Healthier **Together**

Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS

Improving stroke services in Bristol, North Somerset and South Gloucestershire

Factsheet: What are the costs involved with changing stroke services?

1. Will the proposed changes to Stroke services cost more?

- The cost of health and social care for people with stroke will triple in the next 15 years[1]. At the same time, local people told us it is important to spend money on prevention and rehabilitation, as well as hospital treatment and care.
- We plan to invest in specialist stroke services in Bristol, North Somerset and South Gloucestershire (BNSSG).
  - To spend more on preventing stroke
  - To increase survival rates
  - To reduce disability and improve people's independence after a stroke (potentially reduce cost of long-term care)
  - To provide more rehabilitation and help people with other conditions
  - To use NHS resources wisely and deliver effective, sustainable and efficient services[2]
- The options being consulted on deliver significant improvements for treatment and care through a more streamlined pathway. However, the proposed new service model is expected to be more expensive than current provision.
- The additional cost of the options being consulted on is a range between £2.9m and £3.4m
- This is on a baseline (2018/19) of £29.7m already committed to caring for patients with stroke.
- The BNSSG Health System partners have considered the benefits of the proposals being consulted on and the additional costs these could result in and has agreed to support additional investment for stroke services of 10-12% above the baseline costs.

2. What is driving the cost increase?

- A large proportion of care delivery is switching from acute to the community. In total, patients will receive an average of 96 days of stroke care in the future state models compared to an average of 66 days of care in the current state. This represents an increase of 45%, which has been achieved through:
  - A reduction in the number of acute hospital beds
  - A reduction in the number of rehabilitation beds
  - An increase in rehabilitation delivered at home and in the community
- The current baseline for hospital care includes 51 acute beds, some of which are highly staffed. On average, the baseline operational cost per acute bed day is £803, and there is an average length of stay of 10 days.
- The future state models are based on a reduction in acute beds, which will be split between HASU (Hyper Acute Stroke Unit) and ASU (Acute Stroke Unit) care.
  - There will be 22 HASU beds, with an average length of stay of 3 days. The average operational cost per bed day will be £1,313.
  - In option No. 1 (1 ASU) there will be 22 ASU beds with an average operational bed day cost of £617
  - In option No. 2 (2 ASUs) there will be 23 ASU beds and an average operational bed day cost of £672.
- The cost per bed day for HASU bed days will be higher due to the more intensive care provided and specialist staff required to provide this.
- The total predicted change in cost of acute care (HASU & ASU) is £1.5m (option 1) and £2m (option 2).
- In both options, patients would be discharged home, to the community team or to a Stroke Sub-Acute Rehabilitation Unit (SSARU) bed according to clinical need.
- 42 SSARU beds would be required in both options and would have an operational cost per bed day of £363; this is an increase on the baseline cost of £322. The total cost of inpatient rehab in the community will only marginally increase in the new model.
- Community support is required for 756 patients per annum, providing an average of 60 patient visits over 10 weeks per patient. The growth in the resource to support more patients in the community requires investment of £4.7m.
- To support the additional investment in stroke services, the BNSSG Health Partners are committed to finding £0.5m of savings to offset the cost increase. This commitment is the same for both options under consideration.

2. Why does Option 2 (2 ASUs at Southmead & Bristol Royal Infirmary) cost more than option 1 (1 ASU at Southmead)?

- Option 2 will require an additional bed in the total ASU bed number which reflects a higher cost but more importantly smaller units are less efficient and require more staff to achieve the national standards for the delivery of stroke care.

4. Will there be empty beds or services at the other hospital sites?

- The proposals mean that there will be movement of services between hospital sites. This means that hospital beds currently used for stroke at some hospitals would not be in the future. This doesn't mean that they will be empty.
- Where beds or costs appear to be released at a provider as a result of movements in the stroke pathway but in reality are un-releasable at the existing sites, these are recognised as vacated capacity.
- The vacated capacity is acknowledged by the BNSSG Health System partners as an opportunity to address future forecast demand for acute services and address existing constraints within acute capacity and sites.

5. Are the proposals value for money?

- The proposed stroke reconfiguration aims to redistribute available funding, to match funding to clinical and patient need through:
  - Standardising services across BNSSG – All patients living within BNSSG across BNSSG will receive the same service.
  - Increasing clinical input in the first three days following a stroke to reduce disability. All suspected stroke patients will be taken to the single HASU and admitted for immediate specialist hyper-acute stroke care, if clinically appropriate.
  - Increasing community rehabilitation, to further reduce long-term disability, and improve post-hospital patient experience. All patients will have access to an average of 60 sessions of rehabilitation, matched to clinical need.
- Benchmarking has been undertaken to review the extent to which similar stroke reconfigurations have required investment. Most reconfigurations reviewed appeared to require some investment. The best comparable data was available for the Manchester and London reconfigurations:
  - In 2010, the London reconfiguration required an additional investment of £1,816 per stroke (£2,056 indexed to 20/21), and the Manchester reconfiguration required an extra £1,175 per stroke (£1,330 indexed to 20/21).
- This level of investment is equivalent to the proposed investment in BNSSG. However, it should be noted that the BNSSG proposed reconfiguration is more far-reaching than those undertaken in London and Manchester in 2010, and in particular includes a substantial investment (£3.3m) in community rehabilitation that was not part of the baseline provision. Therefore, compared to investments made by other systems, the BNSSG proposals appear to offer value for money.

[1] In 2018/19, our hospitals cared for 1,561 people with a stroke. The cost of hospital and NHS community stroke services was £29.7million. An average cost of £18,000 per stroke per year (not including all the extra ambulance, general practice and social care costs).

[2] Comprehensive Stroke Centres are more likely to be clinically effective and financially sustainable if they see between 600-1500 people with a stroke per year. Breakeven point is about 900 admissions for stroke per year.