

What we think about:

Reorganising acute stroke services



Background

There are strong links between evidence-based care and clinical outcomes. That is why some areas of the UK have made significant progress in centralising or reorganising acute stroke services to improve outcomes. This involves concentrating services onto fewer sites and creating Hyper Acute Stroke Units (HASUs) – large centres of excellence operating 24/7 with the best equipment and clinicians under one roof. During this process, smaller neighbouring stroke units may be either closed or changed to stroke rehabilitation wards. Reorganisation is happening or is planned elsewhere in the UK but progress is variable and sometimes challenging.

What we think

Stroke patients should have access to the best possible treatment and care and a lot of progress has been made in several parts of the UK in recent years to make sure that happens, including reorganising hospital stroke services.

Evidence shows that reorganising stroke services and creating large Hyper Acute Stroke Units (HASUs) with the equipment and experts to treat patients all day, every day, can save lives, improve recoveries and save the NHS money. In Greater Manchester and London, where reorganisation has taken place, patients spend less time in hospital and (in the case of London) are less likely to die as a result of their stroke. This isn't just the case for stroke treatment. Reorganising some services for heart attack patients, for example, has led to lower death rates and it has been effective in saving money.

Stroke survivors and their carers report having positive experiences being treated in HASUs, even if they were unsure at first what treatment in these units would mean and worried about any extra travel.

We know that some people may be worried about smaller stroke units closing or changing purpose to make way for HASUs. We also know that reorganisation may not work in all areas, such as very rural parts of the country. Reorganisation should only happen where it can be demonstrated that stroke patients will benefit.

The evidence is clear that centralised stroke units are more likely to provide effective stroke treatment and we want this to be the case across as much of the country as possible. That is why we are calling on health leaders in all parts of the country to get on with service reorganisation in their areas or explain, after looking at the evidence, why they are not able to do so.

Why do we think this?

Reorganisation can reduce disability, save lives and money

Since the English National Stroke Strategy was introduced in 2007, there have been big improvements in the way stroke is treated in hospital. Stroke is now treated as a medical emergency and if you have a stroke, you are more likely to be treated by a stroke specialist in a stroke unit. You are also more likely to receive disability-reducing life-saving clot-busting drugs.¹

While being treated on any stroke unit is better than not being treated on a stroke unit, we know that larger stroke units (HASUs) work more efficiently than smaller ones. Better organised stroke care – as in HASUs – has been shown to reduce mortality.² They are better staffed, have the latest equipment, open 24 hours a day and patients are more likely to get the treatment they need as a result.³

Since reorganisation in Greater Manchester, stroke patients now spend less time in hospital and the same is true in London. In London, nearly an extra 100 lives a year are being saved thanks to reorganisation.⁴ Also in London, there have been savings to the NHS of £5.2 million per year because of reorganisation, or £811 per patient.⁵

Reorganisation of acute services does not just apply to stroke. For example, reorganising some acute cardiac services led to a significant reduction in mortality, high levels of patient and carer satisfaction, as well as being cost-effective.⁶

Stroke survivors support reorganisation

A big effort needs to be made to explain HASUs to patients and carers if they are to be successful and understood. A combination of bottom-up and top-down leadership has proven to be effective in service reorganisation and so it is essential that health leaders engage with the relevant stakeholders, including patients and carers.⁷ Again, in Greater Manchester and London, this is working, although Greater Manchester has been through two sets of reconfiguration in 2010 and 2015. Despite stroke patients often having to travel further to be admitted to a HASU and family and friends having to do the same when they visit, studies have shown that stroke survivors and their families have been happy with their experience of HASUs.⁸

So do the experts

There is widespread support for reorganising acute stroke services and it is strongly recommended in the latest RCP guidelines on stroke:

“People with an acute neurological presentation suspected to be a stroke should be admitted directly to a hyperacute stroke unit which cares predominantly for stroke patients.”⁹

NHS England’s Five Year Forward View referred to the “compelling case for greater concentration of care” and specifically mentioned the centralisation of stroke units in London.¹⁰ The National Audit Office has said that “stroke patients need to be taken directly to a stroke unit capable of providing hyper acute care”.¹¹

Progress on reorganisation across the country is slow and patchy

The evidence of how effective reorganisation can be is currently only focused on Greater Manchester and London but there have been proposals to reorganise in other areas such as the Midlands, South West and East of England. Elsewhere in the UK, for example in Northern Ireland, reorganisation is either currently underway or being planned. Several areas have, however, faced challenges in persuading commissioners, politicians and patients that reorganisation works. We know that reorganisation is high on the agendas of some NHS Sustainable and Transformation Plans (STPs) but that is not the case everywhere.

