Review of urgent stroke care services: Frequently asked questions – January 2018

Introduction

On Thursday 18 January 2018, the NHS in Kent and Medway announced proposals to establish **three hyper acute stroke units** operating 24 hours a day, seven days a week, to care for all stroke patients across Kent and Medway, in some of our boundary areas. These proposals are still subject to further assessment and final approval. No public consultation on the proposals has begun. The public consultation is expected to start at the beginning of February. We'll make sure that people are aware of the starting date of the consultation nearer the time, as well as making all details available on our website at www.kentandmedway.nhs.uk.

This document addresses some frequently asked questions that we have been asked about the proposals to establish hyper acute stroke units in Kent and Medway.

Frequently asked questions

Question: What is the stroke services review and consultation about?

Answer: This is about improving stroke care and outcomes for patients across Kent and Medway. Although general stroke services are currently provided in Kent and Medway's hospitals, there are currently no specialist hyper acute units. Hyper acute stroke units in other parts of the country have been shown to improve outcomes for people who have had a stroke.

We have published a proposed list of five options for where the three units could be located across Kent and Medway. All five options include the William Harvey Hospital in Ashford, along with two other sites from either Darent Valley Hospital, Medway Maritime Hospital, Maidstone Hospital and Tunbridge Wells Hospital.

Under the proposals, each site would also have:

- an acute stroke unit where people may go after the initial 72 hours for further care until they are ready to be discharged
- a transient ischaemic attack clinic (TIAs are also known as "mini strokes" and can be an indication that a stroke may follow).

These five proposed options are:

A. **Darent Valley Hospital, Medway Maritime Hospital, William Harvey Hospital**
B. **Darent Valley Hospital, Maidstone Hospital, William Harvey Hospital**
C. **Maidstone Hospital, Medway Maritime Hospital, William Harvey Hospital**
D. **Tunbridge Wells Hospital, Medway Maritime Hospital, William Harvey Hospital**
E. **Darent Valley Hospital, Tunbridge Wells Hospital and William Harvey Hospital**

The order is not a ranking and we are not identifying a preferred option until we have fully and carefully considered the views and feedback gathered via public consultation alongside any additional information gathered.

The consultation is expected to start at the beginning of February. We'll make sure that people are aware of the starting date of the consultation nearer the time, but all details will be on our website at www.kentandmedway.nhs.uk.

Question: Why do things need to change? We already have stroke services in six hospitals across Kent and Medway?

Answer: At the moment we don't have any hyper acute stroke units in Kent and Medway and most of our hospitals struggle to meet national best practice standards of care for stroke patients, for example giving people a brain scan within an hour of getting to hospital. This is mainly because our resources are stretched too thinly across too many hospitals.

We want to make sure urgent stroke services in Kent and Medway can meet national best-practice standards so that patients get the best possible care and outcomes. To make this possible we believe we need to consolidate our resources into three specialist hyper acute stroke units, instead of having six general stroke units that can't consistently deliver best-practice. We have planned carefully to make sure that the travel time to the proposed new hyper acute stroke units will be as short as possible.

Question: Are the changes being proposed to save money?

Answer: To make the proposed changes to urgent stroke services we will need to invest up to £40million in hospitals and recruiting more staff. The changes are focused on ensuring the best care and outcomes for people who have a stroke, meaning faster diagnosis and treatment, fewer deaths, and less disability. They are also about getting the best value for the money spent on stroke services. From the time the changes are made, the better outcomes for patients will also mean a reduction in the overall cost of stroke services. The reduction will be mainly due to better recovery for patients who wouldn't then need as much longer-term care.

Question: What will the benefits be of these proposed changes?

Answer: Reorganising urgent stroke services in the way we are proposing will mean everyone treated for stroke in Kent and Medway would get consistently high-quality care regardless of where they live or what time of day or night a stroke occurs. We know from national and international evidence, and from examples in other parts of the country that hyper acute stroke units help reduce disability and death from stroke. In London, hyper acute stroke units have reduced deaths from stroke by nearly 100 a year.

We also believe we will find it easier to staff our services and have the other resources needed (such as scanners) available all the time.

Question: How is this proposal different from what we do now?

Answer: At the moment we don't have any hyper acute stroke units in Kent and Medway. This means that patients treated in our area do not consistently have access to care from a team of stroke specialists and therapists round the clock with consultants on the wards seven days a week. Also:

- We only have **one third of the stroke consultants needed** to deliver a best practice service in all hospitals
- Fewer than one in three stroke patients are **getting brain scans** in recommended time
- Half of appropriate patients **not getting thrombolysis (clot busting drugs)** in recommended time of two hours from calling an ambulance

- Only one unit in Kent and Medway is **seeing enough stroke patients** for staff to maintain and develop expertise (recommended minimum of 500 stroke patients per year)

All these factors mean we are not offering the best care to people experiencing stroke. We want to change this as soon as possible.

Question: Will it take longer for some patients to get to hospital with these proposed new plans? Is that safe?

Answer: Depending on where you live, the ambulance journey to reach one of the proposed hyper acute stroke units may be longer than being taken to your current nearest A&E. However, a shorter journey to a hospital without a hyper acute stroke unit can be worse for stroke patients than a longer journey to a hyper acute stroke unit. The evidence tells us that keeping to a minimum the time it takes from calling 999 to getting a brain scan and appropriate treatment gives stroke patients the best outcomes. Because hyper acute stroke units have dedicated teams on hand 24-7, they can often respond faster when a patient arrives at hospital than A&E departments without a hyper acute stroke unit. This cuts down the overall time between calling 999 and getting treatment, even if the patient has travelled further.

