CONSULTATION THEMES

IMPROVING STROKE SERVICES IN BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE

KEY MESSAGES

Between 7 June and 3 September 2021 NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) consulted about proposed changes to stroke services on behalf of the health and care organisations in the Healthier Together Integrated Care System.

The CCG received 1,833 responses representing about 2,202 individuals and 4 organisations. These were:

- 1,126 door-to-door interviews with people that represented the age, gender and working profile of the area
- 657 consultation feedback forms from 658 people
- notes from 32 online and in-person meetings with 403 people
- 18 letters, emails and telephone calls from 19 people

People could take part more than once.

About half of the responses that specified a location were from Bristol (46%). 2 in 10 were from North Somerset (23%) and 3 in 10 from South Gloucestershire (30%).

An independent organisation compiled themes from the feedback.

EMERGENCY CARE IN HOSPITAL

The CCG proposes that everyone with a suspected stroke in Bristol, North Somerset and South Gloucestershire should be taken to a single centre of excellence (known as a Hyper-acute Stroke Unit or HASU). The CCG says that people have better outcomes if they receive emergency care at a centre of excellence with the most specialist staff and equipment. This centre would be located at Southmead Hospital in North Bristol.

- **9 out of 10 responses stated that they understood** why the NHS thinks that stroke services need to change (94% of responses that commented about this).
- 6 out of 10 said that if they had a stroke, they would rather be **cared for at a hospital with the most specialist staff and equipment** than a hospital close to home or near to family (69% vs 27%).
- **Half of responses fully supported having 1 centre of excellence (Hyper-acute Stroke Unit) at Southmead Hospital** serving all of Bristol, North Somerset and South Gloucestershire (50% of responses that commented fully supported this and 15% partly supported this).
- The organisations that run the hospitals offering emergency stroke care in Bristol, North Somerset and South Gloucestershire all supported this proposal.

The main reasons that responses gave for supporting a single centre of excellence at Southmead Hospital were:

- thinking people would be able to receive the **best care** if specialist staff and equipment were all in one place (15% of 1,538 responses that gave a reason for their views about this)
- thinking that Southmead Hospital is in an **accessible** location, with good parking (11%)
- thinking that Southmead Hospital **already provides** high quality care 24 hours a day, so has all the staff and facilities needed (8%)

The main areas of concern, whether or not responses supported the proposal, were:

- worry that a single unit may not have enough **capacity** to cope with the needs of such a large area (14% questioned capacity, 37% said more than one unit was needed for the large area)
- concern that it may take too long to **travel** to Southmead Hospital from some parts of the area, especially as people said that emergency stroke care needed to begin quickly in order to get the best outcomes for patients (19%)

ONGOING SPECIALIST CARE IN HOSPITAL

After their emergency care, people who have a stroke usually receive ongoing care in hospital. The CCG said that this should be in a specialist stroke ward with staff who are experts in stroke care, not on a general hospital ward. The CCG proposed having 1 specialist stroke ward ('Acute Stroke Unit' or ASU) at Southmead Hospital to serve the whole population of Bristol, North Somerset and South Gloucestershire.

Half of responses supported having 1 specialist stroke ward at Southmead Hospital (50%). Half supported having 2 specialist stroke wards, with the second at Bristol Royal Infirmary (50%).

The main reasons that responses favoured having 1 stroke ward were:

- perception that this would lead to **fewer transfers** and less time in hospital (26% of 1,475 responses that gave a reason for their views)
- thinking that Southmead Hospital is **easy to get to** and park at (14%)

The main reasons that responses favoured 2 stroke wards were:

- believing that 1 stroke ward may not have enough **capacity** to provide services for the large and growing population (28% of 1,475 responses that gave a reason for their views about this proposal)
- thinking that this would give more equal **access** for those in South Bristol and North Somerset (20%)
- thinking that a second unit would spread services out so at least one unit would be closer and more accessible for **visitors** (13%)

SHORT STAY REHABILITATION

The CCG stated that some people who have a stroke are not ready to go home after their hospital-level care ends. They may stay in live-in rehabilitation units for a short time. The CCG proposed to have 2 short stay rehabilitation units ('Stroke Subacute Rehabilitation Units' or SSARU) serving the whole area: one at Weston General Hospital in North Somerset and the other in Bristol or South Gloucestershire.

- 3 out of 10 responses fully supported having 2 short stay rehabilitation units (34% of responses that commented about this)
- **6 out of 10 responses fully supported having 3 or more short stay rehabilitation units (65%)**
- Regardless of how many short stay rehab units there were, 6 out of 10 fully supported having one at Weston General Hospital (58%)

The main reason that responses said they supported having 2 short stay stroke rehabilitation units was that they believed this was a compromise between locating specialist rehabilitation staff together whilst also providing some geographic spread (15% that gave a reason).

The main reasons that responses supported having more than 2 short stay stroke rehabilitation units were:

- thinking that two units would not have enough **capacity** for the large and geographically spread out area (64% that gave a reason)
- concern that it would be difficult for people to **visit** if there were only 2 units, including poor public transport links when visiting (27%)

The CCG invited people and organisations to suggest the location they most preferred for a short stay rehabilitation unit, in addition to Weston General Hospital:

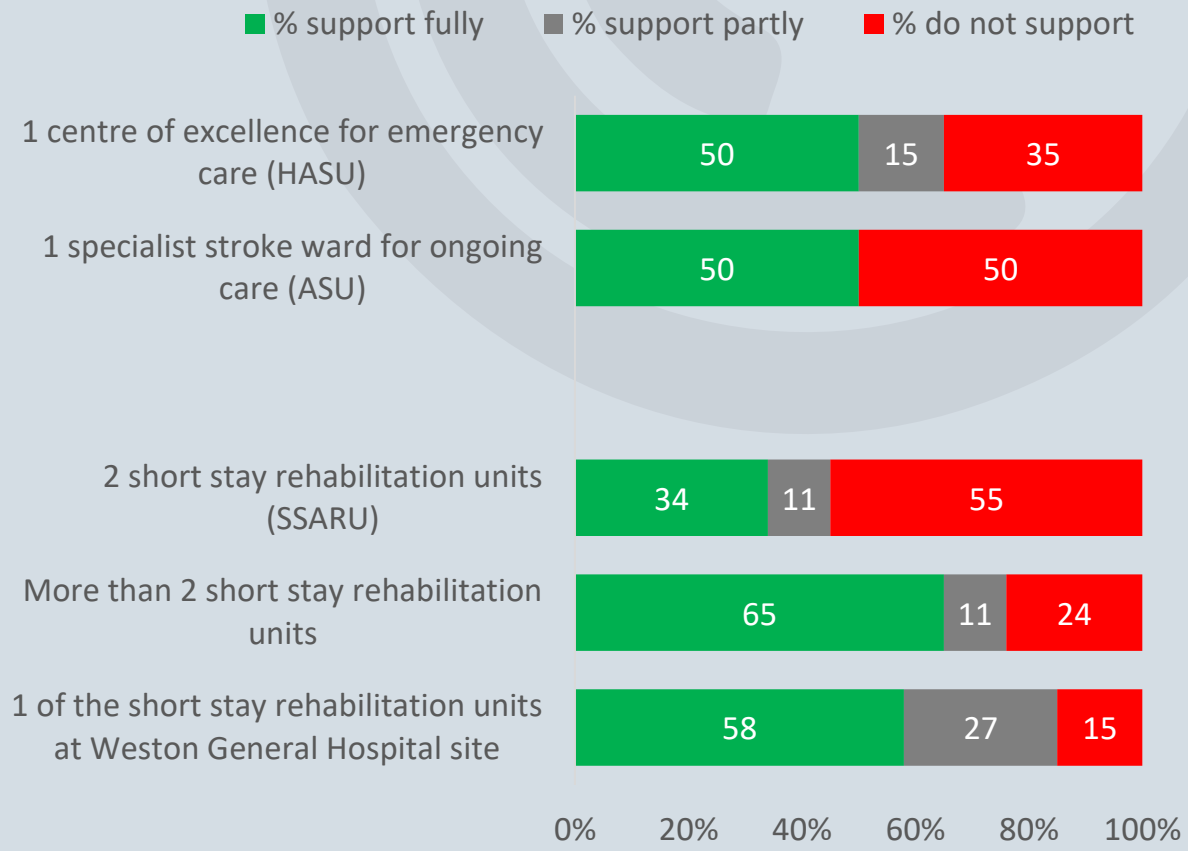
- half chose the Elgar Unit at Southmead Hospital (48% of those that commented about this)
- 1 in 4 chose Frenchay Hospital (25%)
- 1 in 5 chose South Bristol Community Hospital (18%)

The top things that responses wanted the CCG to take into account when deciding on a location for short stay rehabilitation units were:

- **travel time** and cost for families (44% of those that commented about this)
- accessibility by **public transport** (26%)
- sufficient **parking** and free parking (21%)
- **spread** of units across the area (18%)
- **facilities** available at the unit, such as a gym, kitchen, garden and being close to a pool (17%)

The CCG stated that its Governing Body will consider consultation feedback alongside other evidence when it decides on next steps for stroke services. Themes from the consultation feedback will be included in a business case with other information, including data that considers and responds to issues raised during the consultation.

Extent to which consultation responses supported CCG proposals



Note: 1,732 responses provided a view about having a single centre of excellence for emergency hospital care, 1,745 about specialist stroke wards, 1,593 about short stay rehabilitation units and 1.643 about having a short stay rehabilitation unit at Weston General Hospital. A 'response' does not necessarily equal one person. Feedback from an organisation or group was counted as a single response to calculate percentages, as were notes from meetings.

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CONSULTATION PARTICIPANTS

In mid-2021 NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) consulted about proposed changes to help people survive and thrive after stroke. The CCG consulted about three elements of stroke services:

- emergency care in hospital for the first few days after a stroke
- ongoing hospital care in a specialist stroke ward
- short stay rehabilitation for people who are not ready to go home after their hospital-level care ends

The proposals were developed by the Bristol, North Somerset and South Gloucestershire Stroke Programme working with people who had experienced a stroke, their family members, clinicians and voluntary and community groups.

This report summarises themes in the feedback received during the consultation period, which ran between 7 June and 3 September 2021. An independent team compiled the themes.

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WHO TOOK PART?

The CCG received 1,833 responses during the consultation period, representing about 2,202 individuals and 4 organisations. We say 'about 2,202 individuals' because people who provided feedback more than once are counted more than once, such as those who attended a meeting and completed a feedback form.

The appendix to this report describes the methods that the CCG used to promote the consultation and gather feedback. It also describes how this summary of themes was compiled and important things to bear in mind when interpreting the feedback.

Table 1 shows the types of responses received. Nine out of 10 responses were from the public (88%) and the rest from health and care professionals or healthcare organisations.

Table 1: Types of responses

Type of response	Number (%)	People represented
Door-to-door interviews	1,126 (61%)	1,126
Online and posted feedback forms	657 (36%) of which 11 were posted	658
Notes from meetings	32 (2%)	403
Letters, emails and calls	18 (1%)	19
Total	1,833	2,202 individuals and 4 organisations

The CCG and partners kept notes of feedback at 32 meetings:

- 9 meetings with staff
- 7 meetings with stroke support groups or organisations
- 5 public meetings
- 2 targeted meetings with seldom heard groups
- 1 meeting with carers
- 8 other meetings, including visits to stroke services and attending existing meetings with patient and public involvement groups

Each set of meeting notes is counted as one 'response' to the consultation. So throughout this report a response could equate to one person, to a meeting with many people or to a whole organisation.

