

BNSSG Stroke Services: Desktop Review (March 2020)

Background

As part of the NHSE assurance process for large scale service change, it is normal for the regional Clinical Senate to undertake a Clinical Review of proposals to consider the clinical evidence base and clinical model behind proposed changes ahead of public consultation.

A formal clinical review panel is normally set up ahead of, and to inform, the stage 2 NHSE assurance meeting around the clinical model and evidence base for it, along with assessing the bed test (tests 3 and 5). Prior to setting up a full panel, and broadly in line with the stage 1 assurance meeting, a desktop review panel considers draft PCBC documentation (to include the case for change) to highlight any key concerns early on in the review process and inform the development of a robust PCBC prior to sign off to consult publicly. The desktop review panel is normally a smaller grouping of the final panel which reviews documentation virtually rather than through a face to face panel.

Summary of Core Proposals;

There are three acute trusts providing stroke services in the BNSSG (Bristol, North Somerset and South Gloucestershire) STP Area – these are North Bristol NHS Trust (NBT), University Hospital Bristol NHS Foundation Trust (UHB) and Weston Area Health NHS Trust (WAHT) with UHB and WAHT due to merge from 1st April 2020.

The proposals are to agree HASU and ASU provision for the region and develop an integrated stroke pathway for whole of BNSSG. The preferred option provides a single HASU based at NBT, with a co-located Acute Stroke Unit (ASU). The location and number of ASUs at the other two acute hospital locations in BNSSG (UHB and WAHT) is to be determined. Proposals also include the relocation of sub-acute rehabilitation beds into the community with options for relocating 40-50 beds. Currently sub-acute rehabilitation beds are provided in South Bristol Community Hospital as well as in the acute wards themselves in all three hospitals.

This is within the context of there currently being no designated Hyper Acute Stroke Unit (HASU) in BNSSG with suspected strokes taken to any one of three acute hospitals. NBT is the regional thrombectomy centre and is also a major trauma centre and the vascular centre for the region. UHB is the cardiac and oncology centre for the region.

On 1st April 2020 a single community provider, Sirona, will begin delivering community services across the whole of BNSSG which moves from three providers working along local authority boundaries. This gives an opportunity to standardise the community service offer. Current limited community service provision also means that there are very long lengths of stay for patients within hospitals in the area with a shortfall in community service provision.

Desktop Review

Members of the Clinical Senate Council were convened to undertake a desktop review and to consider the case for change and early documentation. They had two weeks from February 10th 2020 to feedback on the following documents:

1. Review template submission (provides an overview)
2. 2020 BNSSG Stroke Draft Case for Change v2
3. HASU evidence review (5a, 5b, 5c and 5d)
4. 202001 ASU Evaluation Workshop 1 of 2 - FINAL
5. Minimum service offer for a hospital without an Acute Stroke Unit v2
6. 20200127 Draft rehab service spec v2
7. Bed numbers Brief

Panel members were specifically required to consider and provide feedback against the following;

1. **What are the proposals and are they clear?**
2. **Is the clinical case for change robust and in line with national best practice and evidence?**
3. **Will the outlined or preferred model improve the quality of care?**
4. **Do the proposed changes address the issues identified in the case for change?**
5. **What might need to be incorporated in future iterations of the model of care, when developing detailed options and where is further information needed?**

Clinical Senate Desktop Review Feedback

Key Comments

- **Robust case for change & model supported by evidence and best practice.**
- **Model for HASU and co-located ASU at NBT broadly supported at this point.**
- **Concerns that workforce and recruitment issues will not be easily addressed.**
- **A preferred option for ASU number and location should be articulated.**
- **Clarity around rehabilitation provision is required.**

Feedback against key questions:

1. **What are the proposals and are they clear?**

The proposals identify the need to centralise stroke services across BNSSG thereby providing equitable service across the region and bringing services in line with the national stroke guidelines.

Their options are:

1. HASU & ASU at NBT
2. HASU & ASU at NBT+ ASU at UHB
3. HASU & ASU at NBT+ ASU at WSH
4. HASU & ASU at NBT + ASU at UHB + ASU at WSH

The proposals clearly detail the emergent model for HASU and ASU provision in the BNSSG area, as well as the relocation of 40-50 sub-acute stroke rehabilitation beds from the acute to the community setting as part of development of an STP wide integrated stroke pathway. The proposal will enable access to thrombectomy for appropriate patients and also highlights the need to develop Early

Supported Discharge (ESD) services across the region, which are currently lacking. It is anticipated that one HASU with a co-located ASU will be developed at NBT with the proviso that the location and number of further ASU are not yet defined.

