Detailed options appraisal for improving stroke specialist bed based rehabilitation in Gloucestershire.

OPTION	ADVANTAGES	DISADVANTAGES
1.Do nothing	• Least programme input. • Current financial envelope maintained. • MDT Specialist team already in place (24 hour medical cover and onsite diagnostics). • Elements of a L2B unit in place.	• No change to patient outcomes which are identified as requiring improvement in the SSNAP (national audit) executive summary of past 2 years results. • Rehab continues to be inappropriately influenced by bed pressures i.e. time limited as oppose to goal driven. • Insufficient therapy staff to meet national guidelines. • Inadequate therapy space. • No capacity to reduce Length of stay(LOS) and improve flow. • Patients continue to stay in an environment not conducive to rehab when they no longer require acute medical care. • Patients do not feel they are progressing towards discharge due to a lack of specialist step down options.
2.Improve service delivery in the acute only	• MDT Specialist team already in place (24 hour medical cover and onsite diagnostics). • Elements of a L2B unit in place.	• Financial implication of increasing therapy staff to meet national guidelines. • Acute therapists historically difficult to recruit. • Financial implication of increasing therapy space plus existing space constraints within the GRH footprint may make this challenging to deliver to the appropriate level. • LOS will increase if patients have all their stroke specialist rehab in acute (excluding those discharged with ESD) • Tensions as medical patients who can be discharged quickly and are outliers having to take priority thus reducing rehab to stroke patients and increasing LOS. • Patients continue to stay in an environment not conducive to rehab. • Patients do not feel they are progressing towards discharge due to a lack of specialist step down options. • Increased bed occupancy requirement for stroke patients within the stroke beds reduces the inability to place outliers on the stroke wards with a negative impact on patient flow or a consequent failure to meet the stroke standard of 80% of stroke patients spending 90% of their stay on a stroke unit

3.Enhance the stroke specialist Early Supported Discharge (ESD) team to in-reach into all 7 community hospitals	• ESD already in place and high performing. • Generally minimal recruitment issues. • Flexible locality based approach. • May offer patient choice subject to bed availability.	• Model exists in a much reduced form already and is challenging to deliver due to the fragmented location of the stroke cohort. • Does not comply with best evidence regarding better outcomes by cohorting patients. • Existing therapy model will need to increase – financial implication • Stroke specialist rehab is a 24 hour approach. Due to widely spread small cohorts of patients nursing and medical staff may never acquire or maintain competences to a high enough quality, standard and outcomes will be poorer thus introducing unacceptable clinical variation. • Communication and management of daily therapy goal based activity and discharge planning are more complex and potentially slower in a less centralised environment. • Some community hospitals may not or are unable to engage in change of practice required. • Pressure re; LOS when the general community hospital culture is working to target of 21 days which is clinically inappropriate for stroke patients presenting a cultural challenge. • Travel challenges to ESD for complex patients widely spread who may need 2 or 3 therapists to treat- inefficient use of resources. • Inefficient use of small resource such as dietetics and consultant cover due to travel time incurred. • Will need to transport specialist equipment e.g. chairs and tilt tables etc. around the county or buy additional equipment – financial implication and poor use of equipment resource.

4.Develop a stroke rehabilitation unit in a community hospital Takes patients at 5 days if MSFD (do not require the input of acute medical staff) and have the potential to improve. 14 beds required	• Bed capacity will be released from moving all stroke beds to 6th floor i.e. up to12 beds are released including all 8 beds are released from 8A. • Better outcomes for patients in acute as all stroke care based on one floor and increased relative therapy provision due to reduction in beds to be covered. May reduce LOS for the cohort discharged with 2 weeks. • Creation of a community stroke rehab team consisting of specialist beds and ESD will result in improved and flexible critical mass of stroke skilled staff in the community. • Generally minimal recruitment issues in community stroke rehab. • Medical requirements can be largely met from existing staff (with time to upskill) • Opportunities to rapidly develop to admit general neurology and acquired brain injury. • Promotes a centre of excellence by rebadging existing community resource creating a sustainable resource.	• Requires some capital investment and uplift for additional staffing to support the community beds– financial implications. • May increase some repatriation to GRH due to risk-averse behaviour of staff. • Not all patients can be pulled out at day 5 if not medically stable or highly complex needs. • Perceived impact on flow by rebadging some community beds.