Additional meetings were held to raise awareness about the consultation, but these were not counted as 'responses' because no record was kept of views shared at those meetings.

CHARACTERISTICS OF RESPONSES

Most responses came from people responding as individuals (1,774 responses). Four responses were from organisations:[1]

- North Bristol NHS Trust
- Sirona Care & Health
- Somerset Clinical Commissioning Group
- University Hospitals Bristol and Weston NHS Foundation Trust

People responding as individuals were asked some background details about themselves when they completed a consultation feedback form or door-to-door interview. This information was usually not available when people responded by letter, email or telephone.

More than 300 responses, or 1 in 6, came from someone who had experienced a stroke (7%, 117 people) or a close family member or carer of someone who had experienced a stroke (10%, 170 people). In addition, the CCG facilitated specific meetings for these groups.

1. The CCG also received feedback forms from the following groups stating that they were responding on behalf of a whole organisation or group: Bristol, North Somerset and South Gloucestershire Local Maternity System; Maternal Medicine Team; North Bristol NHS Trust; St Michael's Hospital; Western Active Stroke Group. The CCG considered that these forms may be from individual members of the group, rather than official organisational responses. They instructed the independent analysts to treat these as individual responses. Notes from meetings were not treated as being an official organisational response. The appendix contains the names of groups that the CCG met with.

About 1 in 5 individual responses were from health and care workers (19%, 337 people). The CCG and partners also facilitated specific meetings with healthcare workers.

Figure 1 shows the geographic location of responses. The CCG reported that the spread of responses broadly matched the proportions of people in the population in each area. Responses received directly by the CCG matched the spread of the population just as well as those collected in door-to-to door interviews. The appendix contains further details about how the interviews were conducted and compares the characteristics of people taking part in interviews versus those who responded directly to the CCG.

Of the 1,687 responses that provided information about their gender, 46% were from men, 54% from women and fewer than 1% from people who defined themselves in another way. The CCG noted that this is representative of the population of the area.

Of the 1,676 responses that provided information about their ethnic group, 4% were from people who identified as Asian or Asian British, 4% Black or Black British, 1% Gypsy or Traveller, 90% White and 1% other ethnic groups. The CCG stated that this is in line with the ethnic groups living in the area.

There was a good spread of age groups (see Figure 2). The CCG reported that the responses received directly by the CCG and the door-to-door interviews were similar to the age distribution of the population. Slightly fewer younger people responded to the CCG directly.

Figure 1: Geographic location of responses

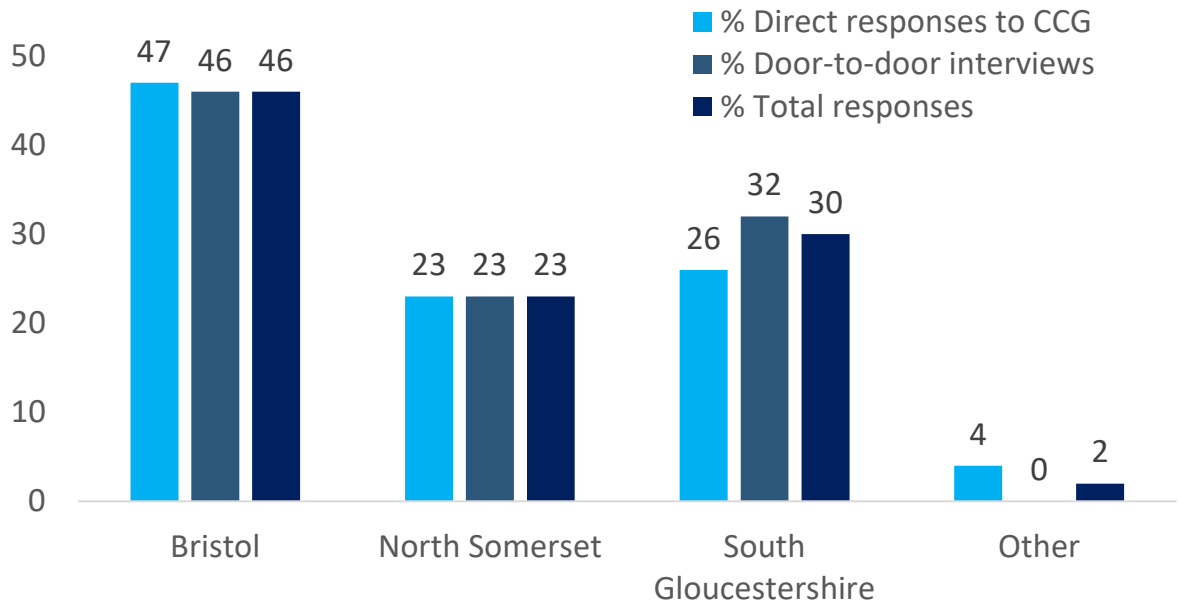
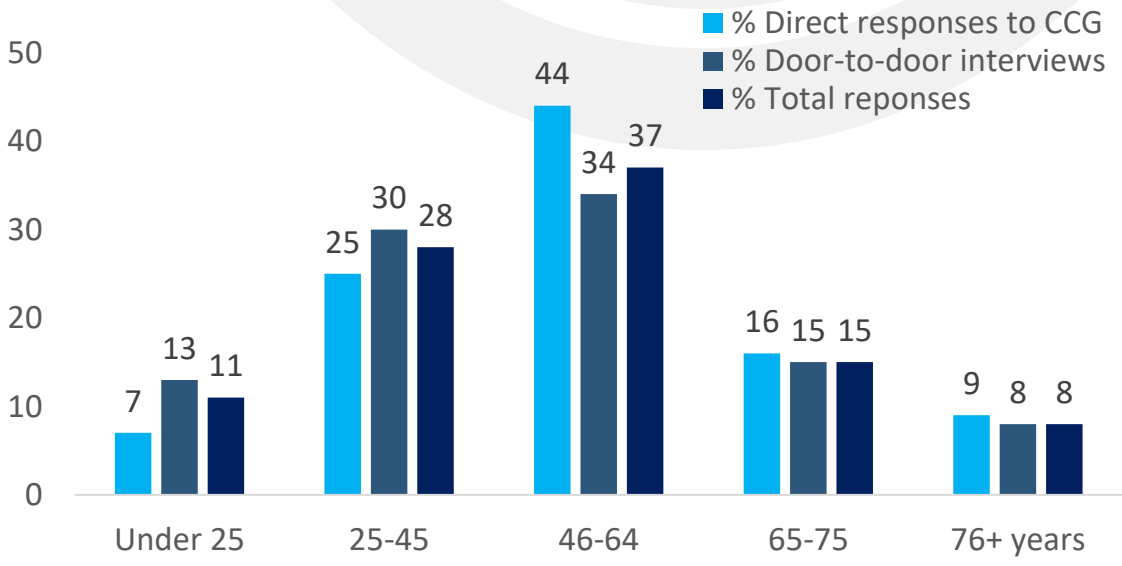


Figure 2: Age groups of individual responses



Note: Based on 1,707 responses that provided a geographic location: 581 were direct responses to the CCG and 1,126 were door-to-door interviews. Some organisational responses and meetings represented people from throughout Bristol, North Somerset and South Gloucestershire and are not included in this figure (<1%).

Note: Based on responses from 1,675 individuals: 549 direct responses to the CCG and 1,126 door-to-door interviews. The door-to-door interviews used a quota approach to ensure that responses represented the age groups in the area.

REASONS FOR CHANGE

The CCG set out reasons why it believes that stroke services need to change.

9 out of 10 responses said that they partly or fully understood why the NHS thinks stroke services need to change:

- 75% of 1,808 responses that commented about this said that they fully understood why the NHS thinks stroke services need to change
- 19% partly understood
- 6% said they did not understand

This does not mean that responses agreed with the proposed changes, but that they understood the reasoning set out by the CCG.

No area, age, gender or ethnic group was more likely than others to say that they did not understand the reasons for change put forward by the NHS. People who took part in a door-to-door interview were just as likely to say they understood as those who provided feedback direct to the CCG.

EMERGENCY CARE IN HOSPITAL

PRIORITIES FOR EMERGENCY CARE

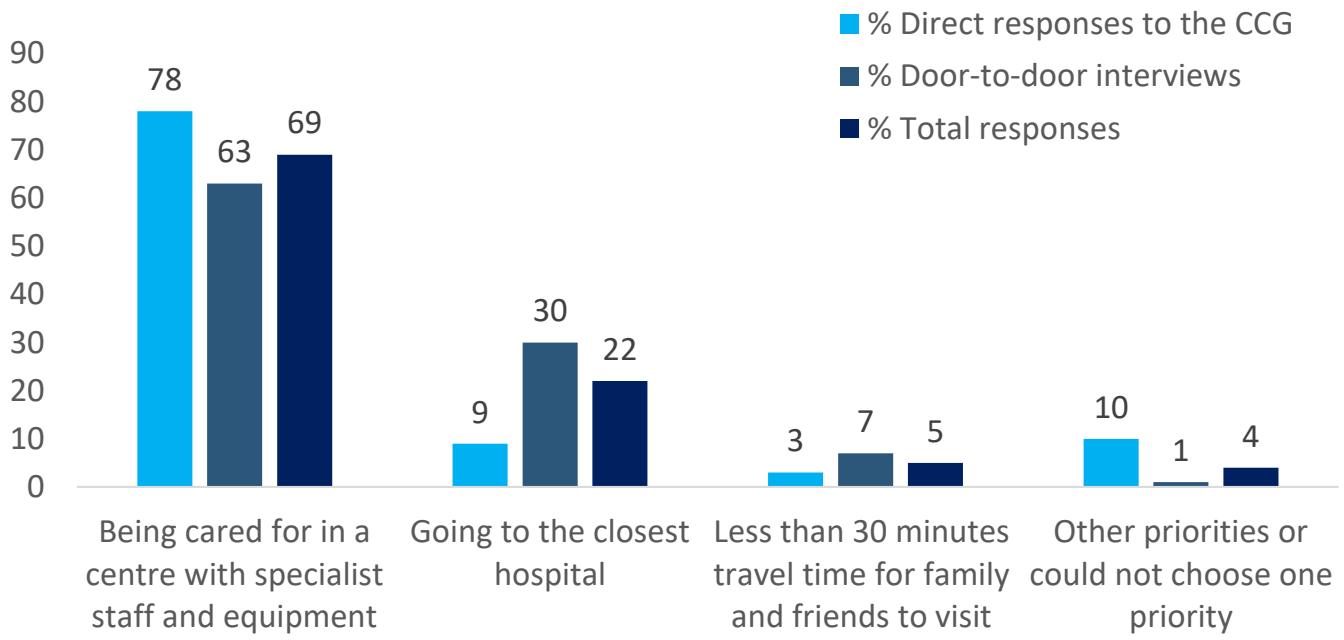
Most people who have a stroke go to hospital to be assessed and start treatment. The CCG wanted to understand whether it was a higher priority for people to receive treatment at the closest hospital or whether it was more important to receive care from the most specialist staff and equipment.

The CCG invited people and organisations to select their top priority from a list.