The quality of the submitted documentation is high and the options for future service models are clearly stated. The rationale for the options being explored is clear and the description of the option appraisal process is clear and comprehensive at this point, assuming that some of the further information requested in this report will be included in the final PCBC.

The description of the support required at hospitals without a HASU and the exploration of pathways for patients presenting to the "wrong" location suggest that the system has given careful consideration to the pathways of care for patients in the proposed models. There is some clear rationale regarding Weston Hospital and its ability to retain its sub-acute rehabilitation beds although there appears to be a less definitive proposal within the Bristol area.

It would be helpful to include a preferred model for the location and number of ASUs in the PCBC and the documents should, as best practice, make it clear what the differences are between a HASU and an ASU for non-experts.

The timescale for change is not currently well outlined and it is not clear whether changes will be sequential or in parallel, which in particular has workforce implications and overall it is not clear how the existing recruitment issues will be overcome.

2. Is the clinical case for change robust and in line with national best practice and evidence?

Overall, the evidence base for the model being described is well documented and reflected in national guidance although there are opportunities to strengthen this at PCBC level.

There is reflection of the NHS Long Term Plan ambitions and frequent reference to national best practice. NICE stroke guidance is briefly referenced in relation to thrombectomy and the initiation of treatment as well as in the draft specification for the Integrated Community Stroke Service. This should reflect the updating of the Clinical guideline [CG68] which has been replaced by NICE guideline Stroke and transient ischaemic attack in over 16s: diagnosis and initial management (NG128). It would be good if the case for change could be more informed by NICE guidance and quality standards in order to help provide further assurance that their proposals are underpinned by robust evidence in order to deliver the best possible care within the resources available*.

The proposal for one HASU at NBT is clear and is in line with national best practice and evidence. There is also a strong financial driver to centralise this unit. Due to the access to thrombectomy services, basing the service at NBT makes sense. The PCBC could also benefit from referencing on-site neurosurgery for complications of stroke such as malignant MCA syndrome, which requires urgent neurosurgical intervention, and is usually seen in the early days post-stroke. For patients on the unit, this would provide best practice care, and would improve the overall level of stroke care currently available in the BNSSG region.

There are several areas where more detail is still required to bolster the evidence. Given the rural nature of the area, and the poor transport links in for instance the Somerset levels, it would be useful to see a travel impact assessment and have some further information on maximum travel times for acute strokes on the edges of the region (and whether it would make more sense for these patients to go to other units eg. Taunton) and accessibility to a HASU, including seasonal variation in

travel times. Although SWAST is mentioned in some documents, there needs to be consideration of what the additional travel times will have on their crews and service, and whether this is going to be feasible. It would be useful to model what hyper-acute strokes have presented to WAHT / UHB over the last year and therefore what impact the proposed changes would have on the region's ambulance services. Currently, the recommendations are that a patient should be conveyed to a HASU within 60 minutes (and preferably within 30 minutes); given the geography the feasibility of this should be detailed.

It would also be helpful to know in more detail how the hyper-acute service would be provided to other Trusts, along with consideration of whether NIHSS training needs to be given to staff at 'outlying' areas, for instance the Medical SpRs or ED SpRs at both WAHT and UHB, to determine whether thrombolysis / thrombectomy would be useful for a patient and therefore the urgency of the patient.

The Stroke Sentinel Audit and other reviews of services favour the hub and spoke model in London, but it is important to remember that the travel times there are significantly different, and the BNSSG service may not be able to provide the same level of improvement. It would be useful for the proposals to highlight the Northumberland service, and how that functions, as a closer model to what they are trying to achieve in BNSSG, given similar levels of rurality.

The documentation suggests the changes are being clinically driven and the engagement of clinicians set out in the structured option appraisal is to be commended. The sense from the documentation however is that the clinical leadership for the changes is mostly from NBT clinicians with no evidence of involvement of clinicians from Sirona. The Senate have observed through the assurance of the proposals for Weston Hospital, the transformational impact of clinical teams working together with a shared sense of ownership for clinical services and will be interested to explore the extent to which this is emulated in these proposals.

