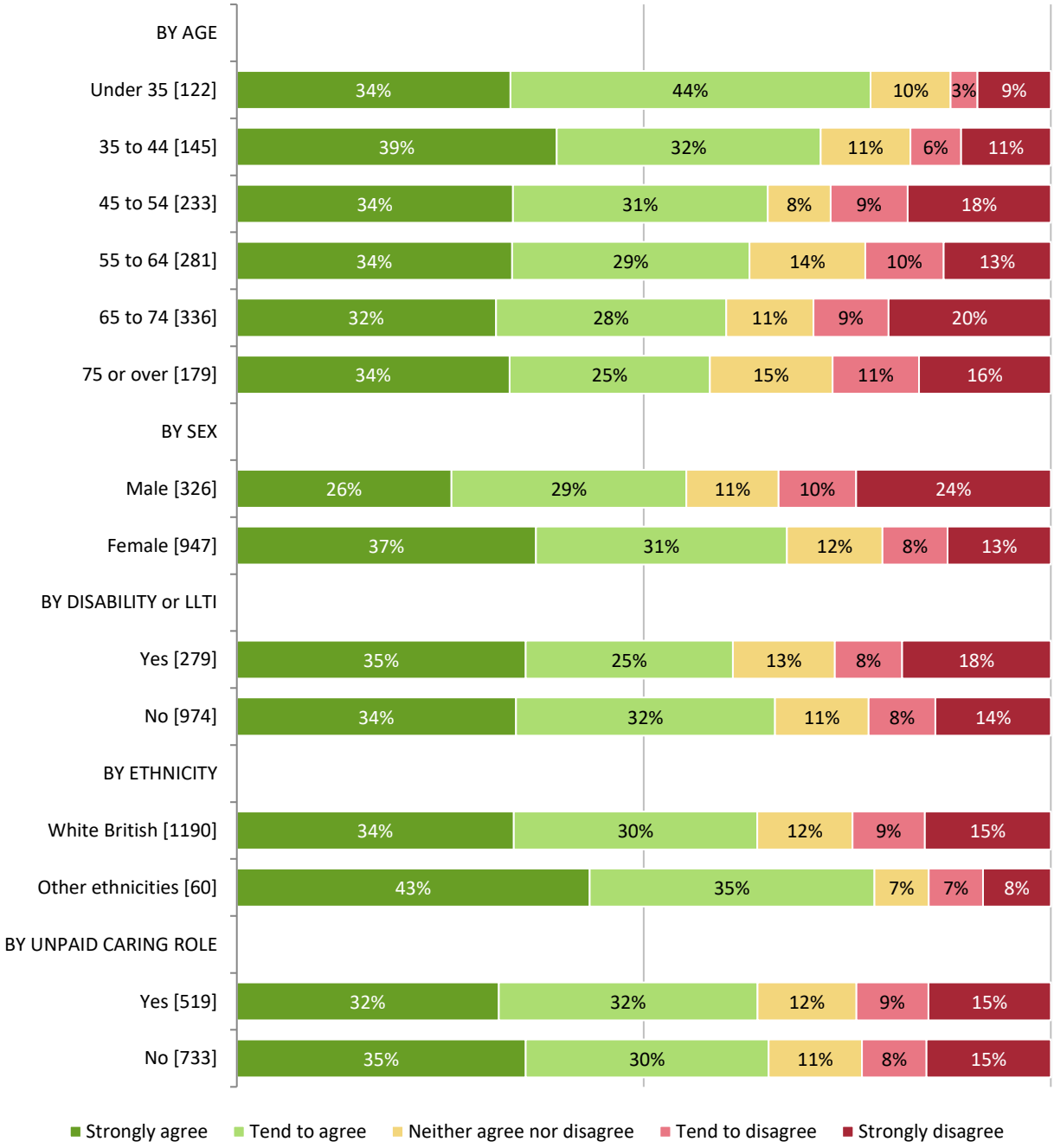
4.34 Overleaf, Figure 14 presents respondents' views on the need for change, broken down by key demographics (including protected characteristics such as age, gender, ethnicity etc). This shows some variation across groups; for example, nearly four fifths (78%) of respondents aged under 35 years agreed with the need for

change, with just over one-in-ten (12%) expressing disagreement. As respondents' ages increase, the strength of agreement lessens, and of those respondents aged 75 or over, less than three fifths (58%) agree with the need for change while more than a quarter (27%) disagree.

4.35 Across other demographic groups, smaller majorities of male respondents (55%), those with disabilities or long-term health conditions (61%) and those who are White British (64%) agreed with the need for change, compared to larger majorities of female respondents (68%), those without disabilities or long-term conditions (66%) and those from other ethnic groups (78%) who agreed with the need for change.

Figure 14: To what extent do you agree or disagree that NHS Somerset need to make changes to respond to these challenges?

BY KEY DEMOGRAPHICS (individual questionnaire respondents only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

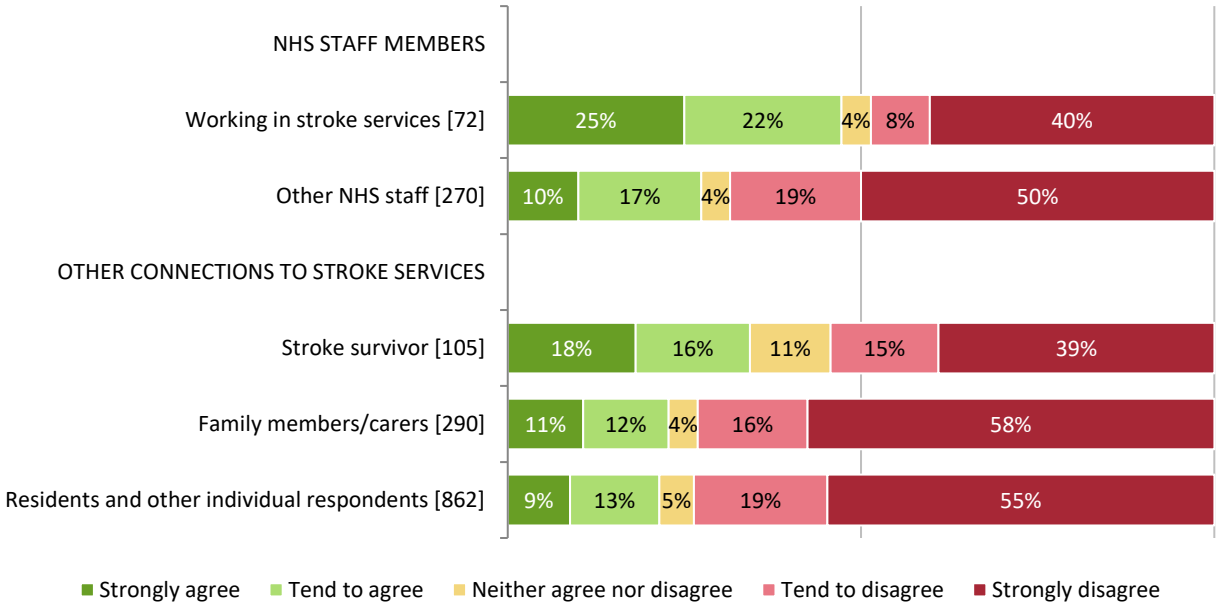
Respondents' views on the proposal to deliver hyper acute stroke services from only one hospital site in future

4.36 While there was broad recognition among questionnaire respondents of the need for challenges facing acute stroke services to be addressed, a sizeable majority of respondents *disagreed* with the specific proposals for a new model of care for hyper acute stroke services in Somerset.

4.37 Among NHS staff members working in stroke services, views were more balanced than among other respondents with nearly half (47%) *agreeing* with the proposal to deliver hyper acute stroke services from one HASU in Somerset in the future, and a marginally greater proportion (49%) disagreeing (Figure 15).

4.38 Among other groups, however, substantially larger proportions of respondents disagreed with the proposal than agreed. Just over a quarter of other NHS staff (27%) and around one third (34%) of stroke survivors agreed with the proposed model of care, compared to more than two thirds (69%) of other NHS staff and more than half (54%) of stroke survivors who disagreed.

Figure 15: To what extent do you agree or disagree with the proposal to deliver hyper acute stroke services from only one hospital site in future? BY STAKEHOLDER TYPE (individual questionnaire respondents only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

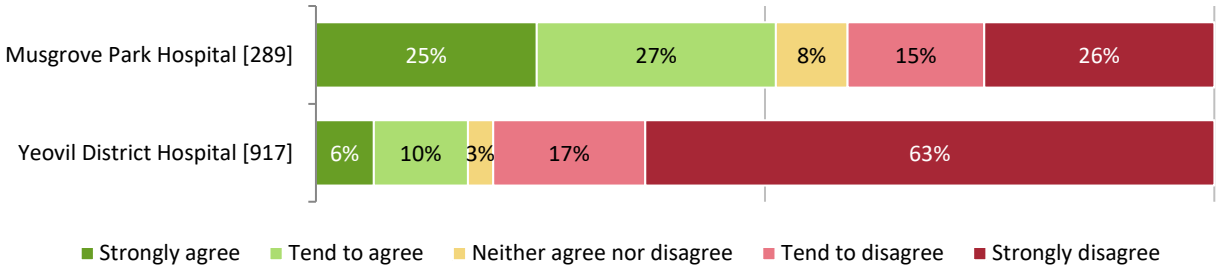
4.39 Views among family members and carers of stroke survivors were more negative, with less than a quarter (23%) agreeing with the proposed model of care while nearly three quarters (73%) disagreed. Similarly, just over a fifth (21%) of other individual respondents (predominantly residents) agreed with the proposal, compared to nearly three-quarters (74%) who disagreed.

Views on the model of care by area of residence

4.40 There is a clear indication that views among questionnaire respondents vary considerably by geography; those questionnaire respondents who provided postcodes and live closest to Musgrove Park Hospital in Taunton were substantially more positive about the proposals than those living closest to Yeovil District Hospital (Figure 16 overleaf). In fact, a small overall majority of those nearest to Musgrove Park Hospital (just over half or 51%) agreed with the proposed model of care, while around two-fifths (41%) disagreed.

4.41 By contrast, only around one-in-six (17%) of those living closest to Yeovil General Hospital (YGH) expressed agreement with the proposal for a single HASU in Somerset to deliver hyper acute stroke services, while the majority (four-fifths or 80%) disagreed.

Figure 16: To what extent do you agree or disagree with the proposal to deliver hyper acute stroke services from only one hospital site in future? BY NEAREST CURRENT STROKE UNIT (individual respondents only, where postcodes were provided)

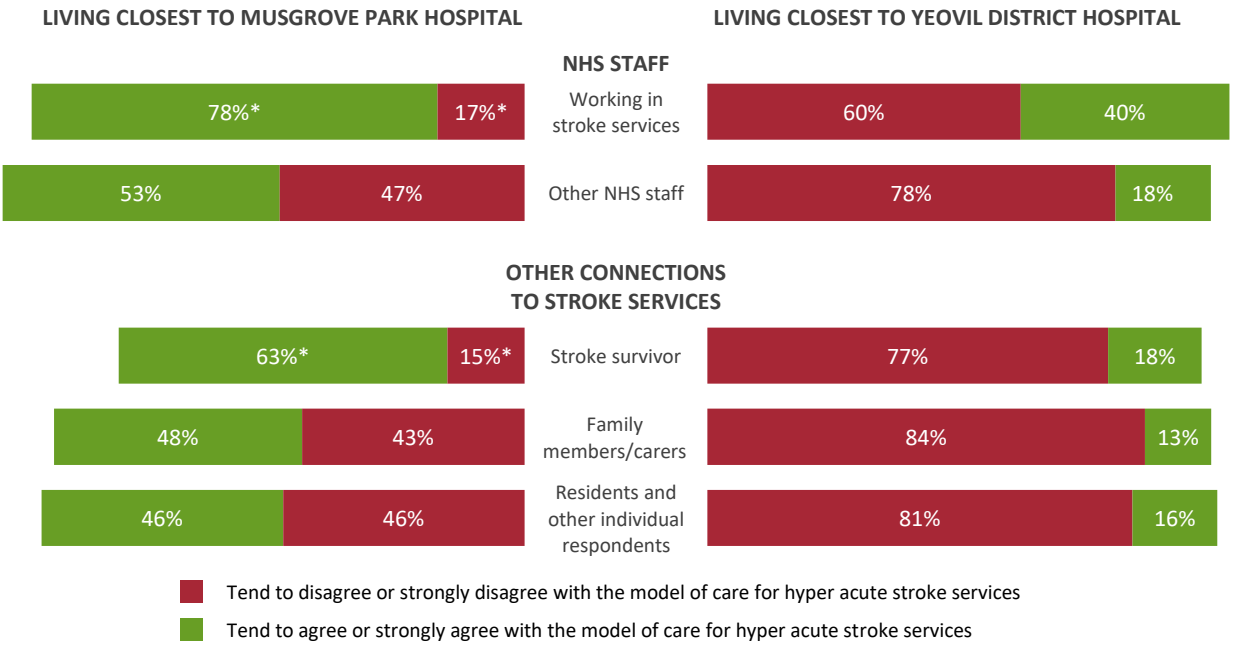


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.42 When breaking down the views of different respondent groups by areas of residence, a similar pattern emerges, with higher levels of agreement (and lower levels of disagreement) among those living closest to Musgrove Park Hospital compared to those living closest to Yeovil District Hospital (Figure 17).

4.43 It also shows, however, that NHS stroke services staff living nearest to Yeovil District Hospital are somewhat more positive about the proposal than other respondents. Two fifths (40%) agreed with the proposal for a single HASU, more than twice the proportion of respondents with other connections to stroke services who live in the same area. It should be noted, however, that there was still *majority* disagreement (three-fifths or 60%) among stroke services staff living closest to Yeovil District Hospital.

Figure 17: To what extent do you agree or disagree with the proposal to deliver hyper acute stroke services from only one hospital site in future? BY RESPONDENT TYPE and NEAREST STROKE UNIT (individual respondents only, where postcodes were provided)



Base: An asterisk (*) indicates low base numbers in that respondent group (<30)

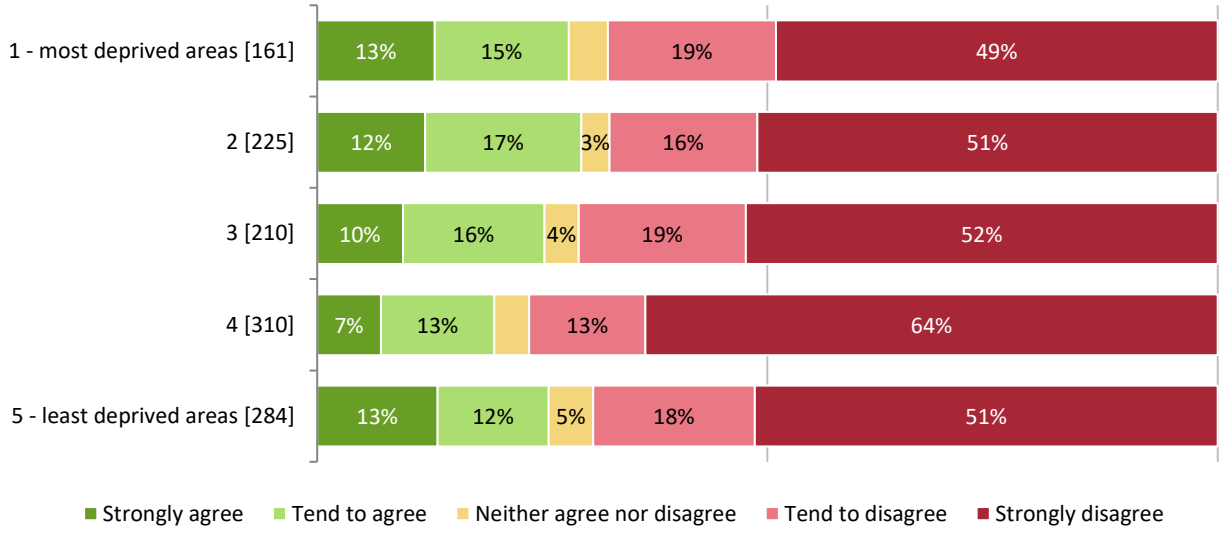
4.44 While the results show that NHS stroke staff and stroke survivors who responded to the questionnaire and live closest to Musgrove Park Hospital are markedly more positive about the proposed model of care compared to other respondent groups from the same area, it should be noted that the 'base numbers' (the numbers of respondents in those groups) are low and so some caution is required.

4.45 Nonetheless, across all respondent types, those living closest to Musgrove Park Hospital in Taunton are more positive about the proposals, with more than half (53%) of non-stroke services NHS staff agreeing with the model of care (compared to 47% who disagreed). Just under half (48%) of family members and carers of stroke survivors also agreed (compared to 43% who disagreed) and views among other individual respondents living closest to Musgrove Park Hospital were evenly balanced between agreement and disagreement.

Views on the proposed model of care, by deprivation

4.46 When broken down by deprivation (IMD quintiles), there is no clear trend. Levels of disagreement are highest among respondents living in the least deprived areas (76% in the fourth quintile).

Figure 18: To what extent do you agree or disagree with the proposal to deliver hyper acute stroke services from only one hospital site in future? BY INDICES OF MULTIPLE DEPRIVATION (IMD) (individual respondents only, where postcodes are provided)

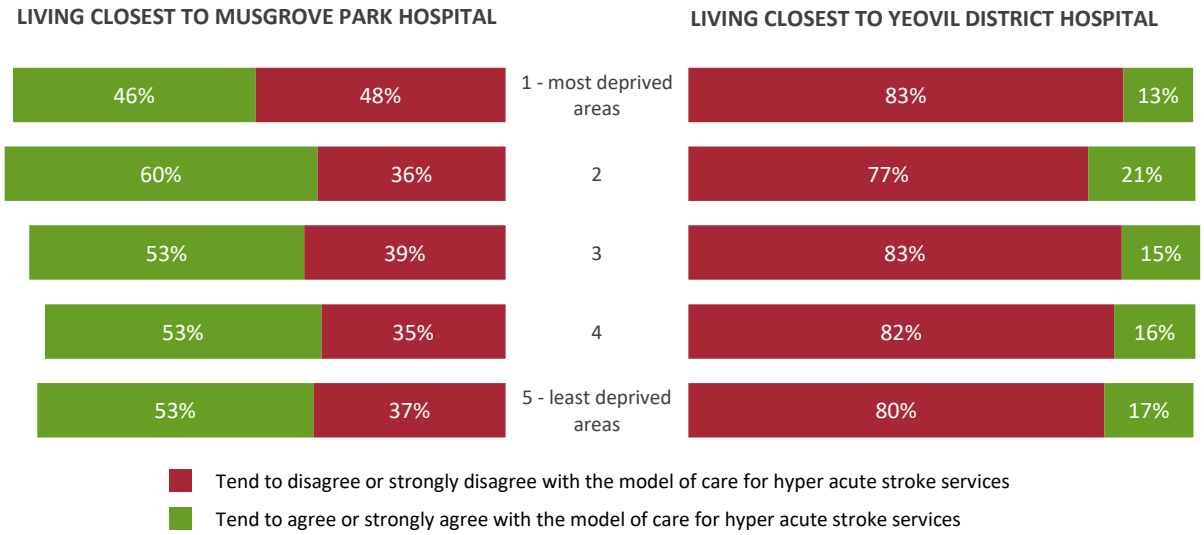


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.47 Among respondents living closest to Musgrove Park Hospital, only those living in the most deprived areas indicated majority disagreement; just over half (52%) disagreed with the proposed model of care (Figure 19 overleaf) while less than half (45%) agreed. Among other respondent living closest to Musgrove Park Hospital, a majority of those living in areas in IMD quintiles 2, 3 and 4 agreed with the proposal for a single HASU, while those in the *least* deprived areas (the 5th quintile) were more evenly split in their views.

4.48 By contrast, across *all* deprivation quintiles, a substantial majority of respondents living closest to Yeovil District Hospital *disagreed* with the proposed model of care, with only between 15-20% indicating that they agreed.

Figure 19: To what extent do you agree or disagree with the proposal to deliver hyper acute stroke services from only one hospital site in future? BY IMD QUINTILE and NEAREST STROKE UNIT (individual respondents only, where postcodes were provided)



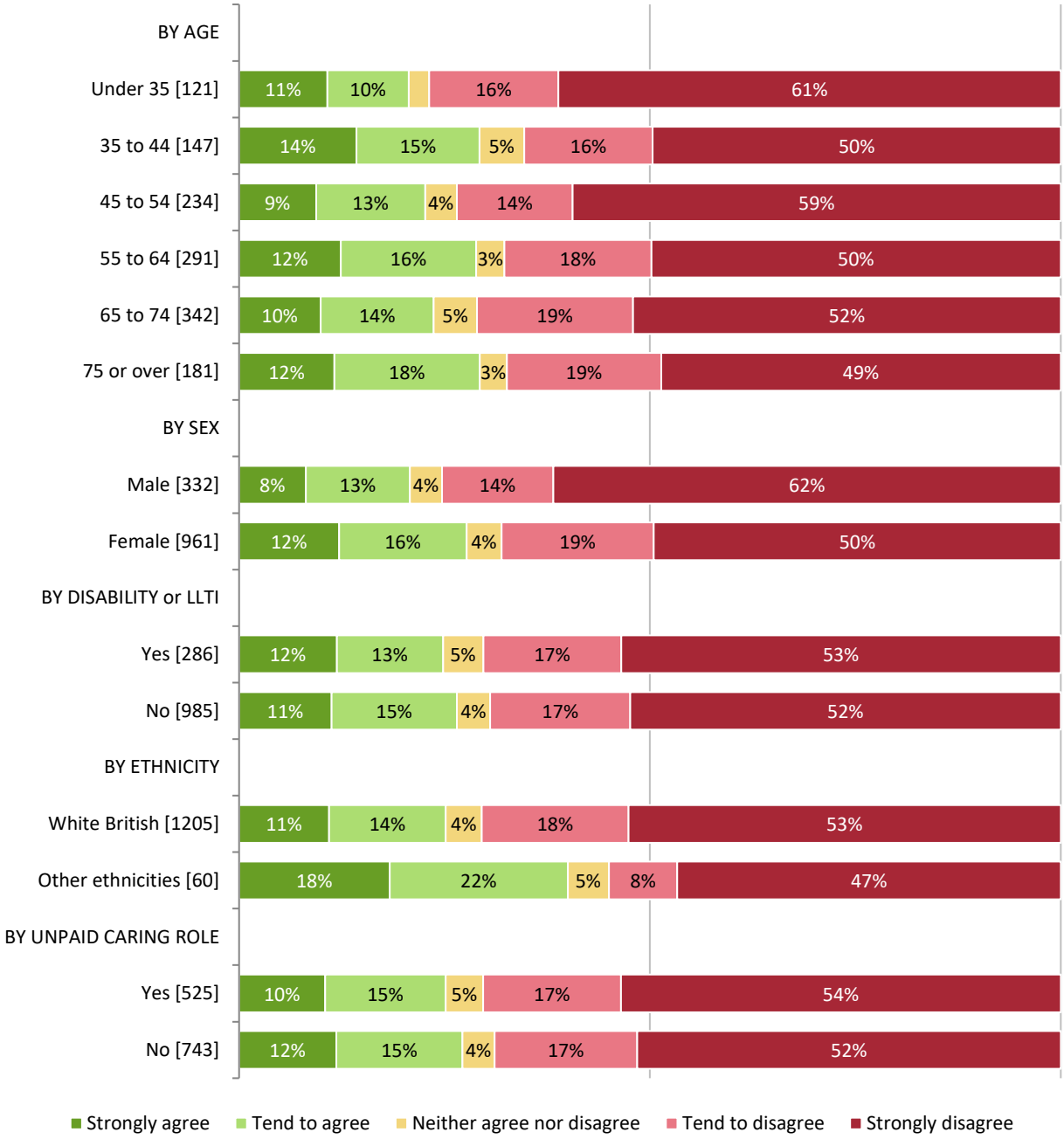
Base: An asterisk (*) indicates low base numbers in that respondent group (<30)

Views on the model of care, by other demographics

4.49 Across other demographic groups (Figure 20 overleaf), there was majority disagreement with the proposed model of care for hyper acute stroke services. Levels of disagreement were highest among respondents who are aged under 35 years (77% disagreed, compared to 21% who agreed), aged 45 to 54 years (74% agreement, 23% disagreement) and male respondents (75% disagreement, 21% agreement).

4.50 Disagreement was also high among White British respondents (70% disagreement, 25% agreement), whereas respondents from other ethnic groups (including White non-British respondents) were somewhat more positive, with two fifths (40%) *agreeing* with the model of care, while more than half (55%) disagreed.

Figure 20: To what extent do you agree or disagree with the proposal to deliver hyper acute stroke services from only one hospital site in future? BY KEY DEMOGRAPHICS (individual questionnaire respondents only)



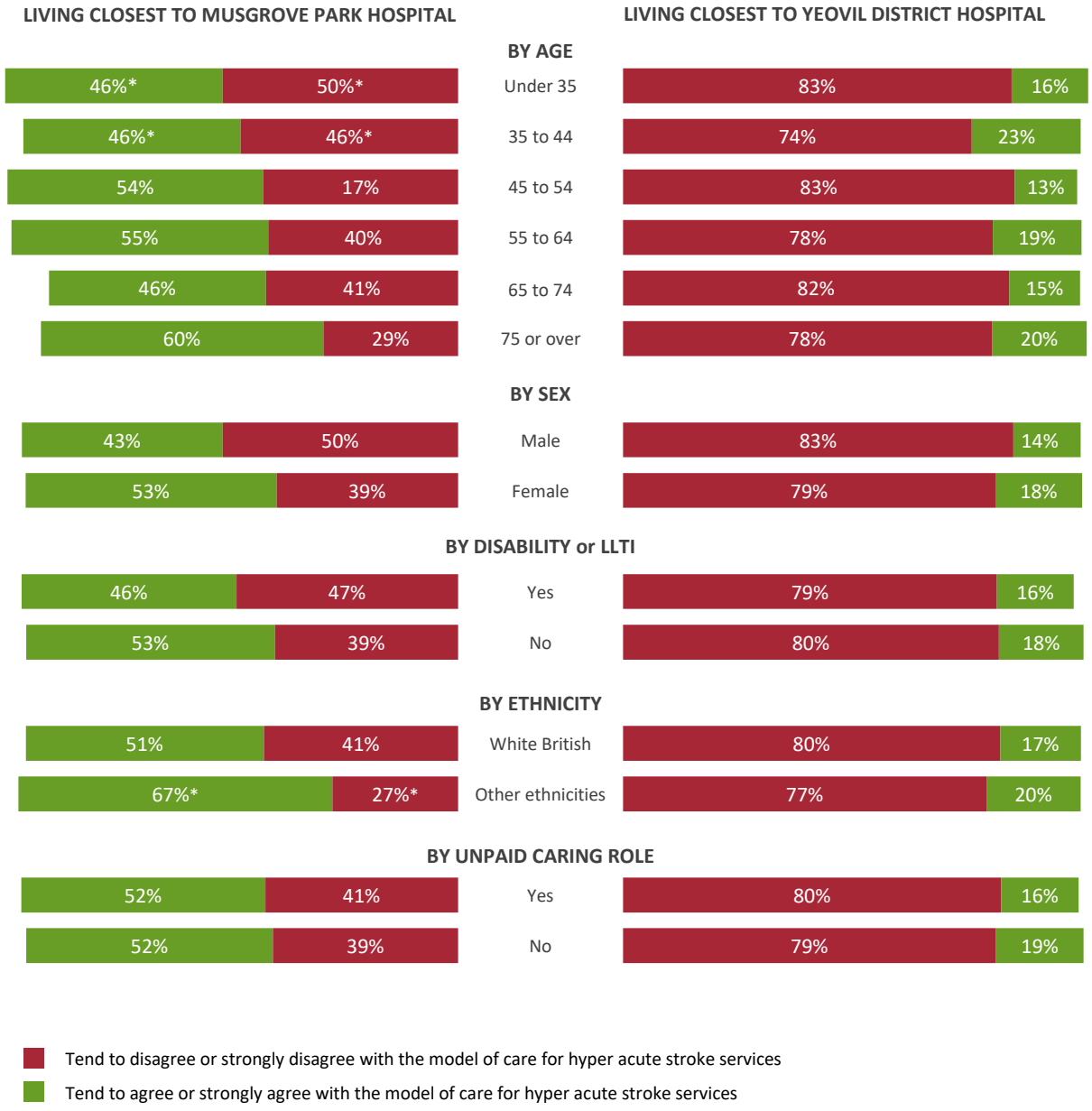
Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.51 When factoring in geography (Figure 21 overleaf), disagreement across all demographics is high among those respondents living closest to Yeovil District Hospital. Views among respondents living closest to Musgrove Park Hospital are more positive (as seen in Figure 16) but there is again evidence that younger respondents, male respondents and those who are White British are less likely to agree, and more likely to disagree, than other demographic groups.

4.52 Similarly, less than half (46%) of respondents with disabilities or limiting long-term illnesses (LLTIs) living closest to Musgrove Park Hospital agreed with the proposed model of care, whereas more than half (53%) of those without disabilities or LLTIs in the same area agreed. Furthermore, nearly half (47%) of respondents

with disabilities or LLTIs living nearest to Musgrove Park Hospital *disagreed* with the proposal for a single HASU in Somerset, compared to two fifths (39%) of those without a disability or long-term condition.

Figure 21: To what extent do you agree or disagree with the proposal to deliver hyper acute stroke services from only one hospital site in future? BY KEY DEMOGRAPHICS (individual respondents only), BY NEAREST STROKE UNIT (where postcodes are provided)



Base: *NB results are marked with an asterisk (*%) are based on low case numbers (<30)

Respondents' views on the proposed location for a single HASU in Somerset at Musgrove Park Hospital in Taunton

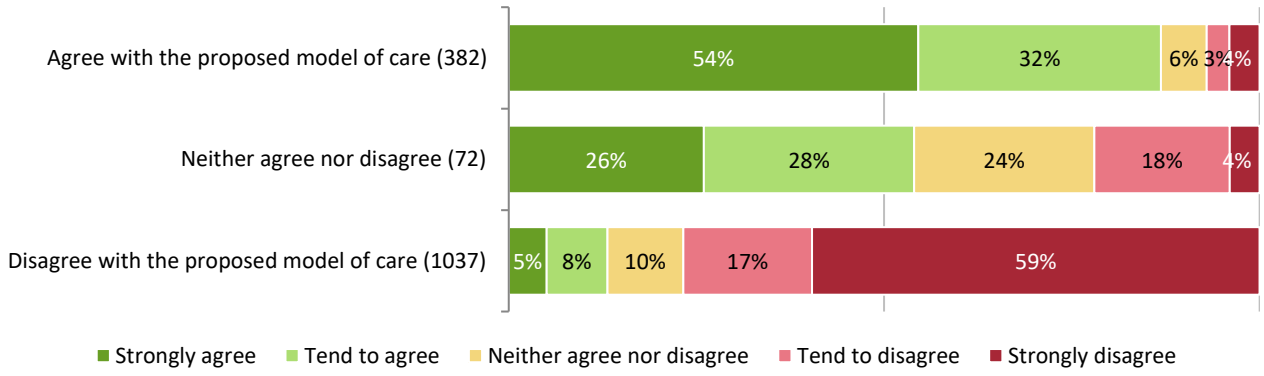
4.53 Following the previous question about the proposed model of care, respondents were asked: 'If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton?'

Views on the proposed model of care for hyper acute stroke services *and* the location of a HASU in Somerset

4.54 Before considering the views of different respondent groups and demographics about the proposed location for a single HASU in Somerset, it is helpful to note that respondents' views tended to echo their views on the proposed model of care (Figure 22). For example, a substantial majority (86%) of those who agreed with the proposal for a single HASU *also* agreed that it should be located at Musgrove Park Hospital, with fewer than one in ten (8%) disagreeing.

4.55 By contrast, more than three quarters (76%) of respondents who disagreed with the proposed model of care also disagreed with the proposed location for a single hyper acute stroke unit in Somerset, while less than one-in-six (14%) agreed. Views among those who had given neutral responses to the proposed model of care where more positive with more than half (54%) agreeing with the proposed location and around one fifth (22%) disagreeing.

Figure 22: If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton? BY VIEWS ON THE PROPOSED MODEL OF CARE (individual respondents only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Respondents views on the proposed location of a single HASU, by connection to stroke services

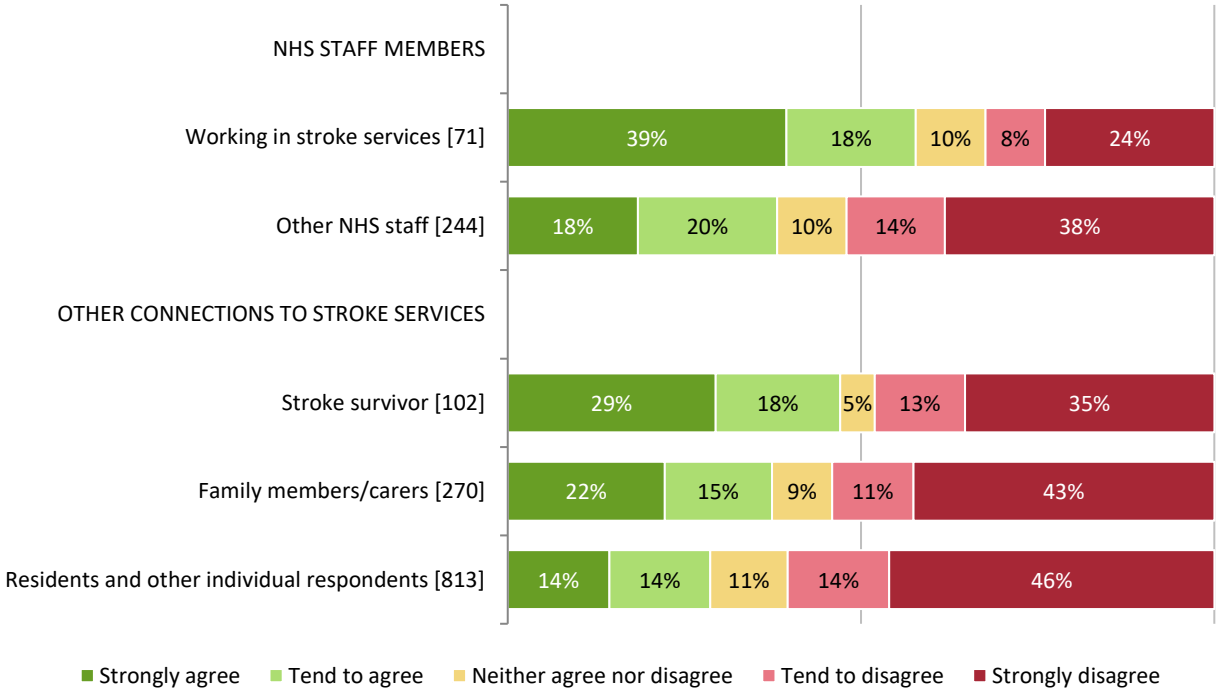
4.56 In response to the question about a location for a HASU, nearly three fifths (58%) of respondents working in NHS stroke services either tended to agree or strongly agreed with the proposal that, if hyper acute stroke services were to be delivered from only one hospital in future, it should be from Musgrove Park Hospital in Taunton (Figure 23 overleaf). Just under one third (32%) of NHS stroke services staff respondents disagreed.

4.57 Other NHS staff members were less positive about the proposed location, however, with less than two-fifths (38%) agreeing with the proposed location compared to more than half (52%) who disagreed. Among non-

staff members, those respondents who identified themselves as stroke survivors had almost evenly split views; nearly half (47%) agreed with the proposed location, while a similar proportion (48%) disagreed.

4.58 Among family members and carers who responded, fewer than four-in-ten (37%) agreed with the proposal, while more half (54%) disagreed. Among residents and other individuals who took part, views were more negative again, with fewer than three out of ten (29%) agreeing with the proposed location for a single HASU, while six out of ten (60%) disagreed.

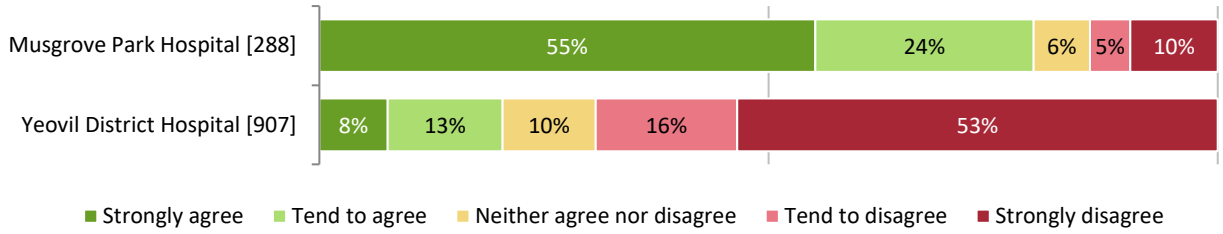
Figure 23: If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton? BY STAKEHOLDER TYPE (individual questionnaire respondents only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.59 Views on the proposed location for a HASU were split geographically (Figure 24 overleaf). Eight-in-ten (80%) respondents (as individuals) living nearest to Musgrove Park Hospital agreed with the proposal that if hyper acute stroke services were to be delivered from only one hospital in future that this should be from Musgrove Park Hospital in Taunton. Those living nearest to Yeovil District Hospital were far less likely to agree with only one-fifth (20%) in agreement and nearly seven-in-ten (69%) disagreeing.

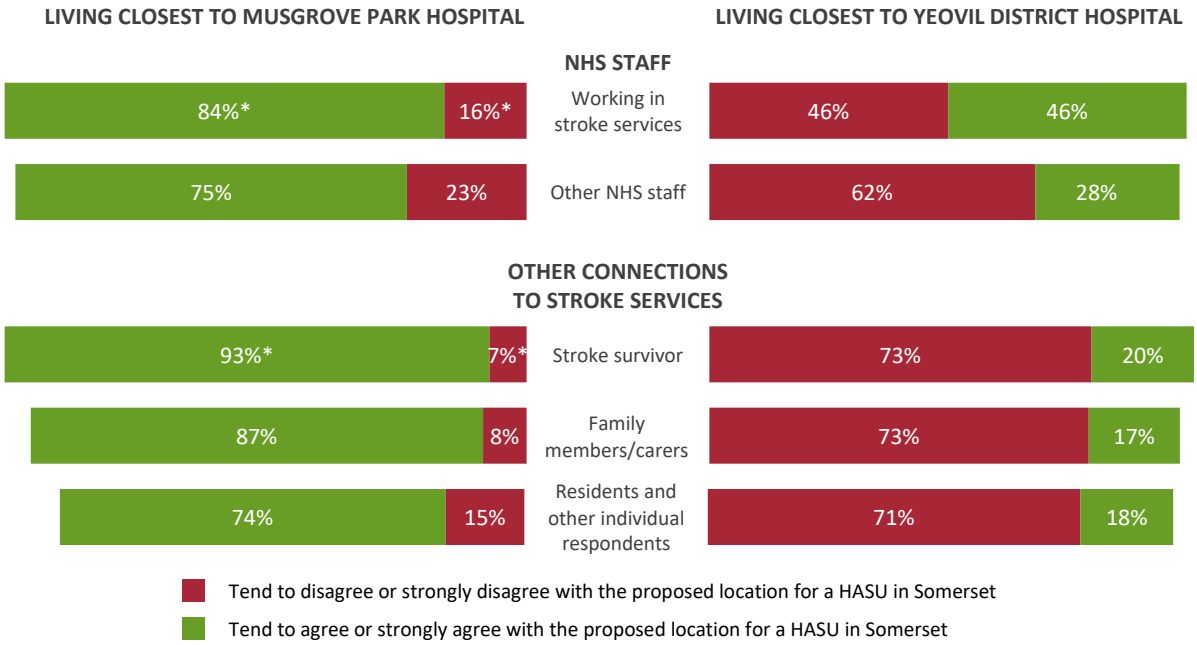
Figure 24: If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton? BY NEAREST STROKE UNIT (individual respondents only, where postcodes were provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.60 It should be noted, however, that NHS stroke services staff living closest to Yeovil District Hospital were far more evenly split in their views on the proposed HASU location than other respondents from the same geographic area (Figure 25).

Figure 25: If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton? BY RESPONDENT TYPE and NEAREST STROKE UNIT (individual respondents only, where postcodes were provided)

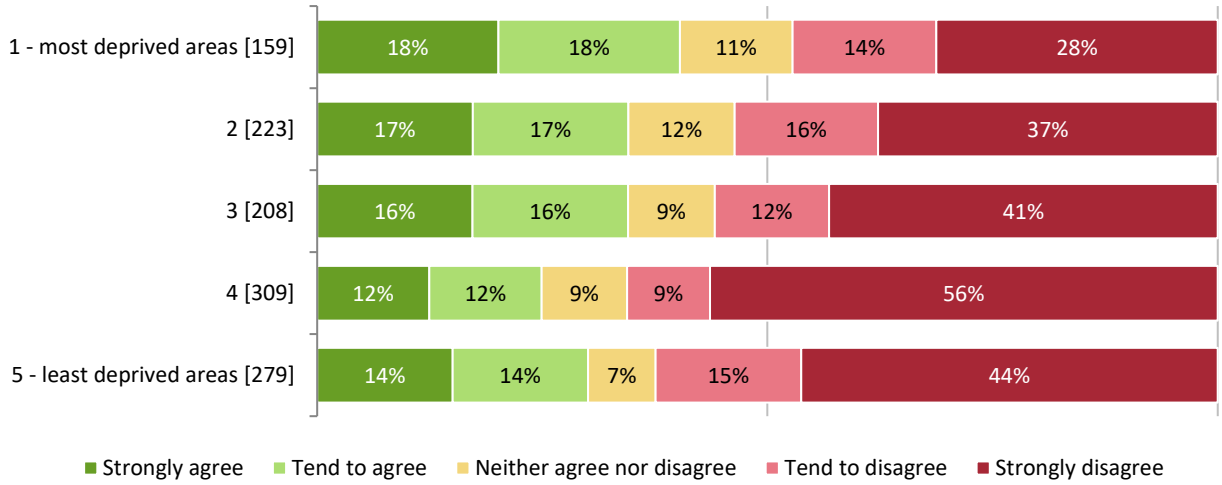


Base: An asterisk (*) indicates low base numbers in that respondent group (<30)

Respondents' views on the proposed location for a HASU, by deprivation

4.61 Figure 26(overleaf) presents all individual questionnaire respondents views on the proposal that if hyper acute stroke services were to be delivered from only one hospital in future, that this should be from Musgrove Park Hospital in Taunton, broken down by IMD quintiles (1 being the most deprived areas within Somerset and surrounding wards, 5 being the least deprived). In the most deprived area, views are reasonably balanced with 46% agreeing and 43% disagreeing, however levels of agreement are lower in less deprived areas.

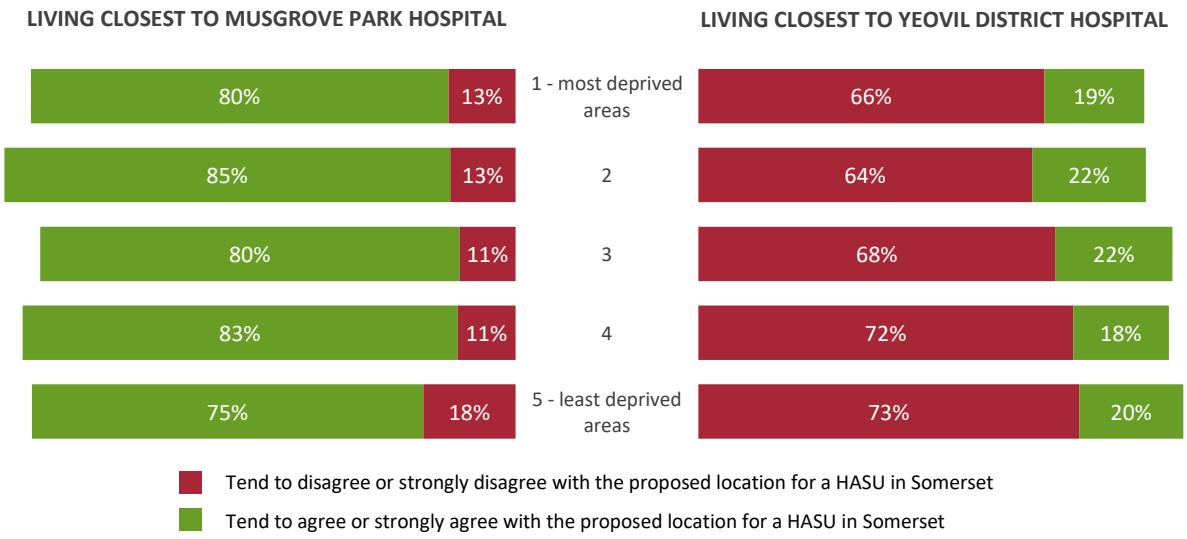
Figure 26: If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton? BY INDICES OF MULTIPLE DEPRIVATION (IMD) (individual respondents only, where postcodes are provided)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.62 Overall, across *all* deprivation quintiles, a substantial majority of respondents living closest to Yeovil District Hospital (Figure 27) *disagreed* with the proposal that a single HASU should be located at Musgrove Park, with only around one-fifth (between 19-22%) indicating that they agreed.

Figure 27: If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton? BY DEPRIVATION and NEAREST STROKE UNIT (individual respondents only, where postcodes were provided)

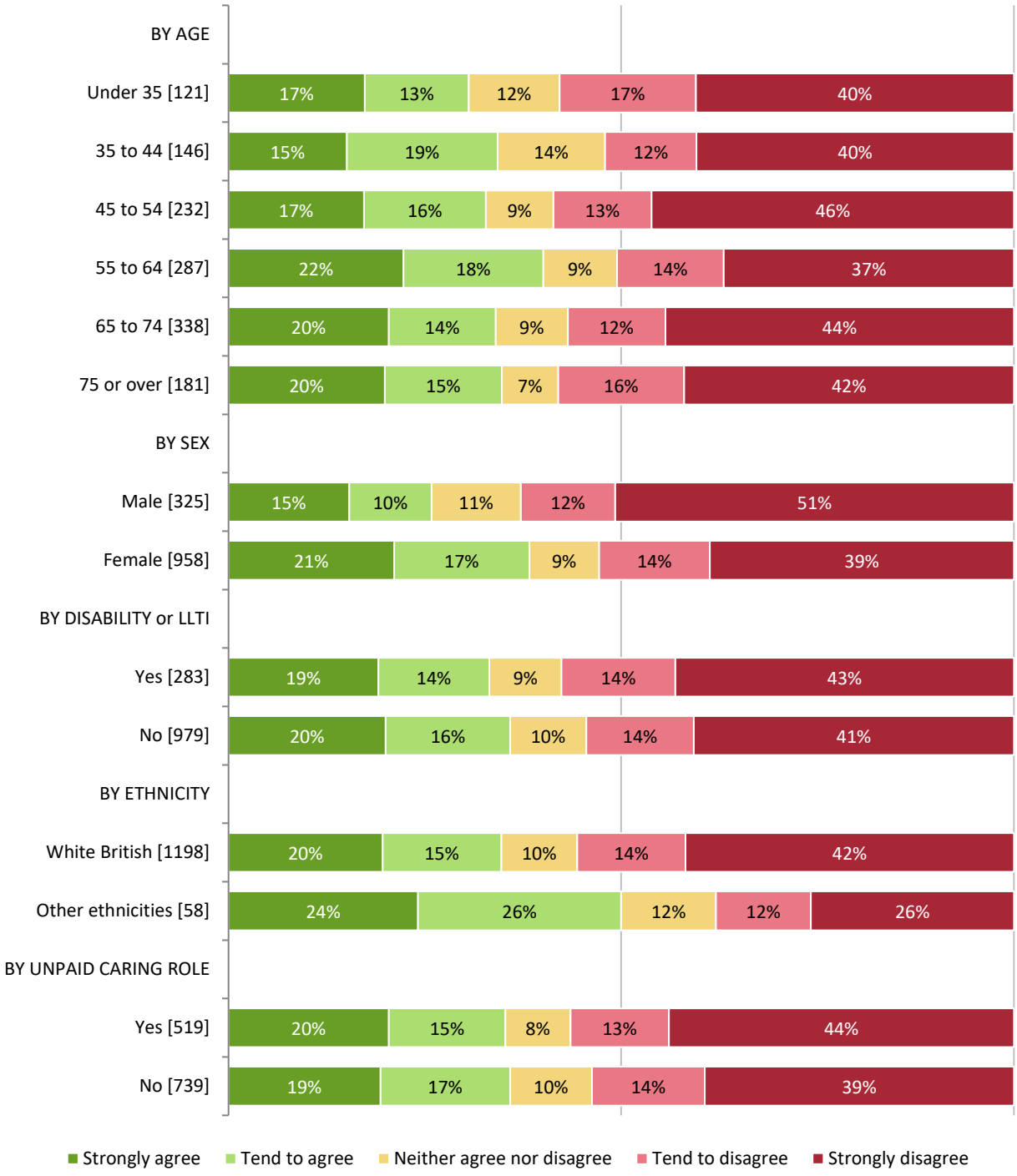


Views on the model of care, by other demographics

4.63 Figure 28 overleaf presents individual questionnaire respondents' views on the proposal that if hyper acute stroke services were to be delivered from only one hospital in future that this should be from Musgrove Park Hospital in Taunton, broken down by key demographics (including protected characteristics such as age, gender, ethnicity etc.). This shows some variation across the groups, with other ethnicities more likely to be in agreement.

Figure 28: If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton?

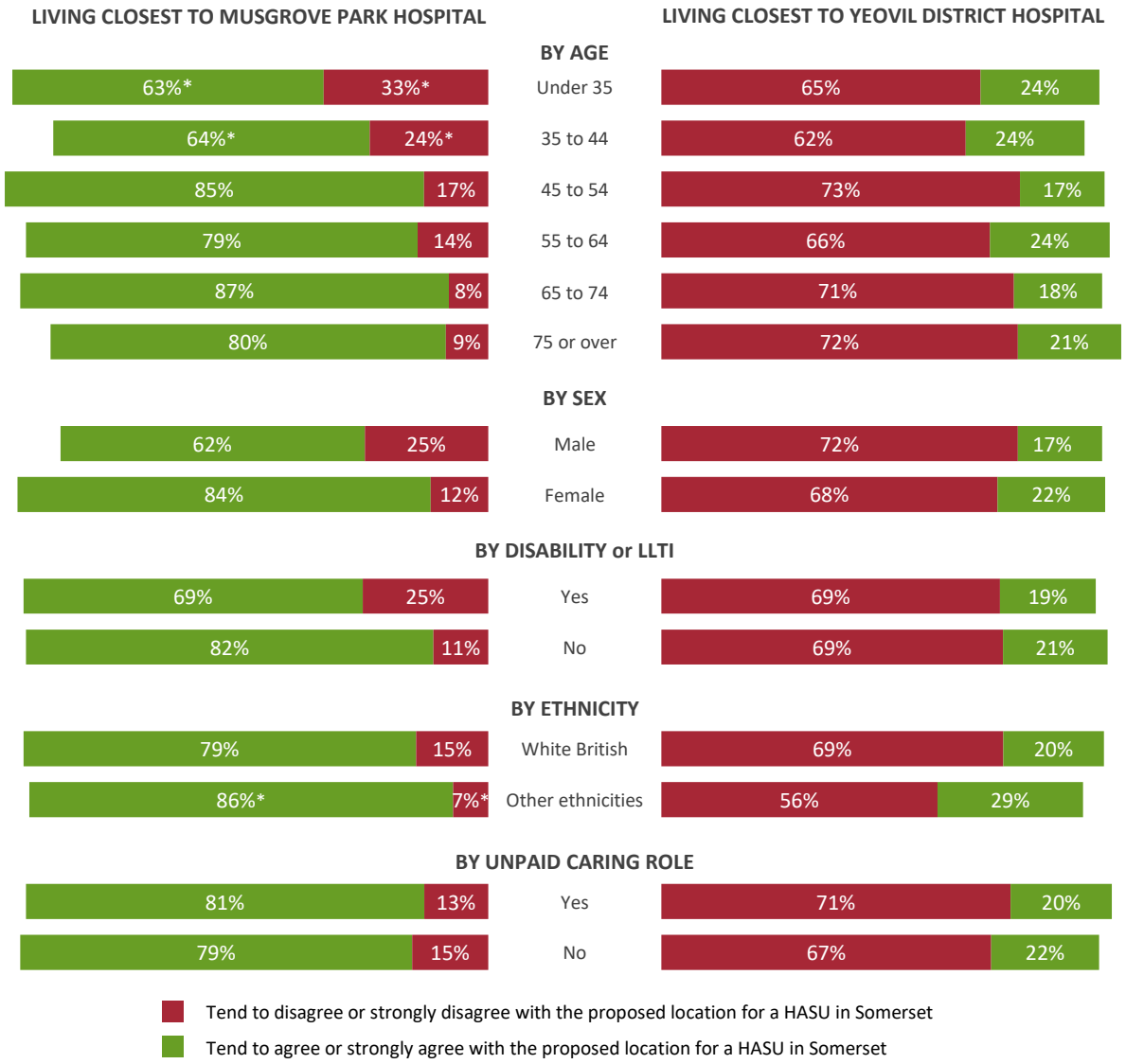
BY KEY DEMOGRAPHICS (individual questionnaire respondents only)



Base: Number of respondents shown in brackets (excludes 'don't know' responses)

4.64 When factoring in geography (Figure 29 overleaf), disagreement across all demographics is high among those respondents living closest to Yeovil District Hospital. Views among respondents living closest to Musgrove Park Hospital are much more positive, but as with the model of care, younger respondents, male respondents, those with long-term illness or disability and those who are White British are less likely to agree with the proposed location, and more likely to disagree, than other demographic groups.

Figure 29: If hyper acute stroke services were to be delivered from only one hospital in future, to what extent do you agree or disagree with the proposal that this should be from Musgrove Park Hospital in Taunton? BY KEY DEMOGRAPHICS and NEAREST STROKE UNIT (individual respondents only, where postcodes were provided)



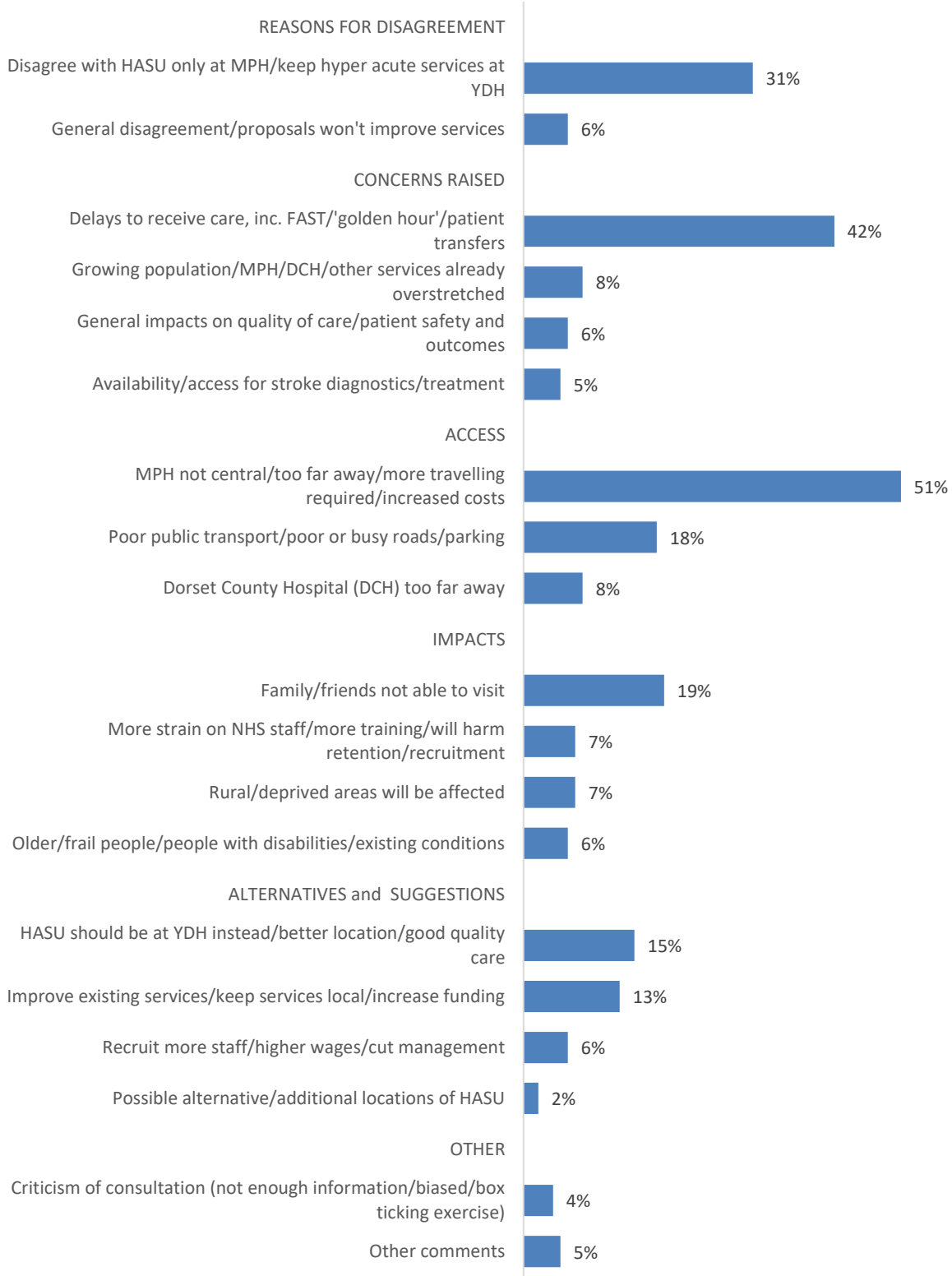
Base: *NB results are marked with an asterisk (*%) are based on extremely low case numbers (<30)

Reasons for disagreeing with the proposed model of care or location for hyper acute stroke services

4.65 Respondents who expressed *disagreement* with either NHS Somerset's proposal to create a single hyper acute stroke unit (HASU) in Somerset, or the proposal to locate that unit at Musgrove Park Hospital in Taunton were invited to provide reasons for their views in an open text box. They were also asked to suggest any alternative solutions or improvements to address the challenges they thought could be considered.

4.66 A summary of responses is provided in Figure 30 (overleaf). The percentages show *the proportion who raised each theme for those responding to this question*. (i.e., the proportion of those who disagreed with the proposal *and* provided feedback to explain why this is the case). Because respondents could provide detailed feedback, some comments cover more than one theme and therefore the total percentages may sum to greater than 100%. In addition to this summary chart, detailed tables of coded text comments can be found in Appendix III of this report for reference.

Figure 30: If you disagree with the proposal to deliver hyper acute stroke services from only one hospital in future, and/or for this to be located at Musgrove Park Hospital in Taunton, please explain the reasons for your views and explain any alternative solutions or improvements to address the challenges that you think should be considered instead (individual questionnaire respondents only)



Base: Individual respondents disagreeing with the proposal to create an Acute Stroke Centre to deliver hospital-based stroke services at only one hospital site in Somerset (819), Themes raised (2,122)

4.67 The vast majority of those who provided comments raised concerns related to the potential impacts of increased journey times to reach an acute stroke unit on patients, visitors and staff members. This included concern that the proposal might put patients at risk if diagnosis and treatment were to be delayed (including references to the 'golden hour' and FAST public health campaign).