- 7 out of 10 responses that commented about this said that their **highest priority was to be cared for at a hospital with specialist staff and equipment** (69%)
- 3 out of 10 responses said their top priority was to be at the closest hospital (22%) or somewhere that visitors could travel within 30 minutes (5%)

Individual responses prioritised having the most specialist staff and equipment over a close location no matter where they lived, or their age. People from minority ethnic groups also prioritised the most specialist staff and equipment, but a significant proportion prioritised care close to home. Exact numbers are listed in the appendix.

Figure 3: Extent to which responses prioritised being close to home vs specialist care



Note: Responses were asked 'Which ONE of these things would be most important for your first few days of hospital care if you had a stroke?' 1,750 responses considered this: 635 direct responses to the CCG and 1,115 door-to-door interviews. Direct responses more likely to prioritise the most specialist staff and equipment than door-to-door interviews (78% vs 63%)

Area	No difference in trends between areas
Age	No difference in trends between age groups
Ethnicity	White people were more likely to prioritise having the most specialist staff and equipment compared to minority ethnic groups (70% vs 60%)
Gender	Women were more likely to prioritise having more specialist staff and equipment (68% vs 59% men)
People who had experienced a stroke	No difference from total responses
Carer of someone who had a stroke	No difference from total responses

CENTRE OF EXCELLENCE FOR EMERGENCY STROKE CARE (HASU)

People suspected of having a stroke in Bristol, North Somerset and South Gloucestershire are currently taken to the closest hospital with an emergency department for assessment and then admitted or transferred to a more specialist team if needed. The CCG proposed the following change:

- Everyone who has a stroke or a suspected stroke would be taken directly to one stroke centre of excellence at Southmead Hospital. This 'Hyper-acute Stroke Unit' (HASU) would have the best equipment and specialist staff and be open 24 hours a day, 7 days a week.
- People living in Sedgemoor district (Northern Somerset) would be taken to their nearest Hyper-acute Stroke Unit at Musgrove Park Hospital.

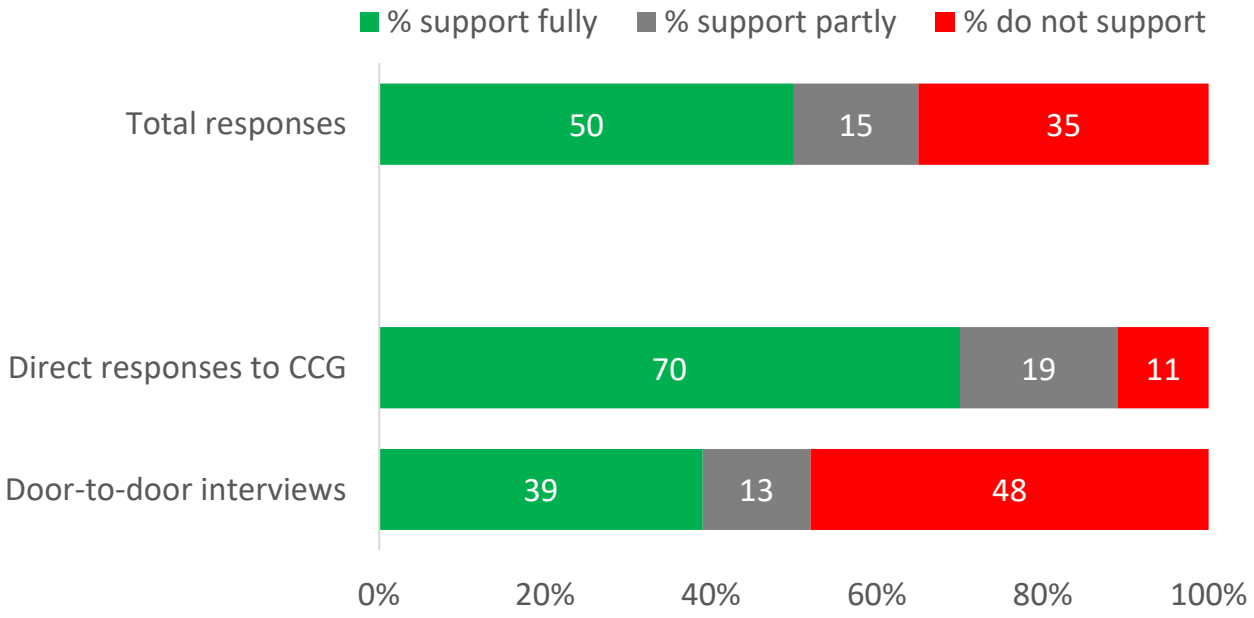
1,732 responses stated whether they supported this proposal (see Figure 4).

Overall half of responses fully supported the CCG's proposal, but there was a significant difference in direct responses to the consultation and door-to-door interviews.

7 out of 10 direct responses to the CCG fully supported having one centre of excellence at Southmead Hospital compared to 4 in 10 door-to-door interviews. Part of this difference may be because the door-to-door interviews asked slightly different questions. The appendix explains the wording used and how feedback was combined. The difference in feedback may also be because people taking part in door-to-door interviews did not have background information about the reasons that the NHS thinks that one centre of excellence would be beneficial. The immediate reaction may be 'more is better', whereas people who took part in consultation meetings or read or watched materials may have had more information to inform their views.

Individual responses had similar views about this proposal regardless of their area, age or ethnicity. People in North Somerset were just as likely to support having a single centre of excellence at Southmead Hospital as people in Bristol and South Gloucestershire. People who had experienced a stroke and health and care professionals were more supportive than other responses. The appendix contains more breakdowns.

Figure 4: Support for single centre of excellence at Southmead Hospital



Note: 1,732 responses provided a view about a single centre of excellence (Hyper-acute Stroke Unit) for emergency stroke care at Southmead Hospital: 626 direct responses and 1,106 door-to-door interviews. At meetings and in the consultation feedback form, people and organisations were asked the extent to which they supported having one Hyper-acute Stroke Unit at Southmead Hospital serving the whole area. The door-to-door interviews asked people whether they preferred a single unit at Southmead or somewhere else. The appendix describes how the different question wording was combined.

Area	No difference between areas
Age	No difference between age groups
Ethnicity	No difference between ethnic groups
Gender	Women were more likely to support a single centre of excellence than men (68% vs 59% men)
People who had experienced a stroke	People who had experienced a stroke were more likely to support a single centre of excellence compared to other responses (85% vs 65% total responses fully or partly supporting)
Carer of someone who had a stroke	No difference from total responses
Health and care professionals	Health and care professionals were more likely to support this proposal compared to total responses (60% fully supported and 17% partly supported)

The two organisations that run the hospitals providing emergency stroke care in Bristol, North Somerset and South Gloucestershire both stated that they supported the proposal to have one centre of excellence at Southmead Hospital serving the whole region.

> **"The proposed changes are evidence-based, and we know that where similar changes have been implemented in other health systems, they make a huge difference for the outcomes of people who suffer a stroke. We are proud that we already offer highly specialised stroke services to many patients each year, including through our stroke thrombectomy service. However, not all BNSSG[2] patients can access these services due to capacity constraints and variations in service provision across our health system. The proposed changes will ensure that we are able to offer all our patients across BNSSG the very best stroke services, 24 hours / 7 days per week."** (Letter from North Bristol NHS Hospitals Trust)

> **"There is strong evidence that immediate transfer of patients to a specialist Hyper-Acute Stroke Unit staffed by highly specialist teams improves patient outcomes. Consolidating our expertise into one HASU will help us to achieve this and the recommendation is supported."** (Letter from University Hospitals Bristol and Weston NHS Foundation Trust)

2. Responses quoted in this report sometimes used the abbreviation BNSSG to refer to Bristol, North Somerset and South Gloucestershire.

The neighbouring Somerset Clinical Commissioning Group said they were eager to work with the CCG to support next steps. They were concerned that ambulances may take more people from North Somerset to a hospital in Somerset, rather than to Southmead Hospital.

> **"We have some concerns that the ambulance service would take more patients to Musgrove Park Hospital than Southmead than the modelling suggests as the crews won't want to be caught up in the traffic in the city… Given that patients from the Sedgemoor area (and possibly from North Somerset) will likely receive their hyperacute stroke care at Musgrove Park Hospital, can assurance be given that patients will be able to transfer in a timely way to Sub Acute Rehab Unit at Weston General Hospital to be closer to home and their relatives? Currently, there are constant challenges with repatriating patients to Weston Hospital so what will be different with this arrangement?... The HASU capacity at Musgrove Park Hospital is four beds and therefore any delay will have an impact on ability to provide care to other patients."** (Letter from Somerset Clinical Commissioning Group)

Only 5 people from the Sedgemoor area responded directly to the consultation so there is not enough feedback to get a sense of what people from this area thought.[3]

3. The CCG reported that people in Sedgemoor currently use stroke services in Bristol, North Somerset and South Gloucestershire, but Sedgemoor is in the Somerset local authority area so was not included in from interviews. Sedgemoor District Council, the Sedgemoor equalities group and Morland community hub reportedly promoted the consultation to Sedgemoor residents.

REASONS FOR SUPPORTING A SINGLE CENTRE OF EXCELLENCE

1,538 responses made 2,276 comments about the reasons why they did or did not support the CCG's proposal for a single centre of excellence for emergency hospital stroke care. Responses could provide more than one reason for their view, so percentages add to more than 100%. The main reasons for supporting this proposal were:

- thinking that a single centre would provide the **best care** because it was perceived that specialist staff and equipment would be available in one place and other advanced hospital services would be on the same site if needed (15% of 1,538 responses that gave a reason)
- perception that Southmead Hospital is **accessible**, including being in a central location with motorway access and sufficient parking (11%)
- feeling that Southmead Hospital **already provides** high quality care 24 hours a day (8%)
- thinking that this would result in **better outcomes** for patients including increased survival, less disability, shorter stays in hospital and more continuity of care (7%)
- thinking that it is better to have one centre of excellence than none at all (6%)
- believing this is a better use of **resources** and would be less costly if funds are all directed into one centre (5%)
- thinking this would **avoid delays**, provide more timely and streamlined care, involve fewer transfers and make sure care is available 7 days a week (5%)
- concern that there would not be enough **workforce** to spread across more than one centre. Some also thought that this proposal would allow staff to develop and maintain their specialist skills because would be seeing the right range of people. They thought this may in turn attract and retain staff and build teamwork (3%)
- perceived **parity** and fairness of access to good care across all of Bristol, North Somerset and South Gloucestershire (2%)

"The hours following a stroke, along with the quality of care provided, are crucial to the outcome so it makes sense to centralise expertise. Accessibility of location is the main factor for location and access to Southmead is better than to Bristol Royal Infirmary." (Feedback form provided by Asian man aged 76+ in South Gloucestershire)

"Southmead is modern and caters for everything. Going to Southmead allows everything to be done under 1 roof. Staff at the individual hospitals such as Weston currently get frustrated because they aren't necessarily seeing the type of acute stroke patients they are trained to care for. Centralised care and therapies would be better for staff and patients. Care can be concentrated on the stroke patients and will allow access to all the equipment needed. Generally the group wouldn't mind travelling further if it meant better care and outcomes." (Notes from meeting with North Somerset Casual Stroke Survivors Group)