What do we want to see happen?

NHS leaders and governments must look at the clear evidence of benefits from areas where reorganisation has already happened and make plans for their own reorganisation if they are not already doing so.

Where there are concerns from patients and the wider public about closing or changing the purpose of some stroke units, those concerns should be openly addressed and the evidence for reorganising services clearly explained.

Guidance must be given to NHS providers and commissioners who want to reorganise, including on how best to engage those affected by stroke and wider communities.¹² Areas looking to reconfigure should have clear implementation strategies, ensuring that the right model gets into practice and is adhered to by all involved. For example, in London (where a 'big bang' single system change took place across the city at one time) there was a coherent plan ensuring that all services involved had the capacity to launch the new system simultaneously. Financial incentives were also used in London to reward standards being met.¹³ We welcome NHS England's recently published guidance and this should be replicated across all four UK nations.

It was the National Stroke Strategy that kick-started reorganisation but adoption of the new model has been slow and a new one is needed to take account of the changes in what is a radically changed NHS compared to 2007. Back in 2007, for example, there were no such things as Sustainability and Transformation Plans, Clinical Commissioning Groups or even NHS England. A new national focus on stroke is needed which takes account of these new ways of working and drive forward reconfiguration.

We want those running health services in Northern Ireland, Wales and Scotland to learn from the examples of Greater Manchester and London and set out their assessment of whether similar models could work or are already working in their areas.

What are we doing?

- We will be asking NHS leaders and governments across the UK to follow NHS England's lead and provide comprehensive guidance on how to reorganise acute stroke services.
- We will also be asking the 44 Sustainability and Transformation Plan 'Footprint' areas in England, as well as Boards and Trusts elsewhere in the UK, what steps they are taking to reorganise their services and what barriers they are facing in doing so. We will be engaging with those who have decided to reorganise to ensure that the needs of stroke patients and their families are being met while asking those who have decided against it why that is the case.
- In Northern Ireland, we are engaging with the NI Stroke Network and will be responding to the forthcoming consultation on the modernisation of stroke services to ensure stroke survivors' views are heard. We will be presenting communities with the latest evidence around reorganisation and supporting local involvement.
- As part of a new National Stroke Strategy for England, we want the UK Government to commit to the further roll-out of the reorganisation of acute stroke services in England.
- Finally, we will be offering our support to all health professionals and organisations that decide to reorganise. We recognise that reorganisation of acute stroke services can be complex and controversial, particularly if it involves the closure of existing stroke units. We will be on hand to set out why reorganised services have the potential to significantly improve outcomes for stroke survivors.

What, exactly, do you mean by a Hyper Acute Stroke Unit (HASU)?

Across the UK, there are various definitions of a HASU. For example, some units describing themselves as HASUs are not even admitting patients 24/7. We agree with the Royal College of Physicians¹⁴ which makes clear that a HASU should include:

- Specialist medical staff trained in the management of stroke patients, including the diagnostic and administrative procedures needed for the safe and timely delivery of stroke treatments;
- Specialist nursing staff trained in the management of stroke patients, covering neurological, general medical and rehabilitation aspects;
- Rehabilitation specialists trained in stroke;
- Diagnostic, imaging and cardiology equipment such as brain scanners;
- Tertiary services for endovascular therapy, neurosurgery and vascular surgery;
- Continuous access to a consultant with expertise in stroke, with a consultant reviewing patients every day.

London and Greater Manchester are mentioned a lot. What has happened there?

In London, 30 hospitals providing acute stroke care were centralised into 8 HASUs. Alongside this, 24 stroke units were redesignated as acute rehabilitation units. This reorganisation was designed to ensure that nobody living in London was further than 30 minutes (by emergency ambulance) from a HASU. Evidence suggests that in London, there was a significant reduction in mortality at 3, 30 and 90 days after admission to a HASU, leading to 96 extra lives being saved per year. There was also a reduction in the length of time stroke patients spent in hospital compared to before reorganisation.