4.68 Whilst the above themes cover the majority of points made by respondents in relation to this question, a few comments raised more specific points, some of which are included below for consideration:

"Hyper acute services should be available more locally for patients because it is what patients prefer. Staff shortages are not resolved by combining services; bigger systems do not make for happy staff. Staff that live in Somerset do not want to travel into a big city, pay for parking, be stuck in traffic etc. Treating staff well makes for happy staff, which makes for happier patients, which makes for a good Trust reputation." **[NHS, Stroke Services Staff]**

"It would have a huge disadvantage to the residents of Yeovil and surrounding area which YDH covers to lose the hyper acute unit at YDH. The journey to Taunton from Yeovil is around 45 minutes on a good day. Traffic already in Taunton is a nightmare. Patients' relatives needing to travel to Musgrove would only add to this. This will also have an impact on the residents of Taunton and surrounding areas. When patients have or are suspected of having a TIA or stroke, they are not able to drive. There is not a regular quick bus service that goes to directly to Musgrove from Yeovil. A Taxi to Taunton would cost an extortionate amount of money. There is no direct train route. Money is already extremely tight for many people also and patients may decide not to seek help due to being unable to. […] Many are elderly, frail, do not have relatives to rely on nearby. With regards to ambulances, there are already shortages and delays. If ambulances are travelling to and from MPH taking patients, how is this going to work on an already stretched service? What would happen to self-presenters to Yeovil? What would happen to the TIA clinic? […] would the extra workload from YDH be sustainable? […] When poorly and especially after having a stroke the extra stress on not being in a local hospital, that is familiar to you and where your loved ones can easily visit will have an impact on recovery. Other departments within YDH rely on the Stroke Service for advice, as well as ED and AEC. Not having specialists onsite will have a big impact on them especially ED." **[NHS, Stroke Services Staff]**

"…With the current strain on SWAST, I worry for such a time critical health condition, that potential delays in getting a patient to one centre or being transferred could cause delay to patient care and reduce their chances of full recovery. I also feel that Yeovil hospital for years has had a high-quality stroke service and it would be a shame for this to disappear. Even with Dorset County Hospital taking on a lot more patients I worry Somerset FT would be covering a large geographical area, and I would worry the facilities/resources don't account for this. […] You talk about Musgrove having vascular services etc. but if the patient requires a thrombectomy they would still have to be transferred to Bristol from either site, so that is not a service Musgrove would supply that Yeovil don't." **[Other NHS Staff]**

"…NHS services have a large problem with recruiting and retaining staff which has been discussed as a reason for this change however if you just have one site and recruitment and retention is not addressed then you will struggle to keep this service open. Then there would be no service in Somerset. Musgrove is not easy to get to for patients families and most importantly staff. For registered health care professionals driving to and from Musgrove for shifts from the furthest parts of the county would be expensive and time consuming. 2 units mean less travel for staff." **[Other NHS Staff]**

"…An ageing and increasing population will lead to an increase demand in these services. Ambulances will end up taken out of the Yeovil area and having a knock-on effect for other patients in the South Somerset/North Dorset area. This makes the time and quality of your healthcare more dependent on your postcode which is entirely unfair and borderline immoral. I sincerely hope that those (and their families) who are discussing these decisions aren't on the negative end of these changes." **[Other NHS Staff]**

"…It does not meet 2/4 (safety/quality and increased demand on stroke services) of the key points made on first page. Only planned/routine services should be one site only." **[Other NHS Staff]**

"…Yeovil is a teaching hospital, and the junior doctors will miss out on training and learning opportunities with removal of this service." **[Other NHS Staff]**

"If a single site is to be picked on financial / sustainability grounds it should be located at the site currently producing the best outcomes (bench marked nationally). Vascular surgery as a specialty has very little if any input into the management of acute stroke. Neurology has limited input. I believe the number of patient transfers from Yeovil to Taunton for these services is minimal. […] A key factor might be the availability of interventional radiology (currently in Taunton). Presumably consolidating the service at Taunton will allow truly "state of the art care" - i.e., timely thrombectomy. Currently patients have to go to Bristol for this - an example of the rural "postcode lottery" disadvantaging the local Somerset population." **[Other NHS Staff]**

"Musgrove Park is already exceeding its capacity and declares OPEL 4 regularly as it is. This change will just add fuel to the fire and will cost patients their lives…" **[Other NHS Staff]**

"If there is recruitment problems now with both hospitals it doesn't mean having the service at one site, MPH, will mean staffing will be better. People choose where they work, staff at Yeovil won't necessarily transfer to work at MPH, the driving to Taunton is a strain on an already long working day. Staff may just leave causing more staff shortages." **[Other NHS Staff]**

"Disagree should just be Taunton or Dorchester as the wait for community beds is so high people will be backlogged in these areas. […] I do agree that Dorset should go to Dorchester due to the difficulties of moving into Dorset pathways from Somerset. Working often on the RTG units a lot of the stroke pathway for Dorset end up here which is not a neuro specialist service." **[Other NHS Staff]**

"Work for the ambulance service. Would cause a delay in treatment for members of the public that live further away. Potentially dangerous for patients requiring airway management/patients having seizures or requiring critical care input. Difficulty in decision making for Paramedics when patients present with less clear-cut symptoms. Prolonged length of call duration/journey time and taking ambulances out of area on an already well overstretched service. Creating the necessity to provide emergency secondary transfers to patients that self-present at a local ED without stroke services on an already stretched ambulance service. Longer blue light journeys for ambulances, which are more dangerous for patients, ambulance crew members and other drivers." **[Other NHS Staff]**

"…technology advances over the last decade will accelerate and allow consultant full data from remote centres. My experience was stroke at 10pm, treatment in the nearest hospital with specialist nurses available 24 hrs and consultant at home with full access to MRI and 2-way video into booth in A&E. Documentation on proposal shows that specialist stroke consultant would not be onsite 7/24 so remote access would still be required, and new treatments would seem to need consultant level knowledge." **[Stroke Survivor]**

"…Please consider investing in a mobile acute stroke unit as can be found in other Scandinavian countries or consider having reduced hours outreach centres maintained in Yeovil so some lifesaving care can be administered quickly prior to getting the patient to the Taunton unit…" **[Resident Living in Somerset]**

"No easy answer, of course, but a solution could be to deploy specialised stroke ambulances. These specially equipped ambulances can scan the patient as soon as they arrive. The scan can be analysed remotely, and appropriate treatment can commence immediately. The solution is used all over Europe […] and have been shown to dramatically improve stroke outcomes…" **[Resident Living in Somerset]**

"We must be looking at tackling inequalities, my worry of moving service to one area we increase the inequalities. My next point is employment of suitably qualified and experienced staff will be critical to the outcomes achieved for the population, and I would need assurance on the confidence of the healthcare providers to be able to employ/attract staff with the expertise required. My worry after the briefing last week was that the staff were not willing to transfer, making the situation worse with less staff and the lack of public transport to get the staff to Taunton. If they don't drive, how are you going to solve this issue? It's important, that the analysis of travel times, which was done before the additional pressure within the system, is stress tested to ensure ambulance and travel times remain within the required times to relay to the nearest hyperacute stroke unit. I also recommend that that a new Equality Impact assessment is carried out." **[Other Connection]**

4.69 Some respondents who mentioned having lost loved ones as a result of stroke, in their comments, spoke of the importance of being able to visit the hospital and the challenges of facing a longer journey. One recalled being able to arrange visits on a daily basis to Yeovil District Hospital during their parent's last few weeks of life and contrasted that with a family member only being able to visit their spouse once during a three-week stay in Musgrove Park Hospital because of the difficult journey by public transport.

Respondents' views on delivery of *acute* stroke services in Somerset

4.70 Following sections of the questionnaire about the proposed model of care and location for delivery of *hyper* acute stroke services, respondents were asked: IF HYPER acute stroke services were to be delivered from only one hospital in future, do you think ACUTE stroke care should be provided...

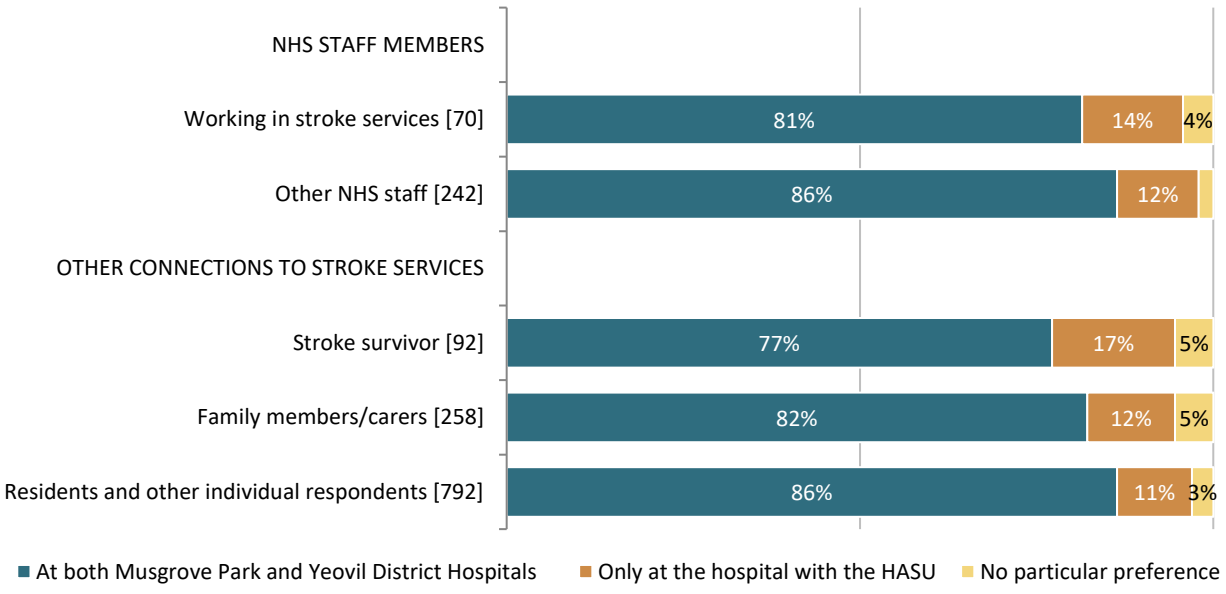
- At both Musgrove Park and Yeovil District Hospitals?
- Only at the hospital with the hyper acute stroke unit?
- No particular preference.

4.71 Just over four-fifths (81%) of respondents working in NHS stroke services thought acute stroke care should be provided at both Musgrove Park and Yeovil District Hospitals if hyper acute stroke services were to be delivered from only one hospital in future (Figure 31), and an ever higher proportion (86%) of other NHS staff members felt the same way. Much smaller proportions thought acute stroke care should be provided only at the hospital with the hyper acute stroke unit (14% and 12% respectively).

4.72 Among stroke survivors who responded, just over three quarters (77%) thought ACUTE stroke care should be provided at both Musgrove Park and Yeovil District Hospitals, with 17% thinking it should be provided only at the hospital with the hyper acute stroke unit.

4.73 More than four-fifths of family members or carers and other individual respondents thought it should be provided at both hospitals (82% and 86% respectively), with over one-in-ten of these stakeholder groups thinking it should be provided only at the hospital with the hyper acute stroke unit (12% and 11% respectively). Just 5% or less across all stakeholder groups had no particular preference for the location of acute stroke care.

Figure 31: IF HYPER acute stroke services were to be delivered from only one hospital in future, do you think ACUTE stroke care should be provided…? BY STAKEHOLDER TYPE (individual questionnaire respondents only)



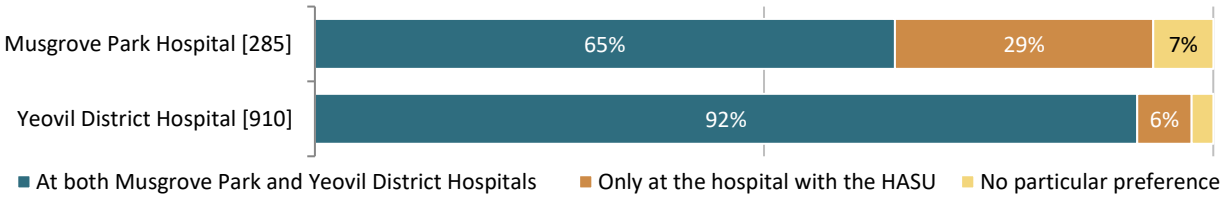
Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Respondents' views on delivery of *acute* stroke services in Somerset by geography

4.74 Just under two-thirds (65%) of those living nearest to Musgrove Park Hospital, and more than nine-in-ten of those living closest to Yeovil District Hospital thought acute stroke care should be provided at both Musgrove Park and Yeovil District Hospitals (Figure 32).

4.75 Just under three-in-ten (29%) of those nearest to Musgrove Park Hospital thought that acute stroke care should only be provided at the hospital with the hyper acute stroke unit, while fewer than only one-in-twenty (6%) respondents living nearest to Yeovil District Hospital thought this. Only a small proportion in either area expressed no particular preference.

Figure 32: IF HYPER acute stroke services were to be delivered from only one hospital in future, do you think ACUTE stroke care should be provided…? BY NEAREST CURRENT SOMERSET STROKE UNIT (individual questionnaire respondents only)



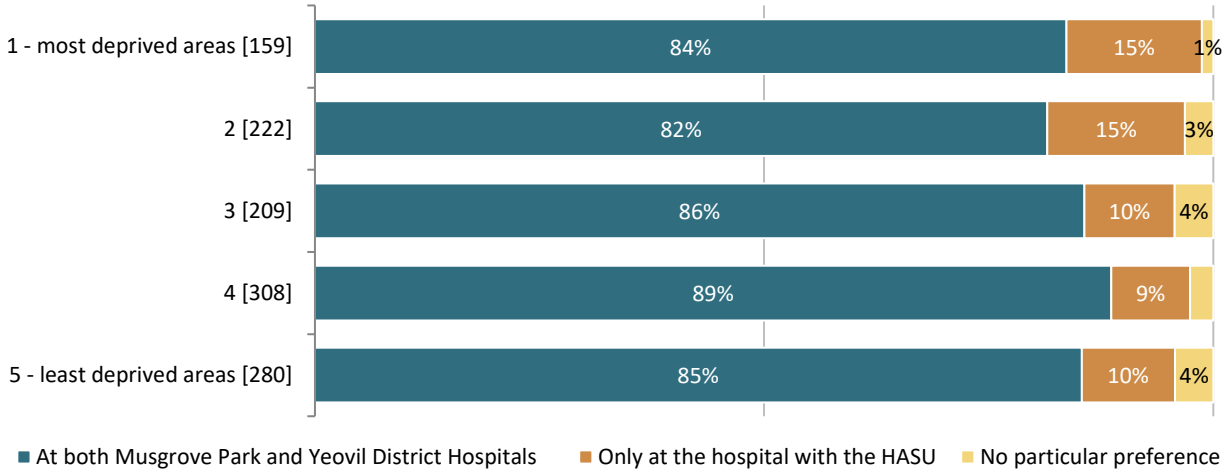
Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Respondents' views on delivery of *acute* stroke services in Somerset by deprivation

4.76 Figure 33 presents all individual questionnaire respondents views on where acute stroke care should be provided if hyper acute stroke services were to be delivered from only one hospital in future, broken down by IMD quintiles (1 being the most deprived areas within Somerset and surrounding wards, 5 being the least deprived).

4.77 Those in the more deprived areas are slightly more likely to think it should only be provided at the hospital with the hyper acute stroke services (15%), this compares to one-in-ten (10%) in the least deprived quintile. 4% or less across all quintiles had no particular preference for the location of acute stroke care.

Figure 33: IF HYPER acute stroke services were to be delivered from only one hospital in future, do you think ACUTE stroke care should be provided…? BY INDICES OF MULTIPLE DEPRIVATION (IMD) (individual respondents, where postcodes are provided)

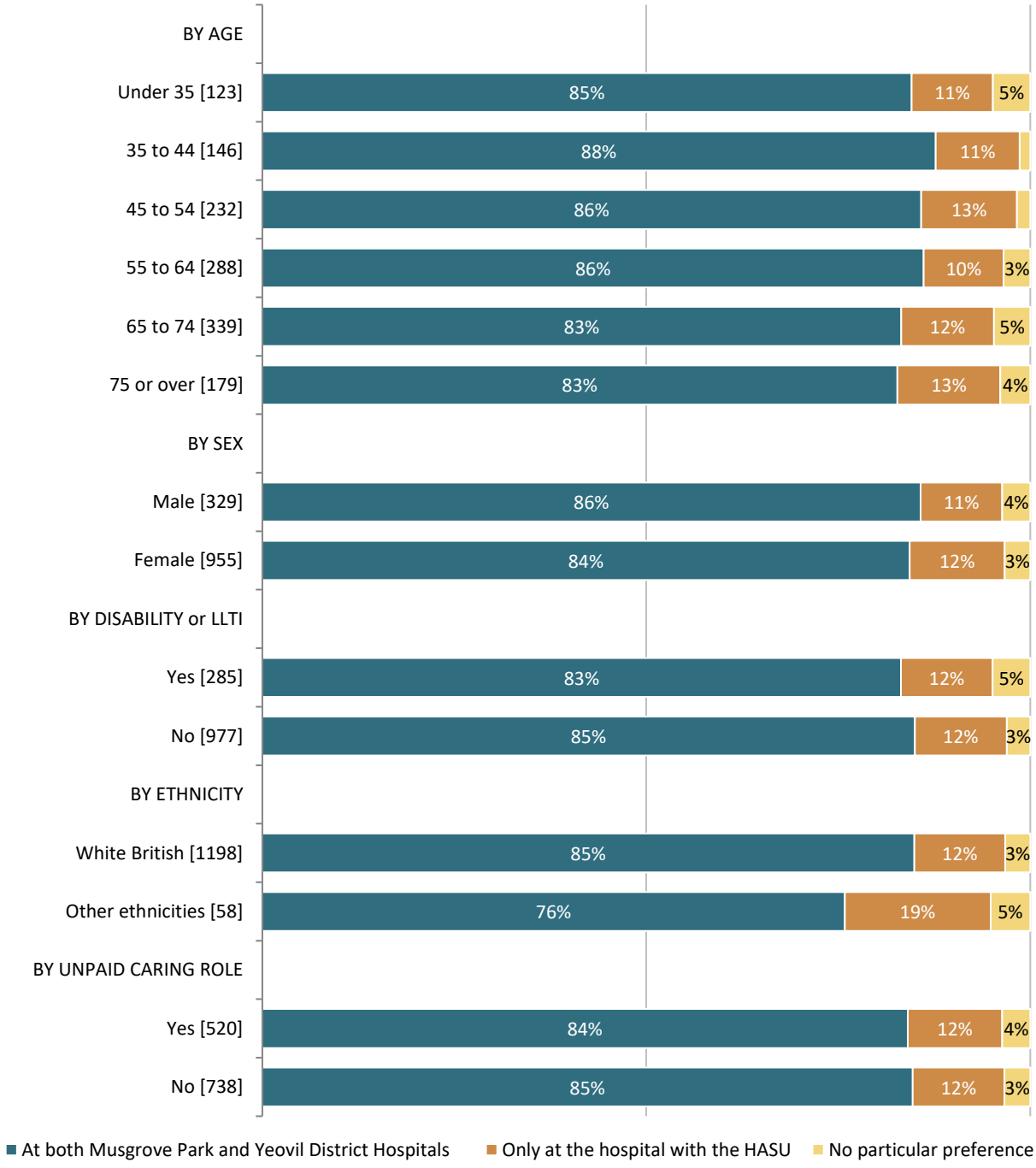


Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Respondents' views on delivery of *acute* stroke services in Somerset by deprivation

4.78 Figure 34 overleaf presents individual questionnaire respondents' views on where acute stroke care should be provided if hyper acute stroke services were to be delivered from only one hospital in future, broken down by key demographics (including protected characteristics such as age, gender, ethnicity etc.). This shows some variation across the groups, with other ethnicities more likely to think it should be located only at the hospital with the hyper acute stroke unit.

Figure 34: IF HYPER acute stroke services were to be delivered from only one hospital in future, do you think ACUTE stroke care should be provided…? BY KEY DEMOGRAPHICS (individual questionnaire respondents only)



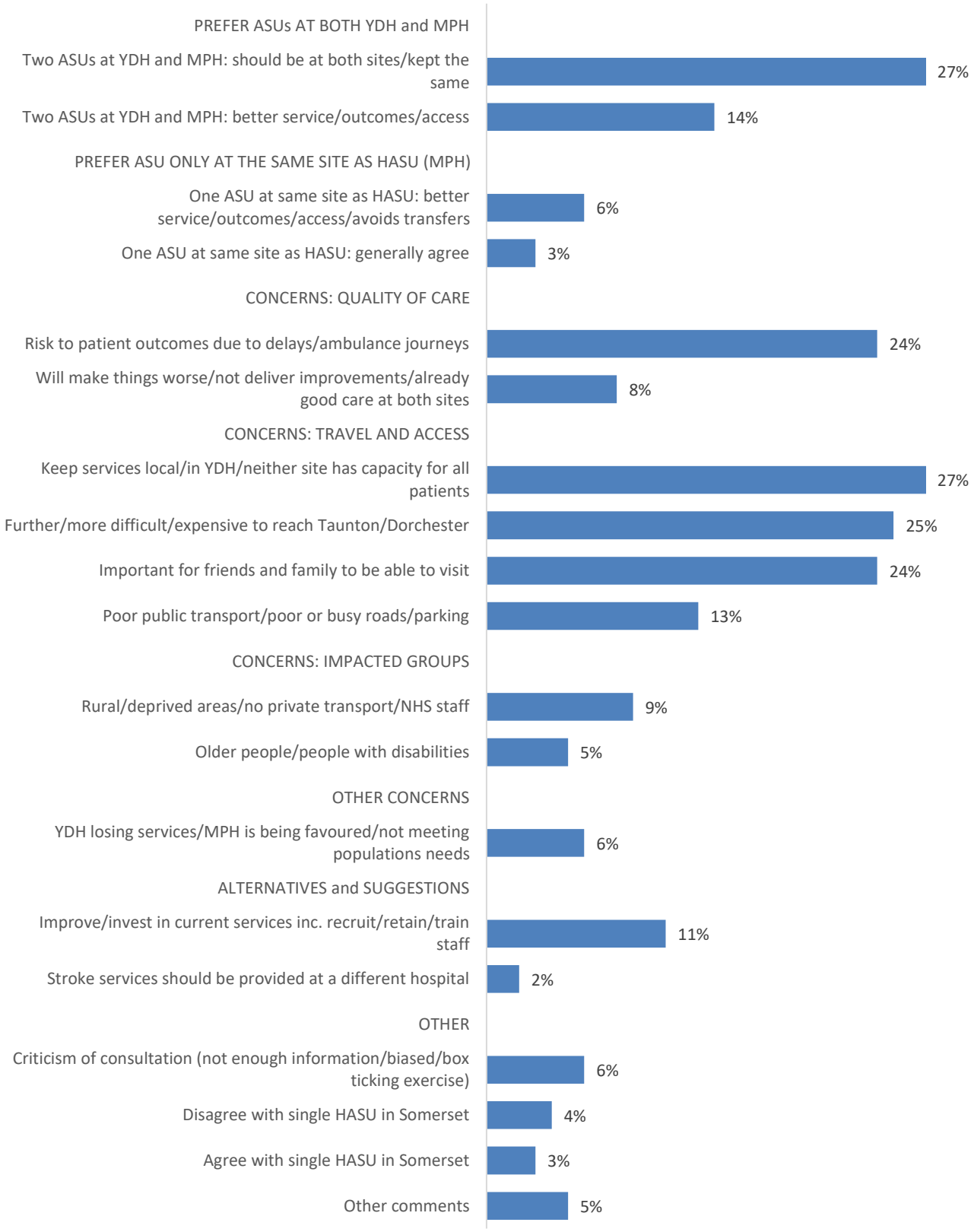
Base: Number of respondents shown in brackets (excludes 'don't know' responses)

Reasons for respondents' views on approaches to *acute* stroke services in Somerset

4.79 In addition to being asked if HYPER acute stroke services were to be delivered from only one hospital in future, where they think ACUTE stroke care should be provided, respondents were given an opportunity to explain the reasons for their preference. They were also asked to suggest any alternative solutions or improvements to address the challenges they thought could be considered instead.

4.80 A summary of responses is provided in Figure 35 (overleaf). The percentages show *the proportion who raised each theme for those responding to this question*. Because respondents could provide detailed feedback, some comments cover more than one theme and therefore the total percentages may sum to greater than 100%. In addition to this summary chart, detailed tables of coded text comments can be found in Appendix III of this report for reference.

Figure 35: If you have a preference, please explain why. If you have any other comments about acute stroke services or alternative suggestions on how the challenges affecting acute stroke services could be addressed (taking into account the other options which have been considered), please explain here (individual questionnaire respondents only)



Base: Individual respondents (731), Themes raised (1,627)

4.81 The vast majority of those who provided comments raised wanting to keep services local and the potential impacts of increased journey times to reach an acute stroke unit on patients, visitors and staff members. This included concern that the proposal might put patients at risk if diagnosis and treatment were to be delayed.

4.82 This reflects that most individuals responding to the questionnaire think acute stroke care should be provided at both Musgrove and Yeovil District Hospitals if hyper acute stroke services were to be delivered from only one hospital in future. A few comments raised more specific points behind the different choices to the question of where to locate acute stroke services:

» For those thinking preferring that acute stroke care be provided at Both Musgrove Park and Yeovil District Hospitals

"Having a community stroke team, would help to prevent a number of hospital admissions…" **[NHS, Stroke Services Staff]**

"…ASU in two sites should […] aid bed flow freeing up HASU beds more quickly." **[NHS, Stroke Services Staff]**

"I work in stroke at Yeovil, I have trained for years to specialise. What will happen to my job?" **[NHS, Stroke Services Staff]**

"…Each hospital has close links with their local community services (both formal & voluntary) so patients will be better supported on discharge if their hyper acute & acute care is in a hospital as near to their home as possible to ensure effective communication with community teams to ensure best continuity of care & support on discharge." **[Other NHS Staff]**

"As a member of staff at Yeovil hospital - we have countless thrombolysis calls from the wards. I worry that if we had no acute services then these patients risk a delay in treatment and risk a possible worse outcome compared to if the acute services were available at both hospitals. […] It would have a big effect on other departments in Musgrove – it would increase demand for radiology examinations, physiotherapy, speech and language therapy – are all these areas going to be given additional staff/resources/support to deal with a large increase in workload in what is already a stretched NHS?" **[Other NHS Staff]**

"… Not all patients have a stroke despite symptoms. Will one hospital cope with this amount of referred patients? What will YDH become without specialist stroke teams? Will YDH still be expected to scan patients before they are transferred without all the funding into their radiology department for staff and scanners? Radiology is often forgotten despite being such an important part in diagnosing strokes." **[Other NHS Staff]**

"…This would ensure specialist stroke doctors and nurses are retained at both locations, should patients walk in as I did. Having a stroke places huge strain not only on the patient but the wider family, travelling further increases the stress and be financially prohibitive for some families, so in turn the patient would receive no support or visits from family or friends. Retaining 2 stroke facilities also provides overflow solution and would ensure there is still a recovery flow process for patients that are nearer to Yeovil. It is not always wise to put all your eggs in one basket, as the recent covid pandemic has shown us hospitals can quickly become over run and if you retain 2 acute stroke locations, isolation for patients would be easier. With regards to obtaining and retaining sufficient numbers of specialist stroke care givers, I suggest you pay them a fair living wage and then fewer care givers would feel the need to leave the NHS…" **[Stroke Survivor]**

"Being nearer to home for longer term needs to be met within a hospital is preferable for extended family and easier for visiting and support as well as being present if doctors or nursing staff are passing on information. Staff skill sets are also better improved and lead to wider understanding and awareness that leads to more holistic and interconnected nursing skill sets." **[Carer/Family Member of a Stroke Survivor]**

"Musgrove Park is too far away for stroke patients in South and East Somerset, particularly in the absence of available ambulances when family members are asked to drive suspected stroke patients to the hospital themselves (which has happened on both occasions for me and also happened to two colleagues who have had strokes at work) …" **[Carer/Family Member of a Stroke Survivor]**

"Travelling with a stroke affected person is difficult and long journeys can be especially troublesome." **[Carer/Family Member of a Stroke Survivor]**

"…Goes against the Trusts environmental policies for the extra travel, lack of public transport to Musgrove…" **[Resident Living in Somerset]**

"Closer to home is better for patients and relatives. Coordinating discharge plans from Dorchester would be a nightmare for social services in terms of organising care, and for OT services for equipment and adaptations." **[Resident Living in Somerset]**

"Having no specialist staff in an entire hospital can cause questions to be missed, proving catastrophic to some." **[Resident Living in Somerset]**

"Information from specialist staff can also be shared over the Internet via video links." **[Resident Living in Somerset]**

"Knowledge and skills shared across both Trusts will be beneficial to all patients – moving staff with particular skills to just one site reduces the shared learning and support for staff at the other site, likely to worsen patient outcomes. As both Trusts will be under the same management, there should be no reason a staff rotation cannot be used to continue to allow staff on both sites to support and upskill colleagues across both sites." **[Resident Living in Somerset]**

» For those preferring that acute care be provided only at the hospital with the hyper acute stroke unit

"Adding in transfers between hospitals always adds in risk – errors happen regularly when the patient is clerked into the new hospital and new notes and drug charts are made." **[Other NHS Staff]**

"I'm concerned that A&E services at Musgrove Park Hospital would be affected. It isn't unusual to have patients waiting over 12 hours in A&E for a bed. Without significant improvements to patient flow, bed establishment and space/staffing in A&E, this may make things worse (unless patients bypass A&E altogether and ambulances go directly to the stroke unit – although the contingency for when this is full would need to be considered)." **[Other NHS Staff]**

"In view of the problems the NHS is facing across all areas it seems sensible to focus specialist care in at one venue. If that is to be the case, then the choice of Taunton would seem to make sense because of its more central location and proximity to better transport links. However, in view of the importance of swift intervention ambulance response times, diagnosis and admission procedures would need to be much improved." **[Stroke Survivor]**

"One centre of excellence focused totally on acute stroke services must be more constructive to patient recovery." **[Carer/Family Member of a Stroke Survivor]**

"I think it is best to centralise specialist care at one centre. However, I would want some assurances that the paramedic crews have the necessary competencies to decide the optimum location for their patients." **[Resident Living in Somerset]**

"I think that although it would be nice to have acute stroke services in both locations, the reality with competence of enough staff to manage two acute units has to be taken into consideration. If hyper acute and acute services were consolidated onto one site, this would mean staffing targets may be met and the expertise of staff working in that one unit could be guaranteed. I would prefer 24/7 services that could meet acute needs in one place rather than a Monday - Friday 9-5 option. This would give stroke sufferers more likelihood of good outcomes. This will cause travel issues for those living in Yeovil but many of the patients here may go to Dorset anyway as this is the closest hyper acute service." **[Resident Living in Somerset]**

"Less patient transfers and better continuity of care. More likely to be able to properly staff the acute service if at same place as hyper acute. In summary - best chance of the best medical care for the patient (although not so for the emotional care as will make it difficult for visitors of from other side of county - perhaps there needs to be an initiative to provide more hospital visiting services staffed by volunteers)" **[Resident Living in Somerset]**

"While Yeovil is a small training hospital, that supports a large area, most doctors/ medical staff move to further specialize in their chosen field to support people. Generally, most people understand, living in and around Yeovil Musgrove or Bristol, is where complex care is provided. As a carer I have spent 10yrs travelling to Bristol Eye clinic and Taunton Eye clinic, so I have experience, on attending appointments, cost and time. The public need to be educated to fully understand the benefits, unless you have fallen ill, or supporting a loved one, there is a lot of ignorance and bad press, for the NHS, which is such a shame, as it is world class first service across these 3 settings that I have been involved with. Providing more beds are available at the Musgrove setting, if the trust can work alongside Dorset trust, it is a step in the right direction. If Yeovil residents are able to access Dorchester, this makes sense, as both settings have more onsite facilities, and will have the staffing and consultancies to put together individual care package and recovery care. Again, providing beds are made available, to support demand, definitely a step forward in planning complex care." **[Resident Living in Somerset]**

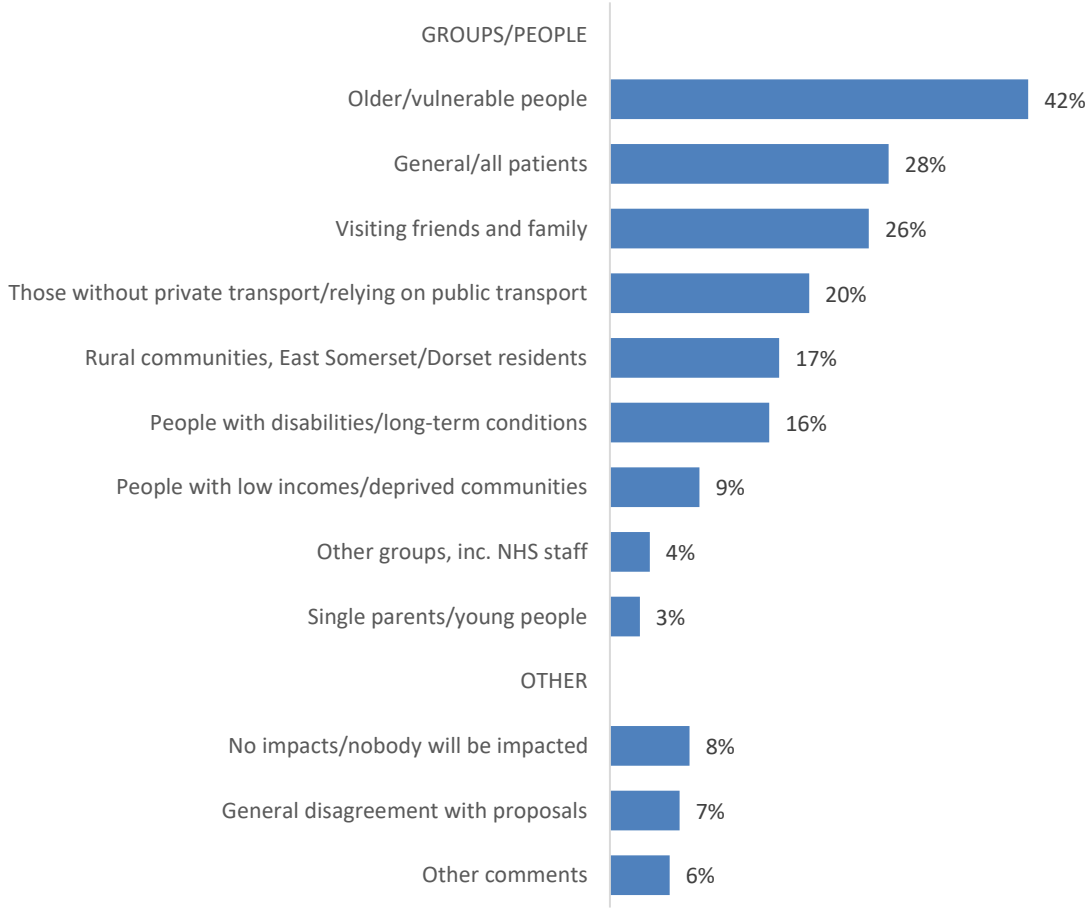
» For those not expressing a preference

"The consultation paper and this question assert "need" without stating why two things are linked or what alternatives have been considered. There is no reassurance that the proposals have been made with due regard to bias and vested interests. I would have expected an introduction which says, studies have shown that this is safe for all patients and does not adversely affect the population currently treated by YDH. I've seen no assertion of safe outcomes, equalities impact or mention of the large holiday traffic and flood prone arteries." **[Resident Living in Somerset]**

Respondents views on potential impacts and mitigations

4.83 All questionnaire respondents were invited to identify any groups or people that they believed might be positively or negatively affected by the proposed changes and to explain how any positive impacts might be enhanced or negative impacts reduced. Figure 36 summarises the groups/people identified while Figure 37 highlights the types of positive/negative impacts that were stated in the same comments, and how they might be mitigated. The full table of coded text comments can be found in Appendix III of this report for reference.

Figure 36: Are there any particular groups or people that you believe might be positively or negatively affected by any of the possible changes to services being considered, including the need to travel further? If so, what groups are these? (individual questionnaire respondents only)



Base: Individual respondents (876), Comments made (1,666)
(Percentages based on the number raising each group/people, as a proportion of all respondents who provided comments to this question, note that respondents could provide comments which covered more than one group/people and therefore the percentages may sum to greater than 100%)

4.84 Over two-fifths (42%) of individual respondents who provided comments identified older/vulnerable people as a group they believed might be positively or negatively affected by the proposed changes. Nearly three-in-ten (28%) provided comments that they believed affected all patients or were more general about the potential impacts raised. Just over a quarter (26%) identified impacts on those visiting friends and family.

4.85 A few comments raised more specific points about the groups/people they believed might be positively or negatively affected by the proposed changes, some of which are included below for consideration:

"I don't think that you have adequately considered the impact of the proposed changes on the RUH Bath. There are patients who live between Shepton Mallet and Yeovil who will live nearer to Bath than to Taunton or Dorchester who will end up in Bath. For example, patients in Bruton, Evercreech, Castle Cary as the ambulance crews in the area just to the north in Shepton Mallet and the rest of the Mendip area are familiar with the RUH Bath and much less so with Dorset County. You have involved Dorset County with the plans and the consultation, but I see no evidence of involvement with the RUH. It would be reassuring if the RUH Bath were also supportive of the plans. If the RUH Bath isn't expecting additional stroke patients from Somerset, then Somerset patients could suffer." **[Other NHS Staff]**

"Housebound, those dependant on hospital transport or ambulance for safe transfer in medical emergency." **[Other NHS Staff]**

"How are the views of the patients with a learning disability and or autism captured? How are reasonable adjustments met for these patients? Thinking of the elderly and other members of my family circle I know that they would all prefer to be cared for in a hospital that they know and have supported and would not understand or wish to manage the effects of having to travel a long distance to another location. How are their needs going to be accommodated? Will there be any assistance for travel etc.?" **[Other NHS Staff]**

"Patients, the most important people, but also staff who are highly trained, and have dedicated their careers to the success of the stroke team." **[Other NHS Staff]**

"People living alone with certain disabilities or mental illnesses that are not able to or are too afraid to call emergency services straight away will have to wait a further 40/50 minutes to get to the chosen hospital." **[Other NHS Staff]**

"Yes, normal every day working class people, the elderly and vulnerable, those without transport, those without a close family support network, those financially struggling, those that are sick which are the very people it is aimed at." **[Other NHS Staff]**

"As Somerset is a diverse area to live in, there may be some people that are negatively impacted by the move of Stroke services to one site, e.g. individuals from overseas who don't hold a UK driving license, single parents who struggle to get support with childcare to enable them to travel to see loved ones in care and individuals with disabilities having to travel much further afield to visit family affected by a Stroke who again, may not have a method of getting to locations so far away." **[Other NHS Staff]**

"Those who have limited means of transportation. Like us, we are immigrants here, me and my partner only rely on each other to look after our kids. The proximity of the hospital to our home is very important since we do not have the luxury of childcare or a relative to help us with our kids. Those frail and old couples who only have each other, it is detrimental for their well-being knowing that their spouse was hospitalised, and they can't even travel to be by their side." **[Other NHS Staff]**

"I believe that this consultation process discriminates against groups including older age and disabled people, who are less likely to have access to online services; stroke patients themselves, who may have trouble reading and/or understanding the text of this consultation, and/or using the keyboard to compose a reply; and those of minority ethnic or immigrant backgrounds for whom English may not be first language. I would like to challenge the decision makers in this process to state explicitly what steps they have taken to engage these groups who, as the more likely service users, are vital stakeholders in the process." **[Other NHS Staff]**

"Non-drivers would be very seriously inconvenienced (and stroke patients are frequently forbidden to drive for a time after a stroke). For example, it is extremely difficult to get to Taunton by public transport from Martock where I live." **[Carer/Family Member of a Stroke Survivor]**

"I believe the farming community who consist of a high percentage of persons of a senior age and thus more likely to be effected by stroke and of necessity of their profession tend to reside in isolation. These are key workers and should not have their access to stroke services reduced." **[Resident Living in Somerset]**

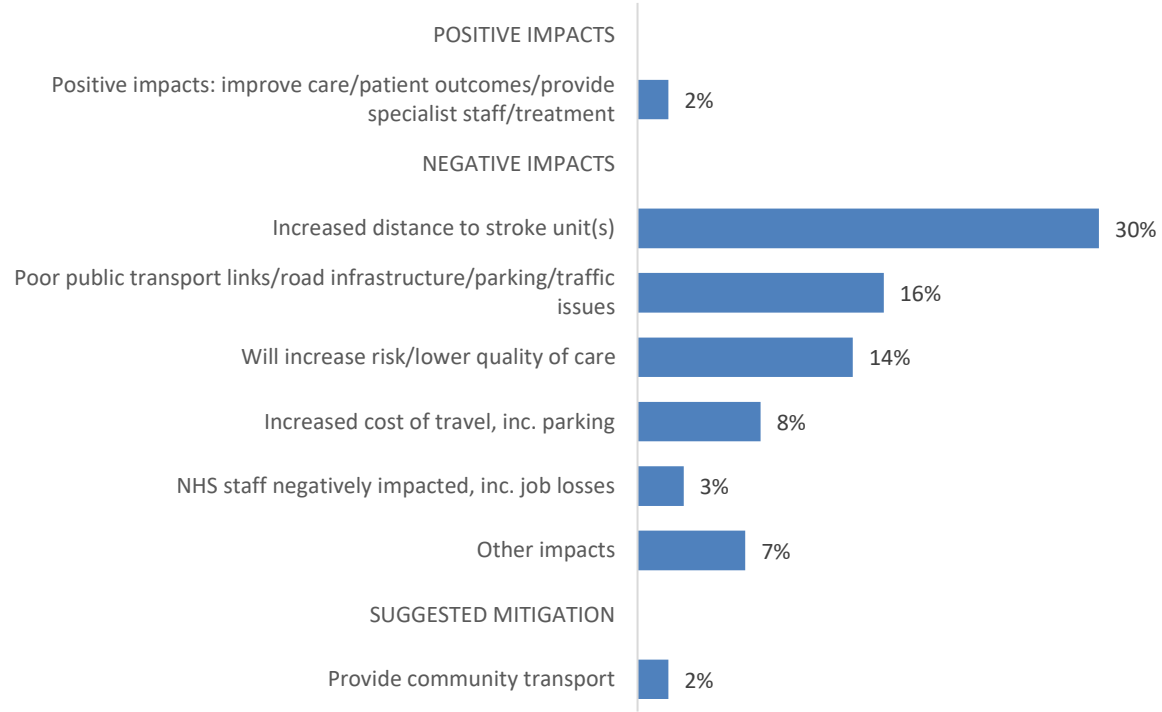
"Neurodiverse people with fear of leaving their locality." **[Resident Living in Somerset]**

"Young stroke patients in particular may have a better long-term outcome if treated at one highly specialised hyper acute centre. However, I worry that already frail stroke patients may have less chance of survival if they have to travel many more miles to be assessed and treatment started asap." **[Resident Living Outside of Somerset]**

"Some who can't travel i.e., disabled and older will have further to travel if services are transferred to one hospital. Musgrove will need to update their attitudes and understanding of mental capacity so as not to discriminate against certain patient groups. The care and attitudes are outdated at times." **[Other Connection]**

4.86 It is also worth noting that over 30 paper questionnaires were received from the Westfield estate in Yeovil, an area of deprivation. As with other respondents from Yeovil, the majority expressed disagreement with the proposed model of care and location for *hyper* acute stroke services, citing concerns about delays to treatment and difficulties for both patients and family members in reaching a more distant stroke unit. With regard to *acute* stroke services, respondents from the Westfield estate in Yeovil strongly supported delivery from ASUs at both Musgrove Park and Yeovil District Hospitals.

Figure 37: Types of impacts suggested by respondents in response to the same question (individual questionnaire respondents only)



Base: Individual respondents (876), Positive/Negative Impacts raised (1,306)
(Percentages based on the number raising each positive/negative impact, as a proportion of all respondents who provided comments to this question, note that respondents could provide comments which covered more than one positive/negative impact and therefore the percentages may sum to greater than 100%)

4.87 The majority of those individual respondents raising comments identified potential impacts that were negative as a result of the possible changes. Three-in-ten (30%) raised an increased distance to the stroke unit as a potential negative impact, 16% noted about poor public transport and issues facing those travelling by car and around one-in-seven (14%) believed the plans might increase risk to the patient and lower the quality of care. Only 2% raised a comment noting a positive impact the plans might have on the mentioned groups/people by improving care and outcomes and 2% suggested that providing community transport might mitigate some of the concerns raised.

4.88 A few comments raised more specific points about the positive/negative impacts for the identified groups/people they believed might be affected by the proposed changes, some of which are included below for consideration:

"Because of the rural nature of Somerset, families may struggle to see the patient, however excellence of care should outweigh this. If necessary, help and provision of modern media, FaceTime or similar, would help with this. However, if families cannot visit, they cannot do patients' clothes washing. This may be a required facility within the unit because this can be distressing for both the patient and their family." **[NHS, Stroke Services Staff]**

"Research opportunities for patients will need to be coordinated and increased at Musgrove Park. Yeovil has the highest recruitment of stroke patients to hyper acute studies in the South West Clinical Research Network. The new service will need to ensure there are equal opportunities for patients across the county and that patients are not disadvantaged." **[Other NHS Staff]**

"Patient's families regarding transport and visiting. For patients the distance and public transport availability (perhaps a shuttle service between hospitals or community transport for patients, staff and family?). Regarding staff, distance to work and public transport etc." **[Stroke Survivor]**

"Carers who do not have transport will have more difficult travelling out of area. Disabled people who do not have transport will also have greater difficulty. What bus and train routes are available? What accommodation will be available for carers? BAME -what language /diversity experts will be available? Those on benefits, including carers will have extra costs getting to Dorchester if travelling from rural areas. How will you support them, so they are not out of pocket? Will there be an interhospital bus service (this applies to staff too)?" **[Carer/Family Member of a Stroke Survivor]**

"Disabled- reduced or more difficult to access services as a patient or carer. Carers - more difficult to arrange time to access the services or support the person you care for. Older people- it is really important that when a patient is unwell or confused that they have someone there to advocate for them and to provide the essential information that medical staff need to know. That means that the location of the service needs to also be accessible for the family member/advocator so as not to disadvantage the patient." **[Carer/Family Member of a Stroke Survivor]**

"We have an ever-increasing elderly population myself included, I am often being called to take members of the British Legion to hospital and sadly there is more demand and fewer people able to do this. Especially concerned about Dementia patients whose carer's are often also very elderly and have more than enough to deal with, any changes to routine causing increasing problems for both." **[Carer/Family Member of a Stroke Survivor]**

Questionnaire feedback from organisations

4.89 All four organisations agreed that NHS Somerset need to make changes to respond to these challenges. Two agreed strongly and two tended to agree.

4.90 There were a mix of opinions with the proposal to deliver hyper acute stroke services from only one hospital site in future. One organisation agreed strongly, one tended to agree, one tended to disagree and the other disagreed strongly.

4.91 There was a similar split in opinion on the proposal that if hyper acute stroke services were to be delivered from only one hospital in future that this should be from Musgrove Park Hospital in Taunton, with two organisations tending to agree and two tending to disagree.

> *"Somerset is a large rural area with very limited public transport. In addition, there are ambulance waiting times and distances travelled. As I know from running my own service, I have resisted centralisation strongly and instead we have grown and trained and supported our own staff in order to provide a localised service. Even then it is still over an hour to our 'local' office. In addition, with this issue, you have vulnerable people and their relatives not being able to get to outpatients especially if they don't qualify for help. This proposal makes it much harder for domestic abuse victims, who may be being coerced and controlled to get to appointments if they have to be dependent on their partner to drive them there rather than having a more accessible service. In addition, prisoners are ageing - and 20% of prisoners are now sexual offenders. Research tells us that prison ages a person roughly by 10 years and they will be at much higher risk of stroke. A number of these people may be excluded from Taunton and not permitted under their licences to travel there, or Dorchester. Having a service in Yeovil and Taunton means the needs of all citizens are addressed. In addition, for Probation we don't want anyone who is in fear of crime or carrying out crime to travel great distances, this means they may travel with their victims, especially if they are not well off, and it all means greater chance for disruptions. In a wider context. this proposal may be fine for big conurbations or for example people within easy reach of Bristol to have a centralised service. But for rural areas, it increases suffering and anxiety and means it is less likely people will seek treatment - all things which are absolutely not desired in a stroke victim."* **[Organisation]**

4.92 All four organisations thought ACUTE stroke care should be provided at both Musgrove Park and Yeovil District Hospitals if HYPER acute stroke services were to be delivered from only one hospital in future.

> *"This is because I think it would be to the patients' benefit in Somerset. I understand the clinical reasons alone for a centralisation programme - and the staffing - but there are other factors to take into account in a rural area, and the risks in other parameters would increase by centralisation. Plus, if there were sufficient resources for ambulance services, and public transport - decent buses and train services between Taunton and Yeovil - that would be different, but there aren't. Not being able to recruit staff is not a reason to change the service which would work for patients. A strategy needs to be put in place to address that separately. Also, with a significantly ageing population in Somerset, a two-centre operation brings a contingency planning element. For example, in a pandemic."* **[Organisation]**

"For families who have a member in either Hyper Acute Units in Taunton or Dorchester there are considerable advantages for visiting if the facility for the follow-up Acute Stroke Care was also located in Yeovil. That is for hospital transfer after Hyper Acute stage. For those without a car, the public transport to Dorchester and Taunton is practically non-existent from and to most parts of North Dorset. The cost of private Taxi hire might well prove beyond reach because of the increased distances and such Car Schemes as may exist in North Dorset would be limited in assisting because of the severe lack of Volunteer Drivers and their inability to provide Family Visitor Journeys. Existing Stroke Staffing in Yeovil may well not be able to transfer their jobs and skills to any Stroke units in Taunton and such skill, though limited in numbers may be irretrievably lost. Parking facilities in Taunton and Yeovil Hospitals are far better than in Dorchester where off-site parking is a long walk to the Hospital site." **[Organisation]**

4.93 All questionnaire respondents were invited to identify any groups or people they believed might be positively or negatively affected by the proposed changes and to explain how any positive impacts might be enhanced or negative impacts reduced. Comments from organisations included:

"Elderly people who live in MINEHEAD or on Exmoor, on fixed incomes are already being negatively affected by the amount of travelling to the main hospitals." **[Organisation]**

"Yes, people on probation, victims of crime, (again could have both offenders and victims visiting the same stroke clinic if only one and they both live far away from Dorchester). People living in rural areas. People excluded who are in rural poverty. People where there is no public transport to Taunton. Already marginalised and poor groups who don't take up access to health care and other services as it is and are often at higher risk of stroke than others." **[Organisation]**

5. Qualitative engagement activities

Introduction

5.1 To further explore the views and concerns raised in consultation feedback, ORS conducted 17 'deliberative' or 'qualitative' engagement activities with smaller groups of stakeholders: two focus groups with residents; and nine individual interviews with stroke survivors/service users, with a focus on residents with protected characteristics and/or impacted by health inequalities. We also undertook a joint organisation interview and four stroke staff/volunteer interviews. Overall, we spoke to 25 participants in depth.

5.2 Taken together, these engagements are best understood as 'deliberative' discussions in which NHS Somerset's proposals for hyper acute and acute stroke units were 'tested' against staff, service users', and other stakeholders' opinions. In this context, it is important to note that the four staff members and one volunteer we spoke to were all based at YDH.

5.3 This provided an opportunity to explore the extent to which the proposals are acceptable or otherwise, and to understand in more detail the issues, arguments, considerations, implications, assumptions, and experiences related to proposals; this feedback from a range of stakeholders provides valuable insights to be considered, alongside all other evidence, by those making decisions.

Summary of main findings

The need for change

5.4 While there was positive feedback on current stroke services, participants also recognised the challenges facing stroke services as identified by NHS Somerset, **and there was broad agreement with the need for change to improve future services.**

5.5 Somerset's ageing population was recognised as placing increasing strain on services that are already restricted due to a limited specialist stroke workforce. Everyone considered the lack of 24/7 specialist clinical cover to be a challenge that should be remedied as a priority so that treatment can be provided quickly.

5.6 Staff members from YDH challenged the statement that the current stroke unit does not see the minimum recommended number of patients, with some suggesting that the figures used may have been lower than usual because of the impact of the COVID-19 pandemic on services.

Hyper Acute Stroke Services: the proposal for one Somerset HASU at Musgrove Park Hospital (MPH), Taunton

5.7 There was positive feedback on the proposed model of care for hyper acute stroke services from most participants, who saw it as having potential to improve efficiency and quality of care. The prospect of 24/7 hyper acute care from specialist staff was viewed especially positively.

5.8 Concerns were raised about the potential impacts of increased journey times on patient outcomes; there was, however, recognition of the benefits of getting stroke patients to the right place with the right equipment and expertise, and that this could be delivered through a single HASU.

5.9 YDH staff members generally agreed that having one HASU providing 24/7 consultant-led specialist care was positive. However, they did raise some concerns, including:

- The possible 'de-skilling' of stroke staff at YDH;
- National challenges around staffing, including potential difficulties recruiting new consultants as specified in the proposal; and
- Not delivering hyper acute stroke care at YDH could have negative impacts on surrounding hospitals such as Dorset County Hospital in Dorchester.

Option A: delivering *acute* stroke care from ASUs at both Somerset hospitals

5.10 The option to continue to deliver *acute* stroke care from ASUs at both YDH and MPH in Taunton was generally viewed positively by participants. Most agreed that **acute stroke care should continue to be delivered as locally as possible** so that:

- The family and friends of stroke patients closer to or in Yeovil could visit easily, benefitting patients' mental health and recovery; and
- Yeovil-area patients would find it easier to attend outpatient appointments, while having to travel further could decrease attendance and take-up of recovery activities.

5.11 Retaining staff expertise in stroke services at both hospitals (including knowledge of local support organisations) was considered a benefit of this option,. Furthermore, some felt that an ASU at YDH would ease pressure on MPH, which is already busy due to having other specialist centres.

Option B: a single ASU located alongside the proposed HASU at MPH, Taunton

5.12 **Feedback was mixed** on the option to co-locate *one* ASU in Somerset alongside the proposed HASU at MPH:

- Those who felt it would be beneficial to have both units in one place considered it an opportunity to streamline and therefore improve the quality of services whilst making the best use of specialist stroke staff; and
- Those who disagreed with this option felt that the longer and more costly journeys for patients, family and friends would have negative impacts on mental health, causing stress and adversely affecting recovery.

Methodology

5.13 Designed to complement the other consultation strands covered in this report, the deliberative activities were used as an opportunity to explore in more depth the themes arising from public meetings, open consultation questionnaire and residents telephone survey, as well as to discuss service users' additional considerations based on their experiences of using existing services.

Participants

5.14 Members of the public were invited to express interest in in-depth engagement via local community and stakeholder organisations, and via 'recontact' questions in the telephone residents survey. To ensure representation, participants from different geographic areas and demographic groups were selected to take

part, including groups identified in NHS Somerset's equality impact assessment, while also ensuring that there was a mixture of views on the proposed changes.

5.15 As part of their wider engagement with NHS staff, NHS Somerset invited members from the stroke teams at YDH and MPH to participate in interviews with the ORS research team to discuss the proposals in depth. ORS undertook four individual interviews with Yeovil District Hospital stroke service staff members and a volunteer.

5.16 Finally, NHS Somerset contacted representatives of organisations working with individuals and communities across Somerset who might be particularly impacted by the proposed changes (as identified in the equality impact assessment) to promote the consultation and provide feedback themselves. In addition to feedback received in writing, via the questionnaire and at the events and activities undertaken by NHS Somerset, representatives of two organisations took part in interviews with ORS researchers.

5.17 A brief summary of those who took part is shown below:

ONLINE FOCUS GROUPS (27th and 28th March 2023)
Nine participants in two groups, including stroke survivors and family members aged 25-65, from West Somerset and Taunton, Sedgemoor, South Somerset, Dorset and Bridgewater.
VIDEO AND TELEPHONE INTERVIEWS
NHS Somerset specialist stroke nurses, clinical ward staff, rehab stroke staff and a volunteer (five interviewees in total)
Stroke survivors and family members (seven interviewees)
A retired GP
Representatives of Headway (an organisation working with people with acquired brain injuries, including stroke)[4]
Representative of a local Learning Disabilities Specialist Health Team

5.18 Focus groups and interviews took place online using video conferencing software (Zoom or Microsoft Teams) and by telephone[5]. All deliberative research activities followed a similar format, beginning with a brief summary of the proposals and the need for change, with an opportunity to ask questions for clarification. Following this, participants took part in semi-structured discussions around the rationale for the proposed changes, the potential benefits and impacts, and mitigations and alternative suggestions for service improvements.

5.19 Interviews typically lasted 30 to 60 minutes and focus groups around 90 minutes to two hours. In recognition of their contribution and the time required to participate, *members of the public* who took part in in-depth engagement activities facilitated by ORS each received a gift voucher.

Analysis and reporting

5.20 Decision-makers will wish to consider the nature and strength of the issues raised by participants, particularly so in this case when those taking part represent or are part of distinct groups and geographies. Attempting

[4] Headway representatives had gathered views from the rest of their organisation, especially colleagues working in Somerset before participating in the interview

[5] Face-to-face engagement with stroke survivors, carers and the general public was undertaken by NHS Somerset and is covered in other sections of this report

to determine a "balance of opinion" would be unreliable, and each viewpoint must be considered on its own merit.

5.21 In analysing and reporting the feedback from deliberative discussions, ORS has identified key themes and concerns, explored in detail below and illustrated - where appropriate - by verbatim quotes. It should be noted that, by including quotes, ORS neither endorses these views nor suggests that they are more important or significant than other feedback. Rather, they illustrate commonly held views and differences in opinions, and highlight feedback about key issues, e.g., potential equalities and health-inequalities impacts.

Views on the need for change

There was broad agreement among service users, staff members, and stakeholders that there is a need for change, and that challenges around the delivery of hyper acute and acute stroke services in Somerset should be addressed

5.22 Across the deliberative activities, there was broad recognition that change is required within stroke services at Musgrove Park and Yeovil District hospitals. However, during the service user focus groups and the staff interviews, it was highlighted that that some of the current challenges with recruiting and retaining specialist stroke staff are nationwide issues, and not unique to Somerset. It was thus suggested that the proposals may not be able to wholly remedy the situation. Indeed, a couple of participants felt strongly that higher wages are the only solution.

> *"We don't have the consultant cover across the county. There is a national shortage of consultants anyway, and it's really hard to recruit nationally."* ***Stroke Nurse***

5.23 The current lack of 24/7 consultant cover within stroke services was a cause of real concern among many service users. All considered this to be a main driver for change and felt that hyper acute stroke units especially should be available at all times given the unpredictable nature of stroke.

> *"When I first heard about them not having enough cover on certain days when people have a stroke it was mind boggling."* ***NHS Volunteer / Stroke Survivor***
>
> *"It has to be open 24/7. You can't have stroke units closed; they need to be open at any point."* ***Stroke Survivor***

5.24 Stroke staff members disputed NHS Somerset's statement that the number of patients attending YDH's stroke unit does not currently meet the minimum required by national guidelines.

> *"That baffles me, because we take a lot of patients from Dorset as well because we're so close to Dorset. We do actually see a good number of stroke patients I would say. At least every day there are two to three admissions, and that would be a quiet day for the nurses."* ***Stroke staff***

5.25 It was suggested that COVID-19 was the main reason for lower numbers of patients and the site not meeting targets, rather than a lack of need.

5.26 Service users also commented on patient numbers, with some suggesting that the rurality and geography of Somerset means that there are less people generally, meaning an inability to meet nationally-set minimum patient numbers.

5.27 Overall, participants agreed that the combination of a current lack of 24/7 cover and limited specialist workforce means that treatments are not being provided quickly enough to some patients. A few described how they or a loved one had to wait hours to be seen by a consultant, and said that the need to rectify this is an important factor driving the need for change.

Views on the proposals

One HASU at MPH, Taunton

There was positive feedback on the model of care for hyper-acute stroke services; participants saw that having one HASU in Somerset could improve efficiency and quality of care for patients requiring the most specialist care

5.28 The proposal to consolidate hyper acute stroke services (i.e., those offered during the first 72 hours following a stroke) at one HASU in Somerset was generally viewed positively. In light of this, participants were often keen to move on to discuss locations and the ASU proposals, meaning there is less feedback around this aspect compared to the following ASU discussions.

5.29 Typically, service users, families/carers, and other stakeholders felt that having specialist staff in one unit 24/7 would lead to shorter waiting times and give patients the best opportunity for recovery.