3. Will the outlined or preferred model improve the quality of care?

The clinical benefits for the proposed model are well understood and have informed the evidence base nationally. Whilst there is good evidence behind the consolidation of services to one HASU at NBT, which would provide in general better patient care, those patients in outlying areas, travel times, and how other parts of the service are going to look need more detail. The Trusts should also consider whether they have future-proofed the proposals enough to cope with strokes in the coming years, including taking more out of area thrombectomy patients.

The current case for change does not really highlight the extent to which the current model may be compromising outcomes such as mortality, long term disability and levels of subsequent independence, all of which should be improved by any of the proposed options.

Successful delivery of the proposal assumes the ability to recruit staff to larger units, producing an effective and efficient Early Supported Discharge service and having a fully established therapy workforce. It is not clear how the model will ensure workforce issues are addressed and there should be some risk assessment of how the system would cope with vacancies. It would also be helpful to include consideration of recruitment and retention in relation to cross working, training and protocols for all disciplines.

For cardiothoracic patients there is no mention of repatriation back to their local hospital or for referral for stroke follow up locally. The patient pathway under the stroke team needs to be

demonstrated, showing they can access all services, including an ESD. The lack of an ASU for these patients is a concern and it would be interesting to see how many of these patients in the past received intensive stroke input (by any discipline).

Whilst the model will provide uniformity across the stroke care pathway both in the hyperacute, acute & sub-acute services, a hospital without a Hyper Acute Stroke Unit or Acute Stroke Unit should demonstrate a minimum service offer for stroke as follows:

1. 24/7 access to telephone stroke advice from a stroke middle grade, ANP or consultant.
2. 24/7 ability to transfer to HASU from hospitals without an ASU for full stroke assessment.
3. Patients requiring specialist assessment prior to transfer should be seen in person or via telemedicine 7 days a week by either an onsite or peripatetic team.
4. Patients who can't be transferred to HASU should be able to access a multidisciplinary in reach service for initial assessments and ongoing stroke care (including hyper acute stroke care), including rehabilitation until discharge or transfer.

It would be helpful to ascertain as to how outcomes will be measured across the whole stroke pathway. NICE Quality standard Stroke in Adults (QS2) supports delivery of outcome frameworks and NICE can help inform the development of outcome indicators. For example the NICE shared learning example could be used; [Developing and implementing a set of outcome measures incorporating NICE Standards across the whole stroke care pathway in Greater Manchester.](#)

4. Do the proposed changes address the issues identified in the case for change?

The proposals, if implemented as described and depending on the preferred option, would address the majority of challenges set out in the case for change, with the highlighted concern around addressing recruitment to be flagged as a key risk. Given the current vacancy rates there is concern as to how achievable the staffing requirements of the new model are, acknowledging that they are likely to be more achievable than the do nothing option.

There is limited information on where any ASU should be situated and identification of a preferred option should be included within the PCBC. The efficiencies of only having one main ASU can be demonstrated, and there are financial downsides to having more than one unit. However, this part of the proposal still seems to be in a state of flux. The outline of what the service currently offers is phrased in a way that makes it hard for external reviewers to understand clearly what the current situation is; this is relevant in understanding how services are going to change in order to help shape a robust and sustainable clinical model. For instance, describing the current service by ward names is not helpful nor provides good evidence in terms of number of beds, staff mix etc. If there is only one ASU, and assuming that this is based at NBT, the provision for stroke support in WAHT and UHB should be clearly articulated along with the support for the cardiothoracic department in UHB.

For staffing for ASUs, there is good evidence that having one unit is more cost efficient and allows better staff flexibility across the HASU / ASU interface at the nursing level. However, there are some over-arching statements that centralising both units will lead to better staff resilience and retention. There is no evidence to support this statement, and the proposals should consider whether they are expecting nursing staff to move from WAHT and UHB to staff the HASU / ASU at NBT. It is also not clear on why the staffing numbers for junior doctors are unchanged whether there are 1, 2 or 3 ASUs. The terminology (i.e. SHO, Registrar, Senior Registrar) is also outdated and not in keeping with

current junior doctor grades. Consolidating these doctors on one site may also mean a change in training rotations across the 3 Trusts, which could have wider implications on the medical services at WAHT and UHB if doctors are also moved to NBT. A better idea of exactly how many doctors would be needed, in what ratios, and how this compares to current staffing would be useful.

There is also no clear sense of what the current levels of consultant staffing are. To cover a HASU requires a minimum of 1:6 BASP trained stroke consultants, but the documents don't contain current numbers for WAHT, UHB and NBT and whether those consultants would also move Trusts. If this is the case, consideration as to whether consultants would also have to travel to UHB and WAHT in order to provide a stroke service on these sites needs to be given.