"After my father suffered a stroke on a Saturday morning, being told that treatment was unavailable due to being out of hours was the most devastating news… Dad had a stent fitted into his brain, just in time. 1 hour longer he would have died. Today you wouldn't know he had ever suffered a stroke. No family should have to go through what I did just because it's the weekend. Surely everyone should be entitled to treatment every day of the week no matter what time of the day/night." (Feedback form provided by 25-40 year old woman in South Gloucestershire who cares for someone who had a stroke)

REASONS FOR NOT SUPPORTING A SINGLE CENTRE OF EXCELLENCE

Concerns about the proposal, whether people supported it or not, were:

- concerns about **capacity**: responses worried that a single centre of excellence may not be able to cope with the number of people having strokes or said that they needed more information to be confident that there was enough capacity. They believed that more than one unit was needed for the large area, with a growing elderly population. They said that the CCG's modelling was too optimistic and that it did not account for delays getting people into the community or staff shortages (51% of 1,538 responses that gave a reason for their view said this. 14% of these primarily spoke about capacity of a single centre. 37% primarily spoke about needing more than one unit for a large or widespread area. Many said both things)
- taking **longer to get to emergency care**, which responses thought may lead to greater rates of death or disability. Responses emphasised the need to act 'FAST' with stroke to get the best outcome. They did not believe the CCG's claim that everyone would be able to be transported to a single centre of excellence within 45-60 minutes and they thought this would lead to poorer clinical outcomes. They felt that more hospitals should offer emergency stroke care because they thought this would let more people get treatment quickly. Some said that the CCG had not accounted for the time it takes an ambulance to get to a patient and unload at the hospital. They were also concerned about ambulance capacity (19%)
- concerns about accessibility for **families** and visitors. Responses said Southmead Hospital would be further for visitors from North Somerset and South Bristol to travel. They aid that there are not good public transport links and that visitors may be elderly and not drive (10%)
- not wanting to lose **existing facilities** and specialist staff at Bristol Royal Infirmary. There was concern that this would leave cardiac and maternity patients without access to specialist stroke care and may deskill staff in other hospitals (3%)
- feeling that there would be better **continuity of care** and better quality of care if there was more than one unit or it was located somewhere else (2%)

"With the increasing traffic and congestion it's a bit of a concern that if we only have one unit journey times could potentially be an hour or more. As stroke is time critical I would worry that some patients far away from Southmead may struggle to get there in time for treatment." (Door-to-door interview with White 65-75 year old man in South Gloucestershire)

"If my husband had another stroke and was taken to Southmead, I could not visit him as I don't drive. Better transport is needed before any more services are centralised in Bristol. I'm petrified of getting poorly or having to have tests as I can't get to Bristol hospitals." (Feedback form from 41-64 year old White woman in North Somerset who cares for someone who had a stroke)

"I think we can and should have 2 hyperacute stroke areas. It would lose far too many skilled staff across the two sites, not everyone will be able to, or want to move areas to work in this specialist field. Looking at amalgamation of one service is very short sighted. Nursing staffing and its workforce is in crisis. To lessen one amazing specialist area is extremely unfair. We need to retain nurses in an area they chose, are good at and can logistically get to on a daily basis." (Feedback form provided by White female healthcare worker aged 41-64 in North Somerset)

ONGOING HOSPITAL CARE

After the first few days of emergency treatment, people may stay in hospital for ongoing stroke care. In Bristol, North Somerset and South Gloucestershire, people usually stay at the hospital they are admitted to. They may be cared for on a specialist ward devoted to stroke care or on a general hospital ward with other patients.

The CCG proposed caring for everyone who has a stroke on a specialist stroke ward (called an 'Acute Stroke Unit' or ASU).

- The CCG proposed having 1 specialist stroke ward at Southmead Hospital serving everyone in Bristol, North Somerset and South Gloucestershire.
- The CCG also wanted to know what people thought of having 2 specialist stroke wards, one at Southmead Hospital and one at Bristol Royal Infirmary. With this approach, everyone would be admitted to Southmead Hospital for their emergency care for the first few days. Some would then be transferred to Bristol Royal Infirmary for ongoing care.

1,745 consultation responses stated whether they supported this proposal. **Half supported having one specialist stroke ward (50%) and half supported having two specialist stroke wards (50%).**

People had similar views about the proposal regardless of their age, gender, ethnicity, whether they had experienced a stroke and whether they provided feedback direct to the CCG or through a door-to-door interview. People from Bristol and North Somerset were slightly more likely to support 2 wards, as were carers of people who had experienced a stroke (see appendix).

There is currently a specialist stroke ward at Bristol Royal Infirmary. This would close under the CCG's preferred proposal. University Hospitals Bristol and Weston NHS Foundation Trust, which runs this hospital, stated that it **supported** the CCG's preferred proposal. It also highlighted a risk that the University Hospitals Bristol and Weston workforce may lose the clinical skills to manage stroke patients who are not able to be transferred to Southmead Hospital and patients on non-stroke pathways (e.g. acquired brain injury).

> **"As a cautionary note, given the scale of workforce changes we already face across the system, we will collectively need to ensure focus on the recruitment and retention of staff across the whole stroke pathway."** (Letter from University Hospitals Bristol and Weston NHS Foundation Trust)

North Bristol NHS Hospitals Trust, which runs Southmead Hospital, did not express a preference related to this proposal.

The neighbouring Somerset Clinical Commissioning Group stated that it was keen to work with the CCG to consider next steps. It raised questions about how transfers would be handled for people from Sedgemoor, who it is proposed would receive their immediate emergency care in Somerset.

> **"If a Somerset patient was taken to a HASU at Southmead would they continue their care in the ASU at Southmead or need to be transferred back into Somerset? If a Somerset patient is taken to the HASU at Southmead, what provision will be made for patients living in Somerset? It has to be appreciated that Southmead Hospital is 40 miles from some areas of Sedgemoor, resulting in an 80 mile round trip, with little public transport provision for visiting relatives."** (Letter from Somerset Clinical Commissioning Group)

Responses from South Gloucestershire were slightly more likely to support having 1 specialist stroke ward at Southmead Hospital and responses from North Somerset were slightly more likely to support having another specialist stroke ward at Bristol Royal Infirmary. However, in all geographic areas, preferences were almost equally split between having 1 or 2 specialist stroke wards.

REASONS FOR SUPPORTING 1 STROKE WARD

1,475 responses made 1,988 comments about why they supported having 1 or 2 specialist stroke wards. Responses could provide more than one reason for their view.

The main reasons for supporting a single specialist stroke ward were:

- perceived smoother **patient journey** including the potential for fewer transfers, more continuity when people are unwell, fewer delays, less time in hospital and less burden on the ambulance service (26% of 1,475 responses that gave a reason said this)
- responses thought the **location** of Southmead Hospital was accessible, with parking space that is not available elsewhere (14%)
- thinking that **better care** may be available if all resources are in 1 ward, rather than diluting into 2 wards (5%)
- perceived better use of **resources** and less cost (4%)
- perception that Southmead Hospital **already** provides a good service (3%)
- believing that 1 ward would consolidate **staff skills**, as it was thought that staffing was too stretched to cover 2 wards (2%)
- perceived better **patient outcomes** and possibility of equitable treatment for all, no matter where people live (2%)
- suggestion that the area may not not need a second unit so **close** (3 miles apart) (1%)

"Keeping services on one site means patients can go back to the emergency bit if needed and also good to have less ambulance transfers for patients." (Feedback form provided by White 25-40 year old man in Bristol)

"All in one place was preferred for the hyperacute and acute phases of stroke care. Everyone agreed that patients should not be transferred during this time." (Notes from online public meeting)

"Keeping patients in one place would be better as patients can be quite frightened and disruptive. Public transport is not great in terms of getting to Bristol Royal Infirmary. There are better services available to Southmead." (Notes from meeting with Virtual Carers Group)

"A single ASU reduces the number of patient transfers and team handovers for the patients which would result in poorer patient experience for the majority of patients and delays. It also consolidates the specialist stroke capacity, enabling a more resilient service. However, it is essential that all parts of the proposed pathway changes are fully implemented to ensure that patients do not spend more time in acute setting than is necessary." (Feedback form from a healthcare professional in Bristol)

There was positive feedback about having one ASU at Southmead, with comments that it would reduce costs and … people would receive the best treatment. There were comments about the financial implications in having two ASU sites, with questions about the level of care if there were to be two sites… They would be concerned that the same services would not be offered at both sites." (Notes from Bristol After Stroke meeting)

REASONS FOR SUPPORTING 2 STROKE WARDS

Reasons that people gave for supporting 2 specialist stroke wards were:

- **capacity**: responses thought that 1 ward may not be able to provide services for an area as large as Bristol, North Somerset and South Gloucestershire (28% of 1,475 responses that gave a reason)
- responses thought there would be more **equal access** for those in North Somerset and southern parts of Bristol. They also said more older people live in North Somerset (20%)
- perception that having an extra ward would mean that it would be easier and more accessible for **families** visiting. Responses stated that visitors were essential for providing support and that Southmead Hospital was difficult to get to by public transport (13%)
- perception that 2 wards would better support other **service pathways**, including for people who have a stroke while at Bristol Royal Infirmary and heart patients who cannot transfer. Responses said that there was already a good stroke ward at Bristol Royal Infirmary that should not be closed (7%)
- perceived improved **patient outcomes** such as more choice about where to receiving ongoing care, perceived better clinical outcomes and more personalised and individualised care (5%)
- perceived increased flexibility and **resilience** of the service since 1 stroke ward may not be able to cope with contingencies (3%)
- perceived negative **impacts on staff** if closing a stroke ward at Bristol Royal Infirmary, such as possibly deskilling staff and reducing training opportunities, which may reduce staff retention (1%)

"Support for having 2 as it's a big area to cover and distance to travel. Bristol Royal Infirmary is hard to get to and no parking though so hard for families to visit. Wanted assurance that the second unit would be the same standard as the one at Southmead." (Notes from meeting with Thornbury and District Stroke Support Group)

"Bristol Hospital is a very well located hospital to offer the specialist treatment." (Door-to-door interview with Asian female aged 41-64 years in South Gloucestershire who had experienced a stroke)

"I'm afraid might get overwhelmed if there are a lot of cases so better to have 2. More choice for patients." (Door-to-door interview with Black male health and care worker aged 25-40 in Bristol)

"Having a cardiac hospital at Bristol Royal Infirmary needs stroke services on site, not moving cardiac patients away from specialist cardiac care because they have had a stroke. Also not fair on relatives to visit from Bristol or North Somerset to Southmead - family contact has a massive positive impact on recovery." (Feedback form provided by 25-40 year old ethnic minority female healthcare worker in South Gloucestershire)

"Issues with overcrowding so 2 sites is good to maintain flow but perhaps better at a site further away from Southmead." (Feedback form provided by 25-40 year old White man, area unknown**)**