> *"It's just having someone there when you go there, specialist clinicians 24/7. As we all know, the initial help you get can make the difference between life or death really."* ***NHS Volunteer / Stroke Survivor***

5.30 Stroke staff agreed, seeing benefits to having one 'centre of excellence' and ensuring patients have access to the best possible care.

> *"To receive the best care, to have whoever had a stroke to get them to the best outcome they can have – be it medicine, thrombectomy, I get it they've got to go to the right place. They've got to have the best care they can have."* ***Stroke Nurse***

It was recognised that having one busier unit would be beneficial to staff in terms of maintaining their skills in specialised procedures

5.31 People were concerned that quality of care could decline if staff are not seeing enough patients and regularly performing highly technical procedures. It was suggested that consolidating hyper acute stroke services at one unit would mitigate against this.

> *"I personally would rather be in a centre of excellence if I'm in a critical health situation because I want to be treated by someone who did four of those procedures the previous day and 25 the previous week."* ***Stroke Survivor***

"If you're not seeing it, you don't know how to give it. You're not confident with it, you get more nervous. […] We're going to have nurses who don't feel confident doing that and then we're going to have risks for patients." ***Stroke Ward Staff***

5.32 It was also felt that one HASU would improve workforce recruitment and retention, as staff would be attracted to work at a specialist centre with the requisite equipment and infrastructure.

"You can recruit and retain specialist staff if they know they're going to be working for the centre of excellence in Somerset and they're seeing enough people to make it worthwhile. It can't be a bad thing." ***Stroke Survivor***

5.33 A few participants, however, were worried about whether the proposed single HASU would really be a 24/7 unit, citing potential ongoing issues with recruitment and staffing.

"If they need to provide a 24-hour service now, I don't see that by combining resources they are going to run a 24 hour care system ***Stroke Survivor***

"Where are they going to get these eight consultants from when they've got two and one is retiring soon? ..." ***NHS Volunteer / Stroke Survivor***

"What wasn't really clear to me was if you're going to have most of the stroke services in one area, how do you know you can definitely recruit there? Taunton is not far from Yeovil, so why is it easier to recruit in Taunton than Yeovil? They're so close together." ***Stroke Survivor***

5.34 One interviewee expressed concern that the proposals might be based on an assumption that current hyper acute staff at YDH would automatically agree to transferring to MPH. They suggested that impacts on current staff have not been sufficiently considered and that the proposed changes might lead to YDH staff leaving their positions.

"It's interesting that they've not put that a negative would be staff having to move sites. There's literally not a thought about [current YDH] staff wellbeing at all." ***Stroke Staff***

Concern was expressed about MPH's capacity to treat more stroke patients

5.35 It was recognised that the proposals for hyper acute care would mean that stroke patients are taken to their closest HASU, which could be outside Somerset (i.e., DCH, Dorchester). As such, a HASU at MPH would not be treating all Somerset patients.

5.36 There were concerns, however, that the site at MPH could become overrun and unable to cope with the increase in patient numbers, in terms of both infrastructure and capacity.

"They [MPH] were very understaffed, and they were working so hard on the wards, and the ward was absolutely rammed in every cubicle. But they were doing their best." ***Stroke Survivor***

5.37 The current shortage of ambulances and paramedics was also raised, and some participants felt that having only one HASU in Somerset could cause Musgrove to become a 'bottleneck' and delay treatment.

Some concerns were expressed about travel and access to one hyper-acute site, and the impacts this might have

5.38 Some people felt that locating the HASU in Taunton could disadvantage those living in Yeovil and further south or west as they would have to travel longer and further to hospital. This, it was said, could cut into the '72-hour window' for critical treatment, and ultimately impact on outcomes. The geography and rurality of Somerset was mentioned in this context, with some suggestion that 30-40 minutes could be added on to some people's journey times.

> *"The risks I'm talking about are the risks I've seen in practice [elsewhere] and where it's gone wrong. They do scare me ... I've seen patients miss their thrombolysis window and sadly not recover from their stroke because of geography, and I think that's a horrendous reason someone should lose their life."* ***Stroke Staff***

5.39 Some, however, felt that this increase in distance and time is less important than ensuring patients are in the best place to receive the best possible care. It was argued that the added travel time would not impact outcomes providing that when a patient arrived at the HASU they were seen quickly, and by the right people.

> *"It's a blue light ambulance job anyway – the distance isn't important if you get better care. When you're in the ambulance you just want to get to wherever will give you the best chance."* ***Stroke Survivor***

5.40 Longer travel times for some friends and family to visit patients during the hyper acute stage were also considered a negative impact of the HASU proposal. Concerns were two-fold: firstly, the extra stress on patients' loved ones in trying to access MPH via busy main roads, sparse public transport, or incurring expensive taxis and parking costs, was noted.

> *"You go and see your loved one when they have had a stroke. You see them that day and the day after and the day after while they are still in the hyper-acute care. That is just not feasible for so many people if you take Yeovil out of the mix."* ***Stroke Survivor***

5.41 Secondly, longer travel times for loved ones would, it was felt, have a detrimental effect on patients' outcomes if they prove to be a barrier to them visiting. Many service users highlighted that having visitors had made a significant positive difference to their mental health and their recovery. All participating staff and organisations also said that having loved ones close by is a clinically proven benefit, and that anything that potentially prevents this would be detrimental.

> *"What I think is important is mental health, and the mental health of the patients not being stuck, in Musgrove Park if their partners can't drive and they can't get visitors."* ***Stroke Nurse***

5.42 It was felt that people from rural villages would feel the effects of this more keenly due to a lack of transport options, especially more elderly and isolated residents. This is discussed in further detail in later sections of this chapter.

5.43 The potential for travel impacts on staff members was also raised. Some said that travelling from Yeovil to Taunton would be time-consuming at peak times and that the significant increase to their daily commute could lead staff to consider leaving the Trust.

> *"Transport links are appalling across the county, so if they insist on consolidation of services, they must keep at least two acute stroke centres as this would be yet another devastating blow to neuro provision otherwise."* ***Headway***

Views on Option A: ASUs at *both* Somerset hospitals

The option to retain an ASU in Yeovil and Taunton was generally viewed positively. Most agreed that keeping stroke staff expertise at both hospitals would be beneficial

5.44 Most staff members and service users felt that keeping an ASU at YDH would be beneficial in ensuring staff are available locally to support stroke patients.

5.45 If there were only a single ASU at MPH, many residents and other people suffering strokes in Somerset (e.g. tourists), may not know of the need to travel to Taunton or Dorchester, and may inadvertently assume they could be treated at Yeovil. As such, it was considered advantageous to retain a ASU at YDH to provide some expertise and care prior to a patient being transferred to a hyper acute unit.

> *"They need urgent diagnosis and support, and not everybody is going to have read about going straight to Taunton. I think they need to have somebody who has done the first aid course in stroke at Yeovil."* ***Stroke Survivor***

5.46 It was also felt that if someone had a stroke while an inpatient at YDH, having stroke staff to hand would be positive for them.

> *"If a patient has a TIA or a stroke whilst in Yeovil there still needs to be staff there who can help them then before transporting them up to Musgrove."* ***Stroke Survivor***
>
> *"When you have people with other disabilities you need to do it on case-by-case basis – so keeping ASU at Yeovil would allow that flexibility."* ***Stroke Survivor***

5.47 Retaining acute stroke care at both sites would also, it was said, mitigate against the aforementioned potential loss of staff as a result of the proposed changes to hyper acute stroke care. Moreover, it was suggested that having two units in the different areas would ensure staff have better knowledge of the local support organisations available to patients upon discharge from the ASU.

> *"In a local unit they are more likely to be aware of other rehab services / community services that they can recommend to you and make the connections for you but in Musgrove they're not necessarily going to have all of them across Somerset. Sometimes a person from the club or support unit can come in and see you in the hospital and make introductions and tell you about what they do. But it's not possible if everything is just in one place."* ***Stroke Survivor***

Easier access for patients, friends and family was a main concern for everyone

5.48 It was considered easier to monitor patients and ensure proper follow-up care and support from a more local unit. Additionally, friends and family being able to visit an ASU easily was considered essential for patients' mental health and recovery. Again, the rurality of Somerset was raised as a barrier to loved ones visiting patients in Taunton if they live nearer Yeovil.

> *"Friends and family do so much hidden work for their patients, and I think a lot of them wouldn't survive without their input."* ***Stroke Survivor***
>
> *"The person needs you to visit them every day, it's what keeps them orientated. Especially the elderly, they get every confused and disorientated in hospital and need support. It's not just a social thing for a quick laugh, it's because it physically enables the person to improve. It reduces hospital time, win-win."* ***Stroke Survivor***
>
> *"It's a very lonely and very depressing place to be when you've just woken up and half of your body doesn't work. You just don't know what to do. With the best will in the world a doctor can speak to you all day, but it's not the same as seeing your family."* ***Stroke Survivor***

5.49 Other considerations were raised, such as if a patient has co-morbidities such as Alzheimer's Disease or diabetes , it would be useful for them to have family close by to ensure those are considered during their care.

5.50 Similarly, if a patient is unable to speak English, their understanding of a situation can be limited if staff are unable to properly communicate with them, or if there is no translator available. In such circumstances, having family or friends close by who can communicate the information needed was said to be essential.

> *"It is very difficult to get a translator through. You're reliant on family, and if they can't make it then you've got a patient who can't communicate in their language. Let alone anything they've got from their stroke, and you don't know if they've got the capacity. You can use a translator service, but to see them talk with their family makes a massive difference."* ***Stroke Staff***

Retaining both ASUs was considered a solution to potential overcrowding at Musgrove

5.51 Retaining ASUs at both Taunton and Yeovil would, it was said, reduce the potential for pinch points at MPH, whereby quality of care might be compromised.

> *"It's just going to put more pressure on the service. Whereas actually, if you're spreading it out then you're easing that pressure. There's going to be more demand, so why put pressure at one point?"* ***Stroke staff***

The concerns raised in relation to Option A were mainly around transferring patients between the two hospitals as they transition from hyper-acute to acute care

5.52 Questions were asked around what would happen if a patient who is transferred from the HASU at MPH to the ASU at YDH was to deteriorate or suffer further complications once at the latter. That is, would they would be transferred back to Taunton again?

5.53 Similarly, if a potential stroke patient is sent to the HASU from YDH and it turns out not to be a stroke, there was concern that MPH may then no longer be the best place for them. They would then have to return to YDH for appropriate treatment.

> *"A lot of people come through thinking they've had strokes but it could be brain tumours, it could be seizures, FND, lots of different things. What does that mean? Do they just stay at Taunton or are they going to come back? You don't want to send the brain tumour ones to Taunton, we've got a lovely brain cancer specialist here in Yeovil; they don't have the equivalent in Musgrove."* ***Stroke Staff***

5.54 While transitioning between sites was considered a negative of having a separate ASU, one stroke survivor noted that all patients have to transition at some point, either to an ASU, a community hospital, or home.

> *"When they're discharged they'd have to transition anyway, or if they went to community hospital it would be a transition. But this way [Option A] there's a lot of family and friends support as well. In MPH or Dorchester, that support will be massively decreased."* ***Stroke Survivor***

Having staff split across the two hospitals was a point of concern for some

5.55 Some participants worried that having two units could cause a disconnect, especially during handovers of care for patients. It was stressed that if this option is taken forward, staff must have effective channels of communication to ensure continuation of care.

> *"One of the things that is absolutely essential is that the units are talking to each other, that we've not got a Musgrove team and a Yeovil team not communicating. They've got to be discussing the patients, there has got to be a very close link for the care to make sure the care is being given at the best possible place."* ***Stroke Survivor***
>
> *"I would personally like anything that happens to me, whether I have to go to Taunton or Yeovil, I'd like to all be connected together. The diabetes affects all sorts of things, and they could give me a drug that's not good for diabetes. The first thing I tell them, if I'm well enough, is 'I'm a type 1 diabetic'. If they don't know where your record is, that thing of your record following you and being together is quite important for me."* ***Stroke Survivor***

5.56 Staff members were of the opinion that effective communication across the two sites can be achieved.

> *"There are benefits I've seen from working in one HASU, which can be replicated in a different format without putting patients at risk …It's that thinking outside of the box rather than 'let's shift it to one hospital, that's where it's all going to go'. It's 'actually, keep them here, let's work collaboratively' which is what they've been saying the whole point of this merger is."* ***Stroke Staff***

Views on Option B: the proposal to co-locate acute and hyper acute services at Musgrove Park

While this option was the least preferred of the two, participants recognised the benefits of having a 'centre of excellence' for hyper-acute and acute stroke services at one hospital

5.57 Co-locating hyper acute and acute care was acknowledged as potentially beneficial in maximising continuity, minimising handovers of care, and ensuring access to specialist care and equipment at all times.

> *"It would just be nice to know you're going to somewhere where you know all the services are and they're in one place."* ***Stroke Survivor***

5.58 It was also felt that having extra staff (with additional support and training) in one place, working as a team from the moment a patient arrives, would enable quick treatment and better explanations of what is happening for patients and families. However, staff members felt that collaborative working could be achieved just as efficiently across the two sites.

The downsides of this option were discussed in conjunction with the benefits of Option A. Longer travelling times for family and friends during acute care was a particular concern

5.59 The importance of visitors was once again emphasised by almost all participants, particularly stroke staff. Having one ASU, which would be further away for a large number of Somerset residents, was considered detrimental in this regard as it would mean longer and more costly journeys, including on public transport for some people, as well as childcare considerations.

> *"You cannot understate how much having your family by your side to guide you through those first couple of days, weeks, months will help lift you out of that because now your legs don't work or now your brain can't process what you want to say and I have seen the frustration first hand and it is awful. Then you want people to travel up to a good 40 minutes each way and spend time with their loved ones after work?"* ***Stroke Survivor***
>
> *"It makes a massive difference having family assisting rehab in stroke. It's clinically proven, there's so much evidence to say the importance of having family and friends around to help with rehab."* ***Stroke Nurse***
>
> *"The travel times for ordinary members of the public from the Dorset area or far West of the county to Musgrove is a very long way, leaving families unable to visit easily and potentially leaves the patient even more isolated than they would be."* ***Stroke Survivor***

5.60 Moreover, it was highlighted that family and friends can advocate for the patient to get the right care, especially when issues of concern can sometimes be overlooked by busy and stretched nurses.

It was felt that YDH staff may be disproportionately affected by the proposals

5.61 There was concern that YDH staff would have to transfer hospitals and have longer commutes to work as a result of this option, upsetting their work–life balance and increasing their outgoings. It was also highlighted that staff could be unwilling to make the move, preferring to leave the Trust. Losing experienced staff was ultimately considered to lessen the benefit of this option, and there was a feeling of resentment among those participating that they had not been sufficiently considered in proposal development.

> *"...the question, 'If it all went to Musgrove, would you go?'... I said, 'No, I live in Yeovil and don't want to have that commute'. I've worked in Yeovil hospital for 20 years, and that's where I want to work."* ***Stroke Nurse***
>
> *"I wouldn't want to move to Taunton. I'm quite lucky in that I live an equal distance between the two hospitals, but I've chosen to come to Yeovil. I don't really want to move and go to Taunton. I've also chosen to be in stroke rehab care. Selfishly, if it does change, what does that mean for my career?"* ***Stroke Nurse***

There were concerns that having both units at MPH could cause capacity issues there, affecting other services and stroke outcomes

5.62 It was said that having a hyper-acute and single acute unit at MPH in Taunton would result in a very large department, with a large workforce. The effect of this on access, parking, communication between the two units, and capacity was a concern.

> *"If there are winter pressures in the emergency department, you've got about 12 ambulances waiting at the door, a stroke, people with fractures, it's just going to make stress for that emergency department. If we had, heaven forbid, another wave of COVID for example how are they going to separate the patients? That was enough pressure as it is on individual trusts without then having the whole of the county go to one place."* ***Stroke Staff***

5.63 Concerns were raised around the physical infrastructure of the hospital and where patients will be placed. Patients and loved ones who had recently been to MPH described it as *"overwhelmed"* and *"rammed"*, and felt that having extra units there could compromise other services. It was also suggested that more beds would have to be provided to have both units at MPH.

> *"A lot of the questions were around logistics and also people wondering where the heck would Musgrove Park find capacity for countywide stroke admissions and what would be compromised … to make space?"* ***Headway***

5.64 Improvements to transport links and access to MPH were considered essential if Option B is implemented. Many expressed the view that MPH is difficult to get to by car, as there is only one main route by which to access the site, and traffic can cause this to become congested easily. Once at the hospital, the cost of parking was described as *"extortionate"*, and there were complaints about a lack of space. It was suggested that these issues would be problematic for patients, visitors, and staff .

> *"Musgrove is a problem for both staff, visitors and patients accessing the site because of the horrendous charge for parking, and the limited availability or parking and the lack of other ways of getting to it. So access to Musgrove presumably should be improved as part of any of these proposals."* ***Stroke Survivor***

5.65 Public transport was also mentioned as needing improvement if Option B is approved, with suggestions that NHS Somerset should work collaboratively with the local council and transport providers to establish more regular links and routes to MPH. Alternative suggestions were a shuttle bus to transfer patients and visitors

to and from Yeovil if both stroke units there were to close; and the provision of affordable accommodation near MPH so that friends and family could stay close by and not have to worry about a long daily commute while their loved one is in hospital.

> *"When you have a child in hospital they provide temporary accommodation for the parents and I do wonder whether we should make the same sort of proviso for close family members in stroke situations."* ***Stroke Survivor***
>
> *"Have a hotel next door that's not too expensive to stay in or something. I think that would solve so many problems. I mean, trying to get in and out everyday … it's so stressful and expensive."* ***Headway***

Stroke staff felt that neighbouring hospitals would suffer adverse effects as a result of Option B

5.66 Staff were concerned that nearby hospitals such as DCH in Dorchester would be affected by the lack of a stroke unit at YDH, as patients from the Yeovil and north Dorset areas who would usually attend YDH would have to attend DCH instead.

> *"Yeovil patients will go to Dorset which is going to have a huge impact. In a year, 30% of our patients are north Dorset patients, so there's going to be a huge impact on them from a north Dorset point of view but also from a Somerset point of view. I think losing an acute stroke unit in Yeovil will be detrimental to the other two hospitals."* ***Stroke Nurse***

There were worries that patients would not attend follow-up appointments or rehabilitation if they had to travel to Taunton

5.67 The cost of getting to Taunton from Yeovil and further afield by car, public transport, and taxi were discussed. It was also noted that stroke survivors are much more likely to be reliant on others for transport. This, it was said, could deter patients from attending follow-up appointments and/or rehabilitation, highlighting the importance of maintaining such provision locally.

> *"I think they need to keep those things local, because the aftercare classes or groups I'd managed to participate in, if they were in Taunton I wouldn't have been able to do it because I couldn't drive and I had to rely on lifts, and Taunton is too far away for that. … Not attending those groups would have made a severe impact on my recovery."* ***Stroke Survivor***
>
> *"Stroke patients, one thing they will tell you afterwards is your confidence to go out into the world will be severely knocked. So suddenly having to negotiate public transport to additional areas that you're not 100% sure about, they're just going to stay at home and they're not going to go."* ***Stroke Survivor***

Equalities impacts and mitigations

Participants discussed the challenges for certain demographic groups in travelling to a more distant site to access stroke services

5.68 Participants across the different qualitative consultation activities frequently raised the needs of particular demographic groups when discussing travel and access for some Somerset residents to get to the proposed HASU and ASU sites. It should be noted, though, that many of the concerns raised around the potential impacts of the changes related to travel via public transport and cars, rather than ambulances, with a particular focus on the implications for family members and carers who might visit patients in stroke units. It was recognised that the travel impacts on stroke patients would be lesser, as most would likely be transported by ambulance.

5.69 People with learning disabilities and other special needs were identified as potentially being put further at risk if their carers are unable to visit or be with them due to distance, traffic or access issues. Their attendance was considered especially important in providing patients' everyday caring needs alongside the stroke support received in hospital.

> *"Learning disabilities, people with special needs suffer more; they need their care givers and it's much more difficult if they're further away. So, that auxiliary care and support would be harder to provide."* ***Stroke Survivor***

5.70 The proposals were said to put people from rural areas and small villages at a disadvantage, in particular those who are reliant on public transport, or isolated individuals without a support network of family and friends who are able and willing to drive them to appointments, and to visit them whilst in hospital. If both stroke units were to be consolidated at MPH, this would, it was felt, cause potential problems for these people due to the rurality of Somerset, and the fact they may already find long journeys difficult.

> *"Unless they improve the transport options, I'm afraid people who live in our direction, it's the rural communities that will be most at risk."* ***Stroke Survivor***
>
> *"Definitely from small towns and villages. When you're well and you can drive everything is alright, but then when you're well and can drive you don't need a hospital."* ***Stroke Survivor***

5.71 In terms of visitors, older people were thought to be less likely to have a support network and are oftentimes more isolated. It was also said that many older people have existing disabilities, frailty, and/or mobility issues, so for those living in the Yeovil area or the far west of the county, having to travel to Taunton could cause real issues with transport for the purpose of visiting.

5.72 Echoing feedback from other consultation strands, concerns were raised about the impact of changes on visitors with disabilities, who might already find travelling to hospital challenging and expensive. Participants thus said that *"in an ideal world"* all services would be available at both sites, but it was recognised that this is not a viable option.

> *"Definitely the worse patients that I saw at the group, huge mobility issues, trouble walking etcetera. I wouldn't want to have to go to those people and say, 'Actually now you've got to stick another 25 minutes on that journey', which is probably already quite difficult as it is."* ***Stroke Survivor***

5.73 Socio- economic issues were also considered: participants raised the potential difficulties faced by people on low incomes who need to visit loved ones in hospital, particularly those with young children and without access to private transport (who may be unable to afford taxis or travel by public transport). Moreover, there is a potential that some people will have to take time off work in order to make the longer journey to visit their loved one in Musgrove Park hospital. It was again recognised, particularly by staff and stroke survivors, that barriers to visiting could have significant impacts on patients' mental health and recovery.

5.74 Similarly, for YDH staff who would have to commute to and from Taunton daily, the time and cost of doing so was a concern.

> *"As much as I love stroke, I just don't think it would work out beneficial for me to go to Musgrove. I would really struggle from an emotional wellbeing point of view, and the cost of travelling."* ***Stroke Nurse***

5.75 Specific mitigations to reduce potential travel and access impacts were raised during discussions, such as improved and increased patient transport services, providing accommodation for visitors, or offering parking passes or tokens to reduce the cost of parking at MPH. It was again stressed that NHS Somerset should work in partnership with transport providers to improve public transport and road infrastructure to simplify journeys to hospitals.

Additional suggestions and other comments

As mentioned above, many people felt that both hospitals should ideally retain 24/7 hyper-acute and acute stroke units

5.76 Some participants felt that the proposals are based primarily around resolving funding issues rather than developing optimal models of care. In this context, some believed that increased funding and more staffing were the only solutions to the problems faced by NHS Somerset's stroke services, allowing the 'ideal' option of all units to remain open on a 24/7 basis.

> *"I personally feel that this is a funding issue that could be resolved with appropriate funding from the higher ups."* ***Service User***

5.77 However, most service users and staff recognised that this would not be possible due to limited resources, and were therefore pragmatic in examining the positives and negatives of the proposed model of care and options.

> *"I wish we could just keep everything, but we've got to be realistic."* ***Stroke Survivor***

5.78 Another suggestion was to locate hyper acute and acute stroke services at YDH rather than MPH, although most participants felt that the latter is the more logical place to host both units if they had to choose one site.

Some staff members would have liked more opportunity to input into the options development process

5.79 A few staff members felt that staff engagement, particularly at YDH, could have been improved during options development to enable concerns to be heard at an earlier stage, though there was also some feeling that their views might not have been *"listened to"* if that had been the case.

> *"… If they're making this proposal and assuming things about people's jobs, then they need to talk to people and say, 'Look, we're making this proposal and we would see it as you are coming over here'. No one has come to talk to us on the stroke ward; we found out in a generic public email. I might've been happy to [move sites] if I was consulted before now, but now I'm digging my heels in."* ***Stroke Staff***

It was said that the finer details and lower-level impacts must be further explored, with particular focus on the Somerset context

5.80 It was again stressed that the rurality of Somerset would impact the effectiveness of the proposals. Several people felt that co-locating hyper-acute and acute units may work in other counties but may not be the most suitable model for Somerset as the geography means it *"takes ages to get across"*.

> *"An important factor is that you have to look at the geographic factors of the area you are dealing with. Dorset and Somerset are very rural areas, and it takes time to get to places."* ***Service User***

One point raised for consideration was how the proposals fit with wider neurological pathways and community support

5.81 While recognising that getting hyper-acute and acute stroke care right increases the chances of positive patient outcomes, one staff member and the Headway representatives felt that establishing patient pathways for recovery in the community and ensuring wider support networks once discharged from acute care must be given due consideration as part of any changes to stroke services.

> *"I think many people will focus on the hospital stay, but … this is just the start of the journey [...] There's a lot of resource goes into that. It's a good service. But actually, once people get out in the community after the six weeks or however long, then people are left with nothing. What actually matters to people is how they live the rest of their lives and what support they have afterwards."* ***Headway***

5.82 It was thus felt that NHS Somerset needs to work holistically with community organisations and support mechanisms to ensure patients know where to go next to access support and continue their recovery, as in-ward care is only the beginning of this journey.

> *"Other things need to be added; that rehab and working with community teams. It's just as important and NHS Somerset needs to establish that dedicated pathway for people."* ***Stroke Staff***

5.83 Following on from this point, service users were of the view that stroke services have become 'reactive' rather than 'proactive' in addressing patients' needs, and that more focus needs to be given to primary care and stroke prevention.

> *"What are they doing to look at the prevention of strokes? Rather than firefighting when they actually happen?"* ***Stroke Survivor***

5.84 Finally, expanding acute care in community hospitals was suggested, thereby keeping services local and easing pressure on the main hospitals.

> *"If they can't go to the bigger hospitals, have services at a community hospital. Like in Shepton Mallet you have a little community hospital, have it in there. They don't have to have that much staff because it's just a small community one but give them the option if they don't want to go to Musgrove or Yeovil and they want to stay closer to home you've got the community hospitals."* ***Stroke Survivor***

6. Written submissions

Introduction

6.1 During the formal consultation process, 25 written submissions were received, as below.

NHS TRUSTS	
NHS Dorset	
NHS STAFF	
Stroke Consultant Physician, Yeovil District Hospital	
LOCAL AUTHORITIES AND ELECTED REPRESENTATIVES	
Sherborne Town Council	Yeovil Without Parish Council
Councillor Peter Seib (sent via Councillor Adam Dance)	
PATIENT GROUPS	
Chairs of Patient Participation Groups (east Somerset and north Dorset) Patient Group, Frome Medical Practice	
INDIVIDUAL SUBMISSIONS	
18 individual respondents (one submission sent via Councillor Adam Dance)	

6.2 ORS has read all the written submissions and reported them in this chapter, with those from organisations or individuals acting in their official capacity, included in full in Appendix IV.

6.3 Most have been reviewed in a thematic, summary format in order to identify the range of views and issues as well as common themes, though some that have presented unique or distinctive arguments, that refer to different evidence or were submitted on behalf of organisations and individuals representing groups of people, have been summarised individually for accessibility and to highlight their main arguments and any alternative proposals.

> *It is important to note that the following section is a report of the views expressed by submission contributors. In some cases, views may not always be fully supported by the available evidence - and while ORS has not sought to highlight or correct incorrect statements or assumptions, this possibility should be borne in mind when considering the submissions.*

6.4 The detailed written submissions in particular do not lend themselves to easy summary and so readers are encouraged to consult the remainder of the chapter below for an account of the views expressed. However, the following overview gives a sense of the types of issues raised - a 'summary of the summaries' if you like.

Summary of main findings

6.5 Concerns around increased travel times to other hospitals for those in Yeovil and surrounding areas were raised most frequently by individual respondents, especially in the context of the time-critical nature of stroke and the need to retain acute stroke services at Yeovil District Hospital (YDH) to avoid worsening patient

outcomes. Furthermore, the importance of easy access for visitors was stressed, as visits from loved ones are crucial to stroke patients' recovery.

6.6 Some issues were raised around quality of care. One respondent criticised current service provision (caused, they felt, by understaffing and a lack of teamwork), while another raised the prospect of possible capacity issues at a centralised hyper acute stroke unit (HASU) if resourcing is not increased. The importance of offering appropriate inpatient environments was stressed, as was the need to support carers.

6.7 Several individual submissions criticised the consultation process, particularly with respect to decisions having already been made; the accessibility and/or accuracy of the consultation document and questionnaire; the poor organisation of some consultation events; and the inappropriateness of using a public questionnaire to ask about such complex issues. There was, though, some praise of the *"fair, balanced and thorough"* process.

6.8 NHS Dorset supports, in principle, the movement to one HASU for Somerset based at Musgrove Park Hospital (MPH). It says that the feedback it has received from providers, patient groups, residents, and partners is unanimously in favour of retaining an ASU at YDH (Option A) for this would allow people living in the Yeovil vicinity to return closer to home following initial hyper acute care.

6.9 A stroke consultant physician at YDH supports centralising HASU Services at MPH *"with the correct resources and workforce",* but strongly opposes Option B on the grounds that *"it will have a disastrous effect on the whole health delivery system and will have a catastrophic impact on the population served by YDH"*.

6.10 Sherborne Town Council sees benefits in concentrating consultancy, nursing expertise, top-level equipment, and facilities in 24-hour hyper acute units at both Dorchester and Taunton. However, should the proposed reorganisation go ahead, the Council believes the following are vitally important considerations to ensure optimum care for the people of Sherborne: DCH should be the default destination for paramedics attending a stroke emergency in Sherborne as the journey time to Dorchester is shorter than that to Taunton; emergency cases should bypass emergency department queues and go straight to a 24/7 hyper acute stroke unit; and the future of the 'step down' stroke recovery unit at the Yeatman Hospital must be secured and capacity potentially increased.

6.11 Yeovil Without Parish Council prefers Option A on the grounds that its residents would be best served by the retention of an acute unit at YDH. This, it was said, would ensure early transfer back to Yeovil, allowing carers/relatives to be more easily involved in patients' ongoing care; and would provide better continuity of care via local therapists and more seamless transitions to home care. The Council also stresses the need for equally good services at YDC and DCH (given its residents are likely to be taken to the latter); and necessary funding for the ambulance service to ensure it can respond to and transfer patients as quickly as possible.

6.12 As well as reiterating the points made in Yeovil Without Parish Council's response, Councillor Seib also states a preference for residents that require thrombectomy to be taken to Bristol rather than Southampton, because of journey length and general lack of acquaintance with the Southampton area.

6.13 The Chairs of Patient Participation Groups in east Somerset and north Dorset feel that both options deteriorate the stroke service in Somerset and Dorset for patients who live closer to Yeovil than Taunton or Dorchester, and their friends/relatives. However, they recognise it is not possible to maintain a full HASU at Yeovil and therefore choose Option A, subject to the following being in place *before* changes are made to current arrangements: outstanding treatment and care at the HASUs; dedicated stroke ambulances equipped appropriately and staffed with knowledgeable paramedics; and every effort being made to reduce the 'door to needle time' on arrival at the HASU to somewhat mitigate the increased travel time by ambulance.

6.14 In a lengthy submission, one individual agrees, in theory, that the important target for stroke care is getting treatment started and that if the standard of care received by a patient can be improved, *"this is more important than a target time to get to hospital"*. However, they are concerned about current significant ambulance delays. In considering the options, they prefer Option A, as early transfer to an ASU at Yeovil would ensure easier access for visitors (which is important for patient recovery); and the availability of stroke services at YDH would make after-care easier for those discharged to a community facility or their own homes.

Summary tables of themes from individual written submissions

6.15 Overleaf are summary tables of the main themes emerging from the shorter or less complex written submissions received from individual respondents.

6.16 Concerns around increased travel times for those in Yeovil and surrounding areas were raised most frequently, especially in the context of the time-critical nature of stroke. Indeed, there was a strong sense that retaining acute stroke services at YDH is essential to avoid worsening patient outcomes.

6.17 Furthermore, the importance of easy access for visitors was stressed. Visits from loved ones were said to be crucial to stroke patients' recovery, and the difficulties involved in travelling from the Yeovil area to hospitals elsewhere was cited as a barrier to this. Those without their own transport would be particularly affected, it was said.

Table 7: Summary of main themes raised in written submissions – concerns over travel and time to reach hyper and acute stroke units

Sub-theme	Example comments/points made
Concern over increased travel time and risks involved in losing acute stroke services from YDH	*"How do you imagine this is agreeable to people of South Somerset who are not only to lose a stroke unit in Yeovil meaning a much longer journey to Taunton, but also that they may well be sent to Dorchester, an 11 minute longer journey than to Taunton. Why is this considered ok if speed of treatment is considered vital in strokes?"* (Individual respondent) *"I wish to lodge my objection to the Acute Stroke Unit being moved from Yeovil District Hospital to Musgrove Park Hospital in Taunton. My sister had a stroke at the age of 79 and we were able to get her to Yeovil District Hospital quickly where she was successfully treated by an excellent team. A longer drive to Taunton could have jeopardised her chance of survival. We are told speed is essential if a stroke is suspected, removing the facility is counterproductive."* (Individual respondent) *"The availability for a fast response has had direct bearing on my mother's and friend's health. My mother lives ten minutes away from YDH. When she had her stroke she was dealt with swiftly and very efficiently … The staff at Yeovil Hospital have been amazing and she has made a complete recovery. My friend's husband lived 25 minutes away from YDH. Unfortunately, he was not so lucky. His stroke occurred over a weekend and he was not able to be assisted to within the crucial first 45 mins. He was left blind and disabled … saving people's wellbeing is first and foremost."* (Individual respondent)

Sub-theme	Example comments/points made
	"It's really obvious to anyone living outside Taunton that the road travel time from the environs of Wincanton or Yeovil is substantial and highly variable. Both weather and tourism play their part, and there are few suitable alternate roads … The first hour is critical … I would suggest that the real problem is that delaying stroke treatment [allows] clots to form, causing irreversible damage … At the moment my feeling is that this 'saving' will endanger people, and specifically deprive this area …" (Councillor Peter Seib)
	"I hope I never have a stroke or a family member. As I would not have, nor my family have any contact during my stay till I return home to Yeovil. They do not have transport to go to Taunton or the time it takes on poor public transport or taxi costs. Besides quick treatment, family helps the recovery. At Yeovil they take patients from Sherborne and further away etc. The time to get to Taunton is at least an hour far too long and that's on a good day. I can't see that this is an improvement …" (Individual respondent) *"Given the distance and time it takes for the relatives to visit and travel to Taunton and back, this is a bad idea, causing great difficulties for the relatives who will already be under great stress and anxiety. I urge you to reconsider your plans."* (Individual respondent)

6.18 Other questions/concerns raised were around the feasibility of using primary health care centres for initial diagnosis (with patients taken to a *"ready-and-waiting service at the centralised hospital"* if a scan is needed); and patient pathways and transfers in the event of readmittance, with one respondent asking*: "If Option B is chosen … if someone from SPCH (South Petherton Community Hospital) recovering from a stroke needed to be blue lighted back to an acute [hospital] because they became unwell, would they go to Yeovil as this is nearer, or to Taunton, or would it entirely depend on the issue at the time?"*

6.19 Some issues were raised in relation to quality of care. One respondent criticised current service provision (caused, they felt, by understaffing and a lack of teamwork), while another raised the prospect of possible capacity issues at a centralised HASU if resourcing is not increased there. The importance of offering appropriate inpatient environments was also stressed, as was the need to support carers through a patient's journey.

Table 8: Summary of main themes raised in written submissions – other stroke service issues

Sub-Theme	Example Comments/points made
Poor experience of current stroke services	*"I'm not impressed with the system at hospital … why did my husband have to wait five hours in a power chair with a stroke? ... There was another lady there who also had had a stroke, she also was left without treatment … We think the departments should be working as a team … only one medic was on duty as stated by the management team that day …"* (Individual respondent)
The need for appropriate inpatient environments	*"Post-acute treatment advice is for the patient to sleep in as quiet, dark and cool environment as possible. Hospital treatment necessarily involves regular, frequent interventions (e.g., blood pressure). But my experience was there was no effort to reduce*

Sub-Theme	Example Comments/points made
	noise and light between these necessities. Noise-reducing headphones and masks would help …" (Individual respondent)
The capacity of the HASU	*"Under the 'improving acute hospital stroke services in Somerset', there will be one HASU located at Musgrove Hospital in Taunton. Are there plans to upgrade the existing service to allow for more patients …?"* (Individual respondent)
The importance of supporting carers	*"There was mention of carers [in the consultation document] but no mention of how important it is to support them"* (Individual respondent)

6.20 Several submissions criticised the consultation process, particularly with respect to decisions having already been made; the accessibility and/or accuracy of the consultation document and questionnaire; the poor organisation of some consultation events; and the inappropriateness of using a public questionnaire to ask about such complex issues. There was also some praise of the *"fair, balanced and thorough"* public consultation process.

Table 9: Summary of main themes raised in written submissions – comments on consultation process

Sub-Theme	Example comments/points made
Criticism of use of public survey	A resident criticised the use of a public survey because it is taking resources from *underfunded* NHS services; and the general public is not qualified to make decisions on clinical priorities and service delivery. They said that board members should reconsider their positions if *they* do not have the appropriate experience and knowledge to make decisions of this nature.
Concern that decision has already been made	*"Why have you already decided the removal of Stroke Services in Yeovil in a supposed 'consultation' exercise? It is quite obvious from your heavily biased 'questionnaire that your purpose in this 'consultation' is to tell people of Somerset that this is what they should want."* (Individual respondent) *"I do not believe that this is a genuine consultation - they never are. People in this area will be outvoted by people from the west of the county who, quite naturally, won't think of the implications for this area"* (Individual respondent)
Criticism of accessibility/ accuracy of consultation document and questionnaire	*"The language used in some cases is far too complex to be readily accessible to most of the population. It is important to remember that a little more than 10% of the population have difficulties reading at all. Generally folk have a working reading age of about 12/13yrs ... I found one passage in your consultative document with which was pitched at post graduate level!"* (Patient Group, Frome Medical Practice) *"[The] web page has serious drafting faults/typos, Option A and Option B are the same! It's clear no-one cared enough to proof-read what was put in front of them for approval"*

Sub-Theme	Example comments/points made
	(Councillor Peter Seib)
Poor organisation of consultation events	*"Today my husband and myself as well as two friends went to the advertised stroke consultation 'drop in' session in Burnham on Sea only to find the building locked and no one there. My husband and one of the friends who tried to attend have both been left severely disabled by strokes, so getting there required some effort. It was extremely disappointing and left us all feeling that the 'consultation' is nothing more than a paper exercise."* (Individual respondent)
Positive comments about consultation programme	*"… congratulations on running a very fair, balanced and thorough PC. You and your engagement team did a super job reaching people in all parts of the county and even in neighbouring counties. Your mix of online and in-person events gave everyone an opportunity to ask questions and make their opinion known."* (Individual respondent)

Summaries of detailed submissions

6.21 As previously mentioned, some written submissions have been summarised in more detail to highlight their main arguments. Those reported here have been chosen either because they cite sources of evidence or raise several 'different' issues to those being repeated by a number of respondents, or because they have been written to represent the views of larger groups of people.

NHS Dorset

NHS Dorset supports, in principle, the movement to one HASU for Somerset based at MPH. It recognises the challenges providing a HASU at YDH would present and says, *"The over-riding concern [is] that patients are treated in the location that can most effectively meet their needs, ensure the best possible outcomes and contribute towards the patients' future wellbeing"*.

The feedback NHS Dorset has received from providers, patient groups, residents, and partners is unanimously in favour of retaining an ASU at YDH (Option A) for this would allow people living in the Yeovil vicinity to return closer to home following initial hyper acute care.

Travel times to Taunton/Dorchester are a concern for residents and providers, though having the right care for patients 24/7 is agreed to be essential even if the journey time to access it is longer. Moreover, Dorset County Hospital (DCH) has highlighted that resistance from patients (and relatives) living in the Yeovil and Somerset border areas to go to Taunton could *"result in delays in transfers for continuation of care and so prevent capacity being available for new admissions and ongoing care at DCH"*.

Finally, the support for Option A is predicated on the understanding that *"there will be an assessment of the impact of moving patients from the HASU at DCH to an acute unit at YDH and confirmation that such a move will not negatively impact on the patient's morbidity and mortality."*

Stroke Consultant Physician, Yeovil District Hospital

The consultant physician is concerned that the proposals for the delivery of the stroke services are *"not in the best interests of the communities served by MPH and YDH"*. They particularly feel that, if adopted, Option B will *"have a catastrophic effect on the whole of the community served by YDH"*.

The consultant also says that much of the consultation information in the public domain is *"misleading and non-factual"*. In particular, the claim that NHS Somerset has engaged with and has the support of partners including medical and nursing staff, therapists, the South Western Ambulance Service, and other affected NHS trusts is disputed. It is said that while medical and nursing staff at the YDH stroke unit were engaged about a single HASU at MPH, they were *"never consulted about Option B."* Furthermore, NHS Somerset has allegedly neither consulted nor received the support of other NHS service providers on Option B.

The consultant says that while the proposals promise high quality and equitable services for the whole community, no guarantees have been given on this. They feel that chronic underfunding and a lack of system/organisational support over many years is one of the main reasons why Somerset stroke services failed to deliver on the A-star Sentinel Stroke National Audit Programme (SSNAP) national rating. Therefore, *"making significant changes to the service with no commitment to extra funding coupled with ongoing workforce shortages most certainly will not deliver the promised long-term benefits."*

Ultimately, the consultant physician supports centralising HASU Services at MPH *"with the correct resources and workforce"* but strongly opposes Option B. Indeed, they feel that if this option is implemented, *"it will have a disastrous effect on the whole health delivery system and will have a catastrophic impact on the population served by YDH"*.

Sherborne Town Council

Sherborne Town Council says that the future of hyper acute stroke treatment is of special interest and concern to its residents for three reasons:

> Nearly a third of Sherborne's population is aged 65 and over and, statistically, demand for acute stroke care is likely to be much higher than the national average;
>
> Sherborne is on the edge of the county borderlands of Dorset and Somerset. The community is concerned that *"its relative geographical isolation does not adversely affect acute care health provision"*; and
>
> YDH is currently the nearest provider of acute stroke response for the area.

The Council does, however, see benefits in concentrating consultancy, nursing expertise, top-level equipment, and facilities in 24-hour hyper acute units at both Dorchester and Taunton.

Should the proposed reorganisation go ahead, the Council believes the following are vitally important considerations to ensure optimum care for the people of Sherborne:

> For paramedics attending a stroke emergency in Sherborne, the default destination should be the hyper acute stroke unit at DCH as the journey time to Dorchester is *"half that of the journey to Taunton";*
>
> Emergency cases should bypass A&E queues and go straight to the hyper acute stroke unit, which should be accessible 24/7 all year round; and

The future of the 'step down' stroke recovery unit at the Yeatman Hospital must be secured and capacity potentially increased, as the ease with which family and friends can visit stroke patients there *"helps improve recovery and release times, speeds up the practical provision of post-hospital support services and helps reduce bed blocking and therefore NHS costs."*

Yeovil Without Parish Council

Yeovil Without Parish Council prefers Option A, believing that the people of its area wish for and would be best served by the retention of an acute unit at Yeovil. This, it is said, would benefit the physical and mental wellbeing of patients and their loved ones, given that early transfer back to Yeovil would allow the latter to be more involved in patients' on-going care much more easily than at Taunton or Dorchester; a 45- to 50-mile round trip. Furthermore, the Council believes that an acute unit at Yeovil would provide better continuity of care because local therapists will be involved at an earlier stage and transition to home care would be more seamless.

The Council understands that its parishioners would most likely be sent to DCH rather than MPH. So they are not disadvantaged in comparison to other Somerset residents, it expects service commissioners to ensure they have *"access to a service at Dorset County equal to that provided at Musgrove Park Hospital"*. In particular, the Council requests that seven-day hyper acute services at YDC are retained until all necessary measures are in place at DCH.

Because of the configuration of regional health services, the Council is concerned that residents who require thrombectomy might be sent to Southampton Hospital rather than Southmead Hospital in Bristol. It would prefer residents to be transferred to Bristol because of journey length and general lack of acquaintance with the Southampton area.

Given recent lengthy ambulance response times, the Council is concerned that any improvements in *"door to needle"* time when the patient reaches a hyper acute unit will be offset by delays in ambulance response and transfer times to Taunton or Dorchester. It expects that *"necessary funding is made to the ambulance service to ensure that they are able to respond speedily to all residents …"*

Councillor Peter Seib (sent via Councillor Adam Dance)

A response from Councillor Seib was submitted that provided views on behalf of Yeovil Without Parish Council. It expresses disappointment that there will not be a Hyper Acute Unit at Yeovil, and in relation to acute stroke care, wishes to record its preference for Option A, i.e. an Acute stroke unit at Musgrove Park Hospital AND at Yeovil District Hospital. They believe it would facilitate early transfer back to Yeovil and allow family and friends to be more involved in on-going care, provide better continuity of care via local therapists, and a more seamless transition back to home.

They note that their parishioners are more likely to be sent to Dorset County Hospital, and request that no changes are made until the service provided there is equal to that at Musgrove Park Hospital, in particular the Hyper Acute unit should be in operation 7 days a week.

For residents who require thrombectomy, they would prefer for them to be taken to Bristol rather than Southampton, because of journey length and general lack of acquaintance with the Southampton area.

Chairs of Patient Participation Groups (east Somerset and north Dorset)

The Chairs have grave concerns about the potential harm to patients who would usually be treated and cared for at Yeovil District Hospital if either consultation option is adopted unamended.

The Chairs firmly reject Option B on the grounds that:

> The additional time patients will spend travelling to hospital elsewhere may set back their recovery and harm their long-term clinical outcome;
>
> The extended period patients would be at MPH would put a greater burden on their families and friends who wish to visit them daily, especially those who travel by public transport as links between Yeovil and Taunton are *"inconvenient and expensive"*. This means the heaviest burden will fall on the disadvantaged and the least well-off; and
>
> If visitor rates fall this will slow patient recovery as face-to-face visits *"can help patients recover quicker by reducing stress and anxiety."*

The Chairs say that their comments around additional travel time to Taunton in relation to Option B apply equally to Option A. In this context, concern is expressed about the worsening trends in 'onset to arrival time' at both Somerset hospitals. The Chairs also note that *"ambulance queues waiting outside hospitals to deliver patients have become commonplace since Covid and national response time targets are consequently not being achieved"*. They are worried that despite these issues, two options have been presented that *"… rely entirely on transporting patients across the county without delay"* and say that unless mitigated, *"this as an unacceptable risk to the clinical outcome for patients"*.

The Chairs reference the difficulty recruiting staff at the Yeovil HASU as a key motivating factor in making the changes proposed. While they accept that recruitment is challenging, they say that a *"manpower planning failure"* should not be used as a reason to close down a service. They also claim that the staff shortage justification is undermined by NHS Dorset's plan to upgrade the stroke unit at DCU to a 24/7 HASU. That is, Dorset and Somerset currently have three HASUs at Yeovil, Taunton and Bournemouth and *"whichever one of your options is approved, the two counties will still have three HASUs, just not at Yeovil"*.

The inadequate number of stroke patients at Yeovil is also rejected as a justification for the planned reconfiguration given that Yeovil has averaged about 450 stroke patients per annum in recent years to no observable detriment to patient care and outcomes in comparison to busier units.

The Chairs feel that both options deteriorate the stroke service in Somerset and Dorset for patients who live closer to Yeovil than Taunton or Dorchester and their friends/relatives. However, they recognise it is not possible to maintain a full HASU at Yeovil and therefore choose Option A, subject to the following being in place *before* changes are made to current arrangements.

> Outstanding treatment and care at the HASU at Taunton, which should be adequately staffed and equipped;
>
> Dedicated stroke ambulances equipped appropriately and staffed with knowledgeable paramedics who can communicate with hospital staff en route; and
>
> Every effort being made to reduce the 'door to needle time' on arrival at the HASU to somewhat mitigate the increased travel time by ambulance.

Finally, the Chairs feel that the cost of establishing an 'A Star' HASU at Taunton will exceed estimates.

Patient Group, Frome Medical Practice

The chair of the group comments that the consultation document had helped him to understand the issues involved and the need for change, although has some reservations about the framing of the questions in the consultation questionnaire. However, concern was expressed around the complexity of the language used, relative to the reading age of the wider population.

Individual resident

The resident agrees, in theory, that the important target in terms of stroke care is getting treatment started and that if the standard of care received by a patient can be improved, *"this is more important than a target time to get to hospital"*. However, they also argue that in the real world, *"there could be delays because of the amount of time that passes between the initial 999 call and the arrival of a paramedic and ambulance and thus transport to hospital …"*

They are also concerned about the prospect of most stroke patients in and around Yeovil being taken either to the HASU at DCH in Dorchester or to those at Bath and Salisbury. As such, the proposed service improvements at MPH will not be felt by the majority of local residents.

It is recognised that, for many people, DCH might be preferable to MPH and that *"Dorchester may well be able to deliver as good a level of care as Musgrove Park"*. Some issues were noted however:

> The HASU at Dorchester is currently operating five days a week. To ensure equity, a seven-day service must be in place before the unit at Yeovil is closed for hyper-acute care; and
>
> Patients at DCH requiring a thrombectomy might be taken to Southampton for the procedure as opposed to the more familiar Southmead Hospital in Bristol (patients at MPH are taken to the latter).

In considering acute stroke care, the resident notes that Option B allows for patients to stay either at Taunton or Dorchester for all their acute care, which would mean a requirement for more beds at both hospitals. If this option is taken forward, the resident states that *"these extra beds would need to be created before any changes"*. Furthermore, the resident says that as care continues after the patient is discharged from acute care and returns home or to a community unit, *"I have concerns about how this will be seamless if the patient remains in Dorchester at this stage"*.

The resident also highlights that patient outcomes do not rely on clinical staff alone, and that understanding the benefits of contact with loved ones is important. It is a 45- to 50-mile round trip from the Yeovil area to Taunton and Dorchester, making it *"much more difficult to get a friend or neighbour to travel from Yeovil to Taunton or Dorchester than to Yeovil Hospital"*, and *"damaging … their emotional wellbeing for this to be needed for a prolonged period of time."*

For these reasons, the resident prefers Option A.

The same resident also makes the following points/asks the following questions:

> It is disingenuous to separate strokes and TIAs (as per the consultation document) as the latter is often a retrospective diagnosis and patients who have had a TIA can still develop a full-blown stroke. If the Yeovil stroke and TIA figures for 2021/22 were amalgamated, they would be 552, putting Yeovil *"in the 500-600 range that NHS England feel is needed for a Hyper unit"*

In the consultation document fictional scenario, 'Arun' arrives at the YDH emergency department, a suspected stroke is confirmed, and he is then transferred by ambulance to MPH after starting thrombolysis treatment. Why MPH and not DCH, when DCH is marginally closer?

Would the transfer of a patient from the YDH emergency department to a hyper-acute unit be regarded as urgent or would the patient *"linger for considerable time awaiting transfer"* in the care of non-specialist staff? Furthermore, would the transfer be treated as urgently as if ambulance had been called to the patient's home?

What happened to the pilot scheme at the Yeatman Hospital, Sherborne?

The costs require clarification as there are discrepancies between the figures in the main consultation document and the easy read summary, and it is unclear whether *"the costs of keeping patients in Dorchester has been taken into consideration in arriving at these figures"*.

Appendix I: Table of figures

Appendix II: NHS Somerset engagement activities

NHS Somerset engagement programme

During the consultation period, 52 online and in person meetings and events were held throughout the county either hosted or attended by the representatives of NHS Somerset (see table below). The consultation activities were primarily intended as an opportunity for the public to find out about the proposals and ask any questions, and to promote broader engagement and signpost stakeholders to further information about the proposal and the open questionnaire and other consultation activities.

Event/activity	Date	Type
Yeovil Library	30th January 2023	Pop-up stand
Crewkerne and Chard After Stroke Club	31st January 2023	Stroke support group
Westlands Entertainment Centre, Yeovil	1st February 2023	Pop-up stand
Yeovil District Hospital, Aspire	2nd February 2023	Stroke support group
Bridgwater, Heather Club	3rd February 2023	Stroke support group
Crispin Community Hall, Street	6th February 2023	Pop-up stand
Martock Information Centre	6th February 2023	Pop-up stand
Talking Café Live	8th February 2023	Live on social media
Chard, The Guildhall	8th February 2023	Talking Café
Langport Library	9th February 2023	Talking Café
Taunton Library	11th February 2023	Pop-up stand
Yeovil District Hospital, entrance lobby	13th February 2023	Pop-up stand
Yeovil District Hospital, entrance lobby	14th February 2023	Pop-up stand
Yeovil, St Peters Community Centre	14th February 2023	Warm space
South Petherton Hospital	15th February 2023	Pop-up stand
Ilminster library	15th February 2023	Pop-up stand
Thursday teatime check-in	16th February 2023	Online
Yeovil District Hospital, entrance lobby	16th February 2023	Pop-up stand
Yeovil, St Peters Community Centre	16th February 2023	Talking Café
Crewkerne Library	17th February 2023	Pop-up stand
Wincanton Library	20th February 2023	Pop-up stand
Taunton Musgrove Park Hospital	20th February 2023	Pop-up stand
Somerset Engagement Advisory Group meeting	20th February 2023	Online
Carers Strategic Partnership Board meeting	21st February 2023	Presentation - online
Yeovil Rugby Club	21st February 2023	Public event – in-person
Taunton Musgrove Park Hospital	22nd February 2023	Pop-up stand
Williton Community Hospital	22nd February 2023	Pop-up stand

Thursday teatime check-in	23rd February 2023	Online
Dorset, Sherborne Library	28th February 2023	Pop-up stand
Burnham on Sea, Methodist Church	28th February 2023	Talking Café
Wellington, St John's Church	28th February 2023	Talking Café
Bridgwater, The Hub, Angel Place	2nd March 2023	Talking Café
Taunton, Albemarle Centre	6th March 2023	Warm space
Taunton Stroke Club	7th March 2023	Stroke club
Online Public Event	8th March 2023	Public meeting - online
Thursday teatime check-in	9th March 2023	Online
Wells, Bishop's Palace Talking Café	9th March 2023	Talking Café
Heather Club, Bridgwater	10th March 2023	Stroke Club
Chard Together, Guildhall Chard	11th March 2023	Public event – in-person
Online meeting targeted to residents on or near the border between Somerset and Dorset	13th March 2023	Public meeting - online
Thursday teatime check-in	16th March 2023	Online
Veterans breakfast, Yeovil Rugby Club	18th March 2023	Pop up stand
Frome stroke group	22nd March 2023	Stroke support group
Thursday teatime check-in	23rd March 2023	Online
Thursday teatime check-in	30th March 2023	Online
Shepton Mallet, The Art Bank	5th April 2023	Talking Café
Dorset, Sturminster Newton Country Market	11th April 2023	Pop up stand
Dorset, Sherborne town centre	12th April 2023	Pop up stand
Thursday teatime check-in	13th April 2023	Online
Morrisons, Glastonbury	13th April 2023	Pop up stand
Dorset, Gillingham library	14th April 2023	Pop up stand
Online meeting with councillors in Somerset	20th April 2023	Online meeting

At some of the activities, members of the public took the opportunity to ask questions and give initial feedback, as well as being provided with documents and information so that they could respond to the consultation questionnaire.

NHS Somerset consultation team staff members took notes of questions and feedback to be forwarded to ORS for analysis and summary reporting (see overleaf).