When considering rehabilitation after stroke, assumptions have been made that all patients who can be cared for at home are being cared for at home when numbers for ASU and rehab beds are modelled. Real-time numbers for this at each site would be helpful to further inform the proposals, as there will probably be a certain number of patients who stay in hospital despite it being possible for their care to be provided at home. The number of rehabilitation beds and where these will be is not clear; WAHT appears to be emerging predominantly as a proposed rehab site, but the exact number of beds is not clear, and there seems to be some concern as to whether they can provide a critical mass of beds. There is a clear pathway for rehab patients from UHB to go to SBCH, though the number of beds available here and the cost of these beds is not clear. It is not clear where NBT patients would go for rehab, and whether this would happen within the Southmead site, or at other areas.

5. What might need to be incorporated in future iterations of the model of care, when developing detailed options and where is further information needed?

The modelling included in the documentation to date is relatively comprehensive for this stage of the process. Inevitably the model makes a number of assumptions and a Clinical Review Panel would wish to see that the risks associated with these assumptions have been considered and will want to explore the robustness of mitigation of these risks. The modelling to date is focused on the specialist resources for stroke. A Clinical Review Panel will also be interested in exploring the impact of these proposals on other associated services including interventional radiology, diagnostics and care of the elderly.

From the data provided it can be shown that a single HASU alongside the centralisation of Stroke services should improve LOS and mortality rates. The following areas of the model however were specifically queried or identified as requiring more information:

Capacity and Demand

1. The existing bed base for stroke across the system is not apparent. It will be helpful to understand if the model increases or decreases the bed base for stroke across the system and if the bed base is decreasing whether alternative provision in the community is appropriate and adequate in order to satisfy the "bed test". If it is increasing then the Review Panel will wish to explore whether this achievable without impacting on other clinical pathways. (It may be worth liaising with Gloucestershire STP who remodelled their stroke services in recent years to understand how accurate their modelling was with real figures.)

2. How secure are the bed estimates and what might be the impact on the stroke pathway and other acute clinical pathways if the numbers prove to be too low?
3. What assumptions have been made about the conveyancing of strokes to a HASU at NBT from other STP populations if it is closer than an existing HASU.
4. Further clarity is required as to whether the proposed number of HASU beds would take into account projected increases in older patients and the projected increased number of strokes which would also result. Is the proposed number of 13 beds going to be sufficient and sustainable in the future?
5. The modelling for a Single HASU of 13 beds appears to be based on a thrombectomy service with its current provision of Monday-Friday, 8am-6pm - as the hours of service increase will the number of beds required increase?
6. As there is reference to providing thrombectomy services for a larger area than the BNSSG region, what sort of numbers would be expected for these patients, and is this built into the projected numbers for the HASU?
7. The demand for stroke services in each department over a 12 month period should be provided. There is a statement within the ASU Option Evaluation document that there is an assumption of repatriation post-HASU care at 72 hours to other ASUs. This is at odds with other proposals regarding minimising the number of ASUs across the region.
8. On P1 of the June 2019 options paper it states that 'the current provision of 17 sub-acute beds at South Bristol is essential for any of the models to be viable'. This statement is not evidenced within the models proposed.
9. The bed modelling is potentially a challenge for ASUs as any proposal for less than 15/16 beds from a nurse and therapy staffing perspective is often not viable.
10. Further detail information will be needed about how & when to repatriate patients, particularly if patients are stroke mimics.

Rehabilitation

1. Further detail regarding the sub-acute beds is needed, such as access to imaging for NG placement and the protocol for returning to an Acute (especially as this is likely to be another hospital rather than the HASU) if there is general deterioration or for routine PEG insertion.
2. There is currently no mention of medical cover in the rehabilitation environment - will there be stroke consultant weekly reviews? If so, these need to be factored into any job plan and workforce modelling.

3. The ESD levels given in the modelling appear low with no mention of those needing ESD following discharge from the subacute units. The impact of a fully established ESD may also alter the number of rehab beds needed - has this been accounted for?
4. There is an assumption that for the model to work there will be a 7/7 ESD service at all the sites. Currently however there is no service or a 5 day a week service. This needs to be modelled.