SHORT STAY REHABILITATION

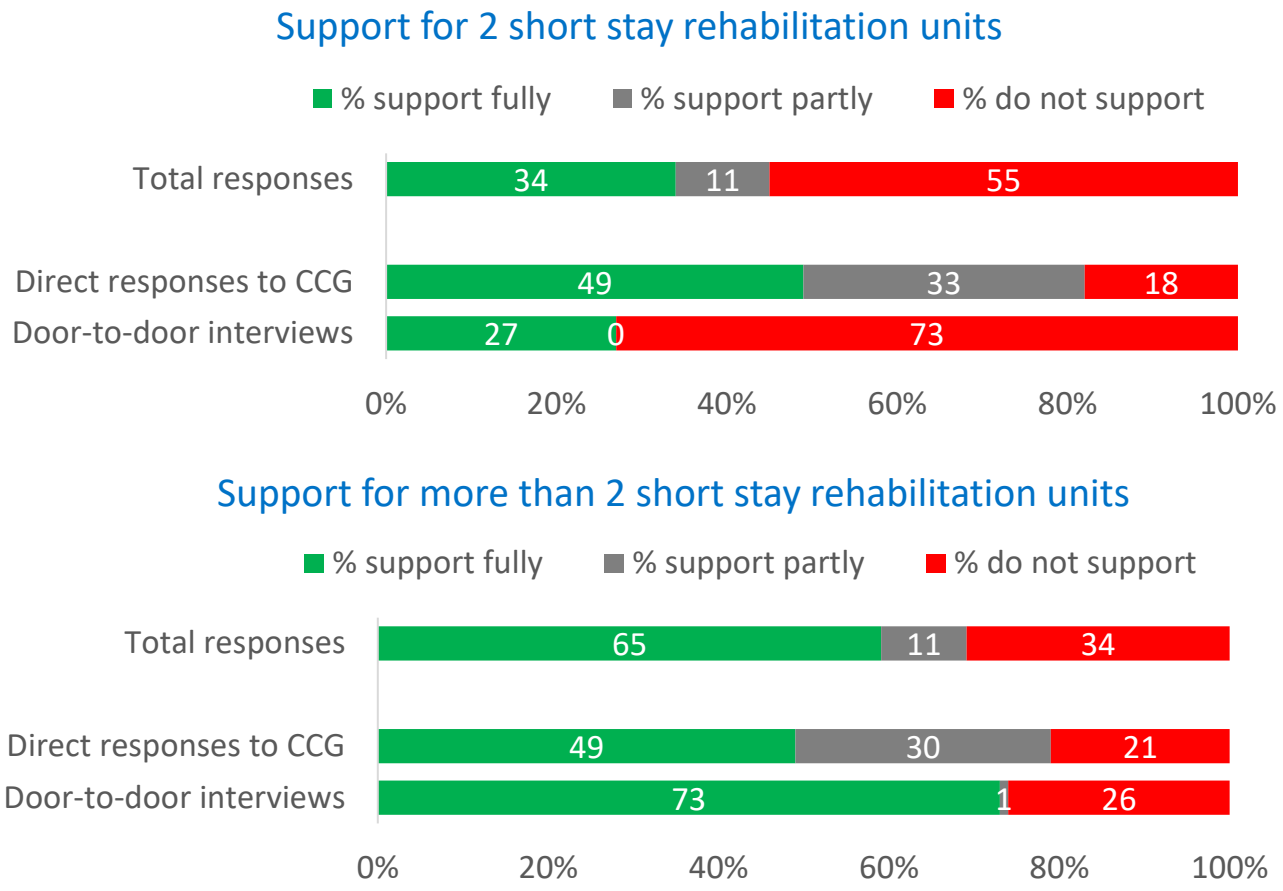
Some people who have a stroke are not ready to go home after their hospital-level care ends. Currently these people may stay in hospital longer, go to a live-in rehabilitation unit or be discharged home or to a care home.

- The CCG proposed setting up 2 short stay rehabilitation units (called 'Stroke Subacute Rehabilitation Units' or SSARU) to serve everyone in Bristol, North Somerset and South Gloucestershire.
- The CCG proposed that 1 of these units would be on the Weston General Hospital site.
- The CCG sought feedback about the location of a second short stay rehabilitation unit.

Of 1,592 consultation responses that commented on this, **one third fully supported 2 short stay rehabilitation units (34%) and two thirds fully supported having 3 units or more (65%).**

Those taking part in door-to-door interviews were more likely to want 3 or more short stay rehabilitation units (see Figure 5). People who had experienced a stroke were more likely to support having 2 units, whereas carers wanted more than 2 units. The appendix contains further demographic differences.

Figure 5: Support for 2 or more short stay rehabilitation units



Note: 1,593 responses stated whether they supported having 2 short stay rehabilitation units. Direct responses to the CCG could express partial support for both options. The door-to-door interviews asked people to choose between them. Open-ended feedback showed that there was sometimes a lack of understanding about what a short stay rehabilitation unit was, particularly in door-to-door interviews. Some confused this with care after discharge or emergency care. Some did not understand the term 'stroke subacute rehabilitation unit' or 'SSARU'. Direct responses were more likely to support 2 units than door-to-door interviews (82% vs 27% interviews partly or fully)

Area

No meaningful differences as all areas preferred 3 or more rehab units, but North Somerset responses also liked the idea of 2 units because one would be at Weston General Hospital

Age

No difference between age groups

Ethnicity

No meaningful difference between ethnic groups

Gender

A larger proportion of people supporting 2 units were women, but the majority of women, men and non-binary people preferred more than 2 units

People who had experienced a stroke

People who had experienced a stroke were more likely to favour 2 units (61% vs 45% total responses partly or fully supporting)

Carer of someone who had a stroke

Carers were more likely to support 3 or more rehab units (77% vs 65% total responses)

Health or care professional

Health and care professionals were more likely than other responses to support 3 or more rehab units

REASONS FOR SUPPORTING 2 SHORT STAY REHABILITATION UNITS

2

1,462 responses made 1,846 comments about the reasons why they did or did not support the CCG's proposals about short stay rehabilitation units. Responses could provide more than one reason for their view.

The main reasons given for supporting having 2 short stay rehabilitation units serving the area were:

- Perceiving this as a good **compromise** that brings staff together at a manageable number of units but also has 1 unit in the north and 1 in south of the area to give easier access (15% of 1,462 responses that gave a reason for their view)
- thinking that there may be **better quality care**, including more continuity and less reduction in standards of care across a greater number of units (3%)
- perceived good use of **resources** (3%)
- thinking that 2 units provide enough **capacity** to cope with the number of strokes (2%)
- thinking that this would boost **Weston General Hospital** (2%)
- potential for improved **staff** recruitment and retention with perceived attractive jobs such as rotational posts (1%)

Reasons that responses supported having 3 or more short stay rehabilitation units were:

- **capacity**: some responses said the area is geographically spread and the population is large so they thought 2 units would not provide sufficient capacity or enough redundancy for contingencies. Responses said that rehabilitation can take a long time so units may get full and create a bottleneck for discharges from hospital (64% of 1,462 responses that gave a reason)
- belief that the more units there are, the closer and easier it will be for **family** to visit, especially given reported limited public transport. Responses said that family visits could be an important part of recovery, and that family should not be expected to travel long distances for an extended period whilst people stay in a rehabilitation unit (27%)
- thinking that it may be better to have rehabilitation locally to support discharge planning, continuity of onward care and perceived **smoother transitions** to the home environment (3%)
- desire to keep **existing services** open, including to reduce the need for staff to move (2%)
- perceived that this would provide more patient **choice** (1%)

3+

REASONS FOR SUPPORTING 3 OR MORE SHORT STAY REHABILITATION UNITS

EXAMPLES OF SUPPORTING 2 REHAB UNITS

"(In addition to Weston), Bristol/South Gloucester needs a dedicated unit to cater for the number of stroke patients. One unit in this area would enable a robust specialist team that can support and develop each other, facilitate cover 7 days a week and promote staffing levels for this thus providing a patient centred service. Working in a smaller rehab unit with a handful of stroke beds is difficult as this has to be juggled with remaining non-stroke patients thus affecting the intensity of rehab required as per national stroke guidelines." (Feedback form from disabled White woman aged 41-64 in South Gloucestershire)

"I think rehab in an inpatient unit should be in a location that is close to a service user's home, to allow links with family and friends and community. However, I understand how financially this may not make sense and to consolidate resources into 2 units would be appropriate." (Feedback form from White female aged 41-64 in Bristol who had experienced a stroke)

"Group felt that is was good that there will be a service in Weston as travel and accessibility for North Somerset residents going to Bristol-based hospitals can be difficult. One attendee mentioned that they have had positive experiences with Weston stroke services previously, so was pleased that part of the pathway could be continued here." (Notes from meeting with North Somerset Patient Participation Group)

"Makes sense to allow specialism in the 2 units rather than spreading staff and beds across multiple locations." (Notes from staff meeting at healthcare organisation)

EXAMPLES OF SUPPORTING 3 OR MORE REHAB UNITS

"I think the whole of the BNSSG area is too big for 2 units. Should definitely have one in Weston for North Somerset, one in South Gloucestershire and South Bristol. A majority of patients with stroke will require a reasonable period of inpatient stroke rehab prior to discharge and 3 units will enable patients to be nearer their home and families while receiving this." (Feedback form provided by White female healthcare worker aged 41-64 years in Bristol)

"Better to have more. Need to keep services more local so it is easier for family to visit." (Notes from visit to people receiving stroke care at Weston General Hospital)

"There should be one in each location so relatives can get there and you are closer to home." (Door-to-door interview with White female aged 41-64 in Bristol who had experienced a stroke)

"Part of the rehabilitation is reengaging with friends and family. Also friends and family need to learn how best to support when the patient returns home. This means that the family and friends support network need to have easy access to the rehab unit - as I did. They can provide the knowledge of the home background and bring stories of past events / photos etc to assist with memory loss and communication." (Feedback form from White female stroke carer aged 25-40 in South Gloucestershire)

LOCATION OF SHORT STAY REHABILITATION UNITS

The CCG proposed to have one short stay rehabilitation unit on the site of Weston General Hospital.

Regardless of the total number of short stay rehabilitation units, **6 out of 10 responses fully supported having one of the units on the Weston General Hospital site**. Only 15% did not support this partly or fully.

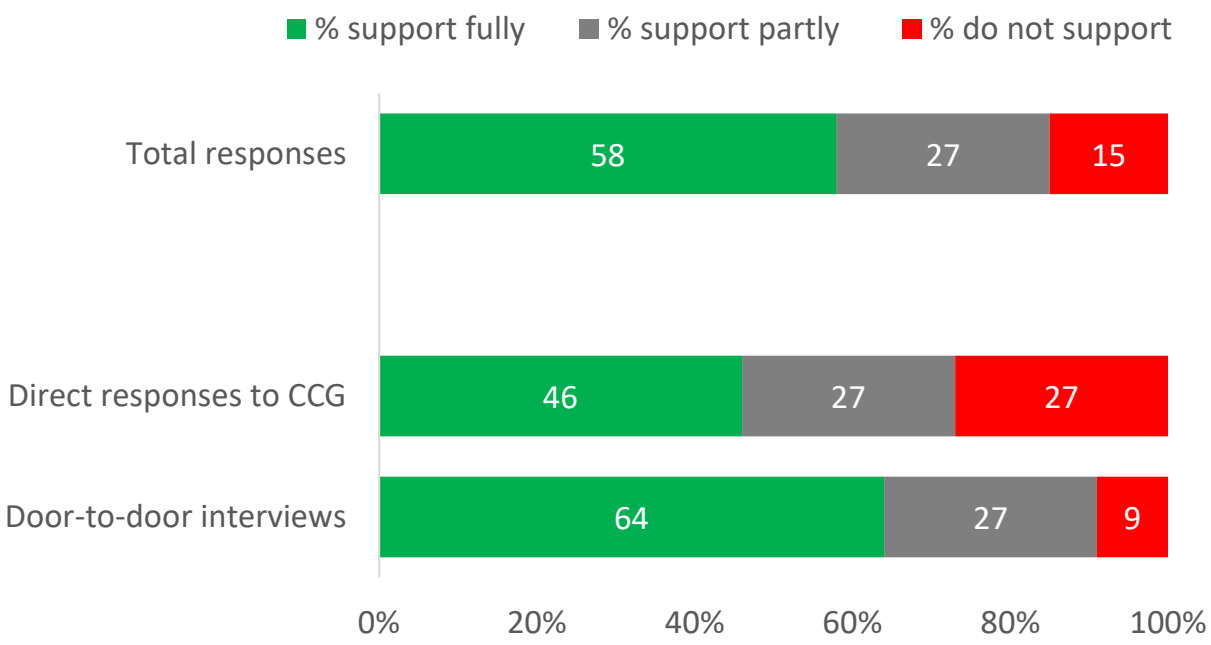
Although there was a high level of support overall, more door-to-door interviews supported this than direct responses to the CCG (see Figure 6).