Examples of questions

Typical questions from the meetings (reported verbatim below) addressed:

Concerns over implications for patients and services

Concerns over provision in Yeovil

1. *"Why can't Yeovil have all services? Why are things being taken from Yeovil. We want a working hospital on our doorstop, no help if everything is in Taunton."* (Westlands, Yeovil, pop-up)
2. *"You say that you are improving hospital-based services, but what will be improved? What stroke services will be left in Yeovil?"* (Yeovil Rugby Club, Public Event)
3. Lady stated that as she lived within walking distance of YDH why would she call an ambulance and end up in MPH? (Yeovil Rugby Club, Public Event)

Importance of time to successful outcomes

4. *"Why are we brushing aside importance of time when we are always told the FAST approach with Time being critical?" (Yeovil Rugby Club, Public Event)*
5. *"People who have had a stroke need to be seen as quickly as possible. Early intervention is key. How will you get the best recovery for patients?"* (Taunton Public Event)
6. *"What would happen if I had a stroke in Sherborne and called 999?"* (Online Public Event)
7. *"Time is an important factor in stroke treatment. If people take longer to get to hospital will they have worse outcomes?"* (Online Public Event)
8. *"Do you have clinical evidence which shows that patients who take longer to be treated have worse outcomes than someone who is treated within 30 minutes? Will the extra time travelling to hospital result in worse outcomes for some patients?"* (Taunton Public Event)
9. Clarification requested on what definition of 'quick' was? (Yeovil Rugby Club, Public Event)

Questions about provision in Dorchester, Dorset

10. *"We are being asked to make decisions on something that there is no reassurance from Dorset. Would like to know what access patients have if going to Dorset. Will Dorset have similar issues recruiting consultants? It would have been helpful to have someone from Dorset here."* (Yeovil Rugby Club, Public Event)
11. Asked for more detail with regard to Yeovil patients going to Dorchester and whether the service there would be equal to what we are trying to provide at MPH or will there be disparity in service provision. (Yeovil Rugby Club, Public Event)
12. Challenged about degree of support from Dorset. (Somerset Engagement Advisory Group)

Concerns over staffing

13. What is being done off the back of the BMA findings that they are currently lobbying government that 40% of NHS consultants are due to retire in the next couple of years? (Yeovil Rugby Club, Public Event)
14. *"If we can't find stroke staff for Yeovil, how will Dorset and Somerset find more staff for their improvements to their hyper acute stroke unit?"* (Taunton Public Event)
15. *"Do you think staff will move from Yeovil District Hospital to Musgrove Park Hospital, or do you think you will lose that expertise?"* (Taunton Public Event)
16. *"Are the number of consultants required based on prevalence or demographics?"* (Yeovil Rugby Club, Public Event)

Other concerns

17. *"Will Taunton have thrombectomy services soon?"* (Burnham on Sea Methodist Church)
18. *"If you maintained two acute stroke units in Somerset, would all the latest equipment be in Musgrove?"* (Taunton Public Event)
19. *"Why are strokes not a category 1 call for ambulance services?"* (Taunton Public Event)
20. *"Could you make facilities available for families with loved ones at Musgrove Park Hospital to stay overnight?"* (Taunton Public Event)
21. Was South Petherton Community Hospital under threat? (South Petherton Community Hospital)
22. Stroke Survivor – *"No one has mentioned outside of Somerset Thrombectomy service – is this something that is, can or will be available in Somerset if HASU is centralised?"* (Yeovil Rugby Club, Public Event)
23. Whether patients are triaged by paramedics and whether patients still have to go through ED or will they go direct to HASU. What is the pathway? (Yeovil Rugby Club, Public Event)
24. *"So, there's no perfusion existing in Taunton?"* (Taunton Public Event)

Reasonings behind the proposals and change planning process

Involvement/engagement processes

25. *"To what extent are we engaging broadly and ensuring representation diversity?"* (Somerset Engagement Advisory Group, online)
26. *"What conversations have been had with staff at YDH. Are staff being expected to relocate to MPH? Will the proposals create more staffing vacancies?"* (Yeovil Rugby Club, Public Event)
27. *"What engagement took place on this before?"* (Williton Community Hospital, pop-up)

Questions over research, analysis and modelling

28. Had not seen document prior to it being published and he challenges the modelling. He is not confident that the financial modelling is accurate to achieve level of care aspiring to. (Yeovil Rugby Club, Public Event)
29. Raised concern around travel times to MPH particularly from East of county – Wincanton 58 minutes, Castle Cary 56 minutes, Henstridge 68 minutes (he had taken these times from AA route planner). He asks what is the ambulance expected travel time from these locations and how were times quoted in documents arrived at, acknowledging that ambulance staff unable to administer treatment. (Yeovil Rugby Club, Public Event)
30. *"I did wonder where the ambulance modelling information was gathered. It seemed to me that their response times are quicker on paper than actual arrival times."* (Taunton Public Event)
31. *"Has anyone done an analysis of travel times from all areas of Somerset to particularly Musgrove Park on public transport for family?"* (Taunton Public Event)
32. *"What evidence base is there for any of this?"* (Williton Community Hospital, pop-up)
33. *"What research has taken place to suggest this is the correct pathway?"* (Williton Community Hospital, pop-up)
34. *"Have we communicated with the powers that be around public transport to ensure that if family need to visit patients at MPH, they can be assured that they will be able to get there and get back home by bus if they don't have access to car? The decline of bus services in Somerset is one of the highest in the country. Real difficulty in weekend and evening travel."* (Yeovil Rugby Club, Public Event)

35. *"What comparative research has been undertaken, comparing other areas that have centralised their hyper acute care and to show that this will be positive in Somerset?"* (Williton Community Hospital, pop-up)
36. *"How much does it cost to look after a patient for 72 hours in a hyper acute stroke unit and how much does it cost to look after a patient in an acute stroke unit?"* (Online Public Event)
37. Request to explain in layman terms the financial columns for Option A and Option B. What is the £800K difference against deficit? (Yeovil Rugby Club, Public Event)
38. *"Which of the two options does DCH support and why?"* (Taunton Public Event)
39. *"Is the hyper acute stroke unit at Yeovil smaller than the hyper acute stroke unit at Musgrove Park Hospital?"* (Taunton Public Event)
40. Very much about explaining consultation itself as well as proposed changes for stroke. Sense that trust in what authorities say is low. (Westlands, Yeovil pop-up)
41. To what extent do the public understand current state and proposals for future state? (Somerset Engagement Advisory Group, online)
42. *"What happens to all of the feedback you gather as part of the consultation?"* (Online Public Event)

Alternative proposals

43. Specialist Stroke Consultant YDH – chronic underfunding of services. Need to look at increased funding and investment rather than savings. More investment in manpower – physios, mental/psychological staff. *"If we want to provide an A* service, then we have to invest."* (Yeovil Rugby Club, Public Event)
44. *"How are you going to recruit more stroke staff? Are you going to do something to what has been done before? Invest more money in recruitment?"* (Williton Community Hospital, pop-up)
45. *"Could we have sub-acute care in Weston?"* (Burnham on Sea Methodist Church)

Other questions

46. *"You said there are many specialist centres, but I've only found three. Are there more?"* (Online public event)
47. Did Dorset look to have one HASU – why did they change plan? (Yeovil Rugby Club, Public Event)
48. *"Is this just a cost cutting exercise?"* (Online Public Event)
49. *"Could the space used for hyper acute stroke services at Yeovil District Hospital be used for other things?"* (Taunton Public Event)
50. *"Could the stroke staff be retrained and moved to other services at Yeovil District Hospital?"* (Taunton Public Event)
51. *"What training do ambulance staff have when they pick up suspected stroke patients and how important is the care that they provide?"* (Taunton Public Event)
52. *"What would the timeline be for implementation?"* (Online Public Event)
53. Wanted to know if we planned to have a community rehab stroke unit in North Sedgemoor as South Petherton and Williton are far away. (Burnham on Sea Methodist Church)

Examples of feedback

General comments and concerns

- [One person] didn't like the idea of hospital services being taken. (Taunton Library)
- From our colleagues a strong understanding that the HASU needs to be improved. (South Petherton Community Hospital)
- Retired woman – warmed when we talked it through (nearly an hour) and we explained that the services are not 24 hour at YDH. (Warm Space, St Peter's Community Centre)
- Good to have 24/7 day service. (Frome Stroke Group)

Concerns around travel and access

Golden Hour

- Concern about the 'golden hour' and driving all the way to Taunton from Yeovil would take up that precious time (person who heard about stroke on Radio Somerset) (Yeovil Library pop-up)
- 'Golden Hour' mentioned – any travel was perceived to mean no treatment within the hour. (Crewkerne and Chard After Stroke Club)
- Traffic will mean no treatment in hour (Westlands, Yeovil pop-up)
- In common among the group is the sense that the best treatment at the earliest opportunity is most important. (Crewkerne and Chard After Stroke Club)
- There was talk about the "golden hour "and I heard twice that you may die in the back of an ambulance if you had to travel to Taunton. (Aspire, Yeovil District Hospital)
- Would be unable to get to any other hospital outside Yeovil (Yeovil Library pop-up)
- Have been told that the golden hour has changed to 4 hours. (Taunton Public Event)

Ambulance Services

- Ambulances raised as an issue (Crewkerne and Chard After Stroke Club)
- I heard twice that you may die in the back of an ambulance if you had to travel to Taunton. (Aspire, Yeovil District Hospital)
- One in the group recalled the length of time they had to wait for an ambulance. (Bridgwater Heather Club)
- Waited a long time for ambulance (both the person talking and a friend) so need to get to the closest hospital, even if this is YDH, as there has already been a delay in treatment so shouldn't have to then travel further to MPH. (Crispin Community Hospital, Street)
- Ambulance waiting times are really too long. (Sturminster Newton Country Market)
- Ambulance response times? Hopefully this improves. (Crewkerne Library, pop-in)
- One person noted ambulance delay had resulted in lack of treatment and paralysis down one side for a family member. (Sherborne Town Centre, pop-up)
- He feels that ambulance wait times are the biggest concern currently. (Sherborne Town Centre, pop-up)

- Concerns around travel times and ambulance response times particularly for Yeovil people. (Burnham on Sea Methodist Church)

Other travel concerns

- Some concern from member of public who heard about stroke consultation that he would end up in Salisbury or Dorchester. This person does not drive (Yeovil Library pop-up)
- Fear of potential travel … Chard is closer to Musgrove and many in the group had been treated in Taunton. (Crewkerne and Chard After Stroke Club)
- Acute Stroke Nurse YDH – feels that having the acute care closer to patients home is better for mental and physical health as well as supporting anxiety for family is really important. (Yeovil Rugby Club, Public Event)
- They are on the cusp so tend to get hospital treatment at Yeovil. (Sturminster Newton Country Market)
- If I had a stroke, it would be 18 miles to Dorchester or 28 miles to MPH. (Yeovil Rugby Club, Public Event)

Little/No concern over travel

- One woman talked about having very little awareness immediately after her stroke and it not mattering where she was. She also was sure that wherever she was, her husband … would have travelled to her every day. (Crewkerne and Chard After Stroke Club)
- One person felt it (travel) irrelevant to them as they live in Bishop's Lydeard (just outside Taunton). (Taunton Library)

Equalities impacts

- Lots of older people not being able to drive, to make the longer distances. (Sturminster Newton Country Market)
- Rurality of Somerset (Sturminster Newton Country Market)
- The engagement for the consultation did not reach far enough to include people who were not digitally empowered. (Warm Space, St Peter's Community Centre)

Proposed option with two ASUs

Positive Comments

- Option with two ASUs resonated for chap who was worried about travel. (Yeovil Library pop-up)
- All agreed Acute Ward following initial treatment close to home was the way forward for both the patient and relatives with both benefitting from frequent visits which would not be practical if a long distance to travel. (Frome Stroke Group)
- Stroke survivor – understands would not necessarily get best treatment if had stroke at weekend but would still prefer there to be a level of care for stroke at both hospital sites and asked why we cannot share the consultants across both sites? He felt he would not have had the motivation to get better if he had been at MPH away from his family and in unfamiliar surroundings. He would like to see care delivered at both sites. (Yeovil Rugby Club, Public Event)

- Good to have better care at Taunton. (St Peter's Community Centre, Talking Café)
- Patients can be moved back to YDH if they want to be, this makes sense. (Morrisons Supermarket, Glastonbury, pop-up)
- All agreed Acute Ward following initial treatment close to home was the way forward for both the patient and relatives with both benefitting from frequent visits which would not be practical if a long distance to travel. (Frome Stroke Club)
- In favour of this option if HASU has to be solely in MPH. (Sherborne Town Centre, Pop-up)
- Positive response to idea of ASU in both Yeovil and Taunton; recognition that being close to loved ones who are in hospital is important. (Crewkerne and Chard After Stroke Club)
- *"I agree on two acute units so it's fairer in both areas".* (Taunton, Public Event)
- Positive response to being informed that options include keeping Acute Stroke Unit at Yeovil, and therefore closer to home for those attending. (Aspire, Yeovil District Hospital)
- One gentleman was concerned that we should keep the services in both hospitals … that Yeovil Hospital was a better hospital and did not want to see services being lost to MPH. He said that he knew of friends and relatives who due to the current situation with ambulance wait times that were taking their loved ones themselves to hospital in an emergency and he felt that going to MPH was just too far. (Yeovil District Hospital, pop-in)
- Quoted that Dorset CCG would only support Option A retaining ASU in YDH and would not support Option B. (Yeovil Rugby Club, Public Event)
- Good that can return to YDH to be visited by friends and family. (Sturminster Newton Country Market)
- Sounds good to have people able to come back to Yeovil for families to support with their rehab needs. (Ilminster Library)
- Like it that people can go back to somewhere that is familiar. (Musgrove Park Hospital, concourse pop-up)
- Good that people can return to Yeovil for help from family and friends. (Williton Community Hospital, pop-up)

Negative comments

- Are you going to have enough staff to maintain two acute units inclusive of allied health professionals? (Taunton, Public Event)

Proposed option for one HASU

Positive

- Important to have 24/7 cover. (Sturminster Newton Country Market)
- Understood it is important for 24/7 cover to be available. (Sherborne Town Centre, pop-up)
- The reality is that 24/7 cover is needed. (Morrisons Supermarket, Glastonbury, pop-up)
- Change is needed. Better for patients is needed. (Bridgwater Heather Club)
- Understand that concentration of resources would make MPH a hub of excellence. (Crispin Community Centre, Street)

- Sounds good, to reconfigure services so that they're excellent for all people in Somerset. (Crewkerne Library, pop-in)
- Makes sense in terms of hyper acute being as good as possible. (Williton Community Hospital, pop-up)
- Good to have a place of excellent stroke care. (Yeovil District Hospital)
- Sounds right choice to have excellent services at Taunton. (Yeovil District Hospital, pop-up)
- Good to get continuous care in one place if all at Taunton (Yeovil District Hospital)
- Sounds good for recruitment to develop MPH as stroke specialist hub. (Ilminster Library)
- Makes sense if recruitment issue. (Musgrove Park Hospital, concourse pop-up)
- Yes, better to have a specialist place, to attract more people. (Musgrove Park Hospital, concourse pop-up)
- Understand that makes sense to appeal to specialists to work in one site which is excellent. (Crispin Community Centre, Street)
- Agreement about being seen by a specialist sooner, if go to MPH (Sturminster Newton Country Market)
- Felt a full and speedy recovery were the most important things. (Sherborne Town Centre, pop-up)
- Understand that a further distance to travel but for a centre of excellence. (Morrisons Supermarket, Glastonbury, pop-up)
- Positive experiences at MPH so would happily see the services move there. (Morrisons Supermarket, Glastonbury, pop-up)
- Medequip – Felt that options being discussed were for the whole population of Somerset and not just those who are close to either YDH or MPH and that it was more important to have a service where there was better availability of expertise. People should be thinking more 'we' and less 'me'. (Yeovil Rugby Club, Public Event)

Negative

- Concern that putting more services at MPH. (Sturminster Newton Country Market)
- Concerned that taking away services from YDH. (Sturminster Newton Country Market)
- Shouldn't take services away from YDH. (Yeovil District Hospital)
- Longer ambulance journey and anything can happen on these. (Ilminster Library)
- But long ambulance wait times, so still feel terrified about how long will have to wait, regardless of what treatment I get at hospital. (Musgrove Park Hospital, concourse pop-up)
- Not happy with Dorset County Hospital option due to standard of road to get there. (Sherborne Town Centre, pop-up)
- Need to make sure it's fair for people of Yeovil. (St Peter's Community Centre, Talking Café)
- Not everyone can or would travel to Musgrove from Yeovil area. And also, not all nursing staff would want to be retrained in other areas. (Taunton Public Event)

- Concern for longer distance to get to the hospital. (Sturminster Newton Country Market)
- Moving stroke services to MPH is not good for people living in Yeovil or across the county, as too far to travel in an ambulance. (Yeovil District Hospital)
- Have really poor health, don't want to be far from home, it's too difficult. (Musgrove Park Hospital, concourse pop-up)
- Stroke survivor – wouldn't want to see service in Yeovil moved. Had received very good treatment and still remembers the names of all those in the hospital that treated him and helped his recovery. He feels strongly that having to go to Taunton or Dorchester will be very difficult for people. However, he understands the difficulty recruiting staff particularly consultants. (Sherborne Town Centre, pop-up)
- Recruitment, might continue to be a problem. Musgrove Park Hospital, concourse pop-up)
- Gentleman from Milborne Port – Stroke survivor … felt very strongly that the Yeovil service must not be lost. He received excellent treatment and rehabilitation care which he could not fault. He is very concerned that patients should have to go to Taunton or Dorchester. (Sherborne Town Centre, pop-up)
- Concerns of distance to a hyper acute stroke unit. (Sherborne Town Centre, pop-up)
- Concerned regarding the time it takes for ambulance to arrive currently then additional time to get to MPH. (Sherborne Town Centre, pop-up)
- *"Why move all the resources to either Yeovil or Musgrove anyway, when I live on the outskirts of Somerset?"* (Crispin Community Centre, Street)
- People do need to be able to visit their loved ones and can't do it if don't drive so can't get to Taunton. (Yeovil District Hospital)

Proposed option for one ASU

Positive comments

- None

Negative comments

- Sense of Yeovil losing out to Musgrove (Yeovil Library pop-up)
- Concern that other services will move too. (Sturminster Newton Country Market)
- It feels like we are devaluing YDH as it's not only stroke services, its ENT, Heart and Cancer services. Yeovil will end up with a second-rate hospital. (Yeovil Rugby Club, Public Event)
- *"Taking services away from Yeovil."* (Aspire, Yeovil District Hospital)
- Removing local services would downgrade YDH to 'community hospital'. (Warm Space, St Peter's Community Centre)
- Acute Stroke Nurse YDH – Fully understands requirement to centralise HASU but has concerns if there is no acute stroke provision at YDH particularly when patients come into A&E and it becomes apparent later that they have had a stroke. (Yeovil Rugby Club, Public Event)
- Concern around decision on options for TIA on page 32 not being made until decision on Stroke services made – surely Stroke services and TIA services decisions need to be made at the same time. And what happens if someone presents thinking it's a TIA and it turns out to be a stroke but there are no stroke staff at YDH? (Yeovil Rugby Club, Public Event)

- Feeling that Taunton was not the place for a single service as this favours Taunton and makes the rest of the county unequal. (Warm Space, St Peter's Community Centre)
- Concerns around travel times and those that cannot drive and needing to be near to loved ones. (Aspire, Yeovil District Hospital)
- Asking people with no car to travel to Taunton very wrong. (Warm Space, St Peter's Community Centre)
- Making travel further a mistake when speed of treatment essential for stroke. (Warm Space, St Peter's Community Centre)
- Travel – if live on the very West of Somerset, too far to travel (e.g. W Mendip) (Crispin Community Centre, Street)
- *"I am a stroke nurse at Yeovil hospital and have been for many years ... I understand about the hyper acute side of things as we do have a national shortage of doctors and support this change. BUT, to lose the acute part of stroke at unit at Yeovil will be so negative for a lot of patients, for example, public transport is far and few between from some areas in the county including Dorset. Also the psychological impact on patients not to have loved ones be able to visit as often will have a massive impact on their recovery."* (Taunton, Public Event)
- No support for this option, felt it was important to be close to family and friends for support and help with rehabilitation. (Sherborne Town Centre, pop-up)
- *"My father has received treatment and care for his stroke at Yeovil and I cannot fault the care, attention, efficiency and overall treatment that he has received. The Yeovil acute stroke unit needs to remain to give patients and carers a choice of where their succession of treatment is delivered. MPH is already congested enough in its delivery of services and Yeovil has superior post-hospital care services in the Home from Hospital scheme".* (Taunton, Public Event)
- Very well-regarded Stroke Consultant at Yeovil (Westlands, Yeovil pop-up)

Decision already made

- Expressed concern following experience with unitary council engagement that decision already made and any public view would be overridden. (Westlands, Yeovil pop-up)
- That there is a bias in the consultation document towards consolidating all stroke services at Musgrove. (Warm Space, St Peter's Community Centre)
- He also said that it didn't matter if we said no decision had been made that in his experience decisions are always made prior to going out to the public. (Yeovil District Hospital, pop-in)
- *"Listening to the panel it feels very much like the decision has been made and the plan is to make MPH a super hospital".* (Yeovil Rugby Club, Public Event)
- When we are told no decision has been made – this is a bit of a myth. People are suspicious and have no trust when consultations take place as decisions have been made in the past removing services from YDH not taking into account views of the public. (Yeovil Rugby Club, Public Event)
- *"As Yeovil District Hospital doesn't meet the 500 patients a year, does this mean that the decision to close the hyper acute stroke unit at Yeovil has already been made?"* (Taunton Public Event)

Other comments

Comments on use and/or experience of current hyper acute/acute stroke services

Poor treatment at Yeovil

» One person in particular talked with real pain at the inadequate treatment they had at Yeovil 20 years ago and reflected that they hoped any progression towards improvement or change was important. (Crewkerne and Chard After Stroke Club)

Good treatment at Yeovil

» Had a stroke, went to YDH and very happy with treatment. (Yeovil District Hospital, pop-in)

» Has experienced very good treatment at Yeovil for Stroke – not aware whether treated by a specialist but the doctors and nurses seemed very good and no complaints. (Crispin Community Centre, Street)

» Really good feedback about the care received at YDH. Support for getting the right care and treatment quickly. (Aspire, Yeovil District Hospital)

Poor treatment at Musgrove

» All of the stroke survivors I spoke with had been treated at Musgrove Park Hospital with mixed experiences – some very negative. One reported being told they have gone to the toilet in their bed (having tried continuously to get attention from nurses). Others reported nurses sat nearby chatting while they were in need. (Bridgwater Heather Club)

Good treatment at Musgrove

» *"My husband had vascular care at Taunton as there is no service at Yeovil and it worked well."* (Aspire, Yeovil District Hospital)

» One woman had had a stroke two years ago. Real success story of Musgrove – had stroke working in a church in Taunton town centre, ambulance arrived in 10 minutes, taken to Musgrove, given clot busting drug, then transported to Southmead. Woke up in ambulance on way to Southmead, spent a single night there and was discharged straight home. (Taunton Library)

Good treatment at Dorchester

» Dorchester Hospital – have received good treatment there before, but issue with distance. (Sturminster Newton Country Market)

Poor treatment at Dorchester

» He has a friend who recently had a stroke and was taken to Dorset and he said that the experience his friend had was not very good with very little follow up care and no occupational health therapy or rehab support. (Sherborne Town Centre, pop-up)

Proposals are intended mainly to save money/degrade the NHS

» Immediate thought that it was about money saving. (Crewkerne and Chard After Stroke Club)

» *"This must be about money or the slow creep privatisation of our NHS."* (Westlands, Yeovil pop-up)

- Group expressed emotional and lifelong connection to NHS. (Westlands, Yeovil pop-up)

Concern that Yeovil losing services and investment

- Yeovil on slippery slope to losing everything (Taunton getting investment) (Westlands, Yeovil pop-up)
- Worry that Aspire (rehab support group for recently discharged stroke survivors) would be taken too. Aspire provides a purpose for stroke survivors who have been through the process to volunteer and help others. (Aspire, Yeovil District Hospital)
- Don't take away Aspire. (Aspire, Yeovil District Hospital)

Sourcing support

- Thought ED was the place to arrive at with a stroke and this would be where they would get specialist treatment. (Aspire, Yeovil District Hospital)
- Unaware that there was not a 24/7 stroke specialist service in Somerset (Aspire, Yeovil District Hospital)
- Did not know that there was not a 24/7 specialist service at Taunton and concerned about that. (Burnham on Sea Methodist Church)

Stroke rehabilitation

- Very difficult to get home care packages for relatives who have had strokes. (Yeovil District Hospital, pop-in)
- Being able to be close to home for recovering is really important to patient and carer. (Somerset Engagement Advisory Group, online)
- Lack of rehabilitation services following initial period. (Frome Stroke Group)
- Lack of follow up by GP / Stroke Nurse following initial period. (Frome Stroke Group)
- Lack of interest in wellbeing when attending GP/Nurse for other issues. (Frome Stroke Group)
- GP not forthcoming about welfare support in light of one stroke survivor being main carer for wife with vascular dementia. (Heather Club, Sydenham Community Centre)
- Both felt that the post stroke medical support was poor. (Burnham on Sea Methodist Church)
- Both said the stroke community teams were brilliant. (Burnham on Sea Methodist Church)
- Would like to see the transition from the stroke service into neuro rehab services in place as otherwise they are lost to the system. (Burnham on Sea Methodist Church)
- Lack of support once discharged – limited community response and feel left to manage alone. (Heather Club, Sydenham Community Centre)
- Being understood in the group and not having to explain the stroke very important to the group. (Heather Club, Sydenham Community Centre)
- This is a super group who want to share their experiences and clearly get a huge amount from being able to meet together … They also evidence how much volunteers give in order that life continues with some sense of purpose. (Bridgwater Heather Club)
- Volunteer run support group a lifeline (one chap said he wouldn't be here if not for the group). (Heather Club, Sydenham Community Centre)

Comments on Consultation itself

- Three people mentioned that the questionnaire was very wordy, the booklet with it too detailed and dense and wanted simple questions, simple words and some diagrams – shorter versions ideally. (Ilminster Library)
- *"Well done on having an easy read version".* (Somerset Engagement Advisory Group, online)
- Asked to be included on agenda to ensure this group had been given notice that public consultation underway. Provided signposting to take part in consultation. Not an opportunity to discuss it. (Carers Strategic Partnership Board, online)
- Names of the people involved in putting this together need to be widely known. (Musgrove Park Hospital, concourse pop-up)
- One colleague reported that there seems to be a lot of misinformation and scaremongering which wasn't helpful. (Somerset Engagement Advisory Group, online)

Carers

- *"There seems to be little included that reflects support for carers".* (Somerset Engagement Advisory Group, online)
- Point made by Carers UK ambassador – also member of our stakeholder reference group for the stroke work - reflected back that there is a lack of offer to support carers (or people who become carers as a result of a loved one having a stroke) in the proposals. (Carers Strategic Partnership Board, online)

Appendix III: Tables of coded questionnaire text comments

The tables below provide a more detailed account of text comments by individuals responding to the three open-ended questions in the consultation questionnaire and discussed in chapter four of this report. Throughout this section, percentages are based on the number of responses raising each code, as a proportion of *all respondents who provided comments to this question*. Note that respondents could provide long comments that covered more than one code; therefore, the percentages sum to more than 100%.

Reasons for disagreeing with the proposed model of care or location for hyper acute stroke services

Table 10: If you disagree with the proposal to deliver hyper acute stroke services from only one hospital in future, and/or for this to be located at Musgrove Park Hospital in Taunton, please explain the reasons for your views and explain any alternative solutions or improvements to address the challenges that you think should be considered instead (individual questionnaire respondents only)

Summary of comments		No. of respondents	%
Reasons for Disagreement	**Disagreement: disagree with HASU only at MPH/keep hyper acute services at YDH:** Disagree with proposal: Keep/don't close HASU at Yeovil	149	18%
	Disagreement: disagree with HASU only at MPH/keep hyper acute services at YDH: Disagree with proposal: Generally disagree with HASU/hyper acute stroke service only at Musgrove	125	15%
	Disagreement: general/proposals won't improve services: Disagree with proposal (non-specific): Generally disagree, it won't work	49	6%
	Disagreement: general/proposals won't improve services: Disagree with proposal: Similar proposals have been rejected previously	4	*%
Concerns Raised	**Concerns: Delays to receive care, inc. FAST/'golden hour'/patient transfers:** Concern: Importance of golden hour incl. patient safety before arriving at hospital	332	41%
	Concerns: Delays to receive care, inc. FAST/'golden hour'/patient transfers: Access: Difficult to transfer patients between hospitals	18	2%
	Concerns: Growing population/MPH/DCH/other services already overstretched: Concern: Growing population	28	3%
	Concerns: Growing population/MPH/DCH/other services already overstretched: Concern: Musgrove is already overstretched	22	3%
	Concerns: Growing population/MPH/DCH/other services already overstretched: Concern: Dorchester/Dorset County is already overstretched	12	1%
	Concerns: Growing population/MPH/DCH/other services already overstretched: Concern: Will put more strain on surrounding areas/fewer resources	10	1%
	Concerns: General impacts on quality of care/patient safety and outcomes: Concern: Patient safety (unspecified)	26	3%
	Concerns: General impacts on quality of care/patient safety and outcomes: Concern: Patient safety/care within hospital	21	3%
	Concerns: Availability/access for stroke diagnostics/treatment: Concern: Availability/access for treatments for blood clots incl. thrombolysis, thrombectomy	29	4%
	Concerns: Availability/access for stroke diagnostics/treatment: Concern: Availability/access for diagnostic service scans e.g., CT & MRI etc.	16	2%
Access	**Access: MPH not central/too far away/more travelling required/increased costs:** Access: Musgrove Hospital is too far away	269	33%
	Access: MPH not central/too far away/more travelling required/increased costs: Access: More travelling required (non-specific)	102	12%
	Access: MPH not central/too far away/more travelling required/increased costs: Access: Increased cost of travelling further e.g. fuel/public transport	28	3%

	Access: MPH not central/too far away/more travelling required/increased costs: Access: Musgrove Hospital is not centrally located or geographically the best location in Somerset	28	3%
	Access: MPH not central/too far away/more travelling required/increased costs: Access: Too far from where I live	15	2%
	Access: Poor public transport/poor or busy roads/parking: Access: High traffic/poor road infrastructure	84	10%
	Access: Poor public transport/poor or busy roads/parking: Access: Poor Public transport	66	8%
	Access: Poor public transport/poor or busy roads/parking: Access: Poor parking	14	2%
	Access: Dorset County Hospital (DCH) too far away: Disagree with proposal: Dorchester/Dorset is too far	69	8%
Impacts	**Impacts: Family/friends not able to visit:** Concern: Family/friends unable to visit	154	19%
	Impacts: More strain on NHS staff/more training/will harm retention/recruitment: Staffing: Added strain to ambulance staff	33	4%
	Impacts: More strain on NHS staff/more training/will harm retention/recruitment: Staffing: Put more strain on the staff incl. longer shifts, distance/cost of travel	11	1%
	Impacts: More strain on NHS staff/more training/will harm retention/recruitment: Staffing: Staff will need to be trained	11	1%
	Impacts: More strain on NHS staff/more training/will harm retention/recruitment: Staffing: Concerned staff will lose their jobs or be demoted	9	1%
	Impacts: More strain on NHS staff/more training/will harm retention/recruitment: Staffing: Will deter staff from applying for jobs at Yeovil	3	*%
	Impacts: Rural/deprived areas will be affected: Equality concern: Rural areas/Yeovil being rural	54	7%
	Impacts: Rural/deprived areas will be affected: Equality concern: Deprivation/low income	3	*%
	Impacts: Older/frail people/people with disabilities/existing conditions: Equality concern: Elderly/aging population	46	6%
	Impacts: Older /frail people/people with disabilities/existing conditions: Equality concern: Disabled	3	*%
	Impacts: Older /frail people/people with disabilities/existing conditions: Equality concern: Ill health	1	*%
Alternatives and Suggestions	**Location: HASU should be at YDH instead/better location/good quality care:** Other: Positive view on Yeovil District Hospital incl. care, staff, service in general	68	8%
	Location: HASU should be at YDH instead/better location/good quality care: Disagree with proposal: Yeovil is closer/better location	53	6%
	Location: HASU should be at YDH instead/better location/good quality care: Disagree with proposal: HASU should be in Yeovil instead	20	2%
	Suggestions: Improve existing services/keep services local/increase funding: Suggestion: Need more local services/keep services local	53	6%
	Suggestions: Improve existing services/keep services local/increase funding: Suggestion: Improve existing services/conditions	40	5%
	Suggestions: Improve existing services/keep services local/increase funding: Suggestion: Get more funding from the government/allocate funding from other areas	20	2%
	Suggestions: Recruit more staff/higher wages/cut management: Staffing: Hire more staff/pay better wages	46	6%
	Suggestions: Recruit more staff/higher wages/cut management: Suggestion: Reduce management to fund frontline staff	4	*%
	Suggestions: Possible alternative/additional locations of HASU: Suggestion: Should also be available at other locations e.g. Minehead	12	1%
	Suggestions: Possible alternative/additional locations of HASU: Suggestion: Should be located at South Petherton	5	1%
Other	**Other: Criticism of consultation (not enough information/biased/box ticking exercise):** Criticism of consultation: More info needed including travel times	23	3%
	Other: Criticism of consultation (not enough information/biased/box ticking exercise): Criticism of consultation: Biased, minds already made up/box ticking exercise	12	1%
	Other: Other comment: Other	41	5%

Base: Individual respondents (819), Codes raised (2,242)

Views on delivery of *acute* stroke services in Somerset

Table 11: If you have a preference for whether acute stroke care should be provided from both hospitals in Somerset or only at the hospital with the hyper acute stroke unit, please explain why. If you have any other comments about acute stroke services or alternative suggestions on how the challenges affecting acute stroke services could be addressed (taking

into account the other options which have been considered), please explain here (individual questionnaire respondents only)

Summary of comments		No. of respondents	%
Prefer ASUs at Both YDH and MPH	**Two ASUs at YDH and MPH: Should be at both sites/kept the same:** Keep two ASUs: Should be situated at both sites/keep things the same	141	19%
	Two ASUs at YDH and MPH: Should be at both sites/kept the same: Keep two ASUs: Need at Yeovil	64	9%
	Two ASUs at YDH and MPH: Better service/outcomes/access: Keep two ASUs: Yeovil easier to access	64	9%
	Two ASUs at YDH and MPH: Better service/outcomes/access: Keep two ASUs: would be better service/outcomes	38	5%
Prefer ASU Only at the Same Site as HASU (MPH)	**One ASU at same site as HASU: Better service/outcomes/access/avoids transfers:** Consolidate to one ASU: Better service/outcomes	41	6%
	One ASU at same site as HASU: Better service/outcomes/access/avoids transfers: Consolidate to one ASU: Avoids problems with transfers to HASU	3	*%
	One ASU at same site as HASU: Better service/outcomes/access/avoids transfers: Consolidate to one ASU: Easier to access	2	*%
	One ASU at same site as HASU: Generally agree: Consolidate to one ASU: Generally agree	23	3%
Concerns: Quality of Care	**Quality of care: Risk to patient outcomes due to delays/ambulance journeys:** Quality of care: Risk to patient outcomes/strokes are time sensitive, golden hour	145	20%
	Quality of care: Risk to patient outcomes due to delays/ambulance journeys: Quality of care: Impact on ambulance services incl. response times	46	6%
	Quality of care: Risk to patient outcomes due to delays/ambulance journeys: Access: Difficulty transferring patients between hospitals	9	1%
	Quality of care: Will make things worse/not deliver improvements/already good care at both sites: Quality of care: There is currently good quality of care at Yeovil Hospital	36	5%
	Quality of care: Will make things worse/not deliver improvements/already good care at both sites: Quality of care: This will make issues worse/won't solve problems	21	3%
	Quality of care: Will make things worse/not deliver improvements/already good care at both sites: Quality of care: There is currently good quality of care at Musgrove Hospital	5	1%
Concerns: Travel and Access	**Access: Keep services local/in YDH/neither site has capacity for all patients:** Access: Keep services local (non-specific)	142	19%
	Access: Keep services local/in YDH/neither site has capacity for all patients: Access: Keep services local to Yeovil	39	5%
	Access: Keep services local/in YDH/neither site has capacity for all patients: Quality of care: Chosen site/either site not having the required capacity	21	3%
	Access: Further/more difficult/expensive to reach Taunton/Dorchester: Access: Difficulties travelling to Taunton, increased travel times and distance	162	22%
	Access: Further/more difficult/expensive to reach Taunton/Dorchester: Access: Increased expenses/will cost more to travel	33	5%
	Access: Further/more difficult/expensive to reach Taunton/Dorchester: Access: Difficulties travelling to Dorchester, increased travel times and distance	26	4%
	Access: Important for friends and family to be able to visit: Access: Consider importance of family members/friends visiting for patient recovery	179	24%
	Access: Poor public transport/poor or busy roads/parking: Access: Poor public transport provision	62	8%
	Access: Poor public transport/poor or busy roads/parking: Access: Delays due to traffic/road accidents	28	4%
	Access: Poor public transport/poor or busy roads/parking: Access: Lack of/improve parking availability	13	2%
Concerns: Impacted Groups	**Impacts: Other groups including rural/deprived areas/no private transport/NHS staff:** Impact: Staffing: Negative impact on staff	25	3%
	Impacts: Other groups including rural/deprived areas/no private transport/NHS staff: Impact: People without access to a vehicle	23	3%
	Impacts: Other groups including rural/deprived areas/no private transport/NHS staff: Impact: Rural areas	20	3%
	Impacts: Other groups including rural/deprived areas/no private transport/NHS staff: Impact: People from a deprived background/low income	2	*%
	Impacts: Older people/people with disabilities: Impact: Older people/elderly people	37	5%
	Impacts: Older people/people with disabilities: Impact: People with disabilities	4	1%

Other Concerns	**Concerns: YDH losing services/MPH is being favoured/not meeting populations needs:** Impact: Yeovil will lose too many services/Taunton is being favoured	27	4%
	Concerns: YDH losing services/MPH is being favoured/not meeting populations needs: Impact: Does not take into account/properly address growing population in Yeovil	15	2%
	Concerns: YDH losing services/MPH is being favoured/not meeting populations needs: Impact: Does not take into account/properly address ageing population (general comment)	5	1%
Alternatives and Suggestions	**Suggestions: Improve/invest in current services including recruit/retain/train staff:** Staffing: Improve wages/benefits/think of innovative ways to recruit/retain staff	21	3%
	Suggestions: Improve/invest in current services including recruit/retain/train staff: Suggestion: Improve/invest in facilities/services at Yeovil Hospital	20	3%
	Suggestions: Improve/invest in current services including recruit/retain/train staff: Quality of care: Need to ensure good access to community and post-hospital care	18	2%
	Suggestions: Improve/invest in current services including recruit/retain/train staff: Suggestion: Improve/invest in facilities/services at Musgrove Hospital	10	1%
	Suggestions: Improve/invest in current services including recruit/retain/train staff: Quality of care: Discharge/aftercare plans	9	1%
	Suggestions: Improve/invest in current services including recruit/retain/train staff: Staffing: Improve staff training	6	1%
	Suggestions: Improve/invest in current services including recruit/retain/train staff: Staffing: Move staff across hospital sites / share knowledge and support	6	1%
	Suggestions: Improve/invest in current services including recruit/retain/train staff: Suggestion: Opening times should be improved	5	1%
	Suggestions: Stroke services should be provided at a different hospital: Suggestion: Stroke services should be provided at a different hospital	13	2%
Other	**Other: Criticism of consultation (not enough information/biased/box ticking exercise):** Criticism of consultation: Consultation is biased/flawed/leading questions	23	3%
	Other: Criticism of consultation (not enough information/biased/box ticking exercise): Criticism of consultation: This is a money-making scheme	17	2%
	Other: Criticism of consultation (not enough information/biased/box ticking exercise): Criticism of consultation: Gather more information from clinical specialists	5	1%
	Other: Criticism of consultation (not enough information/biased/box ticking exercise): Criticism of consultation: Survey does not consider other stroke needs	5	1%
	Other: Criticism of consultation (not enough information/biased/box ticking exercise): Criticism of consultation: Consultation is a waste of money	1	*%
	Other: Disagree with single HASU in Somerset: Hyper acute services: Should be situated at both sites	27	4%
	Other: Agree with single HASU in Somerset: Hyper acute services: Consolidate service to one location - Generally agree	14	2%
	Other: Agree with single HASU in Somerset: Hyper acute services: Consolidate service to one location - Better service/outcomes	7	1%
	Other: Agree with single HASU in Somerset: Hyper acute services: Consolidate service to one location - Easier to access	3	*%
	Other: Other comments: Other	34	5%

Base: Individual respondents (731), Codes raised (1,745)

Groups or people who might be positively or negatively affected by any of the possible changes to services being considered

Table 12: Are there any particular groups or people that you believe might be positively or negatively affected by any of the possible changes to services being considered, including the need to travel further? If so, what groups are these? (individual questionnaire respondents only)

Summary of comments made		No. of respondents	%
Groups/People: Older/Vulnerable People	**Groups/People: Older/Vulnerable People:** Elderly/vulnerable: Distance will be too far to travel	96	11%
	Groups/People: Older/Vulnerable People: Elderly/vulnerable: Poor public transport links	51	6%
	Groups/People: Older/Vulnerable People: Elderly/vulnerable: Increased risk/lower quality of care	44	5%
	Groups/People: Older/Vulnerable People: Elderly/vulnerable: Cost of transport	17	2%
	Groups/People: Older/Vulnerable People: Elderly/vulnerable: Traffic issues including Poor road infrastructure	6	1%
	Groups/People: Older/Vulnerable People: Elderly/vulnerable: Other reason	24	3%
	Groups/People: Older/Vulnerable People: Elderly/vulnerable: No specific reason	178	20%
Groups/People: General/All Patients	**Groups/People: General/All Patients:** General/patients: Distance will be too far to travel	85	10%
	Groups/People: General/All Patients: General/patients: Increased risk/lower quality of care	53	6%
	Groups/People: General/All Patients: General/patients: Poor public transport links	19	2%
	Groups/People: General/All Patients: General/patients: Cost of transport	15	2%
	Groups/People: General/All Patients: General/patients: Traffic issues including Poor road infrastructure	7	1%
	Groups/People: General/All Patients: General/patients: Expensive parking	3	*%
	Groups/People: General/All Patients: General/patients: Other reason	15	2%
	Groups/People: General/All Patients: General/patients: No specific reason	88	10%
Groups/People: Visiting Friends and Family	**Groups/People: Visiting Friends and Family:** Visiting friends and family: Distance will be too far to travel	89	10%
	Groups/People: Visiting Friends and Family: Visiting friends and family: Poor public transport links	46	5%
	Groups/People: Visiting Friends and Family: Visiting friends and family: Cost of transport	22	3%
	Groups/People: Visiting Friends and Family: Visiting friends and family: Expensive parking	4	*%
	Groups/People: Visiting Friends and Family: Visiting friends and family: Traffic issues including Poor road infrastructure	4	*%
	Groups/People: Visiting Friends and Family: Visiting friends and family: Increased risk/lower quality of care	3	*%
	Groups/People: Visiting Friends and Family: Visiting friends and family: Other reason	12	1%
	Groups/People: Visiting Friends and Family: Visiting friends and family: No specific reason	87	10%
Groups/People: Those Without Private Transport/Relying on Public Transport	**Groups/People: Those Without Private Transport/Relying on Public Transport:** People without a car/can't drive: Poor public transport links	37	4%
	Groups/People: Those Without Private Transport/Relying on Public Transport: People without a car/can't drive: Distance will be too far to travel	34	4%
	Groups/People: Those Without Private Transport/Relying on Public Transport: People without a car/can't drive: Cost of transport	13	1%
	Groups/People: Those Without Private Transport/Relying on Public Transport: People without a car/can't drive: Increased risk/lower quality of care	8	1%
	Groups/People: Those Without Private Transport/Relying on Public Transport: People without a car/can't drive: Traffic issues including Poor road infrastructure	3	*%
	Groups/People: Those Without Private Transport/Relying on Public Transport: People without a car/can't drive: Expensive parking	1	*%
	Groups/People: Those Without Private Transport/Relying on Public Transport: People without a car/can't drive: Other reason	1	*%
	Groups/People: Those Without Private Transport/Relying on Public Transport: People without a car/can't drive: No specific reason	98	11%

Groups/People: Rural Communities, East Somerset/Dorset Residents	**Groups/People: Rural Communities, East Somerset/Dorset Residents:** Rural, East Somerset and Dorset residents: Distance will be too far to travel	38	4%
	Groups/People: Rural Communities, East Somerset/Dorset Residents: Rural, East Somerset and Dorset residents: Increased risk/lower quality of care	25	3%
	Groups/People: Rural Communities, East Somerset/Dorset Residents: Rural, East Somerset and Dorset residents: Poor public transport links	21	2%
	Groups/People: Rural Communities, East Somerset/Dorset Residents: Rural, East Somerset and Dorset residents: Cost of transport	8	1%
	Groups/People: Rural Communities, East Somerset/Dorset Residents: Rural, East Somerset and Dorset residents: Traffic issues including Poor road infrastructure	6	1%
	Groups/People: Rural Communities, East Somerset/Dorset Residents: Rural, East Somerset and Dorset residents: Other reason	3	*%
	Groups/People: Rural Communities, East Somerset/Dorset Residents: Rural, East Somerset and Dorset residents: No specific reason	71	8%
Groups/People: People with Disabilities/Long-term Conditions	**Groups/People: People with Disabilities/Long-term Conditions:** Disabled: Distance will be too far to travel	47	5%
	Groups/People: People with Disabilities/Long-term Conditions: Disabled: Poor public transport links	27	3%
	Groups/People: People with Disabilities/Long-term Conditions: Disabled: Cost of transport	9	1%
	Groups/People: People with Disabilities/Long-term Conditions: Disabled: Increased risk/lower quality of care	8	1%
	Groups/People: People with Disabilities/Long-term Conditions: Disabled: Traffic issues including Poor road infrastructure	2	*%
	Groups/People: People with Disabilities/Long-term Conditions: Disabled: Other reason	11	1%
	Groups/People: People with Disabilities/Long-term Conditions: Disabled: No specific reason	54	6%
Groups/People: People with Low Incomes/Deprived Communities	**Groups/People: People with Low Incomes/Deprived Communities:** Low income: Cost of transport	24	3%
	Groups/People: People with Low Incomes/Deprived Communities: Low income: Poor public transport links	16	2%
	Groups/People: People with Low Incomes/Deprived Communities: Low income: Distance will be too far to travel	12	1%
	Groups/People: People with Low Incomes/Deprived Communities: Low income: Expensive parking	2	*%
	Groups/People: People with Low Incomes/Deprived Communities: Low income: Increased risk/lower quality of care	2	*%
	Groups/People: People with Low Incomes/Deprived Communities: Low income: Other reason	1	*%
	Groups/People: People with Low Incomes/Deprived Communities: Low income: No specific reason	33	4%
Groups/People: Other Groups, including NHS Staff	**Groups/People: Other Groups, including NHS Staff:** People with lack of internet/technology: No specific reason	3	*%
	Groups/People: Other Groups, including NHS Staff: Ethnic minorities: Distance will be too far to travel	1	*%
	Groups/People: Other Groups, including NHS Staff: Ethnic minorities: Poor public transport links	1	*%
	Groups/People: Other Groups, including NHS Staff: Ethnic minorities: Increased risk/lower quality of care	1	*%
	Groups/People: Other Groups, including NHS Staff: Ethnic minorities: Other reason	3	*%
	Groups/People: Other Groups, including NHS Staff: Concern: Staff will be negatively impacted	29	3%
	Groups/People: Other Groups, including NHS Staff: Concern: Staff losing jobs	1	*%
Groups/People: Single Parents/Young Families	**Groups/People: Single Parents/Young Families:** Single parent/young families: Distance will be too far to travel	8	1%
	Groups/People: Single Parents/Young Families: Single parent/young families: Cost of transport	2	*%
	Groups/People: Single Parents/Young Families: Single parent/young families: Poor public transport links	2	*%
	Groups/People: Single Parents/Young Families: Single parent/young families: Increased risk/lower quality of care	2	*%
	Groups/People: Single Parents/Young Families: Single parent/young families: Traffic issues including Poor road infrastructure	1	*%
	Groups/People: Single Parents/Young Families: Single parent/young families: Other reason	4	*%
	Groups/People: Single Parents/Young Families: Single parent/young families: No specific reason	11	1%

Other: No impacts/nobody will be impacted: No/nobody will be affected		73	8%
Other: General disagreement with proposals: Suggestion: Provide community transport		16	2%
Other: Other comments: Other		50	6%
Positive Impacts: Improve care/patient outcomes/provide specialist staff/treatment	**Positive Impacts: Improve care/patient outcomes/provide specialist staff/treatment:** Benefits of specialist unit: will provide high quality care	13	1%
	Positive Impacts: Improve care/patient outcomes/provide specialist staff/treatment: Benefits of specialist unit: will ensure continuity of qualified staff	6	1%
	Positive Impacts: Improve care/patient outcomes/provide specialist staff/treatment: Benefits of specialist unit: will provide highly equipped/specialist treatments	5	1%
	Positive Impacts: Improve care/patient outcomes/provide specialist staff/treatment: Benefits of specialist unit: will improve outcomes	5	1%
Disagreement: General disagreement with proposals: Generally disagree with proposal		60	7%

Base: Individual respondents (876), Codes raised (1,881)

Appendix IV: Written submissions

Written submissions received during the consultation are summarised in the main body of this report. Verbatim copies of formal responses from representatives and organisations are included here for reference.

Written submissions

1. NHS Dorset
2. Stroke Consultant Physician, Yeovil District Hospital
3. Sherborne Town Council
4. Yeovil Without Parish Council
5. Councillor Peter Seib (sent via Councillor Adam Dance)
6. Chairs of Patient Participation Groups (east Somerset and north Dorset)

1. NHS Dorset

NHS
Dorset
Integrated Care Board

Vespasian House
Barrack Road
Dorchester
Dorset
DT1 1TG

Tel: 01305 368900
Fax: 01305 368947

20 April 2023

NHS Somerset
Wynford House
Lufton Way
Lufton
Yeovil
Somerset
BA22 8HR

Sent via email - somicb.fitformyfuture@nhs.net

Dear Colleague

RE: IMPROVING HOSPITAL BASED STROKE SERVICES IN SOMERSET- Public Consultation

Thank you for the opportunity to make a formal response to your proposal to reconfigure Stroke Services in Somerset. I am aware of and very much appreciate the coordination between our colleagues and leaders around the development of stroke services both in Dorset and Somerset.

Recognising the impact that the proposed reconfiguration of services in Somerset will have on Dorset residents and Dorset County Hospital we have actively engaged with provider colleagues and Dorset residents to obtain their feedback and thoughts on the proposals.

We support, in principle, the movement to one Hyper-Acute Stroke Unit (HASU) for Somerset based at Taunton. We recognise the challenges that the provision of a HASU at Yeovil will present and the over-riding concern that patients are treated in the location that can most effectively meet their needs, ensure the best possible outcomes and contribute towards the patients' future wellbeing.

The feedback we have received from providers, patient groups, the Dorset population and partners is unanimous in the view that the retention of an Acute Stroke Unit (ASU) at Yeovil Hospital is the preferred option, option A. There are a number of factors which have informed this response and I have summarised them below.

- Residents expressed the importance of an ASU being retained at Yeovil to allow people living in the Yeovil vicinity to return closer to home following initial hyper-acute care.
- Travel times to Taunton and Dorchester were raised by residents as a concern although there was recognition that the right care for patients 24/7 is essential even if the initial journey time to access that care is longer.
- Providers expressed concerns regarding travel times for patients and the need to retain a transient ischemic attack (TIA) service at Yeovil for North Dorset patients.

- DCH highlighted that resistance from patients (and relatives) living in the Yeovil and Somerset border areas to go to Taunton ASU could result in delays in transfers for continuation of care and so prevent capacity being available for new admissions and ongoing care at DCH.

The support for option A is predicated on the understanding that there will be an assessment of the impact of moving patients from the HASU at DCH to an acute unit at YDH and confirmation that such a move will not negatively impact on the patient's morbidity and mortality.

We look forward to continuing to work closely with you as you move from consultation to making your decision on the future configuration of stroke care for the benefit of the communities we serve.

Yours faithfully

Patricia Miller
Chief Executive Officer
NHS Dorset

2. Stroke Consultant Physician, Yeovil District Hospital

Yeovil District Hospital NHS
NHS Foundation Trust

DEPARTMENT OF STROKE

Our Ref: KAR/lp

Document Typed: 24/04/2023

Yeovil District Hospital
Higher Kingston
Yeovil
Somerset
BA21 4AT
Switchboard: 01935 475122
Sec Direct line: 01935 384344

Jonathan Higman – **via email**
Chief Executive NHS Somerset
Wynford House
Lufton Way
Lufton
Yeovil
Somerset BA22 8HR

Dear Jonathan

Re: Somerset Stroke Public Consultation

I am writing to express my concerns about the Somerset stroke public consultation and the proposal to make major changes to the stroke services in Somerset.

Having read all the documents currently in the public domain and having attended, without invitation, one of your public meetings I am now very concerned that the proposals to make radical changes to the delivery of the stroke services is not in the best interests of the communities served by MPH and YDH. Indeed, if adopted, option B which proposes to transfer the whole stroke services in YDH to MPH will have a catastrophic effect on the whole of the community served by YDH.

I am sorry to say that many of the information in the public documents, and reiterated in the public meetings were misleading and non-factual.

It was stated that you had the support and the engagements of many of your partners including medical , nursing staff, therapists, South Western Ambulance Service and the other NHS trusts being affected by the proposals.

I am afraid this is not factual. The team responsible for the preparation of the so called public consultation did consult with the stroke medical and nursing staff in YDH about a single HASU at MPH, but never consulted about option B of your proposal. Indeed none of YDH staff, including myself was allowed to see or comment on the public documents before they were published at the start of the public consultation process.

It is also not factual that you have consulted and had agreement with other NHS service providers about option B. The supporting letters in the public domain from, RUH, DCH, South Western Ambulance Service all agreed to engage and support the Somerset public consultation in relation to the reconfiguration of the stroke hyper acute stroke services and not the acute stroke services and option B. Indeed, I am reliably told that DCH, a key player in the whole process will only support option A.

The proposal promised the delivery of high quality and equitable services for the whole community, but you gave no assurances that making the changes will ensure such delivery. Indeed your proposal and the financial modelling offered no such guarantees that this will be

the case. As you know, I have repeatedly argued in the various meetings attended by yourself and Peter Lewis, that one of the main reasons why Somerset stroke services failed to deliver on the A star SSNAP national rating, is the chronic underfunding of the stroke services in Somerset and lack of system/organisation support over many years. Therefore, making significant changes to the service with no commitment to extra funding coupled with ongoing workforce shortage most certainly will not deliver the promised long term benefits.

I know you and the delivery board are all committed to the delivery of the best and most equitable stroke services to population served by both MPH and YDH. Centralisation of the HASU Services with the correct resources and workforce at MPH makes sense and should be supported. Option B on the other hand, with no stroke services at all in YDH does not make any sense and should be strongly opposed and rejected. Indeed, should this option be implemented, it will have a disastrous effect on the whole health delivery system and will have a catastrophic impact on the population served by YDH.

I hope and trust that you and the board should reject this option.

With kind regards,
Yours sincerely

K A Rashed

K A Rashed MBE, FRCP
Stroke Consultant Physician

Copy to: Peter Lewis, Chief Executive, Somerset NHS Foundation Trust – via email
Colin Drummond, OBE DL, Chairman, Somerset NHS Foundation Trust - via Email
Meridith Kane, Medical Director, Somerset NHS Foundation Trust – via email
Marcus Fysh, MP – via email

3. Sherborne Town Council

Sherborne Town Council response to public consultation on the future of NHS acute hospital-based stroke treatment services in Somerset.

The future of hyper acute stroke treatment is of special interest and concern to the residents of Sherborne, Dorset, for three main reasons:

- Nearly a third of Sherborne's population is aged 65 and over. The average for England and Wales is 18.6%. Statistically, demand for excellent acute stroke care is likely to be much higher than the national norm.
- Sherborne lies right on the edge of the county borderlands of Dorset and Somerset. The community is rightly concerned to ensure that its relative geographical isolation does not adversely affect acute care health provision.
- At the moment, Yeovil District Hospital is the nearest provider of acute stroke response for Sherborne. Any decision to concentrate Somerset's hyper acute stroke care at Musgrove Park Hospital in Taunton is therefore especially important for Sherborne residents.

Having said that, Sherborne Town Council does see benefits in concentrating consultancy and nursing expertise along with top-level equipment and facilities in hyper acute care units open 24 hours a day in both Dorchester and Taunton.

Should such a reorganisation go ahead, we believe the following quid pro quo is vitally important to ensure optimum care for the people of Sherborne.

- For paramedic ambulance crews attending a stroke emergency in Sherborne, the default destination should be the hyper acute stroke unit at Dorset County Hospital in Dorchester. The "blue lights" journey time to Dorchester is half that of the journey to Taunton.
- Such emergency cases should bypass A&E queues and go straight to the hyper acute stroke unit given that time is of the essence in successful treatment of stroke.
- The hyper acute stroke unit should be accessible 24/7 all year round.
- In any reorganisation, the excellent "step down" specialist stroke recovery unit at the Yeatman Hospital, Sherborne, becomes ever more vital. The unit's future must be secured and capacity potentially increased. Essential recovery nursing, occupational therapy and physiotherapy are available there.
- The ease with which family and friends can visit stroke patients in the Yeatman helps improve recovery and release times, speeds up the practical provision of post-hospital support services and helps reduce bed blocking and therefore NHS costs.
- Transport is a particular concern. Nearly a quarter of Sherborne households have no car or van. Public transport is very poor, especially bus services. The Yeatman Hospital is within walking distance for most Sherborne family and friends visiting stroke patients.

17th April 2023

4. Yeovil Without Parish Council

Yeovil Without Parish Council
15 Heather Way, Yeovil, Somerset. BA22 8DZ
Phone: 01935 479975
E-mail: clerk@yeovilwithoutparishcouncil.gov.uk

RESPONSE OF YEOVIL WITHOUT PARISH COUNCIL TO PUBLIC CONSULTATION ON IMPROVING ACUTE HOSPITAL BASED STROKE SERVICES IN SOMERSET.

This council representing the residents of Yeovil Without Parish (6834) resolved at a meeting and wishes to record its preference for Option A i.e. an Acute stroke unit at Musgrove Park Hospital AND at Yeovil District Hospital.

We are disappointed that there will not be a HyperAcute Unit at Yeovil.
We would have liked the opportunity to be consulted on this as an option.

We believe that the people of this area wish for and would be best served by the retention of an acute unit at Yeovil. We believe that this would be of benefit to the physical and mental wellbeing of those of our residents who find themselves in need of this service and their families.

Early transfer back to Yeovil would allow family and friends to be more involved in on-going care. It is vital that relatives are involved in decision making and this will be hindered if they have to travel approximately 50 miles round trip to visit their relative.

Further, we believe that an acute unit at Yeovil will provide better continuity of care because local therapists will be involved at an earlier stage and transition to home care would be more seamless.

Whilst most relatives might be able to tolerate longer visiting journeys for a few days, it is damaging to their emotional wellbeing for this to be needed for a prolonged period of time. This is important because the patient will be returning to the care of these relatives and will suffer if these carers are already exhausted by travelling. The patient and their family must be considered at all time.
It is roughly a 45- 50 mile round trip to these units at Taunton and Dorchester.
It is much more difficult to get a friend or neighbour to travel from Yeovil to Taunton or Dorchester than to Yeovil Hospital.

We understand / believe that it is likely that our parishioners will be more likely to be sent to Dorset County Hospital rather than Musgrove Park Hospital.

Therefore, in order not to be disadvantaged in comparison to other Somerset residents, we expect the commissioners of services to ensure that our parishioners will have access to a service at Dorset County equal to that provided at Musgrove Park Hospital.
In particular, we would request that services for HyperAcute care at Yeovil District Hospital are retained until all necessary measures are in place at Dorset County Hospital. In particular a 7 day Hyper Acute unit should be in operation.

Because of the configuration of regional health services, we are concerned that those residents who require thrombectomy might be sent to Southampton Hospital rather than Southmead Hospital in Bristol and we require clarification on this point. We would prefer for our residents to be transferred to Bristol rather than Southampton because of journey length and general lack of acquaintance with the Southampton area.

Given the enormous problems that we are all aware of with ambulance response time in recent times, we are also concerned that any improvements in " door to needle" time when the patient reaches a hyper-acute unit will be offset by unacceptable delays in ambulance response time and transfer times. Currently, most of our parishioners and other residents of the Yeovil area can be transferred to Yeovil Hospital in a matter of minutes. We would expect that the necessary funding is made to the ambulance service to ensure that they are able to respond speedily to all residents of Somerset.

5. Councillor Peter Seib (sent via Councillor Adam Dance)

Background

To date, there are 2 units that offer care for people suffering an acute stroke in Somerset at Musgrove Park and at Yeovil District Hospital. The services, whilst excellent, do not comply with the level that NHS ENGLAND requires.

There are two elements to stroke care.

The first is called Hyper Acute Stroke service and this is the care in the first three days. This is followed by Acute Stroke care for a period of time until the person is ready for discharge to home or a community unit e.g. South Petherton. This is likely to be at least another week.

There are 2 options on offer. Both only offer Hyper Acute Services at Taunton (or another hospital outside of Somerset if it is nearer)

Option A provides for an acute unit at BOTH Musgrove Park and at Yeovil Hospital

Option B only provides for acute care at Musgrove Park i.e there will be no service at Yeovil.

Basically, if someone calls an ambulance, Stroke symptoms are rated category 2 by the Ambulance service. The theory is that an ambulance and possibly a paramedic will be sent to the patient who will then be transported to a Hyper Acute Unit. On arrival, the patient should bypass the Accident and Emergency Unit and immediately be under the care of a specialist team who will take him/her straight to a CT scanner. to conduct the necessary tests. The target is that 95% of patients would have a specialist assessment within 30 minutes of arrival in hospital. This should allow the team to differentiate between a stroke caused by a clot and one caused by a haemorrhage (bleed).

If there is a clot, the patient should be started on Clot-Busting treatment. There is a need/target to start this within 3 and 1/2 hours. He/she would then stay in the Hyper-Acute Unit for 3 days and then transfer to an Acute unit for the remainder of their time in hospital and during which, rehabilitation would commence.

PROPOSAL FOR HYPER ACUTE CARE

The first difference in their proposals is that patients will be taken to Taunton. Yeovil would no longer accept these patients.

The important target is getting treatment started. The time taken to travel to hospital is not so critical and they believe that the standard of care that the patient receives will be better and that this is more important than a target time to get to hospital. THIS IS THEORETICALLY CORRECT. However, the real world in which we live means that there could be delays because of the amount of time that passes between the initial 999 call and the arrival of a paramedic and ambulance and thus transport to hospital. Delays with this could lead to scanning and treatment delays. This has happened.

For most people in Somerset, this will mean being transported to Musgrove Park in Taunton. However, on page 20 of the summary document it reads that:-

“People who live closer to hyper acute stroke units out of Somerset would be taken to their closest unit, for example Dorset County Hospital”. This has major implication for people in and around Yeovil.

THIS MEANS THAT EVERYONE IN YEOVIL WITHOUT and INDEED ALL OF YEOVIL WILL BE TAKEN TO DORCHESTER (Dorset County Hospital).

Of the 454 patients admitted to the Yeovil Stroke unit in 2021, in the future, 56% (255) would go to Dorchester. Another 10% would go to Bath (50 people) and 4% (17 people) would go to Salisbury.

So 70% of the patients who are currently being admitted to Yeovil Hospital would be sent to hospitals other than Musgrove Park in Taunton. Only 30% of the people who currently go to Yeovil would be taken to Musgrove Park. Thus, any improvements in services at Musgrove Park will not be there for people in Yeovil Without.

At the consultation, I raised this issue because I had looked up addresses all over this area and looked at distances and everywhere in Yeovil was nearer to Dorchester. Dr. Rashid (soon to retire consultant at YDH, who set up the superb system at YDH) said that I was right.

Going to Dorchester instead of Taunton might well be preferable for many people and if it is nearer, that seems good. **So, basically, whilst a unit in Yeovil would be preferable, it is not on offer.** Dorchester may well be able to deliver as good a level of care as Musgrove Park.