Workforce

1. Workforce modelling should be provided in the final PCBC, including modelling of how the system would cope with vacancies and modelling for support services e.g. radiology.
2. Any proposals for HASU and ASUs cannot be done in isolation of community rehab beds or ESD and Sirona's plans for the workforce provision for these and any recruitment challenges should be included.
3. The workforce modelling currently focuses only on medical, nursing, OT, PT and SLT. Other support roles need to be factored in to ensure services meet the national recommendations and these should be fully costed for all units. In many units there is a need for additional unregistered staff to support the rehabilitation of complex dependent patients; in the acute phase, many patients require 2 or more staff to assist them at the beginning of their rehab. There is no provision in the costs for additional support staff.
4. There is concern around the practicalities of the in-reach stroke therapy option given. The job descriptions for the therapy staff need to include giving advice to another trust. Is there an estimation of how much time this will require? Will the cardiothoracic therapists need training?
5. There is little information provided around the workforce strategy for nursing and the models for services across the region used to achieve zero vacancies could potentially be pursued (eg. Yeovil).
6. The fit with the proposed staffing numbers of 1 nurse to every 3 patients on an HASU is also unclear. Would this mean that there would be a minimum of 4 or 5 nurses and has this been costed for both models?
7. The paramedic stroke pathway will need to be developed. Paramedic telemedicine whereby a paramedic can discuss the patient with the stroke consultant on-call at NBT could be used and may help filter out stroke mimics. It was noted that the mimic rate of 25% given in the document could be arguably too low and may need reviewing - some research gives up to 40% and there is some work with East of England ambulance trust having body cameras to help stroke physicians assess remotely and reduce inappropriate transfers.
8. There is no proposal for dietetic support or access to dietitians included.

9. Spasticity management can be very difficult for this patient group and the specialists are often based in the complex neuro-rehab units. There is no clarity of the interface between this unit and stroke services.

Clinical Engagement

1. There is not currently any evidence that radiology or SWAST with regards to timely inter-hospital transfers, have been involved in developing the models. For some patients 3 transfers will be required which will have implications - is the proposal to use SWAST or another transport organisation and if so are they involved?
2. Details of involvement from Sirona managers, clinicians and therapists should be included in the final PCBC.

Other

1. There was a general request from panel members that whilst the content and quality was high, that the number of documents provided resulted in duplication and were quite hard to follow. One overarching PCBC for the panel will be expected.
2. There is no mention of TIA clinics and how these would be provided on each site, which is also key when considering the provision of stroke services across the region. This may mean different provision on different sites, but again, some modelling of the numbers of TIAs, and which days of the week they present on would be helpful to understand how this service can be provided going forwards. If this is going to be limited in some areas (eg 5 days a week for WAHT), is there going to be consideration of the Saturday / Sunday service to be offered at a different site? Will the BNSSG stroke service be considered as one whole service or will services remain discrete for each Trust?
3. To help support the national focus on stroke prevention, quick treatment, and supporting people, the [NHS RightCare stroke pathway](#), underpinned by NICE guidance, has been developed by NHS England, the Royal College of Physicians Intercollegiate Stroke Working Party, the Stroke Association and a range of other stakeholders. It would be good to have a more detailed insight as to their intended stroke pathway and for it to include assurance that its underpinned by NICE guidance and quality standards.
4. It would be useful to know if there has been expertise input from Quality Team persons (commissioners/providers) as their roles include ensuring that evidence based practice associated with service quality are applied (including NICE guidance).

Additional Comments

*The following NICE guidance and quality standard can further help inform the proposals:

Stroke and transient ischaemic attack in over 16s:	This guideline covers interventions in the acute stage of a stroke or transient ischaemic attack (TIA). It offers the best clinical advice on the diagnosis and acute management of stroke and TIA in the 48
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<p>diagnosis and initial management (NG128)</p>	<p>hours after onset of symptoms. It contains recommendations pertaining to:</p> <ul style="list-style-type: none"> • 1.1 Rapid recognition of symptoms and diagnosis • 1.2 Imaging for people who have had a suspected TIA or acute non-disabling stroke • 1.3 Specialist care for people with acute stroke • 1.4 Pharmacological treatments and thrombectomy for people with acute stroke • 1.5 Maintenance or restoration of homeostasis • 1.6 Nutrition and hydration • 1.7 Optimal positioning and early mobilisation for people with acute stroke • 1.8 Avoiding aspiration pneumonia • 1.9 Surgery for people with acute stroke
<p>Stroke rehabilitation in adults (CG162)</p>	<p>This guideline covers stroke rehabilitation for adults and young people aged 16 and over who have had a stroke with continuing impairment, activity limitation or participation restriction. It aims to improve rehabilitation for people who have had a stroke by specifying how stroke units and multidisciplinary stroke teams should be organised. It makes detailed recommendations on assessments and interventions for the functional difficulties caused by stroke. Key priorities for implementation:</p> <ul style="list-style-type: none"> • Stroke units • The core multidisciplinary stroke team • Health and social care interface • Transfer of care from hospital to community • Setting goals for rehabilitation • Intensity of stroke rehabilitation • Cognitive functioning • Emotional functioning • Swallowing • Return to work • Long-term health and social support
<p>Stroke in adults (QS2)</p>	<p>This quality standard covers diagnosing and managing stroke in adults (over 16). It includes diagnosis, initial management, acute-phase care, rehabilitation and long-term support for people with stroke. It describes high-quality care in priority areas for improvement. The quality standard is expected to contribute to improvements in the following outcomes:</p> <ul style="list-style-type: none"> • mortality rates of adults who have a stroke • long-term disability of adults who have a stroke • patient experience of stroke services • experience of carers looking after people who have had a stroke. <p>The quality statements are as follows:</p>

[Statement 1](#) Adults presenting at an accident and emergency (A&E) department with suspected stroke are admitted to a specialist acute stroke unit within 4 hours of arrival.

[Statement 2](#) Adults having stroke rehabilitation in hospital or in the community are offered at least 45 minutes of each relevant therapy for a minimum of 5 days a week.

[Statement 3](#) Adults who have had a stroke have access to a clinical psychologist with expertise in stroke rehabilitation who is part of the core multidisciplinary stroke rehabilitation team.

[Statement 4](#) Adults who have had a stroke are offered early supported discharge if the core multidisciplinary stroke team assess that it is suitable for them.

[Statement 5](#) Adults who have had a stroke are offered active management to return to work if they wish to do so.

[Statement 6](#) Adults who have had a stroke have their rehabilitation goals reviewed at regular intervals.

[Statement 7](#) Adults who have had a stroke have a structured health and social care review at 6 months and 1 year after the stroke, and then annually.

The quality standard for stroke specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole stroke care pathway. A person centred, integrated approach to providing services is fundamental to delivering high quality care to adults who have a stroke. The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high quality services.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE Pathway on [patient experience in adult NHS services](#)), which should be considered alongside QS2. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to people using services.

NICE has a wealth supporting tools and resources that can help support the use of guidance including:

Implementation support in relation to resource impact -

[Impact on NHS workforce and resources](#)

[Resource impact template](#)

[Resource impact report](#)

Shared learning - examples showing how NICE guidance and standards have been put into practice -

[East of England Stroke Telemedicine Stakeholder Partnership](#)

[Stroke care pathway from the emergency department to CT and the improvement of patient time from CT scan to thrombolysis](#)

[Developing and implementing a set of outcome measures incorporating NICE Standards across the whole stroke care pathway in Greater Manchester](#)

[The creation of a therapy scanning wall on the stroke unit for visual inattention: understanding its assessment and therapeutic use.](#)

[Therapy Stroke Groups: Improving patient activity on the stroke unit and efficiency of the workforce](#)

Measuring the use of NICE guidance -

The [NICE impact stroke report](#) focuses on how NICE's evidence-based guidance contributes to improvements in care for people who are at risk of or who have had a stroke.

Patient decision aids -

NICE has produced a [patient decision aid to help people with atrial fibrillation](#) reach a decision about whether to take an anticoagulant to reduce their risk of stroke, and which one to take if they decide to do so.

Next Steps

This desktop report is signed off by the desktop review panel and shared with BNSSG STP and the NHSEI assurance team to inform development of the final PCBC.

30th April has been set as the date for Clinical Review and a panel is being convened for this in.

BNSSG STP are expected to share their final PCBC with the Clinical Senate by 16th April in order that this can be shared with the review panel members in advance of the panel date.

Desktop Review Panel Members

Dr Sally Pearson – Chair, Clinical Senate

Dr David Halpin – Deputy Chair, Clinical Senate (Chest Physician)

Dr Sara Evans – Care of the Elderly Consultant

Caroline Smith - Consultant Nurse for Stroke

Rosamund Wade – Acute Therapies Lead

Dr Annie Chakrabati – Stroke Consultant

Jane Jacobi – NICE field team