In open ended feedback over 50 responses (around 5%) said they did not support having a unit on the site of Weston General Hospital because they perceived there to be concerns about the quality of care and staffing at that site. The perceived reputation of the hospital influenced how confident these people were about the level of care that might be provided in a new rehabilitation unit there. It is important to stress that this was a very small proportion of all responses.

Responses had similar views about this proposal regardless of their age, gender or ethnicity. Responses from North Somerset were slightly more likely to favour this, but there was a high level of support from other areas too.

People who had experienced a stroke, their carers and health and care professionals were less likely to support this than others, though there was still a high level of support.

Figure 6: Support for short stay rehabilitation unit at Weston General Hospital



Note: 1,643 responses stated whether they supported a short stay rehabilitation unit at the Weston General Hospital site. Direct responses were less likely to support this than door-to-door interviews (73% vs 91% fully or partly)

Area	Responses from North Somerset were most likely to support this, but all areas were supportive
Age	No difference between age groups
Ethnicity	No difference between ethnic groups
Gender	No difference between gender groups
People who had experienced a stroke	People who had experienced a stroke were less likely to support this than others, but were still largely favourable (79% vs 85% total responses partly or fully)
Carer of someone who had a stroke	Carers were less likely to support this than others but were still largely favourable (78% vs 85% total responses)
Health or care professional	A higher proportion of health and care staff did not support this compared to total responses (24% vs 15% total), though 52% of health and care professionals did fully support it

LOCATION OF ANOTHER UNIT

Responses were invited to suggest a location for a short stay rehabilitation unit somewhere in Bristol or South Gloucestershire, using a prespecified list or adding their own ideas. There were 1,424 responses about this.

Preferences were:

- Elgar Unit at Southmead Hospital (48%)
- Frenchay Hospital (25%)
- South Bristol Community Hospital (18%)
- Skylark Unit in South Gloucestershire (5%)
- Other (4%), in order of frequency stated: Bristol Royal Infirmary, Cosham Hospital, Thornbury, Emerson Green, Bath, Keynsham, Yate

THINGS TO CONSIDER WHEN SELECTING REHAB UNIT LOCATIONS

Responses wanted the CCG to think about the following things when deciding on the location of a short stay rehabilitation unit:

- **travel time** and cost for families and staff e.g. proximity to motorways (44% of 361 responses that commented about this)
- accessibility by **public transport** or having transport provided (26%)
- sufficient **parking** and free parking (21%)
- **spread** of units across the area (18%)
- the **facilities** available such as gardens, social activities, kitchen, rehabilitation gym, individual rooms to support good sleep and having a swimming pool nearby (17%)
- availability of **staff** specialising in stroke, from many disciplines (11%)
- proximity to **hospital** and other services and support groups in case people need them (8%)
- population **demographics**: focusing on where people most at risk of having a stroke live (7%)
- how long it will take to set up or build the unit, or the ability to use **existing facilities** (5%)
- **capacity** and flexibility of facilities (5%)
- facilities being **purpose built** for stroke (3%)
- not in a care home so as to remain appropriate for younger patients and not restrict visiting hours (3%)
- **cost** to establish and maintain (1%)

CARE IN THE COMMUNITY

The CCG's vision for stroke care involves setting up an 'Integrated Community Stroke Service' working across Bristol, North Somerset and South Gloucestershire.

The CCG did not formally consult about this approach, but invited people and organisations to share any feedback about this idea. 267 responses provided 345 comments about plans for the Integrated Community Stroke Service.

- 1 in 3 said positive things about the idea of an Integrated Community Stroke Service, including the planned mix of roles (36% of 267 responses commenting about this).
- 1 in 5 commented that there was not enough support available currently or reported poor existing services (21%). Although not explicit, the sentiment was that the planned new service may help to alleviate some of these issues.
- About 1 in 5 said they were not convinced that the service would be resourced or implemented as planned, especially not as quickly as stated. Responses said that this service needed to be in place before changes to hospital stroke care (17%).

The rest of the comments about the Integrated Community Stroke Service suggested things that responses would like to see prioritised as part of the service, including:

- good **coordination** and communication across services, including sharing data, reducing duplicated assessments and linking to GPs and the voluntary sector (20% of responses that commented about care in the community)
- **personalisation**, such as providing a list of available services for people to choose between (7%)
- more **staff** capacity and training (7%)
- having a wider **range** of rehabilitation available 7 days a week (6%)
- making support available for a **longer** period (5%)
- **equity** of access to the proposed service (5%)
- involving **family** in ongoing support (4%)
- suggestions for **other services** or roles to include in the team e.g. bladder/bowel support (3%)

"I feel so pleased with what your aims are, we need to do this. When I had my stroke almost six years ago the hospital saved my life, but there is nothing when you come out and we need the continuity of rehabilitation if we are ever going to get better."
(Feedback form from White female aged 76+ in South Gloucestershire who had experienced a stroke)

OTHER THINGS TO CONSIDER

176 direct responses to the CCG provided 213 other comments about things for the CCG to consider when developing stroke services:

- **workforce requirement**s: perceived need to support, value, recruit and train staff (12% of those commenting)
- **communicating what is already available** for people who have a stroke and their families (11%)
- **joining up care** and communication between services (10%)
- developing **stroke support for specific groups** such as younger people, pregnant people, people who do not speak English as a first language and those using the cardiac unit at Bristol Royal Infirmary (7%)
- improving **prevention** and diagnosis (7%)
- providing follow on care for a **longer duration** (3%)
- impacts on people near the **boundaries** of the area (3%)

2 in 10 responses that provided additional comments worried that the proposed changes to stroke services would not happen as described, be well funded or be delivered in a timely manner (21%).

1 in 10 did not think the estimates used were accurate and realistic, such as the estimated travel times or the number of beds needed (10%).

A small number of responses suggested that before making decisions the CCG should hear from a wider range of people such as more people who had experienced a stroke and their carers, cardiac patients and stroke services staff (6%). Some felt that the consultation was not advertised widely.

EXAMPLES OF ADDITIONAL COMMENTS

"We are very supportive of the proposed model for the following reasons: We know that current services are fragmented and inequitable across BNSSG which means that stroke survivors we support have different treatment and rehabilitation depending on where they live before they transfer to community services. The changes support a significant shift to treatment out of hospital, which we believe will deliver better, more cost effective outcomes as well as improving quality of life for stroke survivors. The changes include additional investment across the system to support enhanced treatment and rehabilitation of people who have had a stroke which will contribute significantly to enabling a better outcome and quality of life for individuals and their families." (Letter from Sirona Care & Health)

"General idea seems fine BUT deeply unimpressed by overall reduction of 15 beds. I'm sceptical of the modelling. It assumes a performance improvement which may or may not be achieved. I'd only support bed reduction after improvements clearly demonstrated. Does it take account of growing population adequately?" (Feedback form provided by White man aged 76+ in South Gloucestershire)

"A single HASU for BNSSG is a good idea because it will have the depth of specialist capabilities to provide the very best model of acute care 24 hours per day, 7 days per week - this consistency of specialist service is crucial for giving everyone in BNSSG the best care possible if they have stroke and will significantly improve patient outcomes with reduced mortality and reduced disabilities. However, this model will only work if there is sufficient capacity on the Southmead site to accommodate the additional stroke patients and stroke mimics ... Therefore, it is essential that all parts of the proposed pathway changes including rapid transfer of care to community and social care are achieved for this single site model to work. The volume of additional stroke mimics likely to be routed to Southmead needs to be understood and mitigations agreed to minimise the impact with effective triage protocols applied and rapid repatriation to local hospitals." (Feedback form from healthcare professional in Bristol)

It's great and long overdue. There are pockets of excellence but the system is mostly hugely fragmented and under resourced. After my mum's stroke she refused to eat - but stroke doctors didn't understand mental health issues and she starved …It's been a constant battle for answers so any solutions are welcome, but don't underestimate the extent of the current problem and don't over promise." (Feedback form from White 41-64 year old female carer in Bristol)

SUMMARY

More than 2,000 people and organisations shared their views during Bristol, North Somerset and South Gloucestershire's stroke services consultation. Responses generally supported the CCG's broad goals for stroke services, though often responses did not think that the proposals adequately took into account the geography and demographics of the area or had built in enough capacity and continency to cope with the future demand for stroke services.

The trends in opinions were relatively similar regardless of people's area, age, gender, ethnicity or whether they had had a stroke or cared for someone who had. There were some differences, with people from North Somerset, people who had experience of a stroke, carers and health and care workers more likely to suggest that greater numbers of stroke centres, wards or rehabilitation units were needed.

Overall, people providing feedback through door-to-door interviews were less positive about two out of three of the CCG's proposals compared to those that responded to the consultation directly through meetings, feedback forms, letters, emails and telephone calls. This may be because they had less information about the proposals.

- **Half of responses fully supported the CCG's proposal to have a single centre of excellence for immediate hospital care** (Hyper-acute Stroke Unit) serving everyone suspected of a stroke in Bristol, North Somerset and South Gloucestershire (65% supported partly or fully).

- **Half of responses supported the CCG's proposal to have 1 specialist stroke ward for ongoing hospital care** (Acute Stroke Unit) at Southmead Hospital serving everyone in Bristol, North Somerset and South Gloucestershire. The other half wanted 2 specialist stroke wards, one at Southmead Hospital and one at Bristol Royal Infirmary.

- **One third of responses fully supported the CCG's proposal to have 2 short stay stroke rehabilitation units** serving the area (Stroke Subacute Rehabilitation Units) (45% partly or fully supported this). The majority would prefer to have three or more short stay rehabilitation units (76% partly or fully supported this).

- **Regardless of the number of short stay rehabilitation units, over half of responses fully supported having one of these at Weston General Hospital** (85% partly or fully supported this). The most commonly suggested location for another unit was the Elgar Unit at Southmead Hospital (48%).