HOWEVER, IT CAN PRODUCE PROBLEMS

1) At present, the service at Dorchester is **currently only operating 5 days a week.** I suspect the additional money that would come from Somerset to pay for the care of 255-odd people is what is needed to make this a 7-day service.

I believe we should be insisting that this is in place before the unit at Yeovil is closed for Hyper-Acute (first 3 days) Care.

2) Some patients are found to need surgery to remove clots. This is called thrombectomy. If a patient is at Taunton, he /she would be sent to Southmead Hospital in Bristol to have this surgery carried out. **It is entirely possible that someone admitted to Dorchester would be taken to Southampton for this surgery.**

Reluctantly, I think we have to accept that this is not an ideal world and that there will not be a Hyper Acute stroke unit at Yeovil. I think that it is likely that, even with the longer travel time (which would be a blue light transfer) that patients would receive a better journey of care when they arrive at hospital whether it be Taunton or Dorchester. Staffing levels should be higher than with the current arrangements.

However, we must ask that a 7-day service is in place at Dorchester before the unit at Yeovil is closed for Hyper Acute Stroke services.

ACUTE STROKE CARE.

This starts after 3 days and is the start of rehabilitation.

Option B allows for patients to stay either at Taunton or Dorchester for **all their acute care.**

It is the **opinion of** the authors of the report that this would present greater continuity of care.

However, they admit (page 23) that this would have impact on services at Dorchester because they would have to increase their number of acute stroke beds (currently 20). It would also require more beds in Taunton. These extra beds would need to be created before any changes.

Care continues after the patient is discharged from Acute Care and returns home or to a community unit. **I have concerns about how this will be seamless if the patient remains in Dorchester at this stage.**

Visiting: Outcomes for patients does not dwell with clinical staff alone. It is very important to understand the benefits of contact with near relatives. It is believed that a visit of 20 minutes or less is enough for most stroke patients; longer visits tend to exhaust them.

Whilst most relatives, would try to cope with this for a few days, it is damaging to their emotional wellbeing for this to be needed for a prolonged period of time. This is important because the patient will be returning to the care of these relatives and will suffer if these carers are already exhausted by travelling. It is roughly a 45- 50 mile round trip to these units at Taunton and Dorchester. It is much more difficult to get a friend or neighbour to travel from Yeovil to Taunton or Dorchester, than to Yeovil Hospital.

Given these points, I believe that this council should state that we prefer OPTION A i.e acute services to be provided at Yeovil. Resolution for Yeovil Without Parish Council

PUBLIC CONSULTATION ON IMPROVING ACUTE HOSPITAL BASED STROKE SERVICES IN SOMERSET.

This council representing the residents of Yeovil Without Parish (6834) resolved at a meeting and wishes to record its preference for Option A, i.e. an Acute stroke unit at Musgrove Park Hospital AND at Yeovil District Hospital.

We are disappointed that there will not be a Hyper Acute Unit at Yeovil.

We believe that the people of this area wish for and would be best served by the retention of an acute unit at Yeovil. We believe that this would be of benefit to the physical and mental wellbeing of those of our residents who find themselves in need of this service and their families.

Early transfer back to Yeovil would allow family and friends to be more involved in on-going care. Further, we believe that it will provide better continuity of care because local therapists will be involved at an earlier stage and transition to home care would be more seamless.

We understand / believe that it is likely that our parishioners will be more likely to be sent to Dorset County Hospital rather than Musgrove Park Hospital.

Therefore, in order not to be disadvantaged in comparison to other Somerset residents, we expect the commissioners of services to ensure that our parishioners will have access to a service at Dorset County equal to that provided at Musgrove Park Hospital. In particular, we would request that services for Hyper Acute care at Yeovil District Hospital are retained until all necessary measures are in place at Dorset County Hospital. In particular a 7-day Hyper Acute unit should be in operation.

Because of the configuration of regional health services, we are concerned that those residents who require thrombectomy might be sent to Southampton Hospital rather than Southmead Hospital in Bristol and we require clarification on this point. We would prefer for our residents to be transferred to Bristol rather than Southampton because of journey length and general lack of acquaintance with the Southampton area.

6. Chairs of Patient Participation Groups (east Somerset and north Dorset)

An Open Letter to NHS Somerset

Public Consultation – Somerset Hyperacute Stroke Reconfiguration

13 April 2023

Dear NHS Somerset

As Chairs of Patient Participation Groups throughout east Somerset and north Dorset, we represent the views and opinions of the many thousands of patients registered at our respective General Practice Surgeries. Having carefully considered the two options presented in your public consultation, we have grave concerns about the potential harm to patients if either option is adopted unamended. Our comments specifically relate to the interests of those stroke patients and their families and friends, who have to date been treated and cared for at Yeovil District Hospital.

First, we wish to comment on your Option B, which closes and eliminates all stroke services in Yeovil. In these circumstances, all patients suspected of stroke will be taken by ambulance to the hyper-acute stroke unit at Taunton hospital. Patients will spend up to seventy-two hours in the HASU, and thereafter be moved to the adjacent acute unit for perhaps a further two or three weeks before transferring to South Petherton or Sherborne for ongoing recovery and rehabilitation.

We are all aware of the Government *FAST* advice. The additional time patients will spend travelling to the hospital may well set back their recovery and be harmful to their long-term clinical outcome. In your public meetings you have presented no independent evidence to the contrary.

The extended period patients will be at Taunton puts a greater burden on the families and friends of stroke patients who wish to visit their loved ones daily. Public transport links between Yeovil and Taunton are inconvenient and expensive. Neither train nor bus journeys are direct and the average duration is two hours in each direction. As usual, the heaviest burden will fall on the disadvantaged and the least well-off in our community. Inevitably, visitor rates will fall and will in turn, slow the recovery of the patient. It is well understood that frequent visits from family and friends can help patients recover quicker by reducing stress and anxiety; but to be effective, the contact must be in person – not by social media.

To summarise, the closure of all stroke services at Yeovil, will likely harm the recovery of patients for reasons of (1), travelling further will extend the time from onset of stroke to first treatment by up to sixty minutes, and (2), limiting the benefits of frequent visits by family and friends on the speed of recovery. It may also impose intolerable, additional costs on those families least able to afford them.

We therefore firmly reject Option B.

Second, we comment on your Option A where all patients suspected of stroke will first be taken to the HASU at Taunton to receive treatment for a period of approximately seventy-two hours, but following this, patients will be taken to the ASU at Yeovil for continuing treatment.

Our comments above, regarding the additional travel time to Taunton, apply equally to this option. All respected medical science journals make it clear that reducing the time from onset of stroke to arrival at hospital is a crucial determinant of the patient's clinical outcome.

The most comprehensive review of stroke care in England is the Sentinel Stroke National Audit Programme (SSNAP). In its ninth annual report of stroke care in England between April 2021 and March 2022, SSNAP made special mention of ambulance activity:

"The faster a patient is conveyed to hospital, the more likely they are to receive timely assessments, accurate identification of stroke and delivery of crucial reperfusion treatments. Rapid emergency response to stroke patients is vital to reduce mortality and disability - 'time is brain'. "

SSNAP went on to point out that there has been a significant increase in the time taken from onset of stroke to hospital arrival time in 2021-22 compared to the previous two years. It further stated that:

"The most pressing issue which requires addressing urgently concerns overstretched ambulance services and rising staff shortages coupled with increased COVID-19 hospitalisations, which have been replicated across other emergency conditions. These ongoing pressures at the pre-hospital stage threaten to adversely affect patients throughout the hospital stroke pathway and beyond."

Both Somerset hospitals have seen worsening trends in 'onset to arrival time', consistent with the national picture in 2021-22. Since then, of course, ongoing industrial action, including walkouts by ambulance staff will have deteriorated the situation still further.

It is not widely known by the public, that stroke patients are counted only as category 2 emergencies by the ambulance service following a 999 call. The national standard for an ambulance response time for a cat 2 emergency is 18 minutes. Category 1 is 7 minutes and is reserved for cardiac arrests and serious allergic reactions. Ambulance queues waiting outside hospitals to deliver patients have become commonplace since Covid and national response time targets are consequently not being achieved. New operational guidance for ambulance crews in 2023/24 has changed the cat 2 emergency response time to a new target of 30 minutes. It is uncertain if this much increased target will be achieved either.

Despite the difficulties and worsening performance of our ambulance service, you have presented two options to the public which both rely entirely on transporting patients across the county without delay.

Unless mitigated, we regard this as an unacceptable risk to the clinical outcome for patients.

Turning to related issues, you have emphasised that a key motivating factor in making the changes you propose, is the difficulty in recruiting staff at the Yeovil HASU. We don't doubt that recruitment is indeed a challenge but we cannot allow a manpower planning failure, which is entirely in the hands of the NHS, to be used as a valid reason to close down a highly valued service. The staff shortage problem is, in any event, undermined by the planned actions of NHS Dorset. As you know, a £3.0M investment plan has been approved to upgrade the stroke unit at Dorchester Hospital to a 24/7 HASU. It is interesting to note that right now, Dorset and Somerset between them have three HASUs, located at Yeovil, Taunton and Bournemouth. Whichever one of your options is approved, the two counties will still have three HASUs, just not at Yeovil.

In addition to the recruitment issue, you cite the inadequate number of stroke patients at Yeovil as further justification for your planned reconfiguration. You quote that a minimum of 600 strokes per annum are necessary to maintain the skill and expertise of the clinical staff.

Yeovil has averaged about 450 stroke patients per annum, excluding mimics, in recent years, so it should be possible to observe the performance of the Yeovil stroke unit as inferior to those units where the 600 figure is exceeded; but no such correlation exists. Indeed, in the years prior to the Covid pandemic, the performance of the Yeovil unit was, if anything, superior to its neighbours.

We believe the situation in which we, as patient representatives, find ourselves is unsatisfactory and unfair. Both options you have presented for consideration, deteriorates the stroke service in Somerset and Dorset for patients, their friends and their relatives who happen to reside closer to Yeovil than either Taunton or Dorchester. Had adequate investment been made in the Yeovil stroke facility in the past several years, this unfortunate situation would not have arisen.

However, we recognise it is now not possible to maintain a full HASU at Yeovil. In your public statements you have made it clear that maintaining the status quo is not an option.

We therefore select Option A, subject to the following:

We require your firm assurance on the following matters and that they will be put in place *before* you make any changes to the current arrangements.

1. The HASU at Taunton will provide outstanding treatment and care for all stroke patients and be adequately staffed and equipped. The clinical staff at Taunton will also assist and advise colleagues at Yeovil, despite the Yeovil facility having a reduced role.
   We have taken expert advice on this matter and conclude that to establish an 'A Star' 24/7 HASU at Taunton will require 8 Consultants, 10 additional doctors and 8 Nurses. It will also require 33 dedicated beds to care for and treat in excess of 1000 stroke patients per annum.

2. Particular consideration is given to establishing dedicated stroke ambulances equipped appropriately and with a paramedic on board who is familiar with stroke symptoms and who can communicate with hospital clinical staff en route.

3. To somewhat mitigate the increased travel time by ambulance, every effort is made to reduce the 'door to needle time' upon arrival at Taunton.

Finally, we have made no mention of the financial implications of establishing an 'A Star' HASU at Taunton but we feel sure it will exceed the estimates included in your pre-consultation business case. Nevertheless, if NHS Somerset is to keep the confidence and support of patients in all parts of the county, it is important to provide reassurance on these crucial matters.

Yours sincerely

John Falconer
Ryalls Park Medical Centre
Yeovil

Ray Croissant
Penn Hill Surgery
Yeovil

Andrew Elphick
Hamdon Medical Centre
Stoke-sub-Hamdon

David Hughes
Crewkerne Health Centre
Crewkerne

Roger Marsh
The Grove Medical Centre
Sherborne

Margaret Gulliver
Oakland's Surgery
Yeovil

Ron Kench
Buttercross Health Centre
Somerton

Nigel Engert
Wincanton Health Centre
Wincanton

Michael Beales
Preston Grove MC
Yeovil

Appendix 03:

Example communication materials used in the stroke public consultation

Below are examples of some of the materials produced for the stroke public consultation.

Public facing materials used information contained within our Pre-consultation Business Case (PCBC). The PCBC was signed off by the stroke steering group, Fit for my Future Programme Board and the NHS Somerset Board.

We tested some of our materials and messages with the stroke steering group and Healthwatch readers panel. We adapted materials as the consultation progressed to encourage participation from communities we had received a low response from.

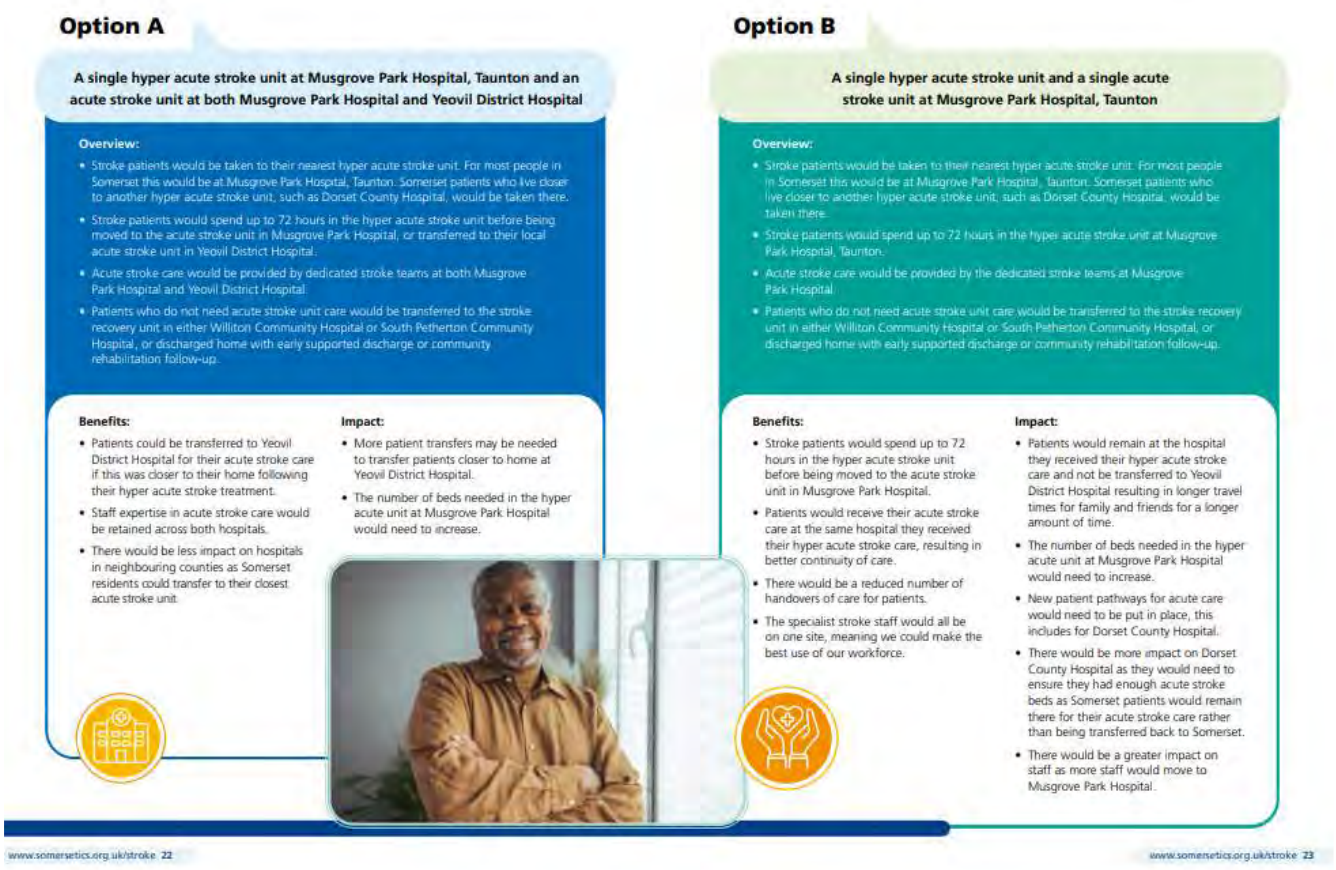
We worked with a graphic designer to create a look and feel for the consultation which was accessible and easily identifiable.

We produced summary materials and created Easy Read and Aphasia friendly versions.

Materials were shared with partners to share across their channels.

Document examples

Consultation document



Option A

A single hyper acute stroke unit at Musgrove Park Hospital, Taunton and an acute stroke unit at both Musgrove Park Hospital and Yeovil District Hospital

Overview:

- Stroke patients would be taken to their nearest hyper acute stroke unit. For most people in Somerset this would be at Musgrove Park Hospital, Taunton. Somerset patients who live closer to another hyper acute stroke unit, such as Dorset County Hospital, would be taken there.
- Stroke patients would spend up to 72 hours in the hyper acute stroke unit before being moved to the acute stroke unit in Musgrove Park Hospital, or transferred to their local acute stroke unit in Yeovil District Hospital.
- Acute stroke care would be provided by dedicated stroke teams at both Musgrove Park Hospital and Yeovil District Hospital.
- Patients who do not need acute stroke unit care would be transferred to the stroke recovery unit in either Williton Community Hospital or South Petherton Community Hospital, or discharged home with early supported discharge or community rehabilitation follow-up.

Benefits:

- Patients could be transferred to Yeovil District Hospital for their acute stroke care if this was closer to their home following their hyper acute stroke treatment.
- Staff expertise in acute stroke care would be retained across both hospitals.
- There would be less impact on hospitals in neighbouring counties as Somerset residents could transfer to their closest acute stroke unit.

Impact:

- More patient transfers may be needed to transfer patients closer to home at Yeovil District Hospital.
- The number of beds needed in the hyper acute unit at Musgrove Park Hospital would need to increase.

Option B

A single hyper acute stroke unit and a single acute stroke unit at Musgrove Park Hospital, Taunton

Overview:

- Stroke patients would be taken to their nearest hyper acute stroke unit. For most people in Somerset this would be at Musgrove Park Hospital, Taunton. Somerset patients who live closer to another hyper acute stroke unit, such as Dorset County Hospital, would be taken there.
- Stroke patients would spend up to 72 hours in the hyper acute stroke unit at Musgrove Park Hospital, Taunton.
- Acute stroke care would be provided by the dedicated stroke teams at Musgrove Park Hospital.
- Patients who do not need acute stroke unit care would be transferred to the stroke recovery unit in either Williton Community Hospital or South Petherton Community Hospital, or discharged home with early supported discharge or community rehabilitation follow-up.

Benefits:

- Stroke patients would spend up to 72 hours in the hyper acute stroke unit before being moved to the acute stroke unit in Musgrove Park Hospital.
- Patients would receive their acute stroke care at the same hospital they received their hyper acute stroke care, resulting in better continuity of care.
- There would be a reduced number of handovers of care for patients.
- The specialist stroke staff would all be on one site, meaning we could make the best use of our workforce.

Impact:

- Patients would remain at the hospital they received their hyper acute stroke care and not be transferred to Yeovil District Hospital resulting in longer travel times for family and friends for a longer amount of time.
- The number of beds needed in the hyper acute unit at Musgrove Park Hospital would need to increase.
- New patient pathways for acute care would need to be put in place, this includes for Dorset County Hospital.
- There would be more impact on Dorset County Hospital as they would need to ensure they had enough acute stroke beds as Somerset patients would remain there for their acute stroke care rather than being transferred back to Somerset.
- There would be a greater impact on staff as more staff would move to Musgrove Park Hospital.

The full consultation document can be found at: https://oursomerset.org.uk/wp-content/uploads/Stroke-Consultation-Document-FINAL.pdf

Consultation summary document


Contents

What is a stroke? 2
What is happening? 2
Why is change needed? 3
How people have been involved so far 3
How local stroke services look now 3
What are we proposing? 4
What would this change mean? 4
What would the change mean for journey times? 6
What would this cost? 6
How can you share your views? 7
What happens next 7

What is a stroke?

A stroke is a life threatening medical condition that happens when the blood supply to part of the brain is cut off by a clot or bleeding from a blood vessel.

Stroke is a sudden and life-changing event. The sooner you are treated, the better your chance of recovery.

What is happening?

Why is change needed?

How people have been involved so far

How local stroke services look now

This map shows the current hospitals providing hyper acute stroke care in and around Somerset. The hospitals coloured green are in Somerset, the hospitals coloured blue are in neighbouring counties.

The consultation summary document can be found at: https://oursomerset.org.uk/wp-content/uploads/NHS-Someset-Stroke-Consultation-Summary-document.pdf

Easy Read consultation document


NHS

introduction

NHS

The NHS in Somerset has been looking at how it can improve care for people who have had a stroke.

A stroke is a serious medical condition that happens when blood can't get to your brain properly.

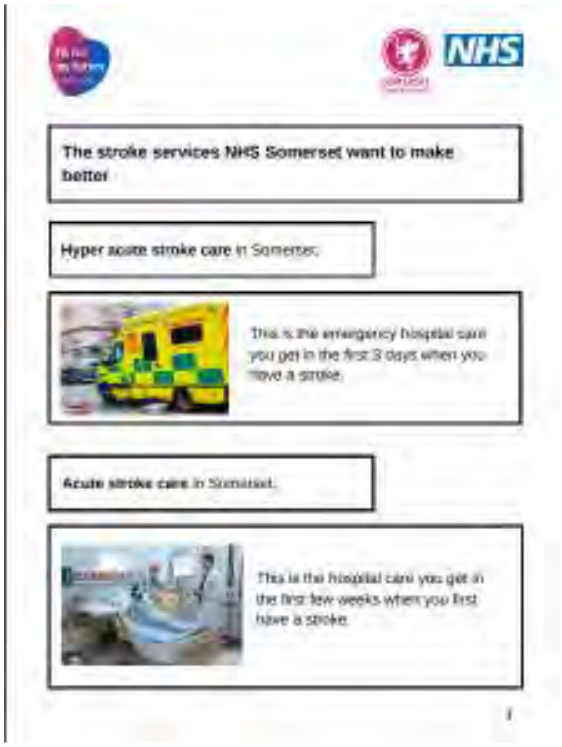
A stroke can damage your brain and affect the way you talk, walk or use other parts of your body.

We have been looking at changing how we provide the care you receive in hospital in the 3 days after having a stroke - this is called hyper acute stroke care.

We have also been looking at changing how we provide the care you receive in hospital in the first few weeks after having a stroke - this is called acute stroke care.

The Easy Read consultation document can be found at: https://oursomerset.org.uk/wp-content/uploads/Stroke-Easy-Read-Consultation-document-summary.pdf

Aphasia friendly consultation document



The Aphasia friendly consultation document can be found at: https://oursomerset.org.uk/wp-content/uploads/Aphasia-Stroke-consultation-summary-document.pdf

Example patient stories

Example patient stories can be found at: https://oursomerset.org.uk/wp-content/uploads/Stroke-patient-stories.pdf

Website

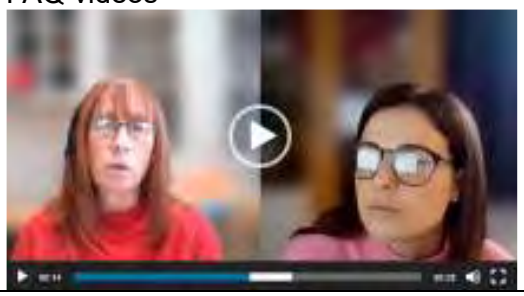
We regularly updated our website with new information – www.oursomerset.org.uk/stroke

Videos:

We created and shared videos to help explain the proposals. Here are some examples.

Case for change video

FAQ videos



Have your say video

Videos can be found on our website: https://oursomerset.org.uk/working-together/stroke/documents-information-sheets-and-videos/

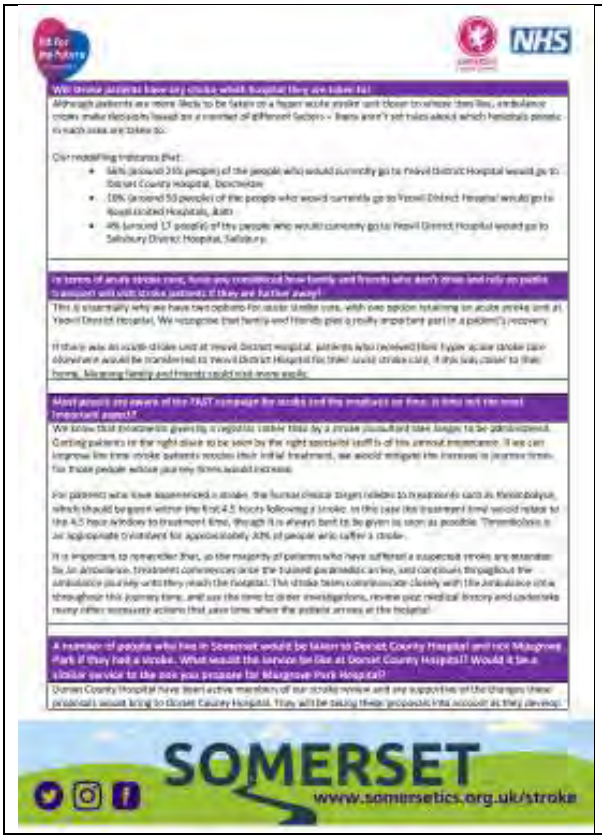
Social media

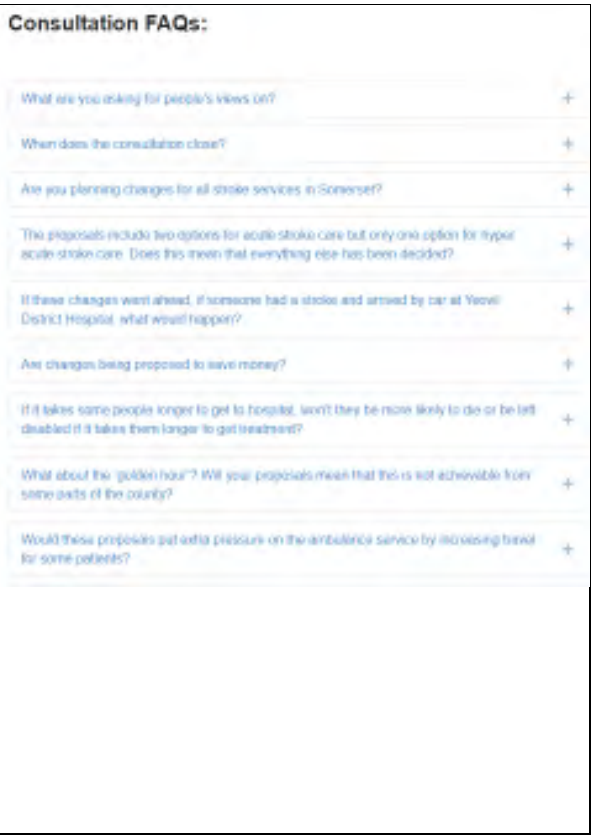
We targeted our social media to particular groups and communities, using both organic and paid for posts. Partners also shared social media across their channels.

We shared content on our NHS Somerset and Our Somerset social media channels.

FAQs

We produced regular FAQs based on questions received during the consultation. These are available on our website - https://oursomerset.org.uk/working-together/stroke/faqs/





APPENDIX 04

Stroke Clinical and Workforce model

Fit for my future Somerset

Proud to be part of Somerset Integrated Care System

SOMERSET County Council

NHS

Clinical Model

People with stroke should be treated in a specialist stroke unit throughout their hospital stay unless their stroke is not the predominant clinical problem.

Twenty-four, seven consultant led stroke service co delivered by consultant and advanced practitioners.

- Stroke Consultant 08:00 – 20:00 seven days a week.
- Advanced practitioners/Consultant practitioners 08:00 – 22:00 seven days a week.
- Band 6 HASU nurse 22.00 – 08:00 seven days a week
- On call stroke Consultant seven days a week between 20:00 – 08:00.

Stroke team will respond to all stroke calls from Emergency Department 24/7 with overnight HASU nurse responding to all stroke calls and the medical registrar responding to thrombolysis calls.

Band 6 HASU nurse will need to be protected to allow response to stroke calls so backfill of an additional band 5, required for cover.

Ensure stroke beds/staffing discussed as part of Trust bed state, HASU beds to be put alongside CCU beds.

All Stroke beds to be ringfenced.

Pre-Alert, Arrival at Emergency Department and Diagnostics

Clinical Model

- SWAST convey patient with suspected stroke to closest HASU
- SWAST continue to Pre-alert all with suspected stroke to the Emergency Department (ED)
- ED differentiate between whether the patient would be eligible for reperfusion or not
- Emergency Department to order CT prior to patient arriving.
- Patient conveyed straight to ED and to CT scanner accompanied by stroke team and crew.
- Patient is assessed by a suitably skilled stroke specialist within 1 hour.
- If confirmed or probable stroke, patient conveyed directly to the HASU to be assessed for emergency stroke treatments by a specialist clinician without delay.
- If not stroke return to ED
- If stroke diagnosis unclear patient to go to the HASU.

Clinical Standards

- Call to hospital arrival < 60 minutes
- A pre-alert system is needed to communicate patient characteristics and ensure all patients are met by the stroke team on arrival at the ASC or CSC. (BASP CS 1.1)

- Patient with suspected stroke should have CT scan within 60 minutes of hospital arrival (BASP CS 2.2)
- Assessed by stroke specialist clinician within 1 hour of hospital arrival
- People with suspected acute stroke should be admitted directly to HASU within 4 hours of arrival (NICE QS 1)
- All eligible patients should receive IV thrombolysis within 60 minutes of arrival to hospital (BASP CS 1.4)

HASU Option A and B

Clinical Model

- Consultant present on-site 8am – 8pm 7 days per week, & available on-call outside these times
- Advanced practitioners/Consultant practitioners 08:00 – 22:00 seven days a week.
- Band 6 HASU nurse able to attend stroke emergency calls 22.00 – 08:00 seven days a week
- Twice daily review of HASU patients by stroke consultant 7 days a week.
- Beds are level 2 beds with associated nurse and therapy staffing as per recommended stroke guidance 2016.
- Continuous physiological monitory including telemetry
- Protocols in place for dysphagia management, continence promotion & prevention of venous thromboembolism
- Specialist seating and equipment to facilitate mobility
- Ring fencing of HASU beds; bed available within 20 minutes if required 24/7 to allow for transfer from Yeovil for those patients who walk in or have a stroke as an inpatient.
- Patients who have been confirmed as not a stroke should be moved out from HASU ASAP

Clinical Standards

- A hyperacute stroke unit should have continuous access to a consultant stroke physician, with consultant physician review 7 days per week.
- Assessed by stroke specialist clinician within 1 hour
- Assessed by a consultant within 14 hours (can be by telemedicine) and seen within 24 hours face to face.

- A hyperacute, acute and rehabilitation stroke service should provide specialist medical, nursing, and rehabilitation staffing levels matching the recommendations
- Patients should receive swallow screening within 4 hours of arrival (BASP CS 3.5)
- Patients should be assessed by all members of stroke multidisciplinary team within 72 hours (BASP CS 3.10)
- Patients should have rehabilitation goals agreed within 5 days and regular review of goals (NICE QS 6)

ASU for Option and B MPH

Clinical Model

- Clearly defined unit (as specified by NICE)
  - Adequate space for fully equipped gym, and functional practice (kitchen and bathroom)
  - Appropriate space to accommodate group work, and quiet space for psychological assessment and sensitive discussions.
  - Adequate hardware to facilitate quick access to clinical systems
- Nursing and MDT staffing as per 2016 guidance.
- 5-day consultant ward rounds.
- Access to consultant advice out-of-hours by telephone or telemedicine where appropriate
- Side rooms available for infection control and palliative / end of life care
- Ringfenced beds
- Ability to recruit to clinical research trials.
- Ability to deliver an ambulatory TIA service

Clinical Standards

- A hyperacute, acute and rehabilitation stroke service should provide specialist medical, nursing, and rehabilitation staffing levels matching the recommendations
- Patients should receive at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for minimum 5 days per week (NICE QS 2)
- All appropriate patients should receive at least 45 minutes of therapy per day (BASP CS 3.11 – 3.13)
- An acute stroke unit should have continuous access to a consultant physician with expertise in stroke medicine, with consultant review 5 days per week
- Patients should spend at least 90% of their in-patient stay on a stroke unit (BASP CS 3.1)
- The stroke services should participate in clinical research (BASP CS 6.5)

Principles for a stand-alone ASU – Option A

- There should be 24/7 access to CT brain imaging and CT angiography
- There should be 24/7 access to telemedicine stroke advice from a stroke consultant where emergency interventions such a thrombectomy, thrombolysis or intensive blood pressure lowering in intracerebral haemorrhage may be indicated
- There should be 24/7 access to transfer a patient to HASU from hospitals with only an acute stroke unit, for full stroke assessment and management
- Patients requiring specialist assessment prior to transfer should be assessed with remote telemedicine support and discussion with the consultant specialist based in the HASU. This would potentially provide another layer of risk mitigation for stroke patients presenting to the non-HASU site where the HASU consultant could visualise the patient
- Patients who cannot be transferred to HASU should be able to access the on-site acute stroke unit, including multidisciplinary assessments and ongoing stroke care (including hyper acute stroke care) and rehabilitation until discharge or transfer
- There will be regular education and training sessions with medical registrars, emergency department staff, and stroke nurses to support safe and effective delivery of stroke thrombolysis where necessary
- The acute stroke unit should be staffed as per Royal College of Physicians recommendations
- There should be access to carotid imaging, ambulatory ECG, and echocardiography
- There should be clinical co-dependencies as set out in section on Clinical Co-dependencies

Principles for Option A Yeovil ASU

- 5-day consultant ward rounds.
- Clearly defined unit with staffing as per stroke guidance
- Adequate space for fully equipped gym, and functional practice (kitchen and bathroom)
- Appropriate space to accommodate group work, and quiet space for psychological assessment and sensitive discussions.
- MDT staffing as per 2016 guidance.
- Ringfencing of beds
- Adequate hardware to facilitate quick access to clinical systems
- Communication with the HASU consultant at weekends by telemedicine.
- Trained transport crew for repatriation – basic infusions, NG tube, sliding scale insulin ??
- Senior Stroke practitioner cover at the weekend
- Ability to admit 7/7 including straight from thrombectomy as well as from any of the feeding HASUs.
- Specialist seating
- Clear pathway for inpatient strokes and those that walk in with ability to use telemedicine to the HASU at Taunton.
- Clear pathway for repatriation 7/7 from both MPH & DCH and back to HASU if required
- Orthoptic and orthotic service
- Ringfenced beds
- Opportunities to recruit patients to clnical research trails
- Ambulatory TIA service.

- A hyperacute, acute and rehabilitation stroke service should provide specialist medical, nursing, and rehabilitation staffing levels matching the recommendations
- An acute stroke unit should have continuous access to a consultant physician with expertise in stroke medicine, with consultant review 5 days per week

TIA

- People to be seen within 24 hours
- Practitioner led with access to consultant supervision if required
- Ambulatory service on the stroke unit
- Space for private conversations
- Flexible access to scanning (i.e. MRI brain, carotid dopplers) and not fixed slots
- Same-day access to ambulatory ECG monitoring
- 7-day service

Digital must do's

- Telemedicine opportunities
- Interface between healthcare systems
- Hardware on HASU and ASU to enable good access to clinical systems.
- Licences for software
- Robust WiFi
- IPADs for hyperacute for patients and families to communicate.

Somerset Stroke Reconfiguration

Demand and Capacity Modelling Approach

The following currencies have been modelled:

- Admissions
- Estimates derived from the admissions baseline (see following sections for assumptions underpinning these estimates):
    - Beds
        - Hyperacute Stroke Unit (HASU)
        - Acute Stroke Unit (ASU)
    - Emergency Department (ED) attendances
    - Diagnostic tests

Data source

- 2022/23 stroke admissions used as the baseline
- Data source: Sentinel Stroke National Audit Programme (SSNAP) patient-level dataset provided by the two hospital sites in Somerset (Musgrove Park Hospital – MPH - and Yeovil District Hospital- YDH).
- Stroke mimic activity based on assumptions (see below)

Assumptions

Key assumptions as follows:

- Length of stay (LoS) for stroke patients as per 2022/23 data
- Assumed HASU LoS for stroke patients is 3 days, unless overall LoS was less than 3 days in which case overall LoS=HASU LoS (apart from exceptions below)
- Assumed ASU LoS=overall LoS – HASU LoS (apart from exceptions below)
- Assumed that transfers/non-initial stroke presentations will not require HASU care i.e. will be admitted directly to ASU
- Percentage of inpatient strokes not requiring HASU bed (these patients will, however, require an ASU bed): 50%
- Assumed that self-presenters to YDH ED will continue to so, and will require emergency transfer to closest HASU (Dorset County Hospital - DCH), regardless of patient postcode
- Target occupancy rates applied in average-based modelling: 85% HASU, 90% ASU
- Percentage of expected stroke presentations which are mimics: 56%
- Percentage of mimics admitted to stroke unit: 39%
- Average LoS (days) for stroke mimic admissions (HASU only): 2.0 days

The assumptions in full are below:

Description	Assumption	Source
Population growth	ONS projections at 5 year age band level, based on CCG of residence	ONS sub-national population projections (2018-based)
Non-demographic growth	Stroke incidence rates will stay the same up to 2035 for those aged 45 to 84, and rise by 0.5% per year for those aged 85 and over	'Current, future and avoidable costs of stroke in the UK' Summary Report published by the Stroke Association
Diagnostic tests - percentage of stroke admissions receiving tests	CT 140 scans per 100 stroke patients	Clinical judgment
	MRI 58%	
Diagnostic tests - percentage of stroke mimic admissions receiving tests	CT 100%	
	MRI 60%	
LoS for hyperacute phase	3 days, unless overall LoS was less than 3 days in which case overall LoS=HASU LoS	- Hyperacute phase defined as first 72 hours: "Stroke patients usually remain on a HASU for up to 72 hours". Rodgers H, Price C. Stroke unit care, inpatient rehabilitation and early supported discharge. Clin Med (Lond). 2017 Apr;17(2):173-177. doi: 10.7861/clinmedicine.17-2-173. PMID: 28365632; PMCID: PMC6297619. - Actual LoS calculated at record-level from baseline data- SSNAP 2022/23
LoS for acute phase	Overall actual LoS – HASU LoS	
Occupancy rates	HASU 85%	'BNSSG Stroke Services Reconfiguration Programme Pre-Consultation Business Case' (p167-8, figure 40) - "The expected flows in the BNSSG future state stroke pathway have been calculated drawing on data from best practice systems, such as London and Greater Manchester (Salford)"
	ASU 90%	
Percentage of expected stroke presentations which are mimics	56% (MPH 49%, YDH 66%)	SSNAP Sprint audit for stroke mimics - YDH and SFT results combined

Description	Assumption	Source
Percentage of mimics admitted to stroke unit	39% (MPH 46%, YDH 30%)	
Average LoS (days) for stroke mimic admissions (stroke unit)	2.0 days (in line with MPH and national average - YDH is an outlier at 7.1 days)	
Percentage of mimics admitted to General Medicine ward	35%	SSNAP Sprint audit for stroke mimic - based on 39% admitted to stroke unit and 26% discharged on day of presentation, so 100%-39%-26%=35%
Average LoS (days) for stroke mimic admissions (General Medicine ward)	2.5 days	Clinical judgment
BNSSG patients expected to attend Musgrove Park as a result of the BNSSG stroke services reconfiguration	3.1 per week (1 stroke, 2 mimic)	'Somerset Stroke: Case for Change' (Table 23, p56), based on analysis by BNSSG
Percentage of (YDH) inpatient strokes not requiring HASU bed (these patients will, however, require a ASU bed)	50%	Clinical judgment
ED attendances - percentage of 999/ED walk ins that attend ED	100%	
ED attendances - percentage of inpatient strokes/transfers (repatriations) that attend ED	0%	

Modelled scenarios

- Current admission levels
- Scenario A – no HASU at YDH, ASH at YDH
- Scenario B – no HASU or ASU at YDH

The following strands of modelling have been undertaken:

1. Average-based bed modelling

- Calculation: admissions x LoS / target occupancy
- The impact of stroke mimics on General Medicine beds has also been modelled.

2. Activity/bed projections

- Assumed growth rates were applied to the 2022/23 activity baseline:
  - Demographic (compound) growth as per latest ONS sub-national population projections[1], at 5-year age band and ICB of residence level.
  - Expected changes in age-specific stroke incidence, in line with published Stroke Association projections[2].
- Activity projections cover the 10-year period from the baseline.
- The average annual growth in admissions over the 10 year period across both Somerset providers is projected to be 2.3%.
- Projections covering beds, ED attendances and diagnostic tests were also derived from the activity projections.
- Initial bed projections assumed that LoS will be static throughout the period of the projection – these projections are shown in section 3 of the DMBC.
- Later iterations of the modelling applied some changes to LoS over the 10-year period as determined by a number of key stakeholders: the agreed change was to assume a 10% reduction in ASU LoS by year 5, with no further changes between year 5 and year 10.

3. Site modelling

- Modelling is focused on activity shifts under option A (no HASU at YDH) and option B (no HASU/ASU at YDH)
- Site modelling logic is that assuming closure of HASU at YDH, activity will shift to the next closest provider based on patient postcode (apart from exceptions listed below), and journey times calculated by the SCW Geospatial Team as follows: journey time from patient's residential postcodes to all current HASUs in the region was modelled using TravelTime routing analysis (https://traveltime.com/). The journey time was modelled based on driving by car at 03:00 on a Tuesday morning (as a proxy for ambulance journey times).
- An assurance exercise was undertaken with South Western Ambulance Service NHS Foundation Trust (SWASFT) to validate volumes affected and resource impact.
- Validation also compared ward of patient residence with pick-up postcode (for 999 calls)– this was the same in 86% of cases.
- Exceptions where patient postcode was not used to define closest provider:
  - ED walk ins, where it's assumed that patients will continue to self-present at YDH and that an emergency transfer will be needed from YDH to the closest HASU (DCH)
  - Inpatient strokes, where it's assumed that 50% will require an emergency transfer from YDH to DCH, whilst 50% will remain in their existing bed and will therefore not be transferred to a HASU (although it's assumed that these patients will require ASU care).
- Modelling assumes that patients attending Musgrove Park will continue to attend Musgrove Park.

[1] Subnational population projections for England: 2018-based: All data related to Subnational population projections for England: 2018-based - Office for National Statistics
[2] https://www.stroke.org.uk/sites/default/files/costs_of_stroke_in_the_uk_summary_report_0.pdf

- Modelling assumes that patients with an unknown/invalid postcode will attend Musgrove Park.
- Repatriation logic:
    - Option A: assumed that Somerset & Dorset patients whose closest ASU is YDH will transfer to YDH for their ASU care
    - Option B: assumed that Somerset patients whose closest HASU is DCH will remain at DCH for their ASU care.
    - Both options: it's assumed that patients whose closest HASU is Royal United Hospital (RUH) or Salisbury FT HASU will remain at these providers for their ASU care.

4. Stochastic Modelling

- Discrete Event Simulation (DES) modelling was run in conjunction with the average-based modelling to determine the variability in bed demand which may result from variability around the average daily admissions and length of stay. The rationale for undertaking DES modelling is that previous studies of stroke pathways have shown that average-based models can under-estimate capacity requirements[3].
- The modelling used the PathSimR tool[4] (based in the R software package).
- The key modelling outputs used to inform stakeholder decision making about the number of beds required were:
    - Accessibility – measured in terms of the likelihood of accessing a bed without having to queue.
    - Bed occupancy rates
- In general, having more beds available results in improved access levels but lower occupancy levels i.e. capacity being unused for much of the time. This could present financial and operational challenges.
- Several different bed scenarios were modelled for each option, including the bed numbers output by the average-based model, with the aim of determining the numbers of HASU and ASU beds achieved the best balance between high levels of access and reasonable levels of occupancy.
- Average levels of access and occupancy rates were assessed for each of the bed scenarios i.e. each combination of HASU and ASU beds. The frequency with which bed capacity would be exceeded was also determined, as was the magnitude by which capacity was exceeded on these occasions. The latter helped to quantify the risks associated with the different bed scenarios in terms of the beds on other wards which could be required.
- The outputs above were presented to stakeholders from the following areas: clinical, operational and financial. Stakeholders used the outputs presented to agree the numbers of HASU and ASU beds they felt would be required to achieve a reasonable balance between accessibility and occupancy, whilst also considering practical constraints e.g. physical ward space.
- The stochastic modelling has been relied upon to provide assurance that the correct bed base has been modelled rather than undertaking additional sensitivity analyses.

[3] Monks, T., Worthington, D., Allen, M., Pitt, M., Stein, K., & James, M. A. (2016). A modelling tool for capacity planning in acute and community stroke services. BMC health services research, 16(1), 1-8. https://doi.org/10.1186/s12913-016-1789-4

[4] https://github.com/nhs-bnssg-analytics/PathSimR

SCW Geospatial Services – Somerset ICB – Stroke Reconfiguration

Geospatial Evidence Pack

1. Introduction

The following maps and tables provide the results of analysis carried out by the SCW Geospatial Services team. The work presented here is intended to provide insight into the impacts in terms of accessibility to resident populations of a potential reconfiguration of service locations.

The analysis includes:

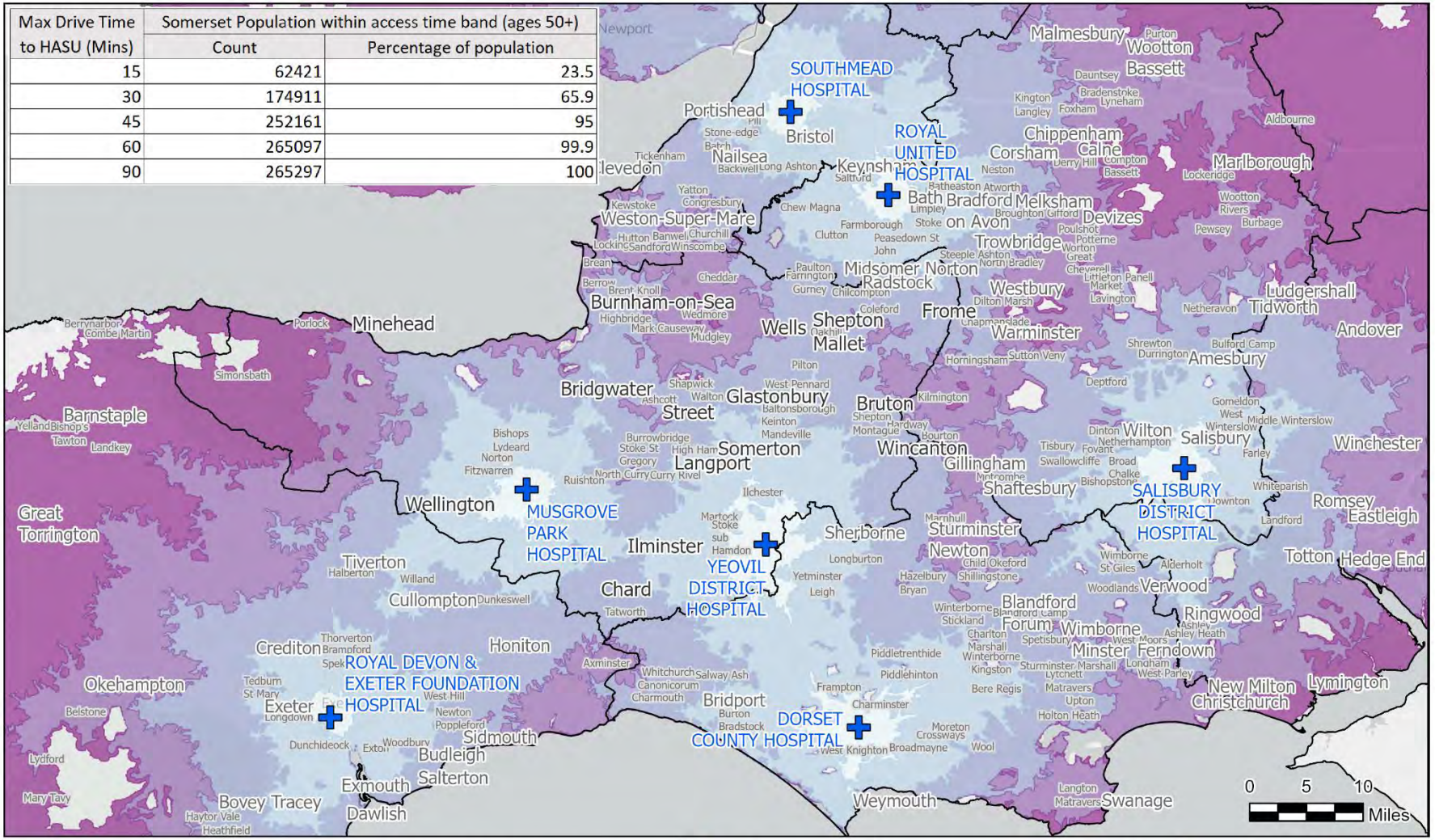
A. Comparison of the journey times under the current and change scenarios for resident population to travel to care locations
B. Modelled additional journey time, distance and CO2 emissions that would arise from changing journey patterns under the change scenario and the geographic distribution of these changes
C. Comparison between the current and change scenario of the accessibility of service locations by public transport
D. Socio-economic factors (deprivation, household access to private cars, levels of population aged 50 plus) in areas where journey accessibility to service locations would be adversely affected.

This document also includes an explanation of factors that should be considered when interpreting results of this analysis.

Contents

1. Comparison of journey times to HASU/ASU between current and change scenario ('blue-light')

Max Drive Time to HASU (Mins)	Somerset Population within access time band (ages 50+)	
	Count	Percentage of population
15	62421	23.5
30	174911	65.9
45	252161	95
60	265097	99.9
90	265297	100



Current Scenario Stroke Care Configuration - off peak driving time to a HASU

Modelled at 03:00 on a Tuesday as a proxy for blue-light drive time

HASU Location (including all current operating HASUs)

ICB boundary

MaxTime

0 - 15 (mins)

15 - 30

30 - 45

45 - 60

60 - 90

Source: Driving time zones generated using TravelTime API. Population coverage calculated by overlaying time zones against Census 2021 population data (COA level population-weighted centroids)

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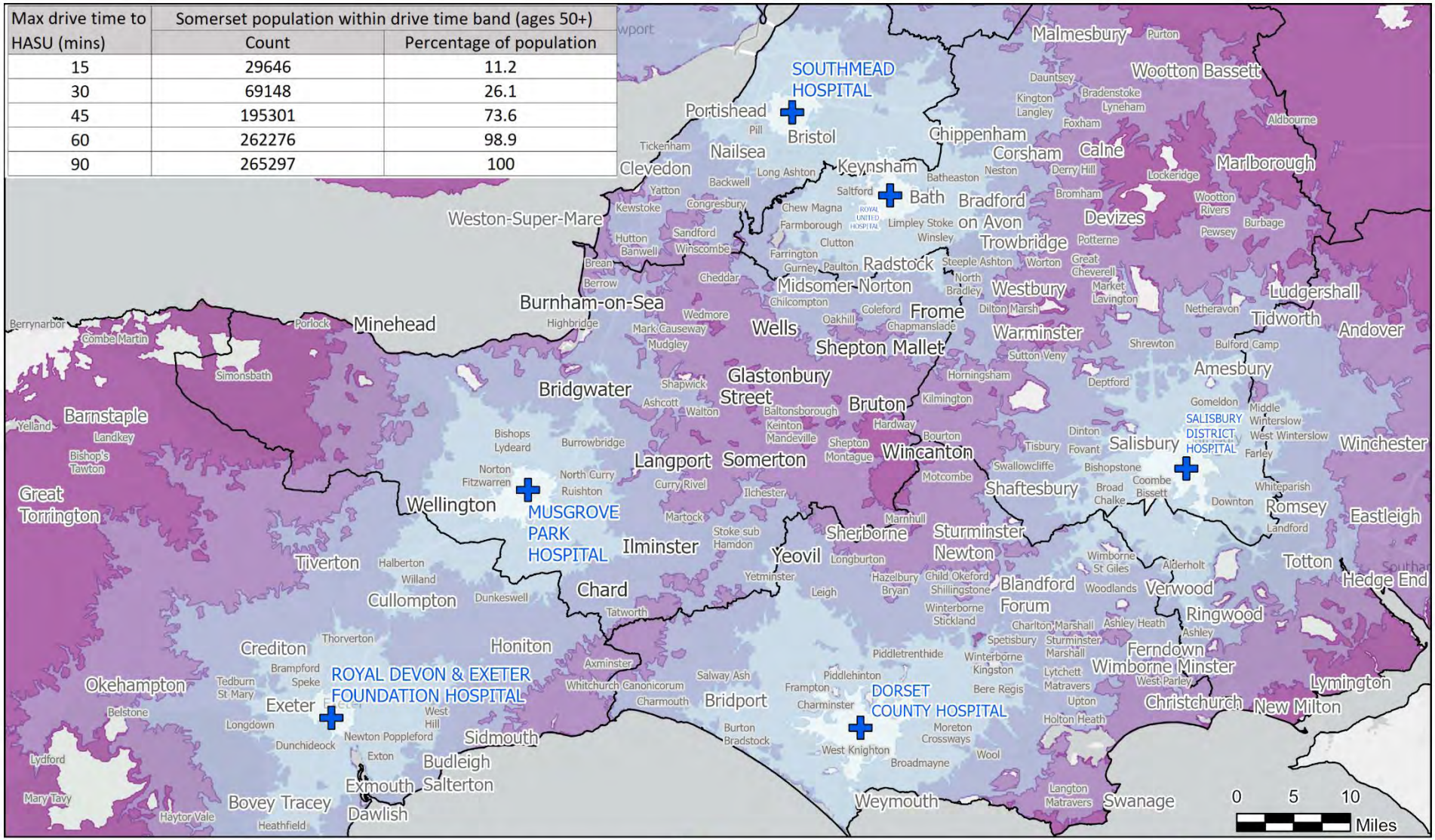
Path: X:\CUSTOMER_WORK\NHS\ICB\SOMERSET\GI3030_Stroke_Reconfiguration\ArcGISPro\GI3030_HASU_IsochroneGeneration\GI3030_HASU_IsochroneGeneration.aprx

Max drive time to HASU (mins)	Somerset population within drive time band (ages 50+)	
	Count	Percentage of population
15	29646	11.2
30	69148	26.1
45	195301	73.6
60	262276	98.9
90	265297	100



Change Scenario Stroke Care Configuration - off peak driving time to a HASU

Modelled at 03:00 on a Tuesday as a proxy for blue-light drive time

HASU Location (including all change scenario HASUs)

ICB boundary

Driving Time Zones

- 0 - 15 (mins)
- 15 - 30
- 30 - 45
- 45 - 60
- 60 - 90

Source: Driving time zones generated using TravelTime API. Population coverage calculated by overlaying time zones against Census 2021 population data (COA level population-weighted centroids)

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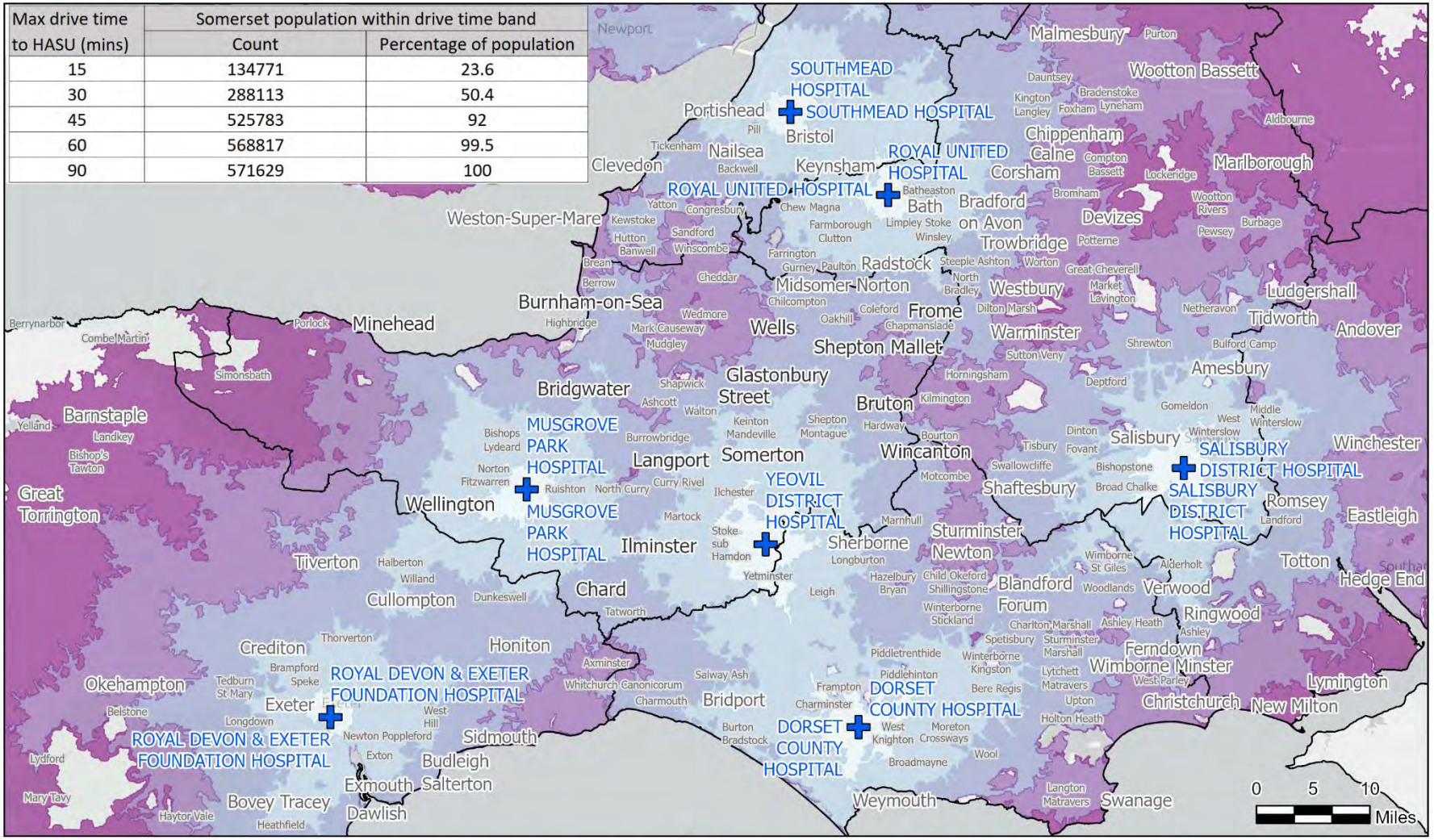
- The preceding two maps illustrate the areas from within which it is possible to travel to a HASU or ASU within specified time bands. These time bands are provided in 15 minute intervals. The first map shows the current service configuration and the second shows the change scenario.
- The travel-time band areas have been generated based on car driving at 03:00. This is intended as a proxy for ambulance journey times
- Each map also includes a count of the Somerset ICB resident population aged 50 plus within each time band. This age range was chosen due to the higher prevalence of Stroke within this age group and it is therefore the most applicable when discussing journeys to HASU by ambulance
- The count of population in each band was derived by overlaying Census 2021 population data against the travel time bands and summing the count within each. This analysis was carried out using Census Output Area Population-Weighted Centroids.
- Comparison of the above maps shows that the change scenario HASU configuration would lead to a reduction in the percentage of Somerset ICB residents whose 'blue-light' journey times would fall within the lower time-bands. This would be expected given the absence of a HASU at Yeovil District Hospital under the change scenario.