Reorganisation was initially done quite differently in Greater Manchester. In both London and Greater Manchester, a small number of HASUs were created to deliver stroke treatment but in Manchester, only patients arriving at hospital within 4 hours of their first symptoms were sent to a HASU.¹⁵ Also, while stroke services in some London hospitals were closed to make way for the HASUs, no services closed in Manchester.¹⁶ As a result, while over 90% of stroke patients were treated in a HASU in London after reorganisation, only 39% were in Greater Manchester. This is as a result of different eligibility criteria for treatment in a HASU.¹⁷ Unlike London, researchers found no significant reduction in mortality for patients treated in Greater Manchester HASUs, but like London, patients did spend less time in hospital. Over the last couple of years, Greater Manchester has moved to a model very like that in London, where the vast majority of stroke patients are taken to a HASU. Manchester stroke services are now performing at least as well as London HASUs.¹⁸

Research is ongoing to evaluate the latest changes to services in Greater Manchester and whether the improvements in London have been sustained.

Is reconfiguration just an excuse for closing local stroke units?

It certainly shouldn't be. Local stroke units should only be closed if it can be demonstrated that stroke patients will benefit from a reorganised service.

How can travelling further to be treated possibly be a good thing?

If you have a stroke, you have a better chance of survival and making a fuller recovery if you are treated in the right way by the right people using the right equipment quickly in a larger specialist stroke unit. That is more likely in a reorganised service, even if the stroke unit you are treated in is located a bit further away than your local hospital. It is important to note that in many cases, you can still be treated quickly after travelling further to reach hospital and travelling for a longer period of time.

Will reconfiguration work for people living in rural areas?

We recognise that reconfiguration won't necessarily work everywhere but it's important that all health leaders consider the available evidence and come up with clear reasoning behind not reconfiguring if they decide that it is not right for their local population. Some studies looking at reconfiguration have shown consistent results when including patients living in rural areas (although there have not been studies looking specifically of reconfiguration in rural areas) but greater travel times in rural areas can make centralisation challenging and might require other solutions.¹⁹

Under what circumstances would you not support reconfiguration?

While there is good evidence that reorganisation has produced good results in some parts of the country, we recognise that it may not be appropriate everywhere. Reorganisation should only happen where it can be demonstrated that stroke patients will benefit. Those wanting to reorganise need to fully engage with patients and set out how it will happen and how services will improve. If we are satisfied that services will improve as a result of reorganisation, we will support the process in local areas.

Reorganisation should certainly not be used as a way to plug staffing gaps. Reorganisation should be approached strategically, ensuring that stroke units are most appropriately located and staffed based on geography and the needs of the local population.

Does this policy apply across the UK?

Yes. Stroke services in all UK nations have to improve. Too many people are not getting brain scans on time, not getting clot-busting drugs or not receiving immediate rehabilitation support.²⁰

In Northern Ireland, Scotland and Wales, national plans for stroke are in place, but more needs to be done within these to introduce reorganised acute stroke services. In Northern Ireland, the Government is planning to consult the public on plans to reorganise stroke services across the country. The National Clinical Strategy for Scotland acknowledges the need to evaluate the HASU model in a Scottish context.²¹

We recognise that for various reasons, reorganisation isn't possible or appropriate everywhere, but health providers across the UK should consider whether reorganisation could improve stroke services and learn from what has happened in Greater Manchester in London, or wherever successful changes have been made.

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We are the Stroke Association

We believe in life after stroke. That's why we support stroke survivors to make the best recovery they can. It's why we campaign for better stroke care. And it's why we fund research to develop new treatments and ways of preventing stroke.

We're here for you. Together we can conquer stroke. If you'd like to know more please get in touch.

Stroke Helpline: 0303 3033 100

Website: stroke.org.uk

Email: info@stroke.org.uk

From a textphone: 18001 0303 3033 100

We are a charity and we rely on your support to change the lives of people affected by stroke and reduce the number of people who are struck down by this devastating condition.

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