Appendix 1

Options Appraisal

	Option 1 - Status quo, which includes closing the beds to new admissions when consultant cover is unavailable	Option 2 - Patients stay longer in the acute hospital, but with extended community services being available	Option 3 - Centralisation of stroke rehab beds to one site model – Evesham Community Hospital	Option 4 - Reconfiguration of stroke rehab beds to a two site model – south/north
Advantages	• Patients can be cared for as close to home as possible, subject to a bed in their local ward being available at the time of transfer • Patient choice as there are 3 sites • Closer transport links for families • Current staffing maintain essential clinical skills (job satisfaction) • Large number of single rooms available, particularly at Timberdine	• Patient and family satisfaction may increase (recovery at home) • Patients would go home earlier following their stroke • Patients can be cared for at home • Better patient quality outcomes – reducing risk of hospital acquired infections and social isolation	• Greater ability to secure appropriate level of consultant cover for one site in terms of experience and frequency; reduced travelling time for consultants • Consultant support already secured from SWFT for 18 beds; WAHT has indicated they will be able to provide cover for the remaining 14 patients • Current community hospital medical model at ECH engaged and supportive • Centralisation of specialist staff providing a consistent offer of care • Greater opportunities to optimise staff skill set • Greater opportunities for community stroke service to attend the MDT on a single site, supporting patients to be discharged earlier • The offer of a specialist unit, located on a single site will be a more attractive offer for future staff recruitment • Evesham already has a multi-disciplinary team who were previously delivering stroke rehab for 16 patients • Releasing the beds at Timberdine and POWCH will provide more general rehab beds in the Worcester and Redditch and Bromsgrove localities • Sufficient capacity for local patients who require general rehab can still be provided within the bed base	• Patients have more choice about being cared for closer to home where possible, subject to a bed in their local ward being available at the time of transfer • Patient choice as there would be 2 sites • Closer transport links for families • Current staffing at 2 sites maintain essential clinical skills (job satisfaction)

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Risks	• Current model shows that there is not sufficient stroke consultant time available to cover 3 sites resulting in an overall reduction in the number of stroke rehabilitation beds currently available and quality of service. • Stroke rehabilitation beds will have to be closed to new admissions periodically when consultant cover is not available • Lack of consultant input impacts on patient outcomes, resulting in delayed decision making of on-going care and increased length of stay • Lack of downstream flow impacts on patient outcomes, as captured in SSNAP audit • Current bed occupancy data suggests that a large proportion of patients cannot receive stroke rehab care as close to home as possible as there are not enough stroke rehab beds available in the north of the county • Inability to meet existing LOS targets both on the ASU, and in community settings plus significant impact on direct admissions to ASU within 4 hours and 90% of stay in a designated Stroke unit targets • Organisational reputation	• There are a cohort of patients that would not be safe in between visits and would still require 24 hour nursing care post stroke; there is no provision currently to care for this cohort of patients at home • Timeliness – not a short term solution as it would require significant financial investment and a corresponding workforce review and recruitment • Longer LOS on the ASU/acute base wards • Whilst patients would go home earlier, some of these patients would still require consultant input and there is no provision for this currently (virtual ward approach would need to be developed) • Lack of downstream flow impacts on patient outcomes, as captured in SSNAP audit • Inability to meet existing LOS targets plus significant impact on direct admissions to ASU within 4 hours and 90% of stay in a designated Stroke unit targets. • Greater risk of readmission without fully resourced workforce • Timely access to medical equipment in the community (e.g. PEG feeds etc.)	• Reduced patient choice as only one site available • Reduced transport links for families • Patients may choose to step off the pathway if they do not wish to receive care at Evesham • Reduced single rooms available compared to current offer • Up-skilling of staff on Abbott ward will be required • Overall reduction in general rehab beds at ECH; however bed modelling indicates that sufficient numbers can still be provided on site for local patients	• Current indication is that there is not sufficient consultant time available to cover 2 site, which may result in an overall reduction in the number of stroke rehabilitation beds currently available and quality of service. • Stroke rehabilitation beds will have to be closed to new admissions periodically when consultant cover is not available • Lack of consultant input impacts on patient outcomes, resulting in delayed decision making around on-going care and increased length of stay • Lack of downstream flow impacts on patient outcomes, as captured in SSNAP audit • The bed modelling data indicated that stroke rehab beds would need to be increased in the north of the county to meet demand; however the bed modelling also indicates that that there is not enough general rehab beds to meet demand, meaning that not all patients could be cared for closer to home • Inability to meet existing LOS targets both on the ASU, and in community settings plus significant impact on direct admissions to ASU within 4 hours and 90% of stay in a designated Stroke unit targets. • Organisational reputation at risk