"At last a really comprehensive plan for the future of stroke! This is so needed. It should be put in place as swiftly as possible." (Feedback form provided by 41-64 year old White woman in Bristol)

The reasons that responses did not always fully support the CCG's proposals tended to be similar for each of the proposals. These were the issues that responses wanted the CCG to consider when planning next steps:

- **Transport issues** including whether it would have a negative impact on outcomes to travel longer to hospital, the perceived inconvenience and cost of travel for family and visitors, the environmental impact of increased longer ambulance and car journeys, the reported lack of public transport to and from services and concerns about the capacity of ambulance services to cope with longer journeys

- **Capacity** of services to cope, specifically whether one or two centres or units would be sufficient for the number of people having a stroke in future and whether centralising services across a large area would account for contingencies in the event of unexpected infections, pandemics or similar

- **Population demographics**, including the size, level of growth, age profile, and rural location of the population and the number of holiday makers that visit the area

The CCG's consultation materials set out that most people having a stroke could be transported to a centre of excellence for emergency care within 30-45 minutes, but responses questioned whether this was accurate. They also emphasised poor transport infrastructure, including public transport and parking, that they said would make it difficult to visit loved ones.

Responses highlighted the need to concentrate on recruitment and retention of the workforce to bring these proposals to fruition. They also said that community services needed to be strengthened to reduce bottlenecks before making changes to hospital care.

The CCG stated that consultation feedback will be considered alongside other evidence when its Governing Body decides on next steps. Themes from the consultation feedback will be included in a business case with other data, including material that considers and addresses issues raised during the consultation.

"Really happy that after many, many years we are in a place for this to be consulted upon and moved forwards. Well done to all for getting this far!"
(Feedback form from 41-64 year old White female in South Gloucestershire who had experienced a stroke)

APPENDICES

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CONSULTATION APPROACH

HOW WERE PEOPLE INVITED TO TAKE PART?

This section summarises information provided by the CCG about the consultation approach.

Between 7 June and 3 September 2021, the CCG and Healthier Together partners sought feedback about the proposals from the public, staff and local organisations. People could give feedback by:

- taking part in a consultation meeting (see details over the page)
- sharing views at an information stand
- completing a consultation feedback form online or via post (freepost)
- providing feedback by post, email, social media or telephone
- taking part in a door-to-door survey if invited
- providing feedback as part of the Healthier Together Citizen's Panel if invited

The CCG promoted the consultation with:

- consultation booklets, factsheets, a video animation and other material placed on the Healthier Together website (https://bnssghealthiertogether.org.uk/)
- 43 engagement events and meetings
- newspaper advertisements, including North Somerset Life magazine (distributed to every household in the North Somerset Council area)
- 56 social media posts
- paid social media advertising on Facebook and Instagram
- paid online content on Bristol Live, Somerset Live, Gloucestershire Live platforms and 'in my area' app
- posters and leaflets
- mail drops in targeted areas of Bristol (about 4,800 homes)
- information stands at COVID-19 vaccination centres
- information shared with Healthier Together partners to distribute, including hospitals, general practices, community services and voluntary and community organisations. The information included wording and images to place on websites, in newsletters and on social media
- materials given to councils to disseminate to elected representatives
- requests to clinical leaders and local authorities to gather feedback from vulnerable groups and people receiving care for stroke in hospital, in the community and at home
- hiring Healthwatch to use their contacts to raise awareness through talks, distributing consultation materials and supporting outreach events

The consultation took place during the COVID-19 pandemic so infection prevention and control requirements meant that materials like leaflets could not always be given out in healthcare settings.

The CCG provided specific materials for areas and groups that may be affected by the proposals in different ways, including people living in the Sedgemoor area and pregnant people.

The CCG also prepared an easy read version of the consultation booklet and a version for people with aphasia. About 1 in 3 people who have a stroke experience aphasia, which affects people's ability to speak, understand what others say, read and write.

Translated materials were available on request, including information in Arabic, Albanian, Bengali, Cantonese, Farsi, Gujrati, Mandarin, Pashto, Punjabi, Somali, Sorani, Turkish and Urdu. An animation about the proposals was also translated into Urdu and Punjabi.

ENGAGEMENT EVENTS AND MEETINGS

The CCG and Healthier Together partners hosted consultation meetings and attended existing meetings to share the proposals and gather feedback. This included events for the public, meetings with healthcare staff and targeted events for older people, people from minority ethnic groups, those living in areas of higher deprivation, men, pregnant people and carers. The meetings also included visits to hospital stroke wards, visits to a traveller site and pop-up engagement stands at COVID-19 vaccination clinics.

The following pages list the meetings.

Most events were held online due to COVID-19 restrictions. When restrictions eased during late-July and August, the CCG began face-to-face activities, adhering to the relevant government guidelines.

The CCG provided the following list of consultation engagement activities. Some of these meetings were used to promote the consultation, not to collect feedback. Notes were taken at the meetings marked with asterisks, and these notes were each counted as a consultation response.

DATE	GROUP / MEETING	PARTICIPANTS	TARGET GROUP
14/06/21	North Somerset casual stroke survivors group*	11	Lived experience
15/06/21	Thornbury and District stroke support group*	12	Lived experience
16/06/21	North Somerset communication support group*	5	Lived experience
16/06/21	Public meeting (online)*	3	Public
17/06/21	4 healthcare staff meetings: one at North Bristol Healthcare Trust, one at Bristol Royal Infirmary, one at Weston General Hospital and one at Sirona (community services)	73	Staff
17/06/21	Bristol After Stroke meeting*	25	Lived experience
24/06/21	Public meeting (online)*	8	Public
25/06/21	Young stroke survivors*	8	Lived experience
30/06/21	Multi-organisational staff event*	15	Staff
30/06/21	Public meeting (online)*	4	Public
06/07/21	South Gloucestershire Patient Participation Group*	22	Public
07/07/21	Public meeting (online)*	7	Public
07/07/21	Carers group (online)*	3	Carers
08/07/21	One Weston Locality Board*	18	Staff
08/07/21	Age UK support hub*	22	Older people
13/07/21	Voluntary Action North Somerset forum*	14	Voluntary sector
14/07/21	Woodspring GP Locality Group*	20	Staff
14/07/21	South Gloucestershire GP membership meeting*	24	Staff
15/07/21	Woodspring integrated primary care group*	20	Staff
21/07/21	Public meeting (face-to-face in Bristol)	0	Public
26/07/21	Social Prescribing Development Group*	20	Voluntary sector

DATE	GROUP / MEETING	PARTICIPANTS	TARGET GROUP
28/07/21	Independent Living Services occupational therapy forum*	19	Staff
29/07/21	Public meeting (face-to-face in North Somerset)*	10	Public
29/07/21	Independent Living Services occupational therapy services meeting*	29	Staff
31/07/21	Pop up event at vaccination clinic	12	Areas of higher deprivation, younger people, minority ethnic groups
04/08/21	Public meeting (face-to-face in South Gloucestershire)*	3	Public
04/08/21	Sirona staff meeting*	22	Staff
11/08/21	North Somerset People First meeting*	12	Disabled people
11/08/21	Pop up event in Easton	50	Areas of higher deprivation, younger people, minority ethnic groups
18/08/21	South Bristol Rehabilitation Unit visit	7	Staff, people with lived experience
19/08/21	Weston General Hospital stroke ward visit (4)*	11	Staff, people with lived experience
20/08/21	Stroke service user group	3	Lived experience
24/08/2021	Weston Active Stroke Group (face-to-face)	35	Lived experience
24/08/2021	Thornbury Aphasia Group (face-to-face)*	6	Lived experience
24/08/2021	North Somerset Patient and Public Involvement Group*	9	Public
25/08/21	Bristol Aphasia Group*	9	Lived experience
25/8/21	Bristol Traveller – three site visits	7	Minority ethnic group
26/08/21	Public meeting (online)*	4	Public
31/08/21	Dhek Bhal meeting*	23	Minority ethnic groups
02/09/21	Multi-organisational staff event	20	Staff

DOOR-TO-DOOR INTERVIEWS

The CCG encouraged people and organisations to share their views online, in writing or at meetings. In addition, the CCG hired a market research organisation to conduct structured face-to-face interviews with people from randomly selected parts of the area. The CCG stated that this was to collect feedback from people of a similar age, ethnic group and socio-economic status to the population overall and so the opinions of those who may be less engaged were included. The questions were designed by the CCG to be similar to those used in the consultation feedback form.

The market research organisation randomly selected geographic areas (streets or blocks) to target, taking into account the size of the area and levels of deprivation. Interviewers knocked on doors in those areas and invited people aged over 16 to take part. The interviewers had quota targets to get feedback from people who matched the age, gender, ethnicity and work status profile of the local population. Interviewers left at least 3 houses between interviews. Interviews were conducted during the day, evening and at weekends.

There were a larger number of door-to-door interviews than direct responses to the CCG through meetings, emails and feedback forms. However it is important that the views of people canvassed door-to-door are not seen as more important than other views, just because of the numbers. We must be careful when interpreting the feedback from the door-to-door interviews because:

- People were not given any material to read or watch in advance so were commenting about proposals that they may not know anything about. This means people responded based on their immediate instincts, rather than an informed reflection. Less than 5% of people interviewed said they had heard anything about potential changes to stroke services before the interviewer knocked on their door, and fewer than 2% said they knew much about the proposals. In contrast, people submitting a feedback form or taking part in a meeting had usually had an opportunity to look at consultation material, see a video or hear a presentation, so they may have more informed opinions, or stronger views, than those who answered questions from an unannounced interviewer.
- Interviews took place between 5 July and 12 August 2021. Some of the interviews happened when England remained under COVID-19 lockdown restrictions so some people may not have felt comfortable opening their door. It is uncertain what proportion of households visited declined to take part or did not answer the door.
- The questions asked by the interviewers were not exactly the same as the consultation feedback form or meeting prompts. The CCG reported that changes were made to give more flow during an interview, but this changed the meaning of some questions and asked about different concepts, particularly related to having a single centre of excellence for emergency stroke care at Southmead Hospital. It appears that these wording changes influenced the feedback.
- The interviewers typed people's responses as they spoke. There was a difference in the quality and quantity of information that interviewers captured. Some interviewers typed people's responses word for word, whereas other interviewers typed only a few words to represent the main things that people said. There was a lot less detail collected about people's reasons in door-to-door interviews compared to other responses.

More people who had experienced a stroke, carers and health and care workers responded directly to the CCG than took part in the door-to-door interviews.

The CCG's consultation activities partly aimed to seek feedback from those most likely to be affected or who may have informed opinions about the proposals.

Characteristics of people responding directly to the CCG versus in door-to-door interviews

Characteristic	% of individual responses received	% of door-to-door interviews	% of all responses
Total number	644	1,126	1,770 responses from individuals
People who had experienced a stroke	14%	2%	7%
Carer of someone who had a stroke	19%	5%	10%
Long term physical or mental health condition other than stroke	9%	9%	9%
Carer of someone with condition other than stroke	8%	5%	6%
Disabled	7%	3%	5%
Health or social care workforce	42%	6%	19%

Note: People could have more than one of these characteristics

COMPILING THEMES

The CCG logged all responses received in a spreadsheet and passed on the responses to an independent team to compile. The independent team read all of the feedback and numerically coded each open comment. The independent team then analysed the themes using a software package (the Statistical Package for the Social Sciences). The team drew out quotes as examples to illustrate common themes.