2. Comparison of journey times to HASU/ASU under the change scenario (friends & family)

Max drive time to HASU (mins)	Somerset population within drive time band	
	Count	Percentage of population
15	134771	23.6
30	288113	50.4
45	525783	92
60	568817	99.5
90	571629	100



Current Stroke Care Configuration - off peak driving time to a HASU or ASU

Modelled at 11:00 on a Tuesday as a proxy for friends and family visiting

HASU Location (including all current operating HASUs)

ICB boundary

Drive Time Zones

0 - 15 (mins)

15 - 30

30 - 45

45 - 60

60 - 90

Source: Driving time zones generated using TravelTime API. Population coverage calculated by overlaying time zones against Census 2021 population data (COA level population-weighted centroids)

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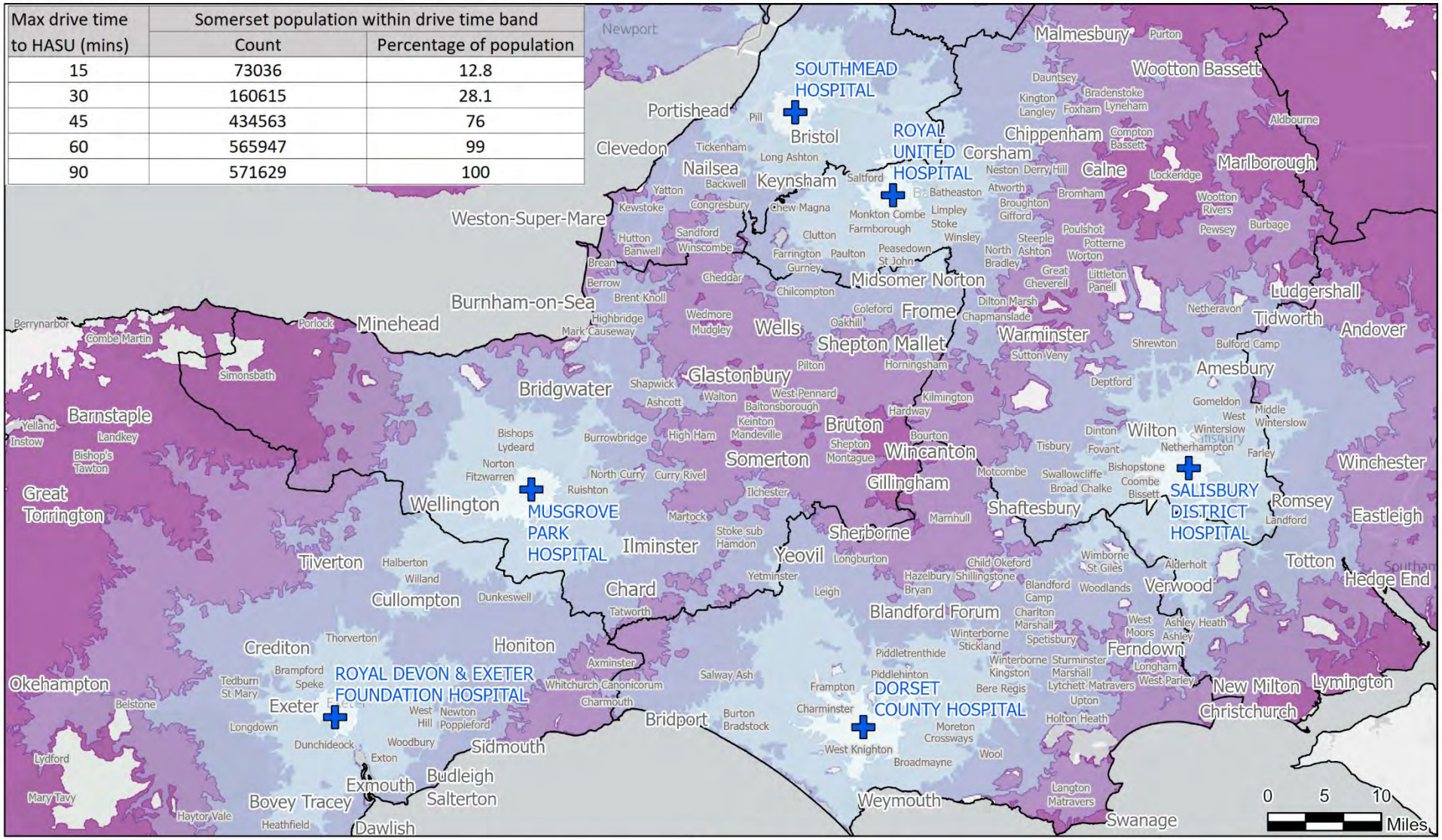
Max drive time to HASU (mins)	Somerset population within drive time band	
	Count	Percentage of population
15	73036	12.8
30	160615	28.1
45	434563	76
60	565947	99
90	571629	100



Change Scenario Stroke Care Configuration - off peak driving time to a HASU or ASU

Modelled at 11:00 on a Tuesday as a proxy for friends and family visiting

HASU Location (including all HASUs operating in a change scenario)

ICB boundary

Drive Time Zones

0 - 15 (mins)

15 - 30

30 - 45

45 - 60

60 - 90

Source: Driving time zones generated using TravelTime API. Population coverage calculated by overlaying time zones against Census 2021 population data (COA level population-weighted centroids)

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- The preceding two maps illustrate the areas from within which it is possible to travel to an ASU or HASU within specified time bands. These time bands are provided in 15 minute intervals. The first map shows the current service configuration and the second shows the change scenario.
- The travel-time band areas have been generated based on car driving to arrive at 11:00. This is intended to be indicative of the arrival time for friends and family visiting a patient.
- Each map also includes a count of the Somerset ICB resident population within each time band. The full residential population was chosen for this analysis as people of all ages may be visiting a stroke patient.
- The count of population in each band was derived by overlaying Census 2021 population data against the travel time bands and summing the count within each. This analysis was carried out using Census Output Area Population-Weighted Centroids.
- Comparison of the above maps shows that the ASU change scenario configuration would lead to a reduction in the percentage of Somerset ICB residents whose daytime off-peak journey times would fall within the lower time-bands. This would be expected given the absence of a HASU at Yeovil District Hospital under the change scenario.

3. Additional journey distance, time and CO2 emissions (activity data)

Analysis of the impact on journey distance, time and CO2 emissions of the changes in journey patterns that could arise from the proposed changes to Stroke service locations was carried out. This was based on supplied stroke activity data from 2021-2022 which records the home postcode and treatment location of stroke patients who attended Musgrove Park Hospital or Yeovil District Hospital.

The following tables show the cumulative changes that would occur related to ambulance journeys to HASU given the same set of activity data but under the HASU change scenario. The basis of the analysis was to identify records from the activity data where the closest HASU (by journey time at 03:00 on a Tuesday) was Yeovil District Hospital and identifying the HASU that would present the equivalent shortest journey under the change scenario. The change in journey distance, time and CO2 emissions from the alternative journey was then calculated.

Additional journey distance:

Additional journey distance (KM)	Number of journeys
-10 to -5	11
-5 to <0	14
No change	634
>0 to 5	15
5 to 10	17
10 to 15	18
15 to 20	51
20 to 25	34
25 to 30	28
30 to 35	174

NB – additional journey distance is negative where Yeovil District Hospital previously presented the quickest journey (by time) but was further away (by distance) than the HASU presenting the second quickest journey time (which would be the quickest under the change scenario). Also the 'No change' value includes 74 patients that attended Musgrove Park Hospital although this wasn't the closest location.

Additional journey time:

Additional journey time (mins)	Number of journeys
No change	634
0 to 5	8
5 to 10	19
10 to 15	26
15 to 20	71
20 to 25	30
25 to 30	89
30 to 35	119

Additional CO2 emissions:

Total Additional KM	Modelled Additional CO2 emissions (KG)
8373.3	2122.3

(NB – carried out using figures from the 2023 UK Government GHG Conversion Factors for Company Reporting. The selected conversion factor used was based on a Class III (1.74 to 3.5 tonnes) Van (Diesel). This equates to 0.253464026845638 kg CO2 per km.)

Additional impacts related to repatriation journeys:

- Under the scenario where HASU care is no longer provided at Yeovil District Hospital and ASU care continues here there would be a need to repatriate patients for the ASU phase of their care. Analysis was carried out to attempt to quantify the impacts from this based on the supplied 2021 – 2022 activity data.
- The identified possible repatriation journeys from the supplied activity data are:

  * Dorset County Hospital to Yeovil District Hospital = 211 journeys

  * Musgrove Park Hospital to Yeovil District Hospital = 43 journeys

- The distance and time related to each journey was derived using the TravelTime API (based on an arrival time of 11:00 on a Tuesday) as follows:

  * Dorset County Hospital to Yeovil District Hospital = 32.79 km (32.1 mins)

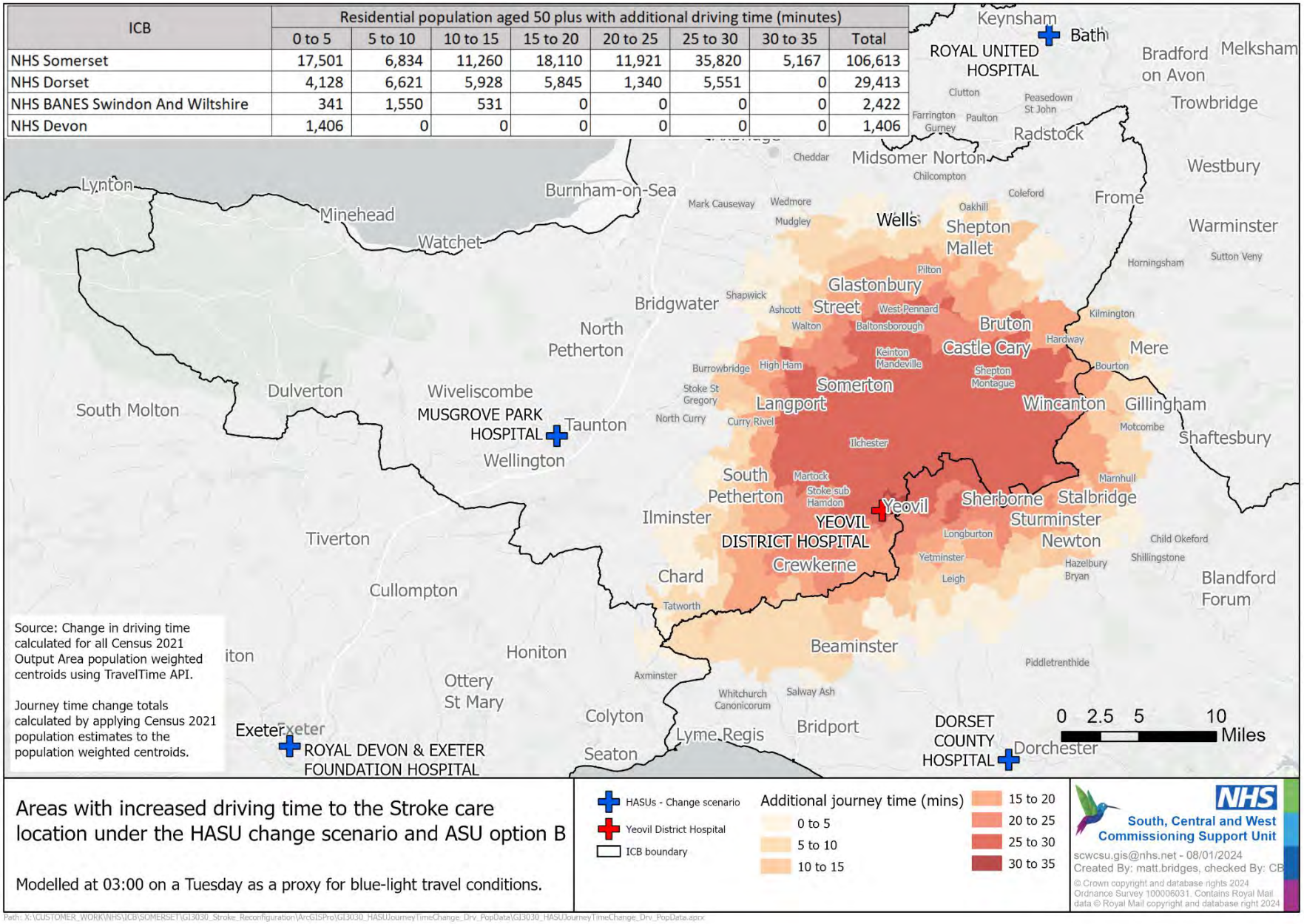
  * Musgrove Park Hospital to Yeovil District Hospital = 46.02 km (45.15 mins)

- Cumulative journey distances were calculated from the above figures
- Cumulative CO2 equivalent emissions were also calculated based on cumulative journey distances. This was carried out using figures from the 2023 UK Government GHG Conversion Factors for Company Reporting. The selected conversion factor used was based on a Class III (1.74 to 3.5 tonnes) Van (Diesel). This equates to 0.253464026845638 kg CO2e per km.

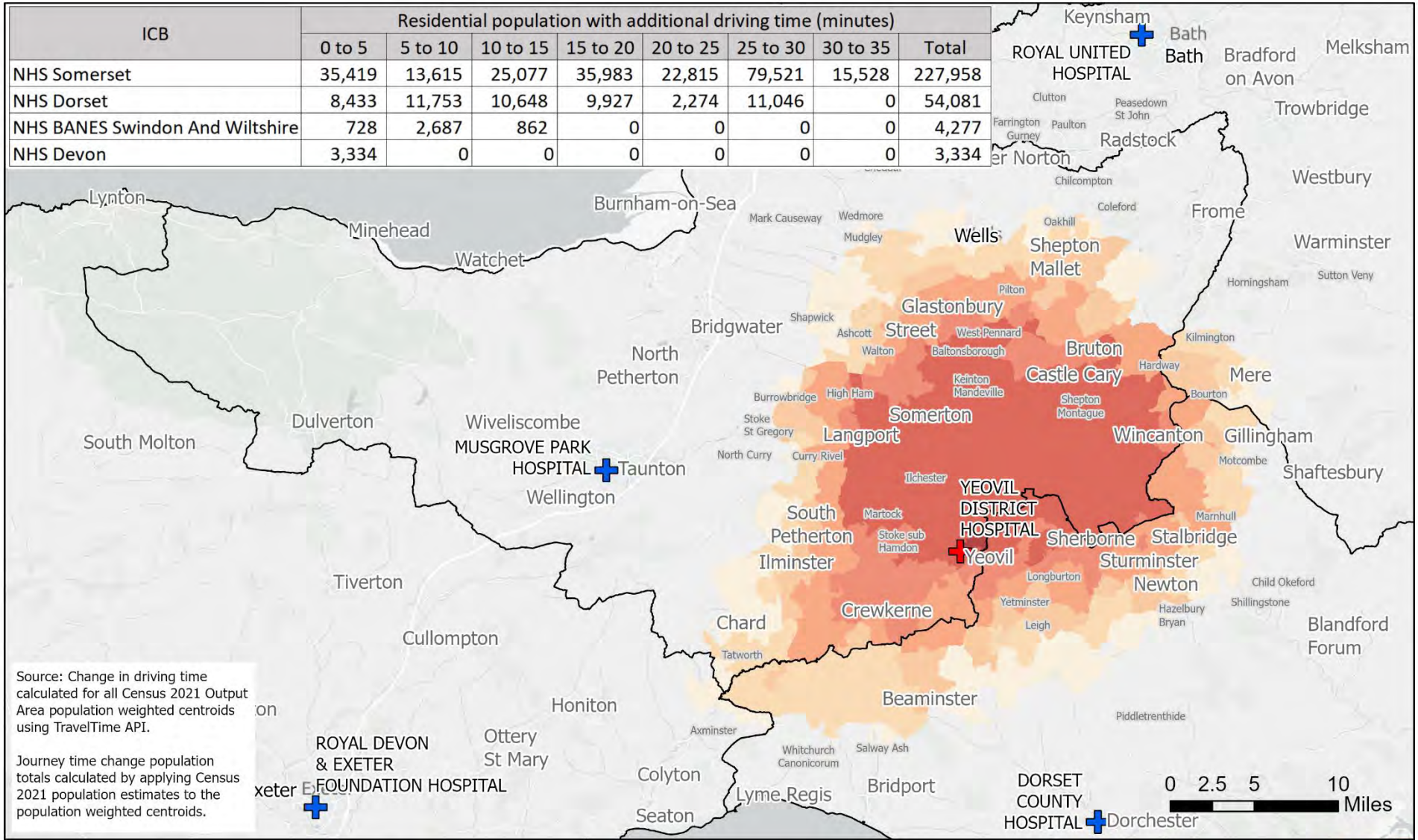
Option A – HASU	Option A – ASU	Number of Repatriation Journeys	Total Travel Time (hours)	Total Travel Distance (kilometres)	Total CO2e emissions (KG)
Dorset County Hospital	Yeovil District Hospital	211	112.6	6900	1748.9
Musgrove Park Hospital	Yeovil District Hospital	43	32.4	1979	501.6

4. Geographic distribution of changes in journey times

ICB	Residential population aged 50 plus with additional driving time (minutes)							
	0 to 5	5 to 10	10 to 15	15 to 20	20 to 25	25 to 30	30 to 35	Total
NHS Somerset	17,501	6,834	11,260	18,110	11,921	35,820	5,167	106,613
NHS Dorset	4,128	6,621	5,928	5,845	1,340	5,551	0	29,413
NHS BANES Swindon And Wiltshire	341	1,550	531	0	0	0	0	2,422
NHS Devon	1,406	0	0	0	0	0	0	1,406



ICB	Residential population with additional driving time (minutes)							
	0 to 5	5 to 10	10 to 15	15 to 20	20 to 25	25 to 30	30 to 35	Total
NHS Somerset	35,419	13,615	25,077	35,983	22,815	79,521	15,528	227,958
NHS Dorset	8,433	11,753	10,648	9,927	2,274	11,046	0	54,081
NHS BANES Swindon And Wiltshire	728	2,687	862	0	0	0	0	4,277
NHS Devon	3,334	0	0	0	0	0	0	3,334



Source: Change in driving time calculated for all Census 2021 Output Area population weighted centroids using TravelTime API.

Journey time change population totals calculated by applying Census 2021 population estimates to the population weighted centroids.

Areas with increased driving time to the Stroke care location under the HASU change scenario and ASU option B

Modelled at 11:00 on a Tuesday as indicative of visitor arrival time.

HASUs / ASUs - change scenarios

Yeovil District Hospital

ICB boundary

Additional journey time (mins)

0 to 5

5 to 10

10 to 15

15 to 20

20 to 25

25 to 30

30 to 35

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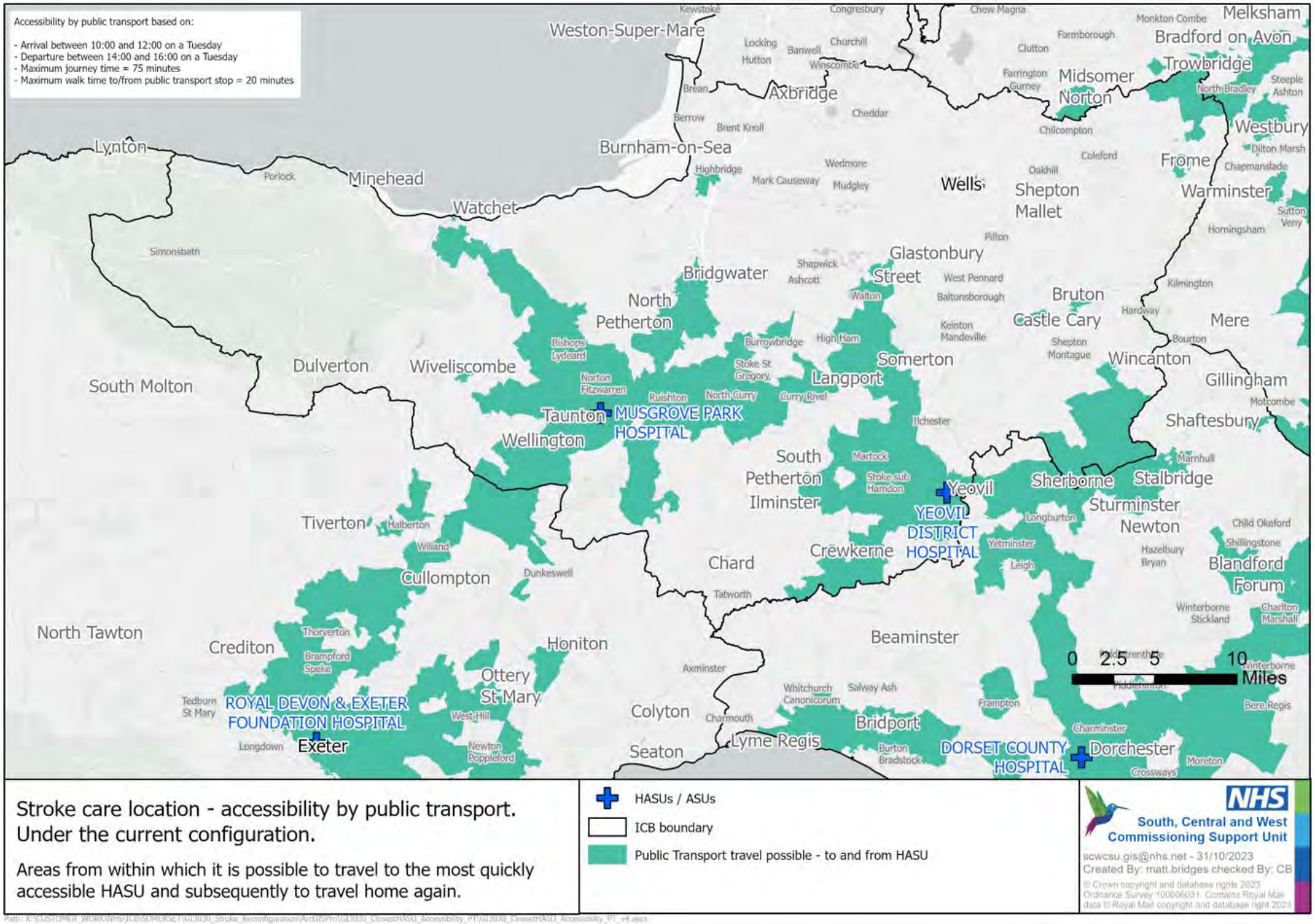
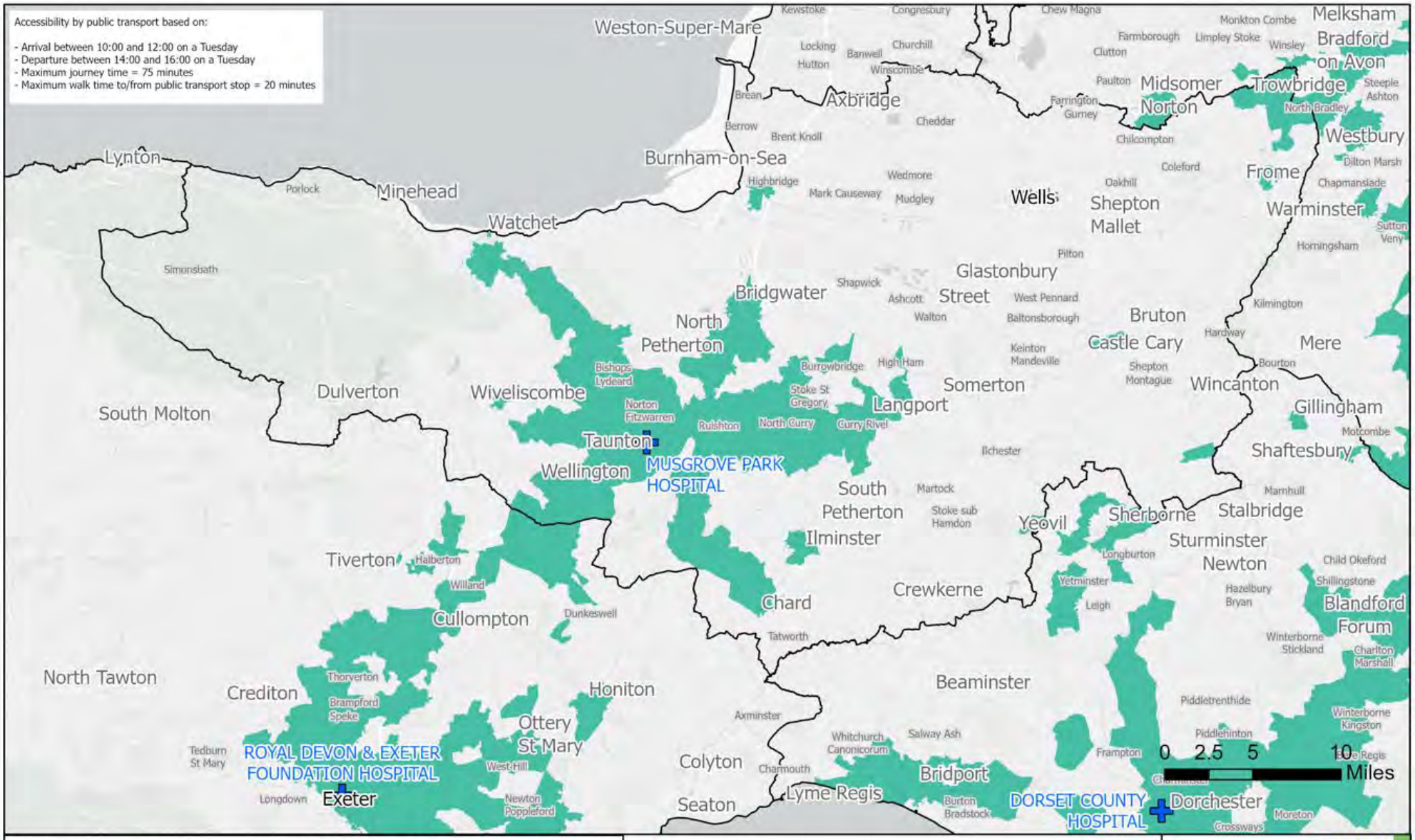
- The preceding two maps show the areas that would experience an increase in travel time to a stroke care location under the change scenarios. The shading within the map shows the level of additional travel time that would be experienced.
- The first map shows the increase in modelled journey time at 03:00 and is intended to be indicative of increased journey time to HASU by ambulance.
- The second map shows the increase in modelled journey time at 11:00 and is intended to illustrate the increase in journey time by private car during the daytime. This is most relevant to journeys by friends and family to visit stroke patients at a HASU or ASU.
- The additional driving time was calculated by comparing the modelled journey time from Census Output Area Population-Weighted Centroids (COA PWC) to each current HASU/ASU location. Those COA PWCs where Yeovil District Hospital provides the shortest journey time were identified. For these locations the additional journey time to the next closest HAS/ASU was then calculated.
- The additional journey time is visualised in the maps using the COA polygons related to each PWC.
- COAs represent around 125 locations and were used in the analysis as they are the smallest area available when publishing Census population statistics. **It is important to note that this approach does represent a generalisation of the location of the resident population and so the population figures provided should be viewed as approximate.**
- The additional journey time is expressed in 5 minute bands and the count of the relevant residential population experiencing each banded increase is also provided. This count was derived using the Census 2021 residential population statistics relating to the identified COAs (ts007a).

5. Accessibility by public transport





Stroke care location - accessibility by public transport.
Under the HASU change scenario and ASU option B.

Areas from within which it is possible to travel to the most quickly accessible care location and subsequently to travel home again.

- HASUs / ASUs
- ICB boundary
- Public Transport travel possible - to and from HASU

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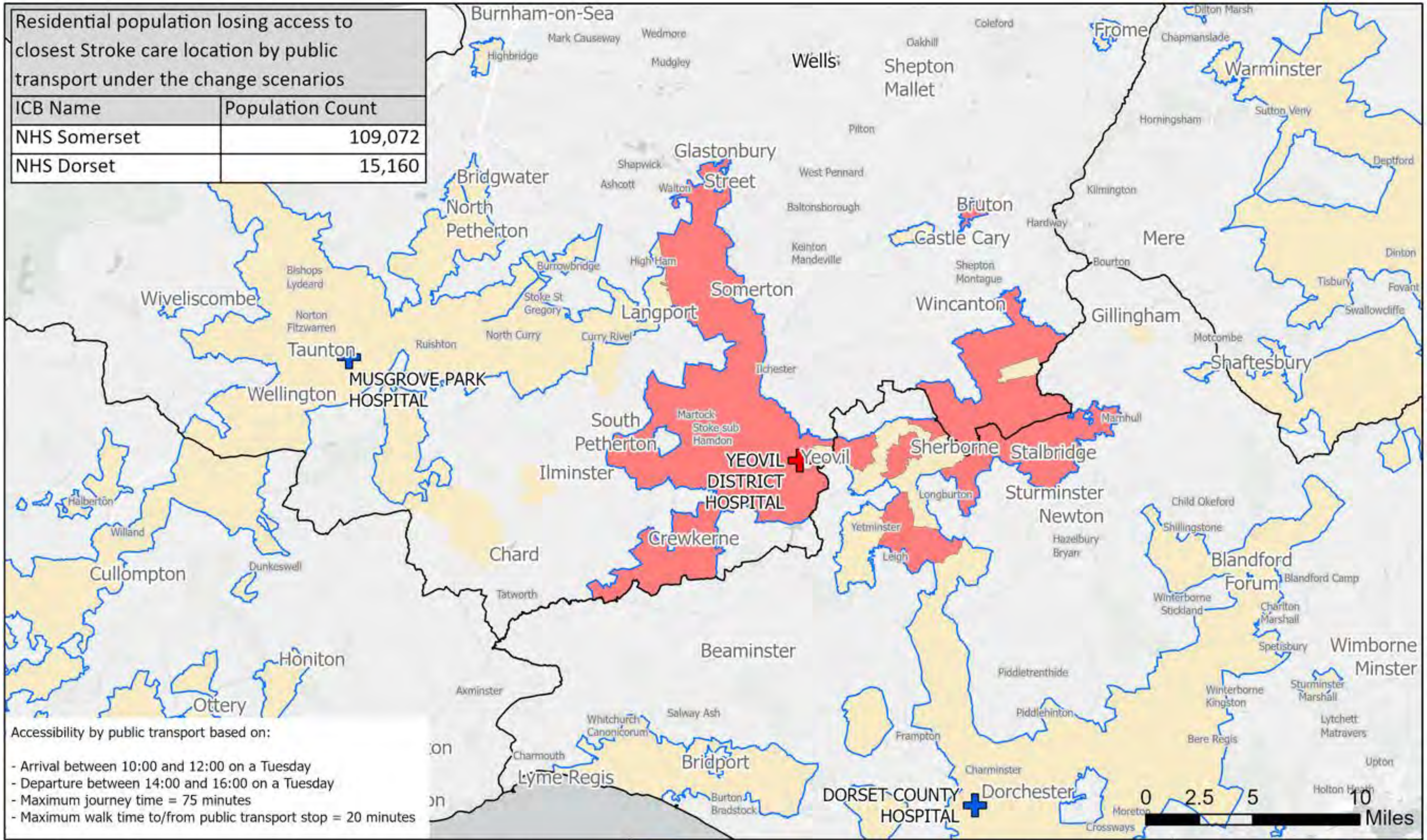
Path: X:\CUSTOMER_WORK\NHS\ICB\SOMERSET\GI3030_Stroke_Reconfiguration\ArcGISPro\GI3030_ClosestHASU_Accessibility_PT\GI3030_ClosestHASU_Accessibility_PT_v8.aprx

Residential population losing access to closest Stroke care location by public transport under the change scenarios	
ICB Name	Population Count
NHS Somerset	109,072
NHS Dorset	15,160



Accessibility by public transport based on:

- Arrival between 10:00 and 12:00 on a Tuesday
- Departure between 14:00 and 16:00 on a Tuesday
- Maximum journey time = 75 minutes
- Maximum walk time to/from public transport stop = 20 minutes

Stroke care location accessibility by public transport - impact of HASU change scenario and ASU option B

Areas that are able to access the closest care location (by driving time) using public transport under the current scenario but cannot do so under the change scenarios

- Areas with access under current scenario
- Areas with access under change scenario
- Areas losing access under change scenario
- Areas without access under either scenario
- HASUs / ASUs - Change Scenario
- Yeovil District Hospital

NB - there are some areas where travel by public transport to the closest Stroke care location under the current scenario is not possible but the journey to the closest HASU under the change scenario is possible. For example Ilminster is better connected to Musgrove Park Hospital than Yeovil District Hospital. This situation applies to 15,863 residents of Somerset ICB and 4,028 in Dorset ICB.

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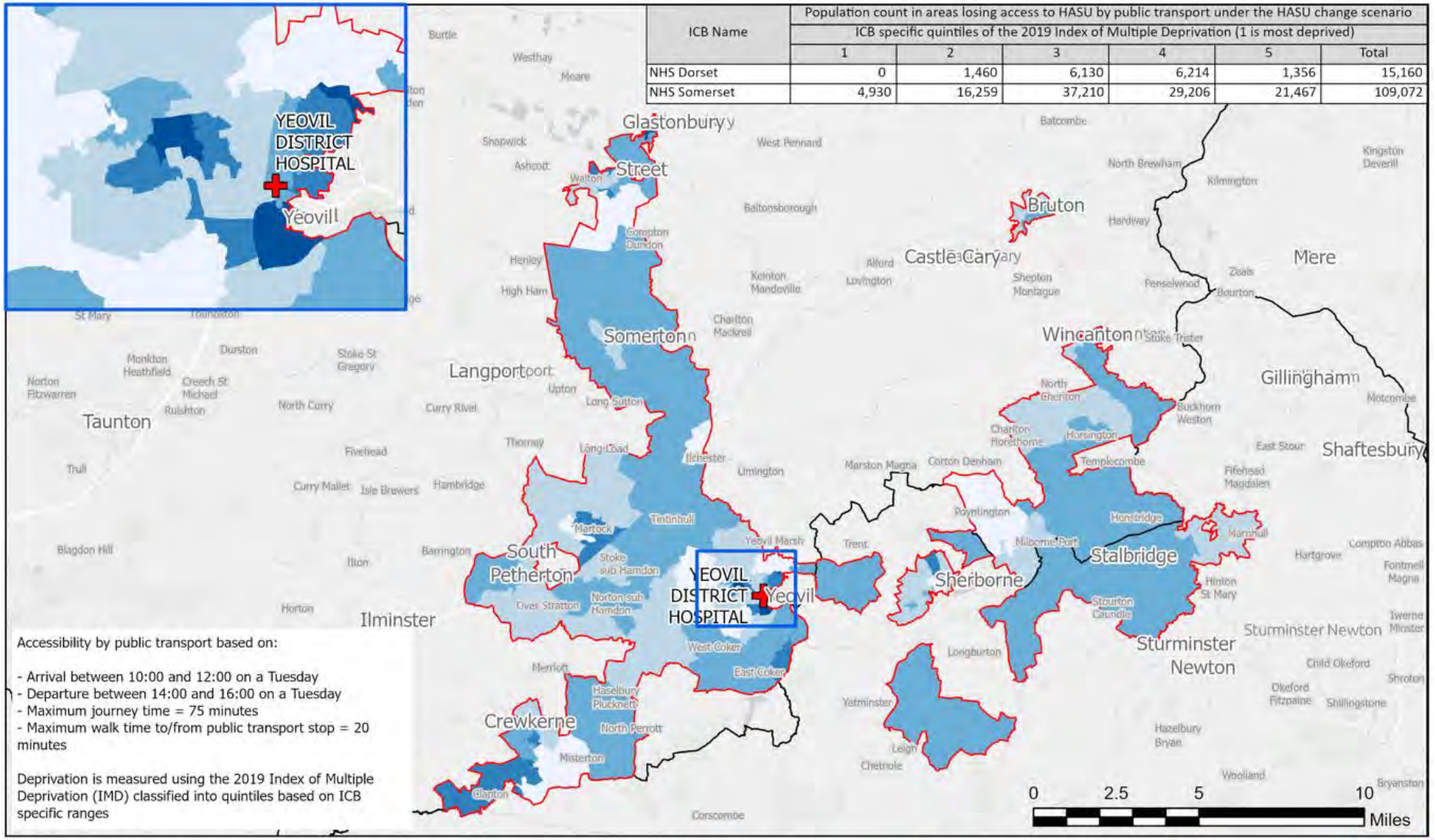
- The preceding three maps are intended to provide insight into the effect upon accessibility by public transport of Stroke care locations under the HASU change scenario and ASU option B. This is most applicable to journeys by friends and family when visiting a stroke patient.
- The intention when considering accessibility by public transport was to model conditions that would enable journeys to and from the care location at a reasonable time. An area is considered to have public transport accessibility only when it is possible to travel to the care location and home again at reasonable times of the day and with reasonable journey lengths.
- Discussion with stakeholders suggested the following criteria:
    - Arrival at the care location between 10:00 and 12:00
    - Departure between 14:00 and 16:00
    - Maximum journey time of 75 minutes
    - Maximum walk to/from a public transport stop of 20 minutes

  The modelling of available public transport journeys was carried out with the above criteria on a Tuesday. The public transport journey planning service used is based on current published public transport timetables. **It is very important to note that different results would be seen if different criteria were applied – for example a different day of the week or different journey time constraints.**
- The first map shows the areas from which it is possible to travel both to and from the HASU/ASU with the quickest 'blue-light' journey time by public transport within the stated constraints under the current HASU/ASU configuration. The quickest blue-light journey location was chosen as this is where the stroke patient would have been taken.
- The second map shows the areas meeting the same criteria under the HASU/ASU change configurations.
- The third map combines the areas identified in the previous maps and highlights the areas that lose the ability to access the relevant HASU/ASU under the change scenario.
- The above analysis uses Census Output Area Population-Weighted Centroids (COA PWC) to represent the location of residential population when modelling journey times. In the supplied maps the centroids have been visualised using the COA polygons related to each point.
- The count of the residential population living within the areas losing accessibility was derived using the Census 2021 residential population statistics relating to the applicable COAs (ts007a). **It is important to note the generalisation of affected areas and population locations implied in the approach used in this analysis. The extent of the affected areas and the population figures should be viewed as indicative.**

6. Socio-economic factors – deprivation in areas losing public transport accessibility in the change scenarios

ICB Name	Population count in areas losing access to HASU by public transport under the HASU change scenario					
	ICB specific quintiles of the 2019 Index of Multiple Deprivation (1 is most deprived)					
	1	2	3	4	5	Total
NHS Dorset	0	1,460	6,130	6,214	1,356	15,160
NHS Somerset	4,930	16,259	37,210	29,206	21,467	109,072



Stroke care location accessibility by public transport and deprivation - HASU change scenario and ASU option B

Levels of deprivation in areas that are able to access the closest care location (by driving time) using public transport under the current scenario but cannot do so under change scenario

Levels of Deprivation
1 - High deprivation
2
3
4
5 - Low deprivation
(Deprivation measured in ICB specific quintiles from the 2019 Index of Multiple Deprivation)

Yeovil District Hospital
ICB boundary
Areas losing access under change scenario

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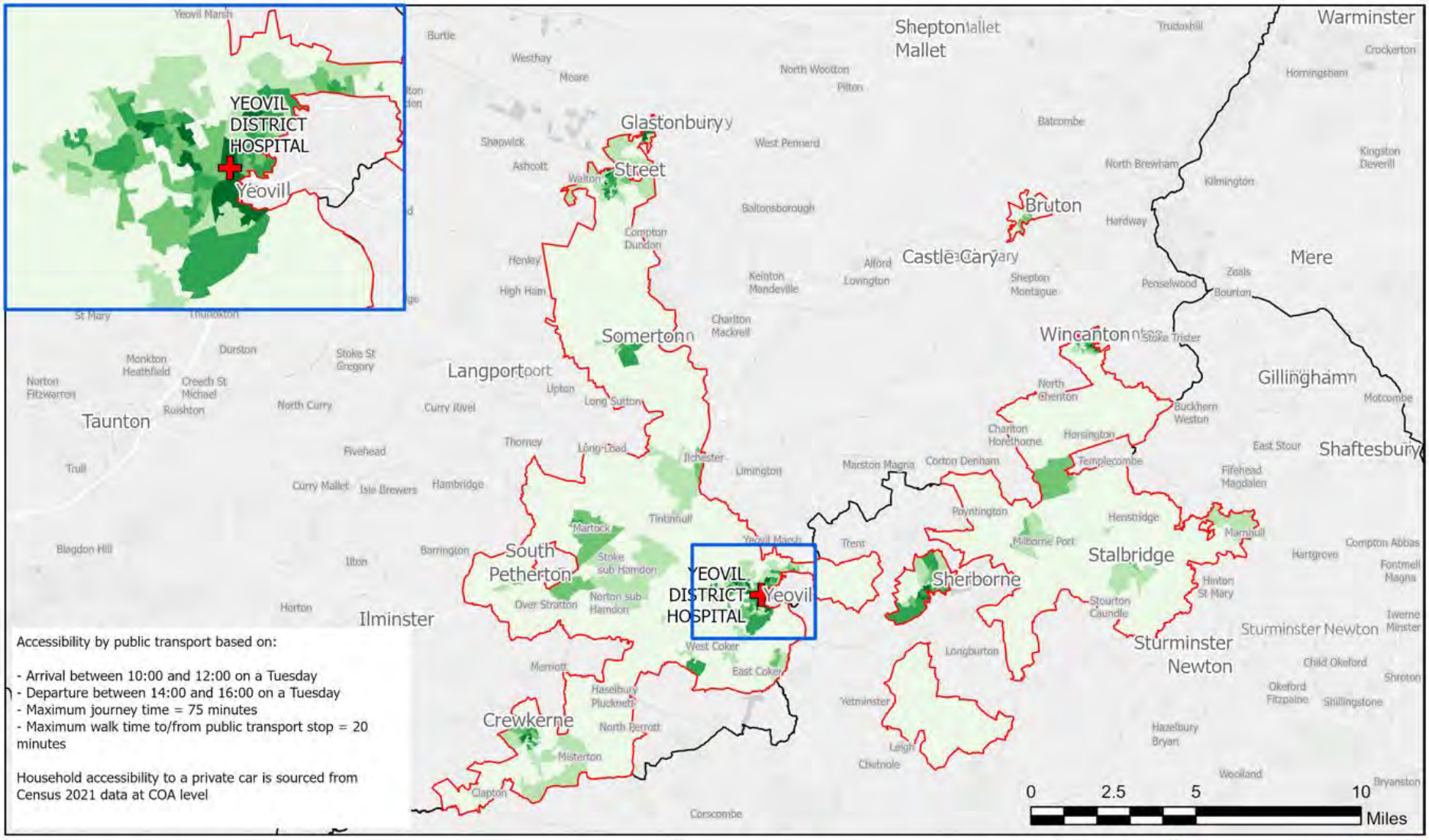
Created By: MB, Checked By: CB

7. Socio-economic factors – household access to private cars in areas losing access by public transport



Stroke care location accessibility by public transport and household access to a private car - HASU change scenario and ASU option B

Percentage of households with no car access. In areas losing access to the closest care location (by driving time) using public transport under the change scenarios.

Percentage of households without access to a car
- 0 - 10
- 10 - 15
- 15 - 20
- 20 - 30
- 30 - 59.4

Yeovil District Hospital
Areas losing access under change scenario
ICB boundary

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South, Central and West Commissioning Support Unit
scwcsu.gis@nhs.net - 15/10/2023
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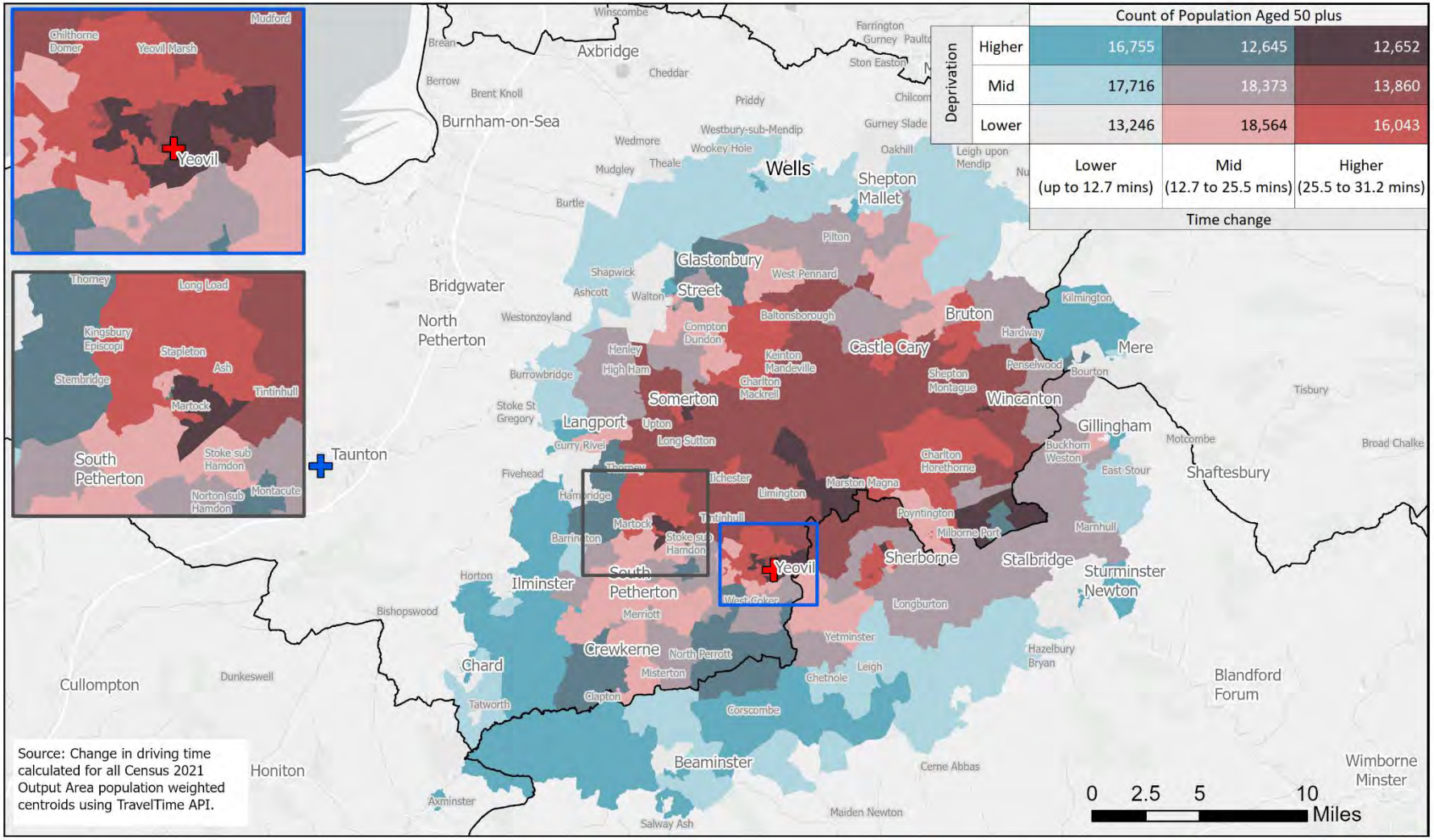
- The previous two maps focus on those areas that were previously identified as losing HASU/ASU accessibility under the change scenarios. Information on the levels of deprivation and households without access to a private vehicle is also provided. The intention of this is to attempt to highlight those areas where adverse impacts on accessibility by public transport might be most impactful.
- The first of these maps shows the levels of deprivation within the identified areas. The measure of deprivation used is the 2019 Index of Multiple Deprivation (IMD) (Source: Ministry of Housing, Communities & Local Government).
- The deprivation values have been classified into quintiles based on the ranges of values within the ICB-wide data. Areas shown as being in the most deprived quintile are in the 20% most deprived areas within each ICB rather than England-wide.
- The map also provides a breakdown of population in each ICB-specific quintile of deprivation in the affected area. The source population data was Census 2021 residential population statistics relating to the applicable COAs (ts007a).
- The second socio-economic map shows the percentage of households without access to a private car in areas where there would be adverse effects on accessibility by public transport. The source data on car access was Census 2021 (YS045 – Car or van availability).
- Previous caveats related to the generalization of affected areas and population counts also apply to these maps.

8. Socio-economic factors – deprivation in areas experiencing increased journey times in the change scenarios



Change Scenario HASU configuration - relative levels of deprivation and journey time increase in areas that would experience increased driving time to the closest HASU.

Modelled at 03:00 on a Tuesday as a proxy for blue-light travel conditions.

HASUs - Change scenario
Yeovil District Hospital
ICB boundary

Levels of deprivation
Drive time change
High
Low
Low High

Deprivation is measured using the 2019 Index of Multiple Deprivation (IMD). The levels of deprivation shown are relative to the values within the mapped areas that would experience an increase in travel time

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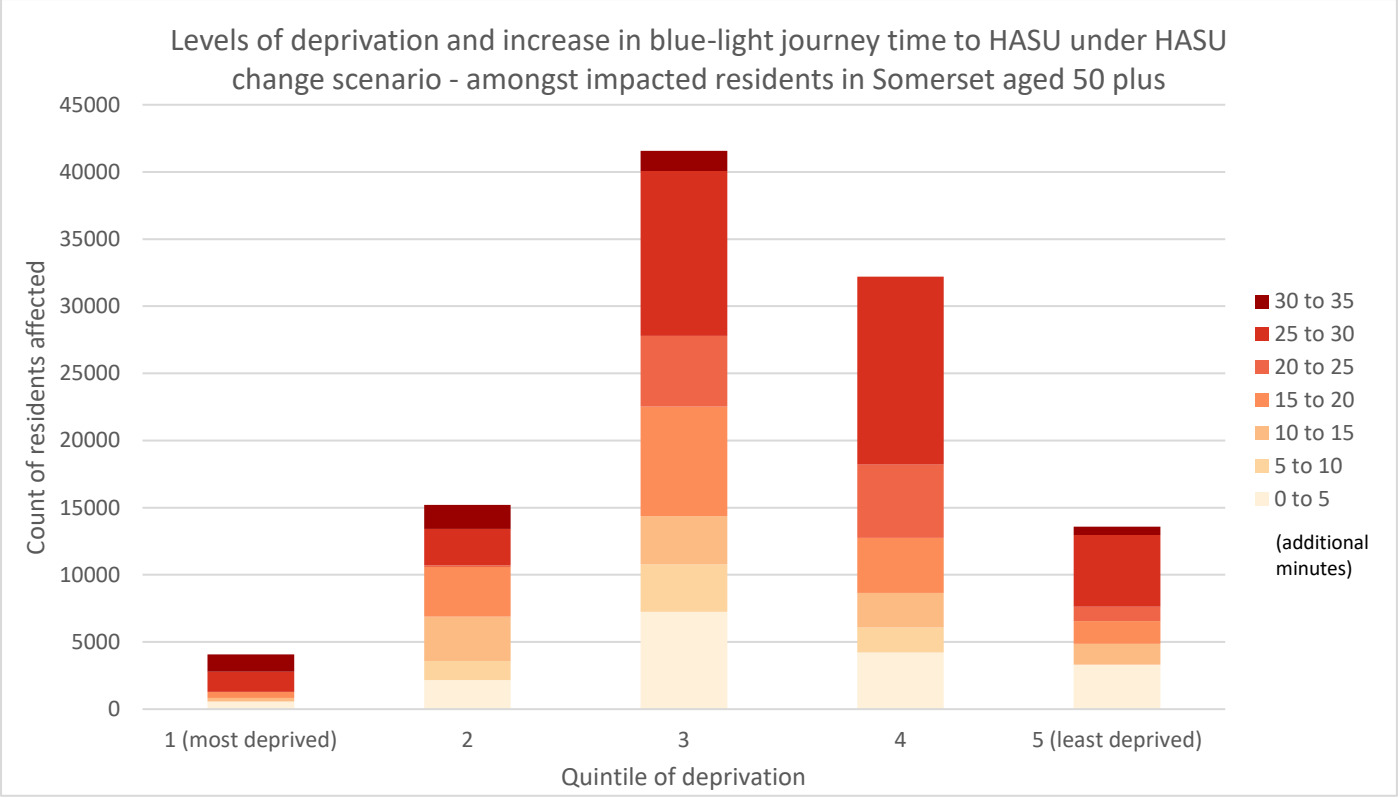
- The previous map focuses on those areas where there would be an increase in modelled blue-light equivalent journey time to a HASU/ASU under the change scenarios. The map shows the bi-variate combination of increase in journey time and relative level of deprivation across these areas.
- The journey times were modelled at 03:00 to be representative of 'blue-light' journey time. The patterns shown are likely to be similar if modelled at daytime hours to be representative of friends and family journeys.
- The intention is to highlight those areas that would simultaneously experience higher levels of travel impact and higher levels of deprivation.
- The map also provides a count of residential population aged 50 plus in each of the identified categories. The source population data was Census 2021 population data at Census Output Area level (COA). Population aged 50 plus was chosen as this group is more likely to require ambulance travel for Stroke treatment.
- As per previous maps the shaded areas used for visualisation are 2021 Census COAs. Journey time calculations were carried out using the population weighted centroids related to these areas.
- It is important to note that the classification within this map of each COA into terciles representing low, mid and high levels of deprivation is relative to the levels of deprivation within this subset of COAs only. An area shown as being in the higher category may not be amongst the highest levels of deprivation when viewed from an ICB-wide perspective.
- Previous caveats related to the generalization of affected areas and population counts also apply to this map.

- Complementary analysis was also carried out to compare levels of blue-light journey time change and ICB-wide levels of deprivation. The following charts are based on residents aged 50 plus in areas that would experience increases in journey time under the HASU change scenario. These residents have been categorized according to the ICB-wide quintiles of deprivation in the areas in which they live. The quintile groups have been stratified according to the increase in journey time to HASU they would experience. The intention is to investigate whether there is a difference in the impact of journey time changes according to varying levels of deprivation.

Somerset ICB

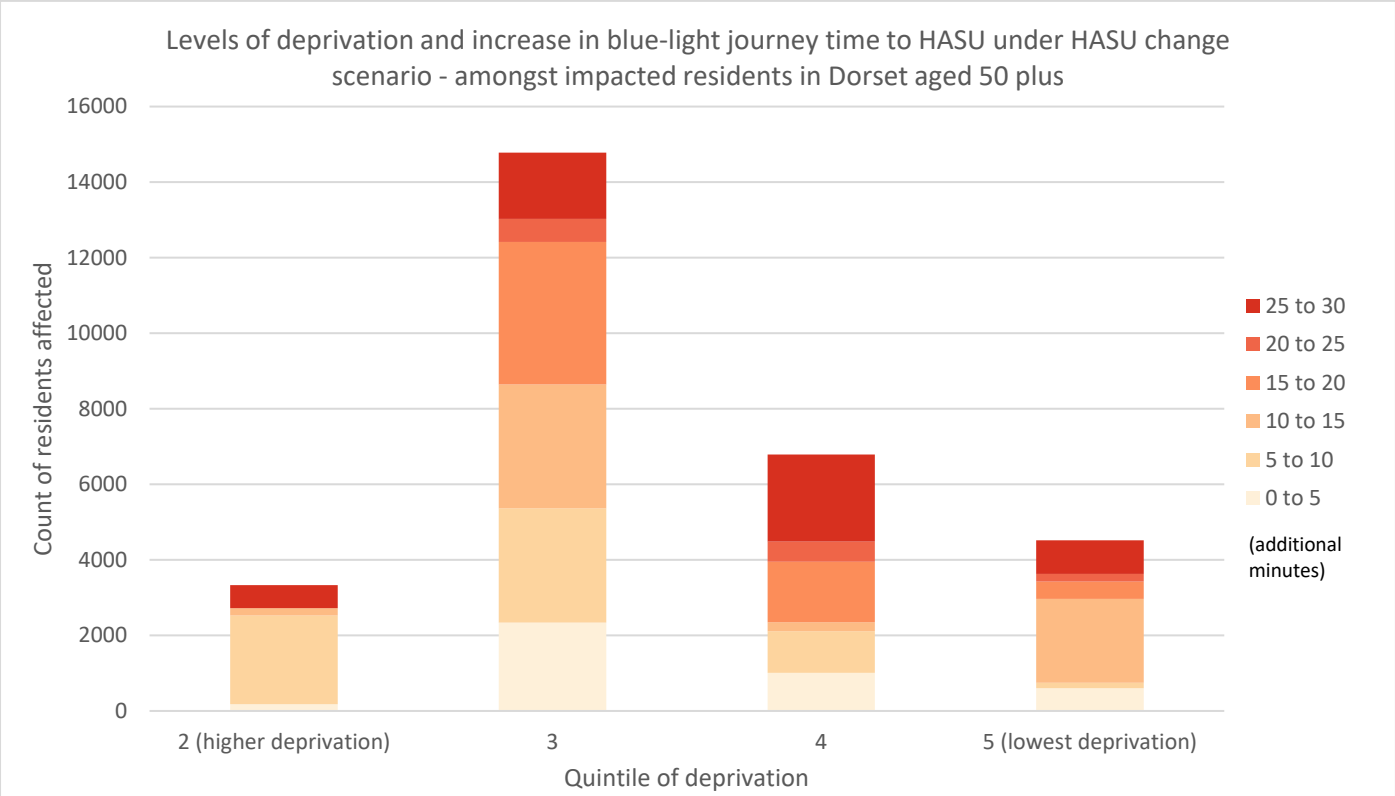
Distribution of increase in 'blue-light' journey time to HASU by levels of deprivation (count of affected residents in each time band)								
Somerset Deprivation Quintile (IMD 2019)	Increase in journey time (minutes)							Count of impacted residents
	0 to 5	5 to 10	10 to 15	15 to 20	20 to 25	25 to 30	30 to 35	
1 (most deprived)	574	0	254	461	0	1511	1265	4065
2	2169	1412	3298	3704	117	2709	1792	15201
3	7242	3540	3602	8146	5252	12283	1495	41560
4	4208	1882	2560	4095	5475	13984	0	32204
5 (least deprived)	3308	0	1546	1704	1077	5333	615	13583



- The above charts suggest that within Somerset ICB a comparatively small number of the impacted residents live in areas with the highest levels of deprivation. However, amongst these residents the travel impact tends to relatively higher.

Dorset

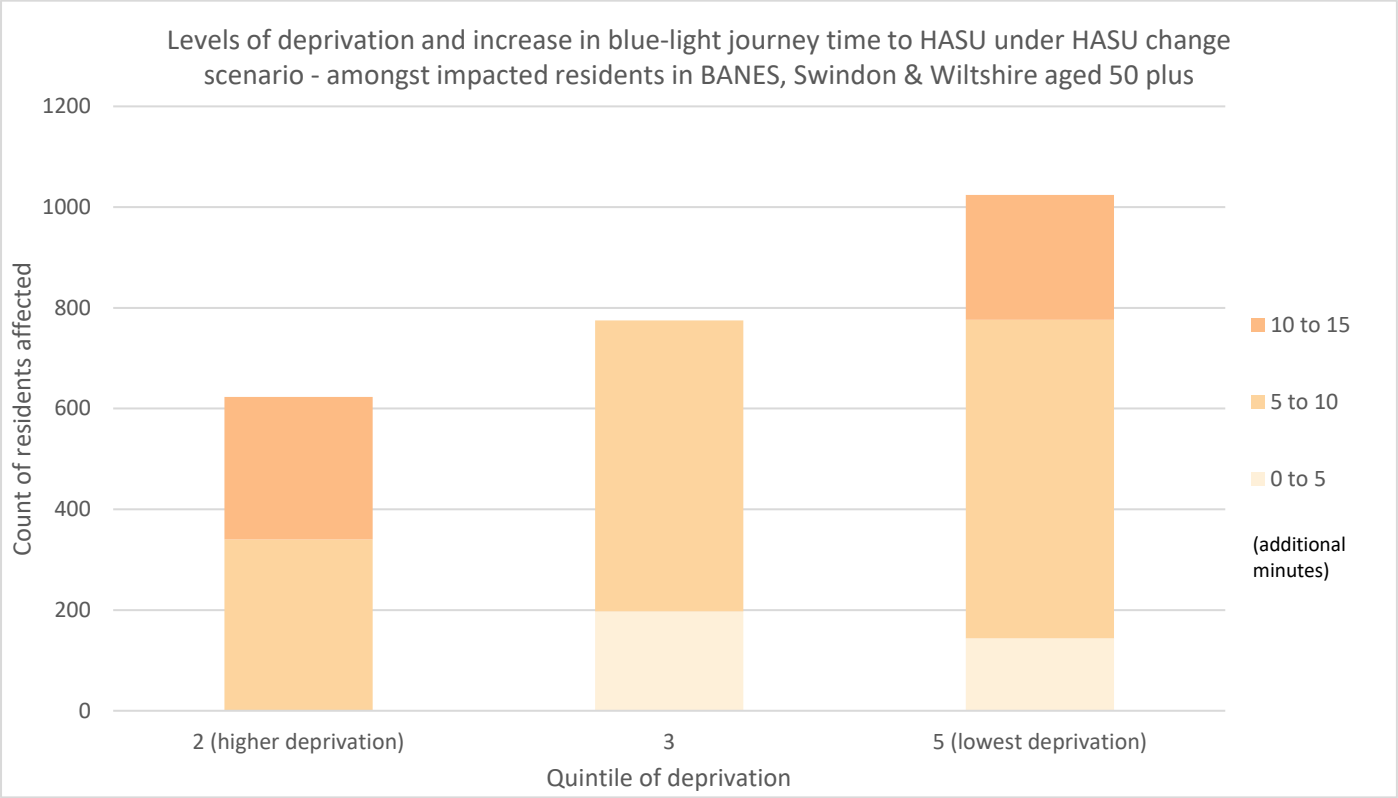
Distribution of increase in 'blue-light' journey time to HASU by levels of deprivation (percentage of affected residents in each time band)								
Dorset Deprivation Quintile (IMD 2019)	Increase in journey time (minutes)							Count of impacted residents
	0 to 5	5 to 10	10 to 15	15 to 20	20 to 25	25 to 30	30 to 35	
2 (higher deprivation)	180	2345	200	0	0	604	0	3329
3	2341	3028	3273	3777	611	1749	0	14779
4	1006	1104	234	1609	527	2310	0	6790
5 (lowest deprivation)	601	144	2221	459	202	888	0	4515



- The numbers of affected patients in Dorset ICB are significantly lower than in Somerset but not inconsequential. This reflects the fact that Yeovil District Hospital is currently the closest HASU for some residents in northern Dorset. Affected Dorset residents who live in areas with higher deprivation levels tend to have lower impacts in terms of additional driving times to a HSAU.

BANES, Swindon & Wiltshire

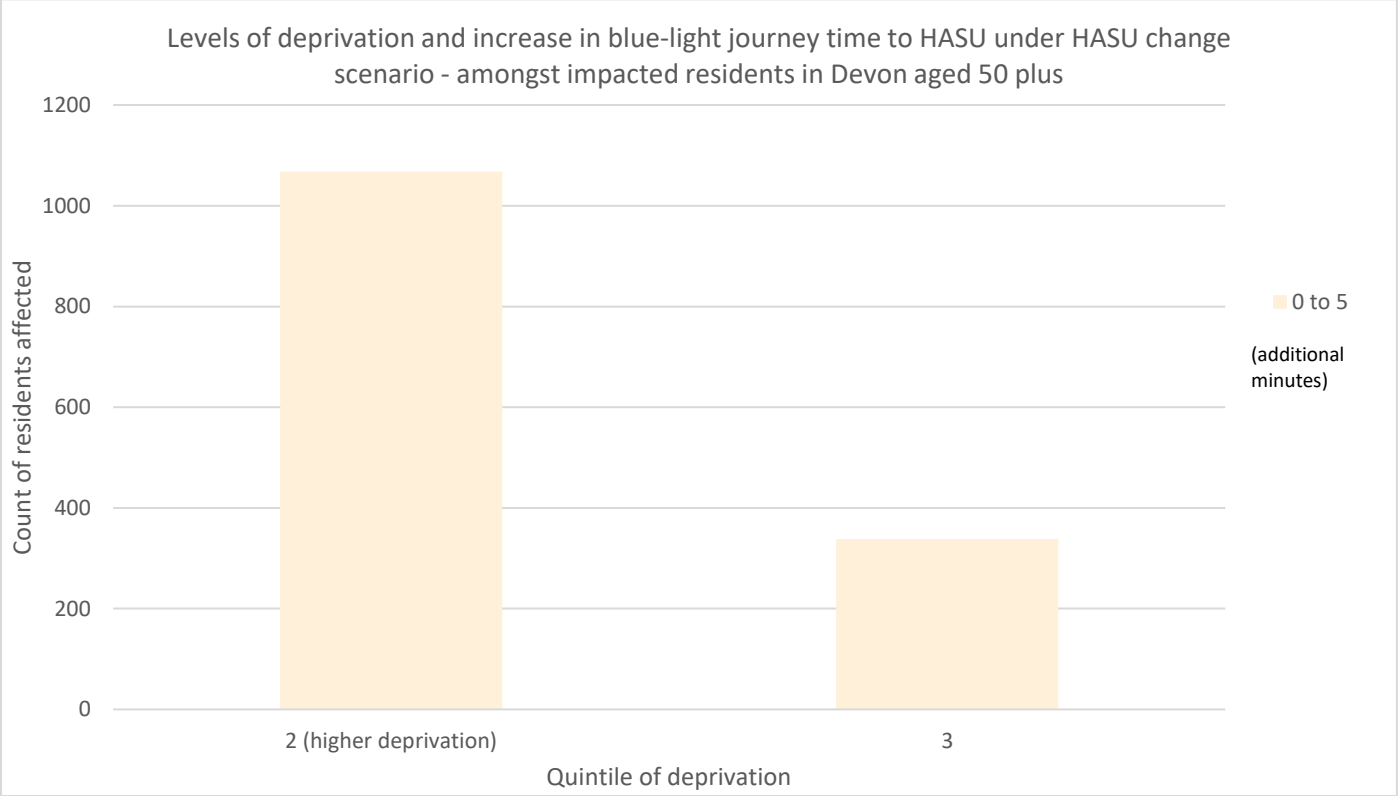
Distribution of increase in 'blue-light' journey time to HASU by levels of deprivation (percentage of affected residents in each time band)								
BANES, Swindon & Wiltshire Deprivation Quintile (IMD 2019)	Increase in journey time (minutes)							Count of impacted residents
	0 to 5	5 to 10	10 to 15	15 to 20	20 to 25	25 to 30	30 to 35	
2 (higher deprivation)	0	340	283	0	0	0	0	623
3	197	578	0	0	0	0	0	775
5 (lowest deprivation)	144	632	248	0	0	0	0	1024



- The numbers of affected patients in BANES, Swindon & Wiltshire are low. This area is somewhat removed from Yeovil District Hospital meaning that this is the closest HASU for a relatively small number of residents. Amongst these residents the additional journey time tends to be relatively low also.

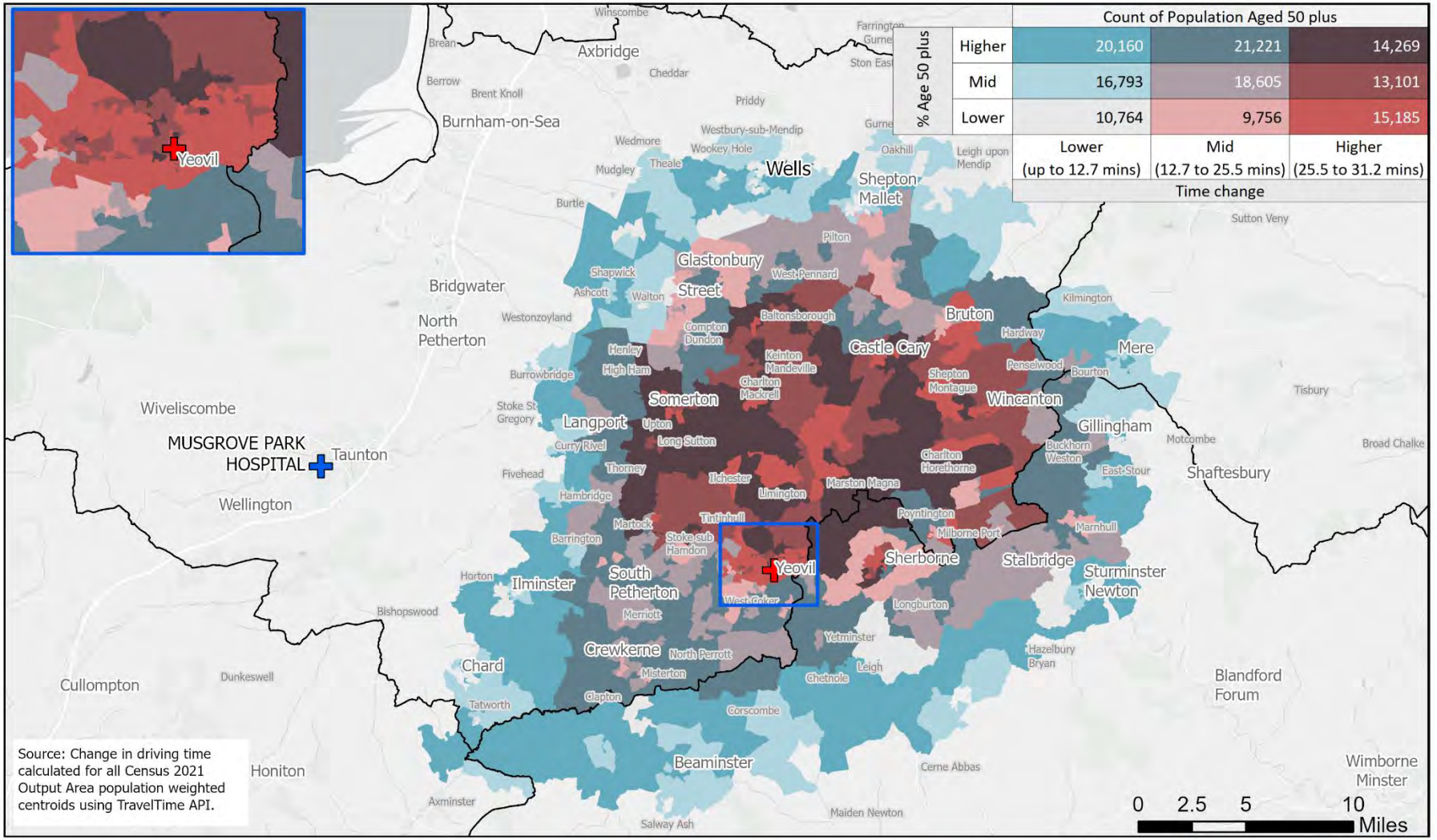
Devon

Distribution of increase in 'blue-light' journey time to HASU by levels of deprivation (percentage of affected residents in each time band)								
Devon (IMD 2019)	Increase in journey time (minutes)							Count of impacted residents
	0 to 5	5 to 10	10 to 15	15 to 20	20 to 25	25 to 30	30 to 35	
2 (higher deprivation)	1068	0	0	0	0	0	0	1068
3	338	0	0	0	0	0	0	338



- The numbers of affected patients in Devon ICB are low. This area is somewhat removed from Yeovil District Hospital meaning that this is the closest HASU for a relatively small number of residents. Amongst these residents the additional journey time tends to be relatively low also.

9. Socio-economic factors – population aged 50 plus in areas experiencing increased journey times in the HASU change scenario



Change Scenario HASU configuration - relative levels of population aged 50 plus and journey time increase in areas that would experience increased driving time to a HASU.

Modelled at 03:00 on a Tuesday as a proxy for blue-light travel conditions.

HASUs - Change scenario
Yeovil District Hospital
ICB boundary

Percentage aged 50 plus
Drive time change
High
Low
Low High

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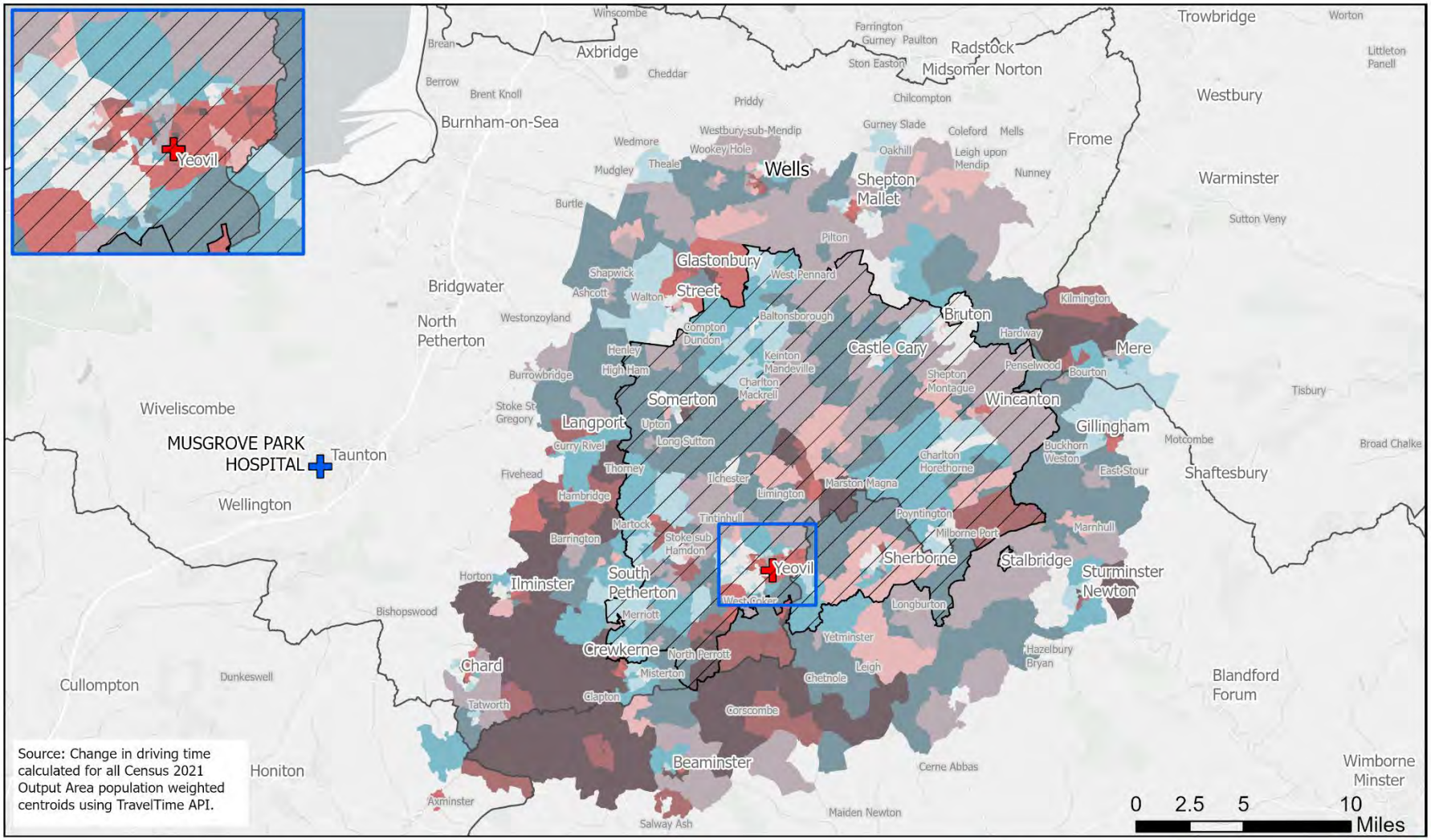
- The previous map focuses on those areas where there would be an increase in modelled blue-light equivalent journey time to a HASU/ASU under the change scenario. The map shows the bi-variate combination of increase in journey time and relative level of population aged 50 plus across these areas.
- The journey times were modelled at 03:00 to be representative of 'blue-light' journey time. The patterns shown are likely to be similar if modelled at daytime hours to be representative of friends and family journeys.
- The intention is to highlight those areas that would simultaneously experience higher levels of travel impact and higher levels of population aged 50 plus and therefore a higher likelihood of residents experiencing a Stroke.
- The map also provides a count of residential population aged 50 plus in each of the identified categories. The source population data was Census 2021 population data at Census Output Area level (COA).
- As per previous maps the shaded areas used for visualisation are 2021 Census COAs. Journey time calculations were carried out using the population weighted centroids related to these areas.
- It is important to note that the classification within this map of each COA into terciles representing low, mid and high levels of population aged 50 plus is relative to the population age structure within this subset of COAs only. An area shown as being in the higher category may not be amongst the highest levels when viewed from an ICB-wide perspective.
- Previous caveats related to the generalization of affected areas and population counts also apply to this map.

10. Socio-economic factors – population aged 50 plus and deprivation in areas experiencing increased journey times in the HASU change scenario

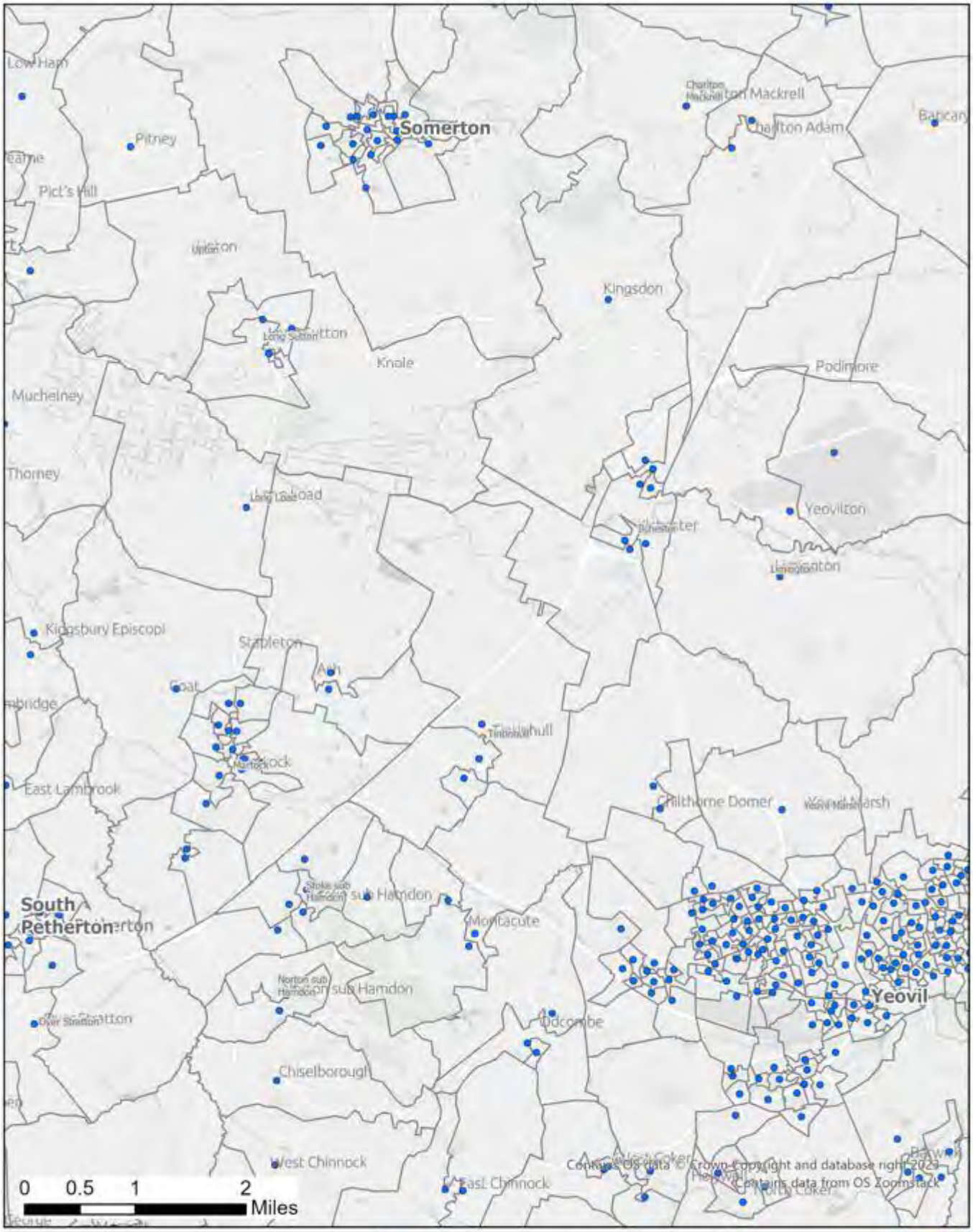


- The previous map focuses on those areas where there would be an increase in modelled blue-light equivalent journey time to a HASU/ASU under the change scenario. The map shows the bi-variate combination of relative level of population aged 50 plus and relative levels of deprivation across these areas.
- The journey times were modelled at 03:00 to be representative of 'blue-light' journey time. The patterns shown are likely to be similar if modelled at daytime hours to be representative of friends and family journeys.
- The intention is to highlight those areas that would simultaneously experience higher levels of population aged 50 plus and higher levels of deprivation. These are thought to be the areas where residents are more likely to experience a stroke given the positive correlation between both increasing age and higher levels of deprivation and Stroke incidence rates.
- The map also highlights those areas where there would be greater than 20 minutes additional drive time to a HASU under blue-light conditions. Areas with higher levels of both deprivation and population aged 50 plus that fall within this area represent the areas where the impacts of the HASU change scenario may be most severe.
- Previous comments about the generalization of areas inherent in this analysis are also applicable to this map.

11. Considerations when interpreting results

Geographies used in analysis

- As previously explained, the analysis presented in this document was carried out using Office for National Statistics (ONS) 2021 Census Output Areas (COA). These geographies were chosen because of the related Census 2021 population data that can used in analysis. These are the smallest geography at which Census data is published and therefore provide the most accurate geographies that are available for this type of analysis.
- A COA is an area defined by the containing between 40 and 250 households and a usually resident population of between 100 and 625 persons.
- When modelling journey times, it is necessary to identify origin points for journeys – it isn't possible to calculate journey times based on areas as an exact origin and destination point is required. For each COA there is an accompanying population-weighted centroid (PWC). These are generated by ONS as the single point that best represents the location of all households within a COA.
- The travel analysis carried out in the work presented in this document uses COA PWCs as the origin points for travel analysis. It is important to note that this is a generalization as the location of all households within a COA are represented as being in a single location and will therefore be assigned the same results in travel-time calculations.
- The extent of the COAs have been used when presenting results as this is visually preferable to using points.
- The following map shows example extents of the COAs used in this analysis and the locations of the COA PWCs that were used in the travel analysis.



Comparison of population-weighted centroids (travel analysis origin points) and the area these points represent

- Census Output Areas - Population-Weighted Centroids
- Census Output Areas

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Created By: matt.bridges

Accuracy of travel analysis

- The results presented in this document are based on travel analysis carried out using the TravelTime API (www.traveltime.com). Analysis of journey times and accessibility can only ever be a model and please note that other travel analysis services may generate slightly different results.

- Given the above limitations derived values for affected population counts should be viewed as indicative rather than absolutely accurate.

APPENDIX 07

WORKFORCE PLAN

CONTENTS

1. Introduction

This document is intended to supplement the detail already contained within the workforce section of the Decision-Making Business Case (section) following the additional views and feedback provided over the course of 2023 in relation to the recruitment and retention activities going forwards.

The implementation of the service changes will involve organisational change to working practices to align rotas. There will be an ongoing requirement for staff to be retained within both Yeovil and Taunton and a move to align to one service two sites model of care.

2 Recruitment and Retention

Within Somerset there is an aspiration to explore more innovative and creative ways to recruit and retain specialist stroke staff and ensure workforce sustainability.

Potential solutions may include greater cross-site working and opportunities for rotations or secondments between sites, the development of a single workforce across the hyperacute and acute phase of the stroke pathway, development of more advanced clinician roles (such as Physicians Associates and Advanced Clinical Practitioners), provision of a clear training and development plan for all staff, creating or utilising digital technology to overcome the workforce challenges created by our geography.

It is important that the workforce is enabled to function in the most efficient and effective way to ensure that their time and skills are being used in the best way, for example by reducing time that specialists may spend on completing tasks that may be more appropriate to be delivered by other members of the team.

The benefits of enhancing the workforce model are extensive and moving to a one service two site model include:

- Creating a more attractive place to work, which will lead to improved recruitment and retention levels, recruitment, and lower vacancy rates.
- Ensuring adequate staffing levels and skill mix to meet national service specifications and deliver the best quality treatment, care and support for people who have had a suspected or confirmed stroke or TIA.
- Improved equity of provision for development, education and high-quality training for all staff involved in the delivery of stroke care across the county.
- A reduction in avoidable temporary staffing levels and costs, either through bank or agency
- Improved sickness levels
- Improved staff satisfaction and engagement levels, leading to improved retention rates.
- Improved succession planning and talent management.

Somerset Foundation Trust (and indeed the stroke service at Somerset Foundation Trust) has a track record of developing the knowledge and skills of associate specialists, including progression to

specialist accreditation through the CESR route. We will continue to explore these opportunities, as well as innovative recruitment methods including appointment of overseas candidates.

Changes to the postgraduate medical training curriculum may create a more streamlined pipeline supply of future consultant stroke physicians: by enabling more trainee doctors to gain exposure to stroke medicine there is a great opportunity to positively influence their career choices.

Collaborative recruitment approaches across the organisation and service will include the following:

- Representatives from both sites participating in selection and/or interviewing.
- Development of recruitment materials for the service standardised across both sites.
- Appointment of joint posts where appropriate (e.g., medical staffing recruitment, rotations)
- Staff will be employed by Somerset Foundation Trust (SFT) but may have a job plan which spans across both sites.
- Advertising will be undertaken with the principles of 'one stroke workforce' set out in an expectation to work flexibly in support of the patient pathway.
- Working with Colleges and Universities and apprenticeships.

Retention initiatives and review of workforce pressures will be considered across the pathway to ensure that specific actions (e.g., recruitment and retention premia, employee experience within the acute environment) are undertaken in a coordinated manner to avoid damaging recruitment and retention in differing settings or areas of the Stroke pathway.

Development of relevant apprenticeship posts, rotations, new roles for internal development (e.g., Advanced Clinical Practitioners' (ACP's) will provide a greater opportunity for staff to develop and maintain skills across the pathway within Stroke which will support staff retention.

Through the decision-making process and implementation phase a series of communication briefings and engagement workshops will be held to ensure staff are well sighted on the details of the future state plans and service specifications. This is aimed at supporting staff in understanding how the future of stroke services will work and to mitigate turnover risk associated with anxiety relating to change management processes.

3 People Strategy

A People Plan has been developed in Somerset Foundation Trust to support the transition to a unified way of working, following the merger, by setting out a vision for how to retain, develop, inspire, and attract staff.

The image below describes the 5 overall commitments, with supporting high level ambitions. The ones most relevant to the stroke workforce and supporting the stroke reconfiguration have been highlighted in yellow.

The table below shows the recruitment activities and turnover information for the core posts within stroke.

Table 1 - Recruitment activities and approaches for core posts

Staff groups	Approaches	Turnover/vacancies	Comments
Registered nursing	International recruitment National recruitment events Enhanced advertising (paid) Enhanced incentives – RRP / relocation Nursing Associates Career development	**9.4 % this is based on a 12 month average across both sites.**	Not a big gap currently.
Support workers nursing and therapies i.e., HCA's and RA's	National advertising Apprenticeships Recruitment Open days Opportunities to develop into nursing associate roles.	8.6%	Relatively easy to recruit through standard recruitment, however being mindful that they could be junior and require support and mentoring and taking through the stroke competency training.
Registered therapists	National advertising Recruitment Open days Links with colleges/universities Social Media campaigns Potential for targeted	**16.7%**	Current successful programme of apprenticeship cohort for OT. Current rotational posts offered.

	recruitment activity for OT's Use apprenticeships. Professional leads to support with professional and clinical development for existing staff. Rotational scheme for band 5 and 6.		
Consultants	International recruitment National recruitment Events Enhanced advertising (paid) Enhanced incentives – RRP	11.3	Enhanced recruitment activities Using the CESR route for attracting to Associate Specialist posts. Attending careers events and being part of the regional and national working groups.
Other medical posts	Allocations through deanery National advertising for gaps Internal developments for specialist roles • CESR route Using Physicians Associates (PA)	**16.7%**	Physicians Associates in place and successful.
Admin and Clerical	Standard recruitment Apprenticeships Traineeships	**20.3%**	To recruit through standard recruitment currently various admin roles advertised within the Trust.

4 Workforce training and development

Workforce training and development is the key to unlocking the workforce challenge by changing to a "skills and capabilities" model rather than one solely based on professional qualifications which allows greater flexibility in the range of workforce solutions available for an existing workforce.

In Somerset Foundation Trust one of the challenges with retaining stroke nursing and therapy staff in the past has been a perceived lack of options in this regard: to seek personal or career development these staff have moved to other specialties / departments, or other NHS trusts.

The Somerset Stroke Framework is designed to describe and support the development of the skills and knowledge that all health care professionals and support staff require to deliver high quality care

as part of the Somerset Stroke Pathway in both the hospital and community setting. This is supported by the Stroke Specific Educational Framework (SSEF) which is an online professional development tool that covers the whole stroke care pathway and is a response to the National Stroke Strategy. Its aim is to provide a structured and standardised approach to education and training for those working within, and affected by, stroke. It is the intention that as they move towards a one team approach with the Somerset stroke framework and the SSEF will be used to deliver a specific stroke development competency programme for all those staff working within the stroke pathway.

Continuous Personal Development (CPD) − or more specifically workforce development – offers staff career progression that motivates them to stay within the stroke service and, just as importantly, equips them with the skills to operate at advanced levels of professional practice and to meet patients' needs of the future.

Advanced practice roles for both nursing and therapists offer opportunities to improve clinical continuity; provide mentoring and training for less-experienced staff; and offer a rewarding, clinically facing career option for experienced staff. They also enable consultant medical staff to work at the top of their licence.

5. Role consistency and standardisation

The approach to staffing will be to meet the appropriate standards as set out in the relevant guidance documentation (e.g., British Association of Stroke Physicians and the National Stroke Clinical Guideline 2016).

Although there are new guidelines for 2023 the DMBC has used 2016 guidance for staffing with an aspiration to work towards the 2023 guidance under the transformation work within stroke.

Roles will be developed across the Stroke pathway to provide a consistent and standardised approach where appropriate and with the principle of avoiding unwarranted variation. This will enable a greater level of flexibility and support staff retention.

Terms and Conditions are standardised across the organisation under national terms and conditions.

6 Staffing deployment

Staff deployed to support the stroke staffing will be determined in line with national standards and associated aligned staffing requirements (i.e., 'Safe Staffing levels').

Staff currently move to different areas of the Trust when in escalation and this would continue from the ASU but not from the HASU where the level of staffing needs to reflect the level of patient dependency.

7 Clinical and management governance

As per service specifications but within the principles outlined below:

- Professions will be led by the clinically appropriate lead responsible for Stroke.

  (i.e., Stroke Matrons, Therapy leads).

- Clinical leads for the service will oversee the patient pathways with a one service approach to clinical governance across both sites.
- Overall performance of the stroke service will be monitored through measures and metrics including SSNAP which will identify if aspects of the pathway is risking the ratings of the service and can be escalated appropriately.

8 Statutory duties and staff rights

Staff will be required to be registered with their professional bodies (e.g., NMC, HCPC etc) which will be managed through SFT.

All employment rights and associated policies will be in line with the relevant national terms and conditions for the staff group (e.g., Agenda for Change) and within the organisational employment legal framework and requirements for organisation where staff are employed.

9 Competency framework

To deliver the "skills and capabilities" workforce model we will use available resources to enable mapping of competencies for our staff that not only ensures they are fully equipped to undertake their current role, but also gives them a clear and objective plan to develop and extend their role. This is key to upskilling our stroke workforce.

The Stroke Specific Educational Framework (SSEF)[1] aims to establish nationally recognised, quality assured and transferable education programmes in stroke. The SSEF consists of 16 Elements of Care; within each Element of Care there are key competencies that reflect the "knowledge and understanding" and "skills and abilities" a member of staff should possess if they work in that area on stroke care delivery. This SSEF has been updated to support education of other key members of the multidisciplinary team, including a more developed section for Advanced Clinical Practitioners (ACPs) and a description of practical competencies for extended and advanced practice roles.

Health education England (HEE) have also produced the Stroke Training Guide[2] which provides learners with a comprehensive list of available resources that can be used simultaneously with the SSEF to support workforce upskilling, training, and development.

The Royal College of Nursing (RCN) has developed a UK Career Framework for Stroke Nurses[3] which outlines the range of career pathways within stroke nursing and minimum recommended education requirements, in addition to knowledge and skills. It provides a guide for stroke services and employers to develop local career development frameworks for the nursing workforce. Registered nurses working

[1] Stroke Specific Educational Framework (SSEF)
[2] Stroke Training Guide
[3] UK Career Framework for Stroke Nurses

in stroke care can map their career development, as well as assess their skills and knowledge based on this resource and linked resources.

Competencies for differing professions will be determined by the requirements relevant to those staff groups and appropriate setting.

A consistent approach will be applied across both sites where work is of a similar nature to ensure that staff competencies are developed equitably, and this have already started for the trainee ACP posts which will standardise competencies across the two sites.

Where the frequency of Stroke supported activities are less (i.e., YDH where no HASU is present) the rotational approach to supporting competency development for the ACP's will be used to ensure that staff are able to maintain core skills to be able to respond to any walk in or inpatient strokes and be able to support the delivery of specialist advice and treatment options.

10 Integration of the stroke workforce

Preparation for the merger of Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital has been a driver for a project aiming to integrate the acute stroke team at Musgrove Park Hospital and Yeovil District Hospital and the stroke rehabilitation teams in the stroke rehabilitation units and community. This led to several developments to break down barriers and improve the ways of working, which included:

Development of integrated stroke clinical governance processes including single integrated stroke performance dashboard

Whole pathway mapping and streamlining of processes (e.g., referral from acute to community teams)

Pathway shadowing so that stroke team members had a greater understanding of colleagues' pressures at other points along the stroke pathway.

Improvement in information sharing to reduce repetition and reduplication of work, and delays.

Therapy staff rotation between acute and rehabilitation setting

Regular Leadership Exchange meetings between senior nurses in acute and rehabilitation units

There are additional opportunities that can now be realised through the merger of Somerset Foundation Trust and Yeovil District Hospital and this stroke reconfiguration, including full integration of the stroke teams to develop a single Somerset-wide stroke team with a single stroke clinical leadership team with shared objectives and goals. Benefits could include:

- Clarity of leadership and direction across the whole stroke pathway, from prevention through to rehabilitation.
- Clearly defined governance, leadership, and employment models.

- Financial adaptability to enable flexibility within recruitment to meet the needs of the service.
- Alignment of pay and reward across roles and sites.
- Harmonisation of paperwork and processes between the two trusts to reduce unnecessary variation, duplication, and delays.
- Single workforce plan across the pathway with visibility of new role development, education pathways, vacancies, and targets.
- Alignment and integration of recruitment
- Opportunities for staff rotations and secondments between hospital sites and across the whole of the stroke pathway
- A consistent Somerset-wide stroke education and training programme

The two trusts have already organised stroke workshops attended by members of the acute stroke services in Musgrove Park Hospital and Yeovil, as well as representatives of the community stroke units and community rehabilitation service.

These enablers are being addressed by a workforce subgroup and will continue to develop as the programme progresses to the decision-making phase.

11 Implementation considerations

During the DMBC governance processes, a series of engagement workshops will be held to support the socialisation of the service specifications. These will be opportunities for staff who have not had direct involvement in the programme to better understand the potential future service delivery.

A series multi organisational CPD events will be held to support staff working in Stroke have opportunities to learn national and local developments within the Stroke specialty.

12 Staff feedback from Public Consultation

While it was noted that this was not a formal staff consultation at this stage, staff engagement and views were invited as part of the public consultation and steps were taken to ensure there was the opportunity to discuss and capture them. Staff were able to attend any public consultation events and to give their response through the same channels as the public. In addition to this, six staff specific events were hosted through the consultation to enable discussion and feedback on the proposals.

The stroke programme team also attended existing staff meetings and visited sites to share the proposals and gather feedback and all the feedback was recorded, logged, and submitted to the independent agency responsible for compiling the thematic review.

Feedback from staff during the public consultation was positive as there were over 100 responses which provided a valuable insight into the proposals.

Most respondents agreed with the rationale for change and that there should be a single HASU on the Musgrove site and an ASU on the Musgrove and Yeovil site. Of those comments which were predominantly workforce associated, concerns over loss of skills in existing areas where change may occur, loss of existing staff due to the proposed changes and the challenges with recruiting to specialist staff posts .

Mitigations for this include recruitment and retention strategies as per the people plan, rotation of staff, alignment of training and development programmes and the opportunities from the merger to become one team.

APPENDIX 08

Somerset Stroke Environmental Impact Assessment

1. Introduction

1.1	NHS Somerset Integrated Care System (ICS) Stroke Programme, is reviewing the delivery of stroke care across the region to understand how changes to the stroke pathway can bring about improvements to patient outcomes.
1.2	This document assesses the environmental impact of the proposed model, as well as the interdependencies with future local initiatives, such as the Somerset Council Travel Plan that is currently being developed.
1.3	Planning for sustainability is so fundamental to health and to the continuation of care provision that sustainability should be considered an aspect of quality in healthcare. The Royal College of Physicians has identified sustainability as a domain of quality "which must run through and moderate other domains" (safety, timeliness, effectiveness, efficiency, equity and patient-centredness).
1.4	Air pollution is one of the greatest environmental risk to health. By reducing air pollution levels, countries can reduce the burden of disease from stroke, heart disease, lung cancer, and both chronic and acute respiratory diseases, including asthma.[1]

2. Identified impacts of the proposed model A

2.1	The proposed option A seeks to centralise the hyper acute care for stroke patients at a single site at Musgrove Park Hospital in Taunton which will have a "hyper acute stroke unit" (HASU) and become a "Comprehensive Stroke Centre" under the new National Stroke Service Specification. This means that ambulances would no longer convey people with suspected strokes to Yeovil District Hospital A&E. For a proportion of patients, this will represent an increase in travel time, although is it expected that centralisation should speed up 'door to intervention time' sufficiently to mitigate against any additional travel time. The increased ambulance travel does pose an environmental question. It is expected that the proposed service will reduce patient length of stay in hospital, which will have an environmental benefit.
2.2	Patients who would normally go to Yeovil would go to **Taunton or Dorset for their HASU** care. Somerset patients would return to Yeovil for the **ASU** care.
2.3	**TIA** service would be delivered 5 days a week in Yeovil and at weekends patients would be directed to Taunton service.

3. Identified impacts of proposed model B

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5 fact-sheet-embodied-carbon-social-housing.pdf (ucl.ac.uk)

3.1	Under option B there would be a single HASU at Musgrove Park Hospital in Taunton. There would be no HASU or ASU at Yeovil. South Western Ambulance Service Foundation Trust (SWASFT) would take patients to the nearest HASU, at Musgrove Park Hospital or Dorset County Hospital. Patients would remain in **Taunton or Dorset for their ASU** care. Yeovil District Hospital would not receive suspected stroke patients unless a patient walks in.
3.2	Once ready for rehabilitation, patients would ideally be **discharged closer to home** following their acute care – either home or to a community hospital. The principle of more care at, or closer to home, is expected to have a significant environmental benefit. It will result in a significant reduction in the number of travel journeys associated for friends and family visiting as well as a number of indirect carbon benefits.
3.3	Air pollution leads to stroke and other respiratory illnesses, meaning the care for the few would impact the many. There are a detailed range of obligations outlined in the NHS Standard Contract 2023/2024 on Green NHS and Sustainability, including that "*providers must take all reasonable steps to minimise its adverse impact on the environment and to deliver its commitments set out in the Delivering a Net Zero NHS*."
3.4	The SWASFT Green Plan sets out key statements around core themes required for all NHS Organisations in their delivery of sustainable development, including but not limited to a commitment to review the purchase of Trust 'grey fleet vehicles' (non-frontline response) to ensure these are 'ultra-low emission vehicles (ULEVs) or zero emission vehicles (ZEVs). Collaborative working and continuous review is essential to understand timeframes around the move to ultra-low emission vehicles (ULEVs) or zero emission vehicles (ZEVs) across the emergency response fleet.
3.5	Additional geospatial travel analysis has been commissioned to demonstrate the impact of travel times associated and concludes that although the majority of residents can drive to hour, there are significant public transport challenges. More detail can be seen in the SCW Geospatial Travel analysis appendices. Those who live in and around Yeovil are the most significantly impacted. The environmental benefits of the utilisation of public transport are well understood, the Somerset ICS Stroke programme will be working closely with local councils including travel and sustainability leads to review suitable mitigations of the challenges posed.
3.6	This will be supported by enhanced use of technology to make interventions and treatment more accessible remotely. It will also help ensure that specialised stroke support can be accessed by local stroke clinicians as and when needed, so that they can provide the best care possible for patients, wherever they are working from (including in peoples' home).

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3.7	**TIA** services would be delivered 7 days a week in Taunton. There would be no TIA service at Yeovil.

4. Staff Travel

4.1	It is recognised that under both options there would be **some changes** to the medical, nursing and AHP workforce which will ultimately have an impact on staff travel to and from work, which subsequently will have an environmental impact. Mitigations are described in 4.2.
4.2	-No change as a result of reconfiguration. -Positive change resulting in shorter travel times. -Negative change resulting in increased travel time to get to and from their work place. In relation to recognising potential impacts of change associated with staffing across multiple sites and locations, analysis has been undertaken to illustrate the potential for staff should they be required to operate from a different base.
4.3	Data from Gov.uk indicates that there are now nearly 300 publicly accessible EV charging points within Somerset, which represents a 30% increase since the summer of 2022.[3] Somerset Council is to be allocated nearly £4m of government funding to expand the county's electrical vehicle charging network. Somerset Council's role is to work with the charge point industry to improve the rollout of local charging infrastructure to ensure that there is good distribution and access for the 27% of Somerset homes that do not have off-street parking.
4.4	In terms of EV charging points across the county, Zapmap is a useful resource to support staff to move to a lower carbon form of transport. Zapmap is a UK-wide map of electric car charging points that helps electric car drivers locate and navigate to their nearest EV charging point. Drivers can search and filter for electric car charging points, as well as plan electric routes with the smart route planner.
4.4	Active travel for staff. A Park and Ride service operates to Musgrove Park Hospital, this will support staff, patient and visitor travel. Encouragement and clear messaging around the efficacy of the service is recommended.
4.5	The individual travel times will be determined based on specific location of residence. The geospatial travel appendix states the distances between the current sites which are involved in the delivery of Stroke care. This will be discussed with staff as part of the ongoing engagement and eventual formal staff consultations required as part of organisational changes or staff transfers as appropriate.

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5. Digital Delivery

5.1	There are a number of environmental benefits that can be realised, as a result of implementing digital advancements as part of the future model. The benefits are summarised in the table 1 below.
5.2	Digital delivery and the use of virtual wards can deliver significant environmental benefits. Use the Greener care at home - Assessing the environmental sustainability of virtual wards Toolkit. Guidance available on Greener NHS Knowledge Hub.[2]

Table 1.

Digital Technology	Benefit
Telemedicine	Reduced need for travel by consultants or other clinicians between sites
Artificial Intelligence (AI) for diagnosis/decision making support: potential to ensure only the right patients are transferred for re-perfusion therapies	Less inappropriate/unnecessary patient transfers
Transfer process transformation	Reduced paper-based systems
All ICS staff reporting on same IT system	Reduced duplication, potential for reduced travel between sites (multiplied by many staff) as all access IT system remotely so notes can be done from anywhere

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Tele-rehab	Reduced travel of clinicians to patients' homes. Also reduced paperwork from all exercise and monitoring data being electronic and immediately accessible

6. Adaptation

6.1	Heat health action plans should be communicated to ensure interventions are effectively implemented.
6.2	Reported impacts of heatwaves include: - Discomfort or distress of patients, and their visitors - Equipment failure, such as failure of essential refrigeration systems including morgue facilities - Disruption or failure of IT services - Disruption of laboratory services - Discomfort of staff (occupational health issues) - Degradation or loss of medicines.
6.3	Modular hospital buildings are at a significant risk of overheating. Older hospital wards (built in 1920's, with open 'Nightingale' wards) appear to be more resilient to hot weather conditions, as well as easier to adapt to be climate resilient. Conversely, hospitals constructed during the 1960s and 70s using more lightweight methods were found to be at greater overheating risk.
6.4	These older wards pose a greater infection prevention and control risk, however, and this has implications for the methods of space cooling that can be used. The building materials and methods of cooling are important, but also some types of wards have restrictions (e.g. secure units) that mean that they are difficult to ventilate.
6.5	Health care facilities can have a high density of medical and non-medical equipment, and the anthropogenic and waste heat from this equipment can act to increase indoor temperatures.
6.6	The climate change in Somerset under the existing global policies when considering yearly averages, is expected to result in the increase of cardiovascular, cerebrovascular and respiratory deaths as well as an increase in sleep disruption and disorders.[4]

7. Conclusions and Recommendations

7.1	The following actions are recommended as a result of this impact assessment document:

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7.2	Continual review of available technology to minimise unnecessary travel as well as systems integration to minimise use of paper.
7.3	Work with local councils and travel leads regarding mitigations associated with the repatriation and ASU options, particularly public transport links.
7.4	Maintain regular updates in relation to local environmental policies to ensure the proposals meet the latest requirements.
7.5	Build on developed channels of communication with ICS sustainability leads to ensure a system approach to the environmental impact of the proposals.
7.6	Develop a further patient with lived experience travel working group to further explore the impacts and mitigations of the proposals.
7.7	Telemedicine to be confirmed by clinicians around suitability. Attend Anywhere is the model they currently use. Existing telemedicine would be easier to implement.
7.8	Additional cooling required for better patient recovery which will result in further carbon emissions. Patient recovery is sub-optimal in warmer wards, or solar impacted.
7.9	Estates have concluded significant improvement would need to be made to the building to allow for the additional beds. YDH to be reviewed, but it is anticipated it is likely to be the same. Embodied carbon should be a key consideration when planning any estates improvement. Embodied carbon means all the CO2 emitted in producing materials. It's estimated from the energy used to extract and transport raw materials as well as emissions from manufacturing processes. The embodied carbon of a building can include all the emissions from the construction materials, the building process, all the fixtures and fittings inside as well as from deconstructing and disposing of it at the end of it's lifetime.[5] This is necessary to account for climate change adaptation of the service. Overall improved patient outcomes and reduced length of stay in acute hospital setting will reduce carbon emissions from the proposed changes compared to the increase in emissions from increased travel distances by ambulance or for visitors.

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APPENDIX 09

Somerset Equality Impact Assessment

Before completing this EIA please ensure you have read the EIA guidance notes – available from your Equality Officer or www.somerset.gov.uk/impactassessment

Organisation prepared for (mark as appropriate)	Somerset Council		NHS Somerset	✓	NHS Somerset NHS Foundation Trust	

Version	**0.13**	**Date Completed**	**07/01/2024**

Description of what is being impact assessed

Somerset is reviewing the delivery of stroke care which started under the Fit for My Future Programme (FFMF) but now sits as part of the Our Somerset ICS work.

In 2019 a review of the current configuration of stroke services was carried out. One of the key recommendations from the strategy was to review the way Hyper Acute Stroke Unit (HASU), Acute Stroke Care (ASU) and Transient Ischaemic Attack (TIA) services are provided in Somerset. These are stroke services that are acute hospital-based services.

The NHS England (NHSE) Getting it Right First Time (GIRFT) team also undertook a review of stroke services across Yeovil and Taunton and this identified that in Somerset, the services performed well clinically and emphasised that the services had progressed well with regards to the stroke community rehabilitation model. However, it identified the following domains as the most challenging:

- Rapid assessment by stroke nursing and medical teams
- Scanning within one hour
- Thrombolysis rate and door to needle times
- MDT therapy assessments

We know there is variation in the ability of services in Somerset to meet national clinical standards, as evidenced in the Sentinel Stroke National Audit Programme (SSNAP) and there is strong evidence from elsewhere in the country that the centralisation of hyper acute stroke services, such as brain scanning and thrombolysis, delivered as part of a 24/7 networked service, will improve outcomes for patients.

The focus of the Case for Change supporting the Decision Making Business Case is the hyperacute (first 72 hours) and acute parts of the whole stroke pathway and provision of Transient Ischaemic Attack (TIA) services, where care for patients is not currently optimal within Somerset for the following reasons:

- Demand for stroke care will increase and the specialist stroke workforce available to provide care is limited.
- The provision of acute stroke services currently does not meet National Guidance resulting in variable outcomes for patients.
- Poorer outcomes from stroke result in higher financial costs for health and care.

The vision for stroke care in Somerset is:

Stroke patients in Somerset will receive timely acute interventions and receive access to world-class services, regardless of where they live.

The NHS Long Term Plan sets out clear ambitions for the delivery of stroke care including increasing access to thrombolysis and thrombectomy and how services are organised will make it possible to meet these ambitions that will ultimately improve patient outcomes and bring greater equity of services to the local population.

Specialist stroke workforce available to provide care is limited: both providers have sub-optimal levels of specialist stroke workforce; neither provider has 24/7 consultant cover; TIA weekend service inequitable.

The stroke pathway can be divided into five distinct phases.

The focus of the change being proposed is the hyperacute (first 72 hours) and acute parts of the whole stroke pathway and provision of TIA services, where care for patients is not currently optimal.

Transient Ischaemic attack
For suspected and confirmed TIAs, guidance states that people need to be seen for assessment within 24 hours of symptom onset. Prompt intervention after TIA can reduce stroke rates by up to 80%. CT scanning should no longer be offered, but MRI considered and if done, performed on the same day as assessment. This is not currently always offered within these timeframes in Somerset.

In addition to the DMBC, more information can be found in the summary of the case for change document and the Pre Consultation Business Case (PCBC) which can be found at Stroke - Case for Change summary (oursomerset.org.uk)

Our preferred option for change, which this EIA reviews, is:

- **A single Hyperacute Stroke Unit in Somerset at Musgrove Park Hospital, Taunton**.
  Patients in Somerset would be taken to their nearest Hyperacute Stroke Unit. This could be Dorchester, Bath, Salisbury or Taunton,

The implications of the change are shown in the diagram below.

Option A Hyperacute and acute stroke care and TIA services
Single HASU at Musgrove Park Hospital in Taunton. No HASU in Yeovil. ASU at Taunton and Yeovil.
SWASFT would take all suspected stroke patients to **nearest HASU**
Yeovil emergency department (A&E) **would not** receive suspected stroke patients at any time unless patient walks in
Patients who would normally go to Yeovil would go to **Taunton or Dorchester for their HASU** care
Somerset patients would return to **Yeovil for their ASU** care
There would be **some changes** to the medical, nursing and AHP workforce
Once ready for rehabilitation, patients would ideally be **discharged closer to home** following their acute care – either home or to a community hospital
There will be **an impact on other health systems** in this option, primarily Dorset
TIA service would be delivered 5 days a week in Yeovil and at weekends patients would be directed to Taunton service.

Evidence: What data/information have you used to assess how this policy/service might impact on protected groups? Sources such asthe Office of National Statistics, Somerset Intelligence Partnership, Somerset's Joint Strategic Needs Analysis (JSNA), Staff and/ or area profiles, should be detailed here

- Independent Analysis of the feedback from Public Consultation which ran from January to April 2023
- Overview | Stroke and transient ischaemic attack in over 16s: diagnosis and initial management | Guidance | NICE
- National Sentinel Stroke National Audit Programme (SSNAP) for MPH and YDH SSNAP - CCG/LHB/LCG (strokeaudit.org)
- Stroke Service Model, Integrated Stroke Delivery Networks (ISDN)
- Evidence hub: What drives health inequalities? - The Health Foundation
- What are health inequalities? | The King's Fund (kingsfund.org.uk)
- NHS England » Core20PLUS5 – An approach to reducing health inequalities
- B0850-RightCare-Stroke-Toolkit_July-2022.pdf (england.nhs.uk)
- NHS RightCare » Stroke toolkit (england.nhs.uk)
- https://fingertips.phe.org.uk/static-reports/health-profiles/2019/e10000027.html?area-name=somerset
- Census 2021 - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisationsDeprivation - Somerset Trends
- The 2019 Index of Multiple Deprivation (IMD)
- Indices of Deprivation 2019 - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations
- English Indices of Deprivation 2019 - Somerset summary.pdf (somersetintelligence.org.uk)
- Stroke Risk Factors | Stroke Association
- Ethnicity and National Identity - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations
- Gypsy Traveller Accommodation - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations
- Circulatory Diseases - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations
- Smoking and Tobacco Control - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations
- Diabetes - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations
- Active People Survey 2012-14
- Healthy diet and physical activity - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations
- https://fingertips.phe.org.uk/static-reports/health-profiles/2019/e10000027.html?area-name=somerset
- Overweight and Obesity - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations
- Health and Disability - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations
- Unpaid Carers - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations
- Geospatial analysis of public travel times.

Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, pleaseexplain why?

Analysis of impact on protected groups				
The Public Sector Equality Duty (PSED) requires us to eliminate discrimination, advance equality of opportunity and foster good relationswith protected groups. Consider how this policy/service will achieve these aims. In the table below, using the evidence outlined above and your own understanding, detail what considerations and potential impacts against each of the three aims of the PSED. Based on this information, assess the likely outcome, before you have implemented any mitigation.				
Protected group	**Summary of impact**	**Negative outcome**	**Neutral outcome**	**Positive outcome**
Age	• Stroke is principally a disease of older adults and therefore any change of service provision needs to consider the impact on this group • Somerset has a higher-than-average population aged over 65years (average 24% per GP practice aged 65+) (Source: PHE Fingertips 2020/21). This results in a high risk of stroke incidence in the County People are having strokes earlier in their lives • The risk of a stroke increases significantly as people get older • A key part of acute stroke reconfiguration is the impact of travel times to access acute stroke care in a timely way, which may negatively impact older people more than younger people due to access to their own vehicle or to public transport. • This was also a key issue we heard during the public consultation. • We recognised that it was important that this group were consulted on the proposals – both as patients and relatives and this was completed as part of the public consultation. • While most people who have a stroke are older, younger people can have strokes too, including children. One in four strokes in the UK happens to people of working age.[1] Lifestyle factors, family history, medical conditions, pregnancy and ethnicity can all increase risks. • For those people who provided demographic details in their questionnaire response, 62% of people were aged over 55, compared to 50% of the Somerset and surrounding wards population have a disability. The representative telephone survey aimed to reach a representative sample across our demographic to ensure we reached a representative sample of people.	☒	☐	☐
Disability	• A key part of acute stroke reconfiguration is the impact of traveltimes to access acute stroke care in a timely way. • The benefits of centralising specialist hyper acute care are well understood (see case for change) - early intervention and treatment can prevent long term disability and subsequent reduction in the need for long term care. • People with a disability may have issues being able to access their own or public transport to travel to hospital sites and therefore any change of service provision needs to consider the impact on this group. This was undertaken as part of the public consultation and travel times were a key issue for carers and relatives. • People with learning disability may have difficulty understanding early warning signs, encourage use of	☒	☐	☐

[1] Stroke Risk Factors | Stroke Association

	999/111 and hyperacute management of stroke, and/or what the proposals may mean for them. • All consultation materials were made available in Easy Read and aphasia friendly formats. • It was important that this group are consulted on the proposals – both as patients and relatives • For those people who provided demographic details in their questionnaire response, 26% stated they had a disability. 21% of the Somerset and surrounding wards population have a disability. The representative telephone survey aimed to reach a representative sample across our demographic to ensure we reached a representative sample of people.			
Gender reassignment	• There is a higher prevalence of negative lifestyle behaviours with people who have undergone gender reassignment. • In the Southwest 16.9% of LGBQT people highlighted drug and alcohol misuse as an issue for them (Source: Intercom Trust 2021). This may predispose them to higher risk of stroke. • There are risks associated with defined male or female specific acute bed provision. This may have an impact on inpatient stroke care. • It is important that we consulted this group on our proposals. • For those people who provided demographic details in their questionnaire response, 3 people stated they had a different gender to that assigned at birth. There are no percentage statistics for the Somerset and surrounding wards population who are transgender. The representative telephone survey aimed to reach a representative sample across our demographic to ensure we reached a representative sample of people.	☐	☒	☐
Marriage and civil partnership	• There is no anticipated impact on this group however need to be aware that there may be considerable effects on a partner who has a stroke, particularly if this leads to new or increased carer responsibilities.	☐	☒	☐
Pregnancy and maternity	• Although pregnancy is associated with increased risk of stroke, the risk is low with an estimated incidence of 30/100,000 (Source: BMC Pregnancy Childbirth Journal – 2019). • It is unlikely that this group of people will be significantly adversely impacted by this change.	☐	☒	☐

Race and ethnicity	• Strokes happen more often in people who are black or from South Asian families[2].
	• Somerset has a below average proportion of non-white British residents.
	  ○ The non-white British population now comprises 2.0% of Somerset's overall population, which is well below the national average of 14.0%.
	  ○ Non-white British residents of Somerset tend to live in towns and urban areas of Somerset, which are well served by public transport and have good road links.
	  ○ Therefore, it is not anticipated that the proposed changes will negatively impact this group.
	  ○ For those people who provided demographic details in their questionnaire response, 5% stated they did not identify as 'white British'. 8% of the Somerset and surrounding wards population are not 'white British'. The representative telephone survey aimed to reach a representative sample across our demographic to ensure we reached a representative sample of people.
	• Gypsy and Traveller community
	  ○ There are an estimated 733 Gypsy or Irish Traveller residents in Somerset, the second highest number of any local authority in the Southwest. Just over a third are resident in Mendip.
	  ○ As in the UK generally, the Gypsy and Traveller community in Somerset experiences notable health inequalities.
	  ○ One in six adults in the Gypsy and Traveller community were reported as long-term sick or disabled (2011 Census) and 15% described themselves as in bad or very bad health, compared with 5% of all adults in Somerset[3].
	  ○ It is important that this group were consulted on the proposals – both as patients and relatives
	  ○ During the consultation, following the mid-point review we liaised with Somerset Gypsy Liaison Service and Friends, Families and Travellers organisation to help ensure we engaged with people from the Gypsy and Traveller community.
		☐	☒	☐

[2] Stroke Risk Factors | Stroke Association

[3] Gypsy Traveller Accommodation - Somerset Intelligence - The home of information and insight on and for Somerset - Run by a partnership of public sector organisations

Religion or belief	• It is not anticipated that this change will adversely affect people of different religions, however people with different religious beliefs access healthcare in different ways and it is important that we understand access points in the context of any service change.	☐	☒	☐
Sex	• Men are at a higher risk of having a stroke at a younger age than women. • However, more women than men die of stroke. This is because women tend to live longer than men, and the risk of stroke increases with age. • The requirement for single sex bays / single rooms presents some organisational challenges to ensure people do not receive poorer quality care due to the lack of beds. • It is not anticipated that the proposed changes will negatively affect people of different genders, but it was important to ensure a balanced representation throughout our engagement activity.	☐	☒	☐
Sexual orientation	• There is limited evidence to suggest the proposed changes to stroke services will disproportionately affect this group. • There is a higher prevalence of negative lifestyle behaviourswith people who are from the LGBQT community. In the Southwest 16.9% of LGBQT people highlighted drug and alcohol misuse as an issue for them (Source: Intercom Trust2021). This predisposes them to higher risk of stroke and therefore consideration of preventative strategies to address the risk factors associated with stroke – high blood pressure and diabetes. • Consider gender sensitivity in care settings, particularly where people who have suffered a stroke struggle with the ability to communicate. We are aware that language and cultural sensitivity within the teams providing care and support will improve the outcomes for those who may have difficulties communicating and for those who may be uncomfortable within a healthcare setting.	☐	☒	☐
Others: **Carers** **Veterans** **Homeless** **Low income** **Rurality** **Probation** **Domestic violence**	• Due to the high numbers of older adults across Somerset and the link of older age to stroke, it is reasonable to assume that carers will be impacted by the proposed changes. • It was important that this group were consulted on the proposals – both as patients and relatives • During the consultation we ensured we reached carers, attending specific groups for carers. We also had a carer representative on the patient and public stakeholder group. • For those people who provided demographic details in their questionnaire response, 41% stated they were unpaid carers. The representative telephone survey aimed to reach a representative sample across our demographic to ensure we reached a representative sample of people. • The population classed as homeless in Somerset have high levels of health deprivation, smoking rates and drug/alcohol misuse therefore predisposing them to higher risk of stroke. • This population are less likely to present early or not at all, predisposing them to higher risk of stroke. • It was important that this group are consulted on the proposals – both as patients and relatives. • During the consultation, following the mid-point review we liaised with Homeless Outreach Nursing Team and Homeless Outreach GP to help ensure we engaged with people who are homeless. • Somerset is a large county with 48.2% of the population living in rural areas. • These areas are likely to have poorer public transport links and poorer road access, especially travelling from East to West and vice versa. • It was important that this group were consulted on the proposals – both as patients and relatives. It's also important to recognise that within the GIS analysis, the sector of the catchment that are likely to experience longer journey times are largely rural.	☒	☐	☐

	• Our consultation activity targeted rural areas to ensure we reached a wide spread population. We attended local groups and existing community spaces to reach a wide population. The representative telephone survey aimed to reach a representative sample across our demographic to ensure we reached a representative sample of people across Somerset and neighbouring areas.
	• Deprivation
	  ○ Somerset ranks 92nd out of 151 local authority areas in terms of deprivation (where 1 is the most deprived and 151 is the least deprived) and scores 57th out of 151 on barriers to housing and services.
	  ○ There is some relationship between the areas of deprivation and higher than expected rates of stroke in Somerset, although not conclusive.
	  ○ People living in more deprived areas have poorer levels of self-reported good health. External factors such as household income which may impact peoples' ability to make healthier choices, and lifestyle factors such as smoking, and drinking are key influences in this. This is significant when we consider the risk factors for stroke.
	  ○ It was important that this group were consulted on the proposals – both as patients and relatives.
	• Our consultation activity targeted all areas of Somerset to ensure we reached a wide spread of the population. We attended local groups and existing community spaces to reach a wide population. The representative telephone survey aimed to reach a representative sample across our demographic to ensure we reached a representative sample of people across Somerset and neighbouring areas.
	• Concerns were raised during the consultation about those who are on probation as there are a number of these people may be excluded from Taunton and not permitted under their licences to travel there, or Dorchester. We spoke to the probation service and they were content that they existing processes in place for people on probation would be sufficient to manage patients who have had a stroke
	• There was concern raised during the consultation that the proposals make it much harder for domestic abuse victims, who may be being coerced and controlled to get to appointments if they have to be dependent on their partner to drive them there rather than having a more accessible service. Having considered this, we are content that the changes proposed involve inpatient care for the first 72 hours and outpatient appointments would not be impacted			

Overall, the provision of access to a single centralised HASU enhances equity of stroke care and improved outcomes across Somerset. When considering deprivation, the GIS mapping does show that certain communities within Yeovil will find it more challenging to visit relatives during their first 72 hours of stroke (HASU) care.