The independent team looked at whether people had different opinions depending on their age, gender, ethnicity, area, whether they had experienced a stroke, were a carer or health professional and whether they gave feedback directly to the CCG or via a door-to-door interview. The independent team used statistical tests to see whether there were any differences between groups (Chi-squared test based on 95% level of confidence). In this report, anywhere a 'difference' between groups is mentioned, this refers to a significant difference based on these statistical tests. This means the difference is not likely to have happened by chance.

It is important to bear in mind the following things when interpreting the feedback.

- The independent summary of themes aimed to compile **common points**, not to describe the detail within each response. The summary of themes is not a substitute for reading each of the responses individually.
- The feedback presented represents people's **opinions**, rather than objective facts. Views from a wide range of people were included and not every person who provided feedback will agree with all of the points raised.
- The summary shows what people and organisations that provided feedback said. It **does not generalise** to represent the opinions of all people in Bristol, North Somerset and South Gloucestershire. The report lists the proportion of responses that mentioned each theme to illustrate how often points were raised, but this does not show the proportion of the population who share this view.
- One 'response' does not necessarily equate to one person. Pieces of feedback varied in size and scale, with some comprising a short email from an individual, others a letter representing an entire organisation and others being notes from meetings with many participants, for example. The theme summary **did not weight** the responses in any way because all feedback was important to the CCG.
- If someone provided feedback in multiple ways, they would be counted more than once. For example, someone who took part in a meeting and also submitted a feedback form would be counted as part of two responses. This is why it is important to use the percentages as a guide to show which opinions were **most common**, but not to focus too much on the exact numbers.
- The consultation is **not a referendum** or 'vote'. The CCG wanted to understand the reasons for people's views so it could consider these opinions when planning next steps. The CCG's Governing Body will consider the consultation feedback alongside other evidence when making decisions.

RESPONSES RECEIVED COMPARED TO TARGETS

The CCG set itself a target of encouraging 1,500 individual responses to the consultation. It achieved this target, with 1,774 individual responses, plus meetings. The table below sets out the targets that the CCG set itself for reaching specific population groups and the extent to which it achieved these. No formal target was set for responses from people with lived experience of stroke but more than 300 responses, or 1 in 6, came from someone who had experienced a stroke (117 people) or a close family member or carer of someone who had a stroke (170 people). In addition, the CCG facilitated meetings with people who had experienced a stroke and their carers.

GROUP	CATEGORIES	MINIMUM TARGET NUMBER OF PEOPLE	NUMBER OF INDIVIDUALS RESPONDING
Age	Under 25 years	150	188
	25-40 years	300	475
	41-64 years	340	628
	65+ years	200	386
Disability, impairment or long-term condition	People with a disability or impairment (including due to stroke) or a long-term condition other than stroke	95 disability	85 disability or impairment 152 long-term condition (193 disability and/or long-term condition)
Ethnicity	Ethnic minority groups	100	155
Sex	Males	490	780
	Females	510	906
Areas of higher deprivation	Multiple deprivation indices 1-2	160	295 (in door to door survey where this information was known)
Geography	Bristol	480	782
	North Somerset	230	387
	South Gloucestershire	290	513
Carers	Those with caring responsibilities	94	170 carers or close family of people who had a stroke; 112 carers of people with other long-term physical or mental health conditions

PRIORITIES FOR EMERGENCY STROKE CARE

CHARACTERISTICS	NUMBER RESPONDING	% PRIORITISED THE MOST SPECIALIST STAFF AND EQUIPMENT	% PRIORITISED HOSPITAL CLOSE TO HOME
All responses	1,750	69%	22%
Area	1,681	70% Bristol 68% North Somerset 67% South Gloucestershire	21% Bristol 23% North Somerset 25% South Gloucestershire
Age	1,662	68% under 25 67% 25-40 73% 41-64 64% 65-75 65% 76+	25% under 25 24% 25-40 20% 41-64 26% 65-75 23% 76+
Ethnicity*	1,662	60% Asian 63% Black 56% Gypsy / Traveller 70% White 39% Other	34% Asian 29% Black 37% Gypsy / Traveller 22% White 33% Other
Gender	1,666	69% women 68% men	23% women 23% men
Person who had experienced a stroke	109	73%	14%
Carer of someone who had a stroke	168	76%	13%
Direct responses to CCG	635	78%	9%
Door-to door interviews*	1,115	63%	30%

Note: * indicates a statistically significant difference between groups.

IMPACT OF DIFFERENCES IN QUESTIONS

The CCG used different questions to ask people about its proposal for a single centre of excellence for emergency stroke care at Southmead Hospital.

In consultation feedback forms and meetings, the CCG asked people the extent to which they supported having a single Hyper-acute Stroke Unit at Southmead Hospital serving the whole area. The door-to-door interviews used two different questions to ask people about this proposal, one about the preferred location of a Hyper-acute Stroke Unit and one about whether people supported having one unit to serve the whole area, regardless of where it was located.

To be able to combine the feedback from the two different types of questions, the analysis used the CCG's official consultation form as the primary question. The analysis then drew out feedback from the door-to-door interviews to match that question. The analysis team first considered whether people interviewed said they supported a single unit at Southmead Hospital if there could be only one unit. Then they looked at people's stated reasons why in order to judge whether they partly or fully supported the proposal. This was cross checked with another interview question about whether or not people supported having one unit serving the whole area.

A validity check combined the proportions from two quantitative interview questions without looking at people's comments. Here all the people were identified who supported BOTH a single unit serving the whole area AND who supported the unit being located in Southmead Hospital. Using this approach, 26% fully supported and 22% partly supported having a single Hyper-acute Stroke Unit at Southmead serving the whole area (48% overall, compared to 52% using the method which took people's open-ended comments into account).

Thus whichever analysis method was used, the trend was about the same: half of people who took part in door-to-door interviews partly or fully supported a single Hyper-acute Stroke Unit at Southmead.

One of the door-to-door interview questions asked "which one of the TWO options do you most prefer?" People were asked to choose between a single Hyper-acute Stroke Unit at Southmead Hospital or a single Hyper-acute Stroke Unit at another hospital. Some people suggested another possibility or said they did not know.

This is forced choice question asking where a unit would be located if there could only be **one** unit. 77% of people interviewed said that if there could only be one unit, they would prefer it at Southmead Hospital. This does **not** mean that 77% preferred only one unit though. In fact, when combined with answers to another question about whether people agreed with having only one unit, the results showed that 26% fully supported having a single unit located at Southmead Hospital.

SUPPORT FOR SINGLE CENTRE OF EXCELLENCE (HASU)

CHARACTERISTICS	NUMBER RESPONDING	% FULLY OR PARTLY SUPPORT	% DO NOT SUPPORT
All responses	1,732	65%	35%
Area	1,681	65% Bristol 61% North Somerset 64% South Gloucestershire	35% Bristol 39% North Somerset 36% South Gloucestershire
Age	1,662	58% under 25 66% 25-40 65% 41-64 60% 65-75 65% 76+	42% under 25 34% 25-40 35% 41-64 40% 65-75 35% 76+
Ethnicity	1,662	64% Asian 61% Black 64% Gypsy / Traveller 64% White 76% Other	36% Asian 39% Black 36% Gypsy / Traveller 36% White 24% Other
Gender*	1,666	68% women 59% men	32% women 41% men
Person who had experienced a stroke*	109	85%	15%
Carer of someone who had a stroke	168	72%	28%
Health or care professional*	254	79%	21%
Direct responses to CCG	626	89%	11%
Door-to door interviews*	1,106	52%	48%

Note: * indicates a statistically significant difference between groups or compared to the overall average.

SUPPORT FOR 1 OR 2 SPECIALIST STROKE WARDS (ASU)

CHARACTERISTICS	NUMBER RESPONDING	% SUPPORT 1 STROKE WARD	% SUPPORT 2 STROKE WARDS
All responses	1,745	50%	50%
Area*	1,688	47% Bristol 46% North Somerset 54% South Gloucestershire	49% Bristol 52% North Somerset 44% South Gloucestershire
Age	1,671	45% under 25 46% 25-40 51% 41-64 53% 65-75 47% 76+	52% under 25 49% 25-40 47% 41-64 46% 65-75 52% 76+
Ethnicity	1,671	52% Asian 40% Black 44% Gypsy / Traveller 49% White 33% Other	45% Asian 56% Black 56% Gypsy / Traveller 48% White 56% Other
Gender	1,673	48% women 49% men	49% women 48% men
Person who had experienced a stroke	109	49%	46%
Carer of someone who had a stroke*	167	39%	56%
Health or care professional	240	47%	53%
Direct responses to CCG	619	48%	52%
Door-to door interviews	1,126	51%	49%

Note: * indicates a statistically significant difference between groups or compared to the overall average. 9% of direct responses said they had ‘no preference’ and are excluded from the figures above. If those responses are taken into account, 44% of direct responses supported 1 specialist stroke ward and 47% supported 2..

SUPPORT FOR 2 OR 3 SHORT STAY REHAB UNITS (SSARU)

CHARACTERISTICS	NUMBER RESPONDING	% PARTLY OR FULLY SUPPORT 2 STOKE REHAB UNITS	% PARTLY OR FULLY SUPPORT 3 OR MORE REHAB UNITS
All responses	1,593	45%	65%
Area*	1,565	43% Bristol 50% North Somerset 41% South Gloucestershire	80% Bristol 79% North Somerset 74% South Gloucestershire
Age	1,533	35% under 25 46% 25-40 45% 41-64 45% 65-75 44% 76+	80% under 25 73% 25-40 75% 41-64 75% 65-75 78% 76+
Ethnicity*	1,671	41% Asian 42% Black 67% Gypsy / Traveller 44% White 60% Other	73% Asian 82% Black 43% Gypsy / Traveller 76% White 93% Other
Gender*	1,673	50% women 37% men	75% women 77% men
Person who had experienced a stroke*	109	74%	69%
Carer of someone who had a stroke*	167	61%	77%
Health or care professional*	233	64%	74%
Direct responses to CCG*	520	82%	79%
Door-to door interviews*	1,073	27%	74%

Note: * indicates a statistically significant difference between groups or compared to the overall average. Percentages add to more than 100% because responses could support both options and some people party supported both.

SUPPORT FOR STROKE REHAB UNIT AT WESTON HOSPITAL

CHARACTERISTICS	NUMBER RESPONDING	% FULLY OR PARTLY SUPPORT	% DO NOT SUPPORT
All responses	1,643	85%	15%
Area*	1,613	82% Bristol 91% North Somerset 86% South Gloucestershire	18% Bristol 9% North Somerset 14% South Gloucestershire
Age	1,598	88% under 25 84% 25-40 86% 41-64 84% 65-75 84% 76+	12% under 25 16% 25-40 14% 41-64 16% 65-75 16% 76+
Ethnicity	1,595	87% Asian 96% Black 87% Gypsy / Traveller 485 White 77% Other	13% Asian 4% Black 13% Gypsy / Traveller 15% White 23% Other
Gender	1,599	83% women 86% men	17% women 14% men
Person who had experienced a stroke*	92	79%	21%
Carer of someone who had a stroke*	151	78%	22%
Health or care professional*	235	76%	24%
Direct responses to CCG	517	73%	27%
Door-to door interviews*	1,126	91%	9%

Note: * indicates a statistically significant difference between groups or compared to the overall average.

This independent compilation of themes was produced by

THE Evidence Centre