Early intervention and access to modern treatment can prevent long term disability related to a stroke.

This will be supported by enhanced use of technology to make interventions and treatment more accessible remotely. Technology needs to be accessible to those with hearing, visual and Neurodiverse needs where possible.

It will also help ensure that specialised stroke support can be accessed by local clinicians as and when needed so that they can provide the best care possible for patients, wherever they are based or working from.

Negative outcomes action plan
Where you have ascertained that there will potentially be negative outcomes, you are required to mitigate the impact of these. Please detail below the actions that you intend to take.

Action taken/to be taken	Date	Person responsible	How will it bemonitored?	Action complete
Age • Ensure ongoing engagement with older people, both those with lived experience of stroke and as carers to inform the ongoing development of the service. • Use age-appropriate communication methods for the age group e.g., use Plain English and consult on what means of communication, e.g., letter, email, or telephone call, are preferred. • Ensure public consultation activity takes place in venues and at times that enable access for older people; provide transport if required; Utilise digital / virtual solutions as appropriate. • Undertake travel time analysis to consider impact of changes; consider public transport options. • Consider implications of pathway on older carers as well as patients. • Aim to provide care and services closer to home to ensure family and carers can support the recovery process. • Involve CVSE partners who are able to provide non-medical support to older people (as patients and carers) • Ensure communication, literature, marketing strategies are relevant and accessible to those who are more vulnerable to strokes (over age 18) • Ensure younger people with identified higher risk of stroke are engaged with appropriately	On going	Sara Bonfanti – Comms & Engagement Julie Jones – Pathways, GIS analysis	Representative stakeholder groups Evaluation of stakeholder activity Effective consultation planning and evaluation	**Actions complete up to DMBC point. Many will continue as the proposals are implemented**
Disability • Ensure on going engagement with people with lived experience of disability (physical, communication and learning) both as a result of stroke and non-stroke related, and their carers to inform our proposals and approach to consultation. • Use appropriate communication methods e.g., use Plain English and consult on what means of communication, e.g., letter, email, or telephone call, are preferred. • Ensure compliance with accessibility standards for written materials • Ensure public consultation activity takes place in venues and at times that enable access; provide transport if required; Utilise digital / virtual solutions as appropriate. • Consider implications of pathway on older carers as well as patients. • Aim to provide care and services closer to home to ensure family and carers can support the recovery process. • Involve VCFSE partners who are able to provide non-medical support to those with disabilities (as patients and carers)Be aware that Disability covers both hidden and Visible including neurodivergent people, who may or may not have a diagnosis In later life. Ensuring venues, transport, literature and language used is inclusive	On going	Sara Bonfanti – Comms & Engagement Julie Jones – Pathways, GIS analysis	Representative stakeholder groups Evaluation of stakeholder activity Effective consultation planning and evaluation	**Actions complete up to DMBC point. Many will continue as the proposals are implemented**

National Autistic Society (autism.org.uk) Autism Spectrum Disorder – Brainwave				
Rurality • . • Consider implications of pathway on older carers as well as patients. • Use the travel time analysis to consider impact of changes; consider public transport options as part of the implementation phase in conjunction with both Councils. • Ensure ongoing improvement on category 2 response times with the Ambulance service (SWAST) ensuring the adoption of best practice nationally and within the region. • Continued utilisation of the Somerset Ambulance Doctor Car – which currently sees and treats c200 patients in their own home who would otherwise have been conveyed. • Monitor the outcomes of the regional telemedicine pilots to establish if more patients (with stroke mimic) can be assessed and treated without conveyance to hospital. • Aim to provide care and services closer to home to ensure family and carers can support the recovery process. • Involve VCFSE partners who are able to provide non-medical support to those living in rural areas	On going	Sara Bonfanti – Comms & Engagement Julie Jones – Pathways, GIS analysis	Representative stakeholder groups Evaluation of stakeholder activity Effective consultation planning and evaluation	**Actions complete up to DMBC point. Many will continue as the proposals are implemented**
Carers • Ensure on going engagement with people with lived experience as carers to inform our implementation plan as it moves into delivery phase.. • . • Consider implications of pathway on older carers as well as patients. • Where possible aim to provide care and services closer to home to ensure family and carers can support the recovery process. • Involve VCFSE partners who are able to provide non-medical support to carers. • Provision of video technology at HASU sites that enables inpatients to speak with loved ones during their first 72 hours of care. • Provision of facilities where families can stay at both Somerset Hospital sites. Ensure the range of accommodation options are made available to carers. • Ensure Dorset County Hospital carer passport scheme is made available to carers to enable greater flexibility on visiting hours. • Essure concessionary parking offers at all 3 hospital sites are communicated to relatives.	On going	Sara Bonfanti – Comms & Engagement Julie Jones – Pathways, GIS analysis	Representative stakeholder groups Evaluation of stakeholder activity Effective consultation planning and evaluation	**Actions complete up to DMBC point. Many will continue as the proposals are implemented**
Probation • Meet with the probation service to consider the impact on those people on probation and whether any mitigations are required		Julie Jones/ Lee Reed	Meeting date and notes	**Complete**

Domestic Violence • Consider the impact of changes on those experiencing domestic violence probation and whether any mitigations are required.		Lee Reed	Meeting dates and notes	**Complete**

If negative impacts remain, please provide an explanation below.

It is not possible to mitigate all the negative impacts on protected groups which have been identified in this EIA.

The impacts that remain are predominantly:

- For patients who will have an increased ambulance travel time following a stroke. This will be mitigated by an improved clinical model of care which will improve outcomes for stroke patients.

- On carers/relatives who are older people, those who live in rural areas and those who are in the more deprived areas in the south of the county (who would normally travel to YDH for their stroke care). This is because a proportion of patients carers/relatives would experience increased travel during the first 72 hours to visit loved ones in a HASU which is different from the current HASU in YDH.
  Travel time by driving for the Somerset residential population - 76% of the Somerset residential population would be able to travel to a HASU by driving within 45 minutes or less, compared to 92% in the current configuration of services. 99% of the Somerset residential population would be able to travel to a HASU by driving within 60 minutes or less, compared to 99.5% in the current configuration of services
  Residents of other systems - Impacts are also apparent for residents of other systems where YDH is the closest HASU – particularly Dorset, with up to 30 minutes of additional ambulance travel for those aged 50+ or drive time for the residential population. Smaller impacts are modelled for residents of BSW of up to 15 minutes additional travel or drive time, and up to 5 minutes for residents of Devon.
  Public transport - The Somerset residential population modelled to lose access to a HASU by public transport is 109,072. The Dorset residential population modelled to lose access to a HASU by public transport is 15,160. It is important to note that a proportion of the Somerset and Dorset residential populations do not have access to a HASU in the current configuration of services.
- The impacts set out have been mitigated in part through the preferred option maintaining the ASU at YDH and plans to reduce impact for patients and their carers in the first 72 hours of care, alongside plans to swiftly repatriate patients back to an ASU once they are medically fit to do so.

In considering this negative impact which remain, we have sought to balance this against the improvement to patient outcomes which by implementing the clinical model which is contained within the DMBC. The new clinical model will ensure compliance with 2016 best practice guidelines, enable greater equity of access to specialist treatment, help address the existing workforce issues and create a service which is sustainable over the long term.

During the implementation phase of this project, we will continue to look for ways to mitigate the negative impacts of this change.

Completed by:	Julie Jones/ Maria Heard
Date	10/01/2024
Signed off by:	David McClay Chief Officer for Strategy, Digital & Integration

Date	10/01/24
Equality Lead / Manager sign off:	Lee Reed
Date:	10/01/24
To be reviewed by: (officer name)	Implementation Lead
Review date:	1 September 2024

APPENDIX 10

Somerset Acute Hospital-based Stroke Services Reconfiguration:

Decision Making Business Case (DMBC)

Including the management of hyperacute and acute stroke care, transient ischaemic attacks and stroke mimics

Benefits

BENEFITS
Why are we doing this?

In the PCBC we said:

Workforce sustainability

This is a burning platform, with significant risks caused ongoing challenges with recruitment and retention of specialist staff. There are currently sub-optimal levels of specialist stroke workforce, with neither provider has the number of specialist staff needed to provide the units with 24/7 consultant cover.

Clinical outcomes

We are failing to meet several national performance targets in relation to hyperacute and acute care which have a negative impact on clinical outcomes including rates of thrombolysis and thrombectomy, time taken to receive thrombolysis, TIA assessments falling outside of 24 hours and access to MDT assessments

Equity of service

There is currently variation and inequitable provision of acute stroke care across the county, especially over weekends and out of hours where it takes significantly longer for patients to receive treatments such as thrombolysis. Patients admitted to Yeovil District Hospital at weekends are much less likely to see a consultant stroke specialist until after the weekend. There is no weekend outpatient service for patients suffering a TIA in the Yeovil area.

Financial sustainability

There is currently a poor correlation between the money spent on stroke and the outcomes achieved. There is opportunity to reduce the long-term care costs associated with stroke by improving the outcomes in the hyperacute phase

Benefits
Workforce sustainability

Benefit	Include yes/no	Measurable Yes/No	How	Baseline available	Financially quantifiable
Lower turnover rates	Yes for all group of staff	Yes	Workforce data monthly	Yes	Recruitment costs and agency use ?
Improved staff satisfaction	Yes	Yes	Staff survey	Yes, if broken down into stroke	Yes in lower turnover and sickness rates.
Reduction in agency	Yes	Yes	Monthly budget	Yes	Yes improved value for money
Lower vacancy rates	Yes	Yes	Monthly workforce data	Yes	Recruitment and advertising costs/DBS checks etc.

Benefits - Clinical Outcomes HASU Care

Standard	Measurable Yes/No	How	Baseline available	Financially quantifiable	Benefit
Patient with suspected stroke should have CT scan within 60 minutes of hospital arrival (BASP CS 2.2)	Yes	SSNAP	Yes		Quicker diagnosis and access to treatment increase in number receiving scan within one hour
People with suspected acute stroke should be admitted directly to HASU within 4 hours of arrival (NICE QS 1)	Yes	SSNAP	Yes	Reduction in ASC costs	Specialist review and care leading to quicker treatment and reduced disability. Increase in number admitted to HASU within 4 hours
All eligible patients should receive IV thrombolysis within 60 minutes of arrival to hospital (BASP CS 1.4)	Yes	SSNAP	Yes	Reduction in ASC costs	Quicker treatment and reduced disability and more lives saved after 90 days after discharge. Improved independence. Improved door to needle times

Benefits - Clinical Outcomes HASU Care

Standard	Measurable Yes/No	How	Baseline available	Financially quantifiable	Benefit
A hyperacute stroke unit should have continuous access to a consultant stroke physician, with consultant physician review 7 days per week.	Yes	SSNAP	Yes	No	Improved independence and patients experience
Assessed by a consultant within 14 hours (can be by telemedicine) and seen within 24 hours face to face.	Yes	SSNAP	Yes	No	Improved independence and patients experience
Patients should receive swallow screening within 4 hours of arrival (BASP CS 3.5)	Yes	SSNAP	Yes		Appropriate referral and review by specialist Speech and Language team to avoid
Patients should be assessed by all members of stroke multidisciplinary team within 72 hours (BASP CS 3.10)	Yes	SSNAP	Yes		Improved independence and patient experience

Benefits - Clinical Outcomes ASU

Inputs	Measurable Yes/No	How	Baseline available	Financially quantifiable	Outcome
Patients should have rehabilitation goals agreed within 5 days and regular review of goals (NICE QS 6)	Yes	SSNAP	Yes	Reduction in ASC costs	Improved independence and patient experience
Patients should receive at least 3 hours of rehabilitation covering a range of multidisciplinary therapy for minimum 5 days per week (NICE QS 2)	Yes	SSNAP	Yes		Improved independence and patient experience
All appropriate patients should receive at least 45 minutes of therapy per day (BASP CS 3.11 – 3.13)	Yes	SSNAP	Yes		Improved independence and patient experience
An acute stroke unit should have continuous access to a consultant physician with expertise in stroke medicine, with consultant review 5 days per week	Yes	SSNAP	Yes		Improved independence and patient experience

Benefits - Equity of service

Standard	Include yes/no	Measurable Yes/No	How	Baseline available	Financially quantifiable	Benefit
% of patients being seen by a stroke specialist within 30 minutes of arrival	Yes	Yes	SSNAP	Yes		Improved independence and patient experience. Improved door to needle times
Repatriation rates back to Somerset	Yes	Yes	Local data collection	No		Care closer to home and throughput of the HASU. Increase in number of patients staying on a stroke ward
24/7 stroke and 7 day TIA service for all Somerset patients						Access to stroke and TIA specialist care, improved patient experience

Benefits Financial

Benefit	Include yes/no	Measurable Yes/No	How	Baseline available	Financially quantifiable
Reduction in spend on bank and agency	Yes	Yes	Monthly budget	Yes	Yes
Reduced Length of Stay	Yes	Yes	Local data	Yes	Yes
Reduction in long term care costs	Yes	Yes	Local data	Yes	Yes
Reduction in acute care needs in the first 90 days post stroke	Yes	Yes	Local data	Yes	Yes

APPENDIX 11

CLINICAL SENATE REVIEW OF FEEDBACK

	Clinical Senate recommendation	Evidence	Complete
Ready to proceed to public consultation			
1	Offer assurance on Option A and B based on the staffing assumptions in the models being fully realised, particularly relevant in Option A where it is essential that the standards for specialist stroke skills are met in both ASUs	Both options have been modelled against the 2016 guidance. Workforce plan	Complete
2	The panel observed that it is also important for patient flow, that stroke beds at the ASU(s) are ringfenced so that patients at the HASU can be stepped down to the ASU. If the ASU is intended to part of a ward with general medical beds it is vital that the ASU beds comprise more than 50% of the total bed complement and that the ASU is a standalone dedicated unit.	Number of ASU beds at Yeovil is over the 50% and will be a dedicated unit with the appropriate staffing as referred to in the DMBC and clinical model.	Complete
Before public consultation			
3	Work should be done to describe the rehabilitation model within the business case and the consultation documentation.	Referred to in the consultation document	Complete
At implementation stage			
4	The business case should describe what will be done to strengthen the offer in Northeast Somerset. If this has resourcing implications, it would be	Discussions with Bath around implications of changes and access to community stroke services.	Complete

CLINICAL SENATE REVIEW OF FEEDBACK

	important to include these in the business case.	SFT to have discussions with RUH around better pathways into Somerset services particularly South Petherton and ESD. ? not for DMBC and in the scope of this work.	
5	The workforce plan for each of the models needs to be made more robust within the business case, including the assumptions, assessment of risk, and risk mitigation.	Workforce modelling and workforce plan within DMBC .	Complete
6	The system could review models implemented in other areas to explore the potential contribution from emerging roles across professions and the more innovative use of technology to support the workforce in decision making and maintaining patient flow.	Discussions had with BNSSG and other centres. Consideration of digital technology and telemedicine. Video triage not being piloted in Somerset yet. Dorset are starting this year. There is some evidence to say it is helpful and reduces conveyance to hospital Advanced practitioners roles included in workforce plan and modelling.	Complete
Flow			
7	The beds in both the HASU and ASU(s) should be ringfenced.	This has been discussed with a commitment to ring fence HASU beds but not ASU. . This will need to be included in a SOP for implementation.	Complete
8	The transportation model needs to be clearly articulated in the business case	Included in the financial modelling DMBC	

CLINICAL SENATE REVIEW OF FEEDBACK

	and any additional resources required reflected.		
Impact on other Providers			
9	Whilst there has been good engagement with Dorset, there is concern that Dorset is being impacted by significant service changes in several areas: (Somerset, Poole, and Bournemouth). Both options are likely to increase the presentation of acute strokes to Dorset. Whilst there are plans to increase their capacity the timescale for this is not clear.	Financials from Dorset - received. Confirmation of implementation and staffing for 7/7 HASU spring 2024 Implementation plan to map all changes required to deliver the Somerset final decision and implementation plans will align.	Complete
Modelling			
10	The modelling to support the business case appears to be based on the one set of clinical assumptions relating to incidence and presentations and progress through the pathway. Consideration should be given to stress testing within the model to demonstrate the tolerances in the model and how any risks would be mitigated.	Stress testing has been done through stochastic modelling, looking at bed occupancy rates and % of people who will be able to access a HASU Agreed bed numbers include stochastic modelling assumptions. SOP for risk and issues when demand outstrips bed availability to be done within the implementation phase.	Complete
11	There appeared to be an assumption that if the modelling resulted in small changes in numbers then this would be manageable, but the panel observed that small changes can create inefficiencies in already stressed systems. Further work is to be done to look at this.	Development of clinical model to support one HASU Discussions with RUH around access to Somerset stroke services Work on in hospital strokes and Self Presenters to be completed	Complete
12	The modelling assumptions and pathways for stroke mimics need to be	Used 56% for modelling	Complete

CLINICAL SENATE REVIEW OF FEEDBACK

	clarified within the proposals. i.e. If the FAST pathway is used, this has a 50% specificity1 and so 50% of patients starting in the pathway are not stroke patients. The pathways need to clarify how these patients are rapidly transferred to other pathways to ensure flow is maintained.	TIA pathway completed and now discussions with DCH agreed that Somerset patients will have access to Somerset services and referral pathways. Detail to be part of implementation plan	
13		Pathway mapped and agreed and in DMBC	Complete
14	Whilst the aspiration is for a 24/7 service the model assumes access to specialist stroke skills 12 hours a day. Clarification is required on the Out-Of-Hours pathway in terms of the staffing cover, particularly to understand the implications of non-stroke specialist staff.	This will be covered by stoke consultants and practitioners and is in the clinical model and will be a phased approach over the implementation phase.	Complete
General comments from document			
15	The business case needs to include the acceptable compromise for the options that may not provide the greater clinical benefit but are preferred by the different stakeholders.	Option B discounted due to DCH not being able to deliver and consultation feedback on how loved ones play a big part in recovery.	Complete
16	Utilising the opportunity of the forthcoming merger of Musgrove Park Hospital Somerset NHS FT (SFT) and Yeovil District Hospital (YDH) to create a single stroke delivery team.	Workforce plan addresses this and ongoing work following the merger. Stroke was part of the patient benefits merger case and will continue under the transformation work within SFT.	Complete

CLINICAL SENATE REVIEW OF FEEDBACK

17	Consideration should be given to the benefit to patient experience if stroke care (particularly outside of the hyperacute phase) is carried out close to the patient's home.	Feedback from consultation and covered by discounting Option B	Complete
18	Further detail is required in the business case on the provision of rehabilitation support, across the pathway both within the HASU and ASU environments and in the community to support initiatives such as Early Supported Discharge (ESD) for adult stroke patients, where this is deemed appropriate.	In hospital rehabilitation part of proposed model and AHP staff costed against 2016 guidance ESD part of existing rehabilitation pathways	Complete
19	In the options where stroke care is continuing to be delivered at Yeovil, (Option A) the panel did not share the optimism of the system around the willingness of staff to travel between hospital sites.	As Option A is the preferred option staff will not be required to travel. Recruitment to consultant post at Yeovil means there will be 5-day cover for the ASU. Cross cover will be provided from Taunton.	Complete
20	The panel recommended that more work is done on the workforce model to clearly delineate the requirements of both Options A and B across all staff groups	Covered by the workforce modelling	Complete
21	The Panel recognised that a robust Training and Development Programme will be attractive to existing and new staff and recommended that more work be done on how this activity will be coordinated and who will provide leadership	A workforce group has been in place where discussions have been had around developing competencies for all staff working (excluding medical staff) within stroke using the Stroke Specific Educational Framework (SSEF) and incorporating any local plans in place.	

CLINICAL SENATE REVIEW OF FEEDBACK

		A workforce and training and development plan will be developed as part of the implementation plan led by the senior stroke team within SFT.	
22	The Panel noted that the modelling is based on journey times at 03:00hrs on a Tuesday to reflect a blue light journey and questioned the realism of this benchmark, given that ambulances will be travelling further distances albeit blue lights can be used but questioned whether applicable roads would be subject to traffic and whether these roads will have physical space to move, to allow ambulances move quickly through the traffic. This could have a significant impact on estimated journey times. The Panel was informed that the geospatial team had undertaken the travel time mapping and had used 03.00hrs as a proxy for blue light travel time, and that further work would be undertaken to understand the impact of the condition of roads in Somerset, on journey & travel times and whether a specific approach (and/or mitigation) would be required.	This was tested out with SWASFT who were happy with the approach.	Complete
23	The Panel probed how the Somerset team had taken into account any concern around the potential extension of journey times from the patient's	Evidence suggests that getting to a HASU where decisions can be made by a stroke physician increases the	Complete

CLINICAL SENATE REVIEW OF FEEDBACK

	home to the HASU, given the current level of demand and activity balanced against the enhanced level of care and intervention available to patients at the HASU.	likelihood of commencing treatment quickly. Covered within the DMBC.	
24	The Panel sought clarification on the numbers used for the modelling, estimating that the number of stroke mimics alone per day would take the numbers beyond what was used in the modelling.	Stroke mimics were included in the modelling numbers	Complete
25	The Panel sought clarification as to how the business case would mitigate the environmental impact of increased journey times and increased journeys by patients and their families, given the ambition toward becoming a carbon neutral system over the next couple of decades.	Environmental impact assessment done and included in geospatial modelling	Complete
26	The Panel questioned whether the additional demand would outstrip the capacity of the single front door scanner.	Adam Turner has confirmed that this is not a problem as diagnostic centre will take routine scanning and there are two scanners in Taunton that will be mainly used for urgent scans. Straight to CT pathway. Plan to have CT scanner in ED next year.	Complete
27	The Panel questioned whether the radiology department will work across	SFT are working to integrate the two radiology services and there is a	

	both hospital sites, (Yeovil, Musgrove) with access to high-quality acute imaging. The Panel probed whether both hospital sites had the same Picture Archiving and Communications System (PACS) and more importantly, whether a consultant at one site would be able to access images taken at another site.	manager responsible for cross-county Radiology services, although this doesn't include Dorchester. Across all of SFT, the same PACS system, which means that examinations will be visible between YDH & MPH. Dorchester sharing is more of a challenge as we don't share systems but are able to transfer examinations via Image Exchange Portal. Will need to be part of the implementation plan. Plan is for any inpatient or walk in patients to YDH to be covered initially clinically by the consultant in the HASU at Taunton prior to transfer to HASU.	

Appendix 12: Stakeholders

Stroke Core Team

Name	Role	Organisation
Rob Whiting	Consultant Stroke Physician Clinical Lead for Stroke	Somerset FT
Julie Jones	Programme Manager Stroke	Somerset FT
Sara Bonfanti	Head of Communications and Engagement	Somerset ICB
Laura Alexander	Engagement Lead Officer	Somerset ICB
Rachel Watts	Project Manager Stroke	NHS SCW CSU
Simone Rooks	Project Officer	Somerset ICB

Stroke Steering Group

A partnership of clinicians, people with lived experience of stroke and other health and social care staff from across Somerset as well as colleagues from Dorset. They were responsible to design a new clinical model of acute hospital-based stroke services that meets both clinical best practice and one that is grounded in what matters most to people, through consideration of public consultation feedback and delivers the best outcomes for patients.

The steering group were supported by a clinical reference group (comprised of stroke clinicians, clinicians from services impacted by the change, VCFSE, and an expert by experience) which was established to consider the clinical evidence and develop best practice pathways for the stroke service.

Name	Role	Organisation
Rob Whiting	Consultant Stroke Physician Clinical Lead for Stroke	Somerset FT
Rick Hein	Expert by Experience	n/a
Jacqui Cuthbert	Associate Director	Stroke Association
Caroline Smith	Nurse Consultant Stroke and ISDN Representative	Yeovil District Hospital
Sarmad Shah	ED Consultant	Yeovil District Hospital
Emma Machin	Consultant Emergency Medicine	Somerset FT
Alex Sharp	Senior Clinical Lead (Dorset)	SWASFT
Wendy Longley	Consultant Nurse	Dorset County Hospital
Maria Smith		Dorset County Hospital
Tracey Hall	Head of Elective Care	Dorset ICB
Claire Kremer	Programme Manager - Stroke Service	NHS Dorset ICS

Julie Jones	Programme Manager Stroke	Somerset FT
Sara Bonfanti	Comms & Engagement Lead	Somerset ICB
Scott Sealey	Associate Director of Finance Strategy - Finance Lead	Somerset ICB
Rachel Watts	Project Manager Stroke	NHS SCW CSU
Simone Rooks	Project Officer	Somerset ICB

Stroke Expert by Experience Reference Group

Key voluntary sector organisations and people with lived experience. The group provided feedback on our developing solutions and offered their perspectives and insights on how we can inform and engage local people in the hyper acute stroke public consultation. The group informed the development of the proposals and supported us to plan the consultation activity and materials.

Organisations (no individual names due to confidentiality)
Two people who survived a stroke
Carer and Ambassador for Carers UK
Loved one of person who had a stroke
Carer for person who had a stroke mimic
Stroke Association
Healthwatch Somerset
PPG Chair
Experience and Engagement Manager, Yeovil District Hospital
Diversity Voice

Stroke DMBC Working Group

The purpose of the Stroke DMBC modelling and assessment working group is to form an expert group to complete the options assessment process for acute stroke services, and to develop and prepare evidence to support a recommended option, culminating in a Decision-Making Business Case for consideration by Somerset decision makers

Name	Role	Organisation
Julie Jones	Stroke Programme Lead Cross System Interdependencies	Somerset Foundation Trust
Rachel Watts	Project Manager Stroke DMBC Pen Holder	NHS SCW CSU
John Sonke	Demand and Capacity Modelling	NHS SCW CSU
Rob Whiting	Clinical Lead	Somerset Foundation Trust, Musgrove Park Hospital
Caroline Smith	Clinical Lead	Somerset Foundation Trust, Yeovil District Hospital
Janet Schmitt	Therapies Lead	Somerset Foundation Trust
Katherine Robinson	Finance and Economic SME Support	NHS SCW CSU
Scott Sealey	Finance and Economic Workplan Lead	NHS Somerset ICB
Mark Hocking	Finance – Deputy Chief Finance Officer	Somerset Foundation Trust
Polly Burns-Cox	Finance Manager – Medical Services Group	Somerset Foundation Trust
Lorna Brown	Service Manager – Neurology, Neuro Rehabilitation and Stroke	Somerset Foundation Trust
Corrine Morrissey	Patient Flow Lead	Somerset Foundation Trust
Steven Power	Estates Workplan Lead	Somerset Foundation Trust
Paul Derrick	Estates Equipment	Somerset Foundation Trust
Clive Radestock		Somerset Foundation Trust
Richard Harper	Net Zero	Somerset Foundation Trust
Christine Young	Net Zero	NHS Somerset ICB
Stuart Hill	Digital	Somerset Foundation Trust

Rebecca Garrett	Digital	Somerset Foundation Trust
Gary Risdale	Digital	Somerset Foundation Trust
Kim Short	Digital	Somerset Foundation Trust
Chelsey Baker	Quality Workplan Lead	NHS Somerset ICB
Lee Reed	EIA Workplan Lead	NHS Somerset ICB
Matt Bridges	Geospatial Mapping	NHS SCW CSU
Cerys Butterill	Geospatial Mapping	NHS SCW CSU

Fit for My Future Programme Board up to 13 March 2023

Name	Role	Organisation
Jonathan Higman	Chief Executive	NHS Somerset ICB
Peter Lewis	Chief Executive	Somerset FT and Yeovil District Hospital
Maria Heard	Programme Director, Fit for My Future	NHS Somerset ICB
Julie Jones	Stroke Programme Lead	Somerset FT
Caroline Greaves	Programme Manager, Fit for My Future	NHS Somerset ICB
Judith Goodchild	Board Chair	Healthwatch Somerset
Alison Henly	Director of Finance, Performance and Contracting	NHS Somerset ICB
Shelagh Meldrum	Chief Nurse	NHS Somerset ICB
Trudi Grant	Director of Public Health	Somerset County Council
Sara Bonfanti	Head of Communication and Engagement	NHS Somerset ICB
Sarah James	Acting Executive Director of Quality and Clinical Care	SWASFT
Alex Sharp	Head of Clinical Development	SWASFT
Andy Miller	Divisional Manager for Urgent and Integrated Care	Dorchester County Hospital
Neil Bacon	Chief Strategy and Transformation Officer	NHS Dorset ICB

Stroke Project Board from 13 March 2023, First meeting 25 July 2023

A cross organisational group comprising of partners from organisations which are impacted by the proposed changes to stroke service and includes representatives from Somerset ICB, SFT, DCH, Dorset ICB, SWAST and Health Watch. Its purpose is to ensure that feedback received during the consultation is considered, new clinical evidence and guidelines are considered, deliver this Decision Making Business Case along with recommendations to the ICB Board.

Name	Role	Organisation
David McClay	Chief Officer of Strategy, Digital and Integration (Chair)	NHS Somerset ICB
Jonathan Higman	Chief Executive	NHS Somerset ICB
Peter Lewis	Chief Executive	Somerset Foundation Trust
Maria Heard	Deputy Director of Innovation and Transformation	NHS Somerset ICB
Julie Jones	Stroke Programme Lead	Somerset Foundation Trust
Bernie Marden	Chief Medical Officer	NHS Somerset ICB
Judith Goodchild	Board Chair	Healthwatch Somerset
Alison Henly	Chief Finance Officer and Director of Performance	NHS Somerset ICB
Scott Sealey	Associate Director of Finance	NHS Somerset ICB
Mel Lock	Executive Director Adult Services and Lead Commissioner Adults & Health	Somerset Council
Sara Bonfanti	Head of Communication and Engagement	NHS Somerset ICB
Alex Sharp	Head of Clinical Development	SWASFT
Andy Miller	Divisional Manager for Urgent and Integrated Care	Dorchester County Hospital
Neil Bacon	Chief Strategy and Transformation Officer	NHS Dorset ICB

Somerset ICB Board

The Decision Making Authority on this DMBC and will make the final decision. They have also considered and approved the PCBC which commenced the start of the public consultation and the decision to progress with a preferred option.

Name	Role	Organisation
Paul von der Heyde	Chair (V)	NHS Somerset ICB
Suresh Ariaratnam	Non-Executive Director (Chair of Primary Care Commissioning Committee) (V)	NHSE Somerset ICB
Dr Berge Balian	Primary Care Partner Member (V)	Symphony Healthcare Services South Somerset West Primary Care Network
Charlotte Callen	Director of Communications and Engagement (NV)	NHS Somerset ICB
Victoria Downing-Burn	Director of Workforce Strategy (NV)	NHS Somerset ICB
Christopher Foster	Non-Executive Director (Chair of Remuneration Committee; and Somerset People Board) (V)	NHS Somerset ICB
Dr Caroline Gamlin	Non-Executive Director (Chair of Safety and Quality Committee) (V)	NHS Somerset ICB
Judith Goodchild	Participant (NV)	Healthwatch
Trudi Grant	Executive Director (V)	Public and Population Health
Alison Henly	Chief Finance Officer and Director of Performance (V)	NHS Somerset ICB
Jonathan Higman	Chief Executive (V)	NHS Somerset ICB
Peter Lewis	Chief Executive (Trust Partner Member) (V)	Somerset Foundation Trust
Dr Bernie Marden	Chief Medical Officer (V)	NHS Somerset ICB
David McClay	Chief Officer of Strategy, Digital and Integration (Designate*) (NV)	NHS Somerset ICB
Shelagh Meldrum	Chief Nursing Officer (V)	NHS Somerset ICB
Katherine Nolan	VCSE sector (Participant) (NV)	SPARK Somerset
Grahame Paine	Non-Executive Director and Deputy Chair (Chair of Audit Committee) (V)	NHS Somerset ICB

Jade Renville	Director of Corporate Affairs (NV)	NHS Somerset ICB
Duncan Sharkey	Chief Executive (Partner Member) (V)	Somerset Council

Somerset ICB Leadership Committee

The Leadership Committee is an executive decision-making committee of the ICB Board, with updates and recommendations cascaded via the executive updates and reports to the Board

Name	Role	Organisation
Jonathan Higman	Chief Executive and Chair	NHS Somerset ICB
Dr Bernie Marden	Chief Medical Officer and Vice Chair	NHS Somerset ICB
Shelagh Meldrum	Chief Nursing Officer and Chief Operating Officer	NHS Somerset ICB
Jade Renville	Director of Corporate Affairs	NHS Somerset ICB
Victoria Downing-Burn	Director of Workforce Strategy	NHS Somerset ICB
Alison Henly	Chief Finance Officer and Director of Performance	NHS Somerset ICB
Charlotte Cullen	Director of Communications and Engagement	NHS Somerset ICB
David McClay	Chief Officer of Strategy, Digital and Integration	NHS Somerset ICB
Maria Heard	Deputy Director of Innovation and Transformation	NHS Somerset ICB
Alison Rowswell	Interim Director of Commissioning	NHS Somerset ICB
Emma Savage	Deputy Director of Quality and Nursing	NHS Somerset ICB
Sarah Ashe	Associate Director of Safeguarding, Mental Health, Learning Disability and Autism	NHS Somerset ICB
Sara Bonfanti	Head of Communications and Engagement	NHS Somerset ICB
Kevin Caldwell	Head of Information Governance and Risk	NHS Somerset ICB
Carmen Chadwick-Cox	Deputy Director of Commissioning, Planned Care	NHS Somerset ICB
Bernice Cooke	Deputy Director Nursing and Inclusion	NHS Somerset ICB
Lynette Emsley	Associate Director of Continuing Healthcare Services	NHS Somerset ICB

Jane Graham	Associate Director, Workforce Transofrmation and Innovation	Somerset Integrated Care System (ICS)
Trudi Grant	Executive Director	Public Health and Population Health
Shaun Green	Deputy Director of Clinical Effectiveness and Medicines Management	NHS Somerset ICB
Sophie Islington	Associate Director of People and Transformation	NHS Somerset ICB
Sukaina Kassam	Deputy Director of Primary Care Contracting	NHS Somerset ICB
Andrew Keefe	Deputy Director of Commissioning – Mental Health, Autism and Learning Disabilities	NHS Somerset ICB
Marianne King	Associate Director of Human Resources and Organisational Development	NHS Somerset ICB
Allison Nation	Associate Director – Digital Strategy	NHS Somerset ICB
Peter Osborne	Head of EPRR and Estates	NHS Somerset ICB
Scott Sealey	Associate Director of Finance	NHS Somerset ICB
Michelle Skillings	Head of Performance	NHS Somerset ICB
Helen Stapleton	Associate Director of Workforce Strategy	Somerset Integrated Care System
Tracey Tilsley	Associate Director of Corporate Affairs	NHS Somerset ICB
Shona Turnbull-Kirk	Associate Director of Somerset Covid Vaccination Programme	NHS Somerset ICB

Somerset Collaboration Forum

The Collaboration Forum is a way of facilitating collaboration between the constituent organisations within the Somerset Integrated Care System (ICS) to drive the delivery of the overall health and care strategy that is established by the Integrated Care Partnership (ICP). The Collaboration Forum supported the interactions and dependencies between the stroke programme and other programmes that are responsible for delivering our strategic aims.

Name	Role	Organisation
Jonathan Higman	Chief Executive and Co-Chair	NHS Somerset ICB
Peter Lewis	Chief Executive and Co-Chair	Somerset Foundation Trust
Duncan Sharkey	Chief Executive (Partner Member) (V)	Somerset Council
Trudi Grant	Executive Director of Public Health	Somerset Council
David McClay	Strategy Lead	NHS Somerset ICB
Alison Henly	Chief Finance Officer and Director of Performance	NHS Somerset ICB
Dr Berge Balian	Representative from Primary Care	Symphony Healthcare Services South Somerset West Primary Care Network
Katherine Nolan	Chief Executive	Representative from Voluntary, Community, Faith and Social Enterprise (VCFSE) sector SPARK Somerset
Tim Bishop	Executive Director of IM&T	Representative from South Western Ambulance Service NHS Foundation Trust (SWAST)

APPENDIX 13

Royal United Hospitals Bath
NHS Foundation Trust

3rd January 2024

Directors' Office
Royal United Hospitals Bath
NHS Foundation Trust
Combe Park
Bath
BA1 3NG

Tel: 01225 824032
Email: cara.charlesbarks@nhs.net
www.ruh.nhs.uk

Sent via Email
Maria Heard
Deputy Director of Innovation & Transformation
NHS Somerset

Dear Maria

Somerset Acute Stroke Service Review

Thank you for your letter dated 20th December 2023 seeking the Trust's continued support regarding the Somerset Acute Stroke service review. Following discussion with our Clinical Lead for Acute Stroke, Dr Louise Shaw, I can confirm that the Trust is able to confirm its continued support of Somerset's proposal for the acute stroke pathway.

The RUH can also confirm that we will continue to work with Somerset as they develop their detailed implementation plan. However, the Trust would like the following noted, which requires specific clarification.

- Clarity and assurance regarding the repatriation process. Following a hyperacute episode (variable between 24-72 hours), the RUH requires patients to be repatriated to either Taunton or Yeovil within 24 hours of the patient being made green to step down to Acute Stroke Unit Somerset care by the RUH team.
- Stroke mimics. Based upon actual patient admissions, the number of stroke mimics stated in the table is a conservative estimate as we find the "false FAST positive" rates of patients brought to RUH by SWASFT as hyperacute stroke is a higher percentage. Clarification is required regarding the options to repatriate to Somerset prior to admission, which would require SWASFT input as it would be a redirection from the Emergency Department.

I hope that the above confirmation is helpful and we look forward to receiving a response to the items which require clarification.

Yours sincerely

Cara Charles-Barks
Chief Executive

APPENDIX 14

South Western Ambulance Service
NHS Foundation Trust

Trust Headquarters
Abbey Court
Eagle Way
Exeter
Devon
EX2 7HY

Tel: 01392 261500
Fax: 01392 261510
Website: www.swast.nhs.uk

Our ref: JM004.ash
Your ref: MH/SWASFT/221223

15 January 2024

CONFIDENTIAL

Maria Heard
Deputy Director of Innovation and Transformation
NHS Somerset
Wynford House
Lufton Way
Lufton
Yeovil
SomersetBA22 8HR

Sent Via email to: somicb.somersethealthandcarestrategy.nhs.net

Dear Mrs Heard

Somerset Acute Stroke Service Review

Thank you for your letter of 20 December 2023. We are keen to improve stroke care across Somerset for our patients. We confirm that we have been fully engaged and supportive of the Stroke Service Review.

We can confirm that we have been involved in the modelling for the additional activity for SWASFT within the business case and are supportive of the modelling outputs within the Business Case. We would need this additional activity to be appropriately funded.

By way of this letter, I can confirm that our organisation continues to support the recommendations to reconfigure stroke services within Somerset. We will continue to work with NHS Somerset, Somerset NHS Foundation Trust, and Dorset County Hospital NHS Foundation Trust in developing their detailed implementation plans. This will be overseen by our Clinical Team.

Yours sincerely

Dr John Martin KAM FCPara
Chief Executive

ccs
David McClay, Chief Officer, Digital and Integration
Julie Jones, Programme Manager, Stroke, Neurorehabilitation and Community Hospitals
Simone Rooks, Somerset Health & Care Strategy Project Officer
Alex Sharp, Deputy Head of Clinical Development (Organisational Learning), South Western Ambulance Service NHS Foundation Trust

APPENDIX 15

Somerset NHS Foundation Trust was created from the merger with Yeovil District Hospital NHS Foundation Trust

NHS
Somerset
NHS Foundation Trust

DEPARTMENT OF STROKE

Yeovil District Hospital
Higher Kingston
Yeovil
Somerset
BA21 4AT
Switchboard: 01935 475122
Direct Line: 01935 384344

Our Ref: KAR/lp

28/12/2023

Mr Paul von der Heyde
Chairman
Somerset Integrated Health Care Board
Wynford House
Lufton Way
Yeovil BA22 8HR

Dear Mr von der Heyde

Re: Stroke Reconfiguration Services in Somerset

I am writing to express my concerns about the forthcoming Integrated Care Board (ICB) plan to decide on the so-called option A, as detailed in the recent stroke public consultation in Somerset. The proposal in option A, is to remove the Hyper Acute Stroke Unit (HASU) from Yeovil District Hospital (YDH) and transfer the service provision to four HASU's with four different providers, a decision that will have a negative effect on 70% of the population served by YDH. The 4 HASU's are Musgrove Park Hospital, Dorset County Hospital, Salisbury Hospital and Royal United Hospital.

The recent ICB decision to reject option B, for all the good reasons stated at the time of making the decision, was a brave and correct one and should be applauded. The ICB Board should now seriously consider rejecting option A in favour of another option that is much more cost-effective, more beneficial to the community and will provide more equitable services to the population served by both Musgrove Park Hospital (MPH) and Yeovil District Hospital (YDH). Until now, and to my surprise, this alternative option has not been considered, presented or discussed by the ICB.

I have recently been approached by members of the patient groups' representatives and others, all very concerned about the loss of YDH HASU. They are very worried about the adverse effect on the quality of care to given to the stroke patients, the negative impact on the community and the extra financial burden of the proposed changes to the whole health and social services system. They are concerned that they were repeatedly told, in a number of public meetings, that there are no other plans on the table other than option A. They were all very keen to know if there is other alternative option that should be considered by the ICB.

I am sure you will not be very surprised to know that I do think there is another option, let us call this option C. This option and for unknown reasons, was not considered by the stroke clinical reference group, NHS Somerset and the ICB. It was also not costed and not presented to the stroke Senate prior to the launch of the public consultation. This option, in my opinion, does not involve removal of YDH HASU, will ensure the delivery of high quality and equitable stroke services and more importantly will be more cost effective than option A.

I urge you and the ICB Board to consider Plan C, summarised as:

1. Continue to provide Yeovil HASU Services at Yeovil District Hospital.

2. Commit the extra investment desperately needed to ensure the delivery of high-quality stroke services at both MPH and YDH.

3. Provide and ensure both organisational and operational support, to deliver equitable services across both hospitals.

4. Constitute a single strong stroke leadership and a single stroke workforce that will ensure safe delivery of the service on both Musgrove Park Hospital and Yeovil District Hospital.

5. Give YDH a Yeovil Stroke Ward with dedicated HASU beds, both ringfenced, and dedicated staff to deliver on the National Guidelines.

Finally, I strongly believe that both MPH and YDH, with its existing strong protocols and systems are well positioned and equipped to deliver on most of the National Guidelines (SSNAP). Work force shortage, a key drive to the proposed changes, has not been the main reason for Somerset poor performance.

The stroke services at MPH and YDH are in desperate need for extra investment, good organisational support and strong leadership. Work force problems can be solved with appropriate recruitment drive and strong leadership. Without this, the current proposal in front of the ICB to remove YDH HASU will have catastrophic effect on the community, will not guarantee delivery of better services and will be more costly to the health and social care system.

With kind regards,
Yours sincerely

K A Rashed

K A Rashed MBE, FRCP
Consultant Stroke Physician

Copy to:

Peter Lewis, Chief Executive, Somerset NHS Foundation Trust – by hand
Jonathan Higman, Chief Executive NHS Somerset – via email
Marcus Fysh, MP, via email

Our Ref: BM/SP/150124

15 January 2024

Dr K A Rashed
Consultant Stroke Physician
Yeovil District Hospital

Email:Khalid.Rashed@SomersetFT.nhs.uk

Wynford House
Lufton Way
Lufton
Yeovil
Somerset
BA22 8HR

Tel: 01935 384000

Email: somicb.enquiries@nhs.net

Dear Dr Rashed

Reconfiguration of Stroke Services in Somerset

Thank you for your letter of 28 December in which you shared your concerns on the ongoing development of a proposal for Acute Hospital Based Stroke Services in Somerset and proposing an alternative delivery model. Our Chairman Paul von der Heyde has asked me to address the issues you raise. It was very helpful to have met with you yesterday on Teams to get further clarification on the proposal you are tabling.

You have suggested an alternate model of care – 'Option C', one which would enable a HASU service at YDH. I would like to take this opportunity to confirm that the model you proposed was one which we have considered as part of the extensive programme of work we have undertaken.

You will be aware that the current proposals for stroke commenced 2018 when we considered how we could improve outcomes for people experiencing a stroke in Somerset. The strategy to improve stroke care was developed in 2019 and outlined how we could improve services, ranging from prevention to supporting people living with a stroke. Many of the actions have been put into place and we started looking at the recommendation to consider how we could better configure acute hospital-based stroke services in 2022.

We know that you and your colleagues work hard to provide the best care possible for people who have experienced a stroke, but we know that the way our current services are set up could be improved to enable patients to experience better outcomes following a stroke. Our ambition is to provide consistent stroke services no matter what time of day or where someone lives 24 hours a day, 7 days a week. As you will be well aware, there is a shortage of specialist workforce to care for people with a stroke both locally and nationally which has led to problems over a number of years in medical cover in our hospitals and meant we are not able to provide specialist support 24 hours a day, 7 days a week within our current configuration of two Hyper Acute Stroke Units in Somerset.

In considering the options for stroke reconfiguration, a number of colleagues including Doctors, nurses, other professionals involved in stroke care, people with lived experience including carers, and Voluntary Community Social Enterprise organisations came together to identify a long list of potential solutions for transforming acute hospital-based stroke services in Somerset. This list was reviewed with a broad group of professional and clinical stakeholders at a facilitated workshop.

This long list of options included four which would see a HASU retained at Yeovil District Hospital (options 1, 2, 8 and 9) and two options (options 3 and 4) where HASU services would be shared either with Dorset County Hospital or Musgrove Park Hospital.

A set of hurdle criteria were used by a range of expert groups to assess each of the options using a 'pass/fail' criterion. This resulted in number of options being discounted and are shown below. Options for keeping a HASU in Yeovil District Hospital (Options 1 and 2) remained in the list to continue exploring options on keep services in place. The final shortlist is shown below.

Option A	Option B	Option C	Option D
Do Nothing No change to current model	**Do Minimum** As for option A, but with shared medical workforce	**1 HASU** Single HASU at Musgrove Park Hospital in Taunton. No HASU in Yeovil. ASU at Taunton and Yeovil.	**1 HASU and ASU** Single HASU and ASU at Musgrove Park Hospital in Taunton. No HASU or ASU at Yeovil
There would be **no change** to the current delivery model	There would be **no change** to the current delivery model	SWASFT would take all suspected stroke patients to **nearest HASU**	SWASFT would take all suspected stroke patients to **nearest HASU**
Yeovil emergency department (A&E) would continue to receive suspected stroke patients	Yeovil emergency department (A&E) would continue to receive suspected stroke patients	Yeovil emergency department (A&E) **would not** receive suspected stroke patients at any time	Yeovil emergency department (A&E) **would not** receive suspected stroke patients at any time
HASU services would continue to be delivered in both Taunton and Yeovil in the same way	HASU services would continue to be delivered in both Taunton and Yeovil in the same way	Most patients who would normally go to Yeovil would go to **Taunton or Dorset for their HASU** care	Most patients who would normally go to Yeovil would go to either **Taunton or Dorset for their HASU** care
Patients would receive their ASU care in the same way they currently do	Patients would receive their ASU care in the same way they currently do	Patients would return to **Yeovil for their ASU** care	Patients would remain in **Taunton or Dorset for their ASU** care
There would be **no change** to the workforce	There would be a **single medical workforce** would be shared across both sites. There would be no change to the nursing, AHP or support staff workforce	There would be **some changes** to the medical, nursing and AHP workforce	There would be **some changes** to the medical, nursing and AHP workforce
Once ready for rehabilitation, patients would ideally be **discharged closer to home** following their acute care –	Once ready for rehabilitation, patients would ideally be **discharged closer to home** following their acute care –	Once ready for rehabilitation, patients would ideally be **discharged closer to home** following their acute care –	Once ready for rehabilitation, patients would ideally be **discharged closer to home** following their acute care –

either home or to a community hospital	either home or to a community hospital	either home or to a community hospital	either home or to a community hospital
There will be **no impact** on other health systems in this option	There will be **no impact** on other health systems in this option	There will be **an impact on other health systems** in this option, primarily Dorset	There will be an **impact on other health systems** in this option, primarily Dorset

The four shortlisted options were assessed by a Clinical Review panel of the South West Clinical Senate in September 2022. The panel deemed that the first two options would not clinically address the reasons set out in the Case for Change and provided assurance for two options that were consistent with a strong clinical evidence base: Option C (HASU at SFT only) and Option D (All HASU and ASU beds at a single hospital site - SFT).

At this point, a decision was made to discount Options A & B on a clinical basis and no option was retained to keep a HASU at YDH. Because there was no clinical assurance, no detailed financial modelling was undertaken. There are a number of reasons why there were concerns with the deliverability of Option B:

- The Clinical Senate could not provide clinical assurance of this model of care
- A HASU at YDH would not meet the recommended minimum of 600 patients per year
- Ability to recruit sufficient stroke consultant staff to deliver the required standards on 2 separate HASUs and ASUs
- Trying to make consultants work across two sites, seven days a week may risk them resigning and taking up employment elsewhere, potentially worsening the situation

Following the review of the shortlisted options and the clinical senate review, two preferred options were identified to take forward and they formed the basis of consultation between 30th January and 24th April 2023.

We undertook an Equality Impact Assessment to consider who would be impacted by the proposed change and this was used to understand both the impact and who we needed speak to as part of a formal consultation.

We consulted widely across Somerset with a strong focus on reaching those in rural areas, utilising warm spaces and community talking cafes to reach people. This was supported by the representative telephone survey undertaken by an independent research organisation. We adjusted our approach during the consultation to ensure we reached people in areas with multiple deprivation.

Following the consultation, the findings were independently analysed and we gained insights from rural areas across the different questions we had asked. Key areas highlighted related to increased travel times and lack of public transport. We are taking a number of actions in relation to travel times as part of working towards a final decision. These include:

- Undertaking additional travel time analysis to further assess travel times
- We took the question of ‘how long is acceptable to travel to visit a loved one by car or public transport’ to our stakeholder reference group to hear in more detail what matters for those with lived experience.
- Shared concerns with the Sustainability Steering Group.
- Working with Somerset Council to inform their travel plan.
- Looking in more detail on the ambulance handover times and actions in place to improve these.

We have also updated our Equality Impact Assessment to include the impacts which were identified during the consultation.

Our work to consider the preferred option is continuing and is expected to be concluded imminently. We expect to take a final Decision Making Business Case which will detail all of our analysis and make a final recommendation to the ICB Board this month. We appreciate the level of public interest in the project and have outlined at the ICB Bord meeting in November that once a decision has been made, that any planned change would be accompanied by an implementation plan including ongoing public engagement and communication to respond to, and allay, any concerns. We will continue to keep members of the Committee informed of progress.

Yours sincerely,

Dr Bernie Marden
Chief Medical Officer

Copies to: Paul von der Heyde
Peter Lewis
Jonathan Higman
David McClay
Marcus Fysh, MP

APPENDIX 16

Somerset Council
County Hall, Taunton
Somerset, TA1 4DY

Somerset Council

Cllr Bill Revans
Chair of Executive
Somerset Council

Please ask for: Jennie Murphy

Email:Jennie.Murphy@Somerset.gov.uk

Direct Dial: 01823 357686

Date: 20 September 2023

Dear Bill,

Acute Hospital Based Stroke Services in Somerset

NHS Somerset has just finished a public consultation to gather feedback about the future of acute hospital based stroke services in Somerset, from people living in Somerset and people who use Somerset hospitals. The consultation ran for 12 weeks from Monday 30 January 2023 until Monday 23 April 2023.

The Scrutiny for Policies Adults and Health Committee has been kept informed of this consultation and the various options under discussion since September 2022.

Today the Committee had a final presentation on the preferred option selected to go before the NHS Somerset Board in January 2024. This option was to have two Acute Stroke units (in Yeovil and Taunton) and one Hyper Acute Stroke based in Taunton Musgrove Park Hospital.

The Committee feel very strongly that they have concerns that the proposal as it stands is not in the best interests of all the residents of Somerset. In particular there is a concern for those living in the rural parts of our County.

Please on behalf of the Scrutiny Committee and Somerset residents make it clear to the Somerset NHS board this decision needs to be delayed and other options considered to safeguard the welfare of residents living in the south west part of the County.

Yours sincerely,

Councillor Graham Oates
Acting Chair of Somerset Adults and Health Scrutiny Committee

Our Ref: MH/bm/cvl

18 December 2023

Wynford House
Lufton Way
Lufton
Yeovil
Somerset
BA22 8HR

Tel: 01935 384000

Email: somicb.enquiries@nhs.net

Councillor Graham Oakes
Acting Chair of Somerset Adults and
Health Scrutiny Committee

Email: graham.oakes@somerset.gov.uk

Dear Councilor Oakes

Acute Hospital Based Stroke Services in Somerset

Thank you for your letter dated 20 September 2023, received on 9 December 2023, in which you shared your concerns on the ongoing development of a proposal for Acute Hospital Based Stroke Services in Somerset. Your letter highlighted a belief that it is not in the best interests of all the residents of Somerset, with particular concern for those living in the rural parts of our County. Our Chairman Paul von der Heyde has asked me to address the issues you raise.

Although a final decision on Stroke reconfiguration has not been made a preferred option outlined in the update paper to the Somerset Adults and Health Scrutiny Committee meeting on 7 December is to have one Hyperacute Stroke Unit (HASU) in Somerset at Musgrove Park Hospital and an Acute Stroke Unit (ASU) at both Musgrove Park Hospital and Yeovil District Hospital. This preferred option was approved by NHS Somerset Integrated Care Board on 30 November 2023. We have reached this decision based on what we heard during the consultation and further analysis of the two options which we consulted on.

We appreciate the update paper taken to the Committee did not contain a summary of all the information presented to it during the course of this work.

The process to reach this point follows an extensive programme of work, commencing in 2018 to review how we improve outcomes for people experiencing a stroke in Somerset. A strategy to improve stroke care was developed in 2019 and outlined how we could improve services, ranging from prevention to supporting people living with a stroke. Many of the actions have been put into place and we started looking at the recommendation to consider how we could better configure acute hospital-based stroke services in 2022.

Our staff work hard to provide the best care possible for people who have experienced a stroke, but we know that the way our current services are set up could be improved to enable patients to experience better outcomes following a stroke. Our ambition is to provide consistent stroke services no matter what time of day or where someone lives 24 hours a day, 7 days a week. We are not achieving this currently.

We recognise that Somerset is a rural county with an older than average population alongside the fact that the number of people over 75 expected to double in the next 25 years. This will result in an increased demand in stroke care.

Unfortunately, there is a shortage of specialist workforce to care for people with a stroke both locally and nationally which has led to problems over a number of years in medical cover in our hospitals and meant we are not able to provide specialist support 24 hours a day, 7 days a week within our current configuration of two Hyper Acute Stroke Units in Somerset.

We don't always provide treatment fast enough in Somerset. Increasingly, there are new and specialist treatments to reduce brain damage and disability after stroke which requires highly skilled staff and the latest technologies. The time from symptom onset to definitive treatment such as thrombolysis is the most important determinant of outcome. Safe access to consistently reliable and continually available expertise and investigations is vital to shorten this door to needle time following arrival at hospital." As our expertise is spread over two sites, we're unable to offer this level of service at both hospitals all the time.

Doctors, nurses, other professionals involved in stroke care, people with lived experience including carers, and Voluntary Community Social Enterprise organisations came together to identify a long list of potential solutions for transforming acute hospital-based stroke services in Somerset. This list was reviewed with a broad group of professional and clinical stakeholders at a facilitated workshop.

This long list of options included four which would see a HASU retained at Yeovil District Hospital (options 1, 2, 8 and 9) and two options (options 3 and 4) where HASU services would be shared either with Dorset County Hospital or Musgrove Park Hospital.

A set of hurdle criteria were used by a range of expert groups to assess each of the options using a 'pass/fail' criterion. This resulted in number of options being discounted and are shown below. Options for keeping a HASU in Yeovil District Hospital (Options 1 and 2) remained in the list to continue exploring options on keep services in place. The final shortlist is shown below.

Option A	Option B	Option C	Option D
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The four shortlisted options were assessed by a Clinical Review panel of the South West Clinical Senate in September 2022. The panel deemed that the first two options would not address the reasons set out in the Case for Change and provided assurance for two options that were consistent with a strong clinical evidence base: Option C (HASU at SFT only) and Option D (All HASU and ASU beds at a single hospital site - SFT).

Following the review of the shortlisted options and the clinical senate review, two preferred options were identified to take forward and they formed the basis of consultation between 30th January and 24th April 2023.

We undertook an Equality Impact Assessment to consider who would be impacted by the proposed change and this was used to understand both the impact and who we needed speak to as part of a formal consultation.

We consulted widely across Somerset with a strong focus on reaching those in rural areas, utilising warm spaces and community talking cafes to reach people. This was supported by the representative telephone survey undertaken by an independent research organisation. We

adjusted our approach during the consultation to ensure we reached people in areas with multiple deprivation.

Following the consultation, the findings were independently analysed and we gained insights from rural areas across the different questions we had asked. Key areas highlighted related to increased travel times and lack of public transport. We are taking a number of actions in relation to travel times as part of working towards a final decision. These include:

- Undertaking additional travel time analysis to further assess travel times
- We took the question of 'how long is acceptable to travel to visit a loved one by car or public transport' to our stakeholder reference group to hear in more detail what matters for those with lived experience.
- Shared concerns with the Sustainability Steering Group.
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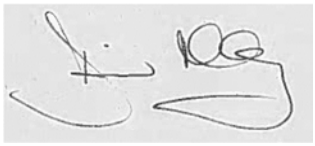
- Looking in more detail on the ambulance handover times and actions in place to improve these.

We have also updated our Equality Impact Assessment to include the impacts which were identified during the consultation.

Our work to consider the preferred option is continuing and is expected to be concluded in the New Year. We expect to take a final Decision Making Business Case which will detail all of our analysis and make a final recommendation to the ICB Board in January. We appreciate the level of public interest in the project and have outlined at the ICB Bord meeting in November that once a decision has been made, that any planned change would be accompanied by an implementation plan including ongoing public engagement and communication to respond to, and allay, any concerns. We will continue to keep members of the Committee informed of progress.

Yours sincerely,



David McClay
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