The evidence, from elsewhere in the country where similar changes have already been made, shows that patients who are treated in a hyper acute stroke unit have a much better chance of surviving and making a good recovery, even if they travel further to get there.

National standards say that patients should get clot-busting drugs, if they need them, as early as possible but ideally within two hours of calling for an ambulance. Therefore, we considered that an hour was the maximum acceptable journey time by ambulance, to allow enough time once a patient gets to a hyper acute stroke unit to have a scan and be given clot busting drugs if needed. Up to one third of stroke patients may need clot busting therapy.

It is also important to remember that ambulance paramedics are skilled professionals who begin assessment as soon as they arrive and provide care throughout the journey. The ambulance service's call handlers are also an essential part of identifying potential strokes and ensuring patients are taken to the most appropriate hospital and receive a quick response when they arrive.

Question: Could you explain more about how you considered travel times for patients when deciding on the proposed shortlist?

Answer: We have spent a significant amount of time modelling the travel times as part of the development of these proposals. All five of the proposed options mean that 98 per cent of people could reach a hyper acute stroke unit by ambulance within an hour. The journey for the other 2 per cent of people would be just a few minutes longer. For all the proposed options, over 90 per cent of people could reach a hyper acute stroke unit within 45 minutes by both ambulance and car. Around 75 per cent of people could reach a hyper acute stroke unit within 30 minutes by both ambulance and car. In developing our shortlist of potential options, we rated the options with the shortest journey times for the most people more positively.

Question: Why are you proposing three HASUs specifically?

Answer: Having more than three hyper acute stroke units would spread our staff and patients too thinly to make the service safe, sustainable and to allow the delivery of high

quality care. By consolidating specialist staff, our equipment and other resources into three hyper acute stroke units we can provide care to the best-practice standard that all patients should expect, and staff want to provide.

Stroke specialists, and other stakeholders, including patients and the public, have broadly agreed that the option of one or two hyper acute stroke units should be excluded. This was because three units will make the system more resilient - for example to help manage peaks in demand, or if one unit was not usable due to damage from say a flood or fire – as well as offering fast access to patients.

Question: How does the rehabilitation and long-term care of stroke patients fit in to these plans?

Answer: Everyone who has a stroke benefits from receiving care in a hospital with specialist stroke staff, followed by specialist stroke rehabilitation and then support in the community if needed. While these proposals deal with the creation of specialist stroke units (which includes the rapid start of intensive rehabilitation), on-going rehabilitation and care and support provided to stroke patients within the community will continue. As part of our wider programme of work looking at how best to deliver health and care services to people across Kent and Medway, we will be looking at improving existing support and rehabilitation services.

Question: Why are some hospitals in Kent and Medway not included in any of the options?

At different stages of the evaluation process we excluded some of the hospitals in Kent and Medway because they did not meet the required criteria. Two of the seven sites have been excluded from all the shortlisted options:

Queen Elizabeth, the Queen Mother Hospital: Some hospital trusts in Kent and Medway currently provide stroke services on more than one hospital site. We asked these trusts to assess whether they could set up and run more than one hyper acute stroke unit. East Kent Hospitals University NHS Foundation Trust (EKHUFT) concluded that it would be very difficult to attract enough specialist stroke staff to safely run two units. Therefore, options with a hyper acute stroke unit at both the William Harvey Hospital and the Queen Elizabeth the Queen Mother hospital (the two sites managed by EKHUFT) were evaluated more poorly than the other options.

Kent and Canterbury Hospital: The reasons outlined for why the Queen Elizabeth, the Queen Mother Hospital are not included in proposals also applies to the Kent and Canterbury Hospital. Namely, East Kent Hospitals University NHS Foundation Trust (EKHUFT) concluded that it would be very difficult to attract enough specialist stroke staff to safely run two units.

In addition, the Kent and Canterbury Hospital does not currently offer acute stroke services or the range of other emergency and urgent care services that are needed to support a hyper acute stroke unit.

Of the sites run by the trust, (notwithstanding the note below about potential future changes in east Kent) the William Harvey Hospital was identified as the best option for a hyper acute stroke unit. This was in part because of the existence of other services that are desirable to have located alongside a hyper acute stroke unit.

There is a separate review of the possible options for the future location of emergency care and specialist services in east Kent. It would be wrong to wait for this work to be completed

because this would slow down the essential decisions we need to make on stroke services. If, following the east Kent review, the William Harvey Hospital was no longer a long-term option for emergency and specialist services and these moved elsewhere – then we would anticipate any hyper acute stroke service would also move with them, subject to a formal public consultation.

Question: How does the work looking at the configuration of hospitals in east Kent link in with these proposals?

Answer: In December 2017, we published the 'medium list' of options for how hospital services in east Kent might be organised in the future. One of these options included the creation of a new hospital site in Canterbury. This is being looked at along with other ways of providing emergency hospital care across east Kent. Any decision to build a new hospital would be subject to planning permission and part of a much longer process. We need to act now to create a new and better system for urgent stroke services across the whole of Kent and Medway based on the facilities that we currently have. If a new hospital is built and the William Harvey Hospital was no longer a long-term option for emergency and specialist services – then we would anticipate any hyper acute stroke service would also move with them, subject to a formal public consultation.

Question: Are there enough staff to support these proposed changes?

Answer: There is a shortage of stroke consultants – nationally around 40% of stoke consultant posts are vacant – and of specialist stroke nurses and therapists. This is partly why we want to organise services so that can use the staff we have more effectively. All the proposed options will mean we need to recruit additional consultants, but we have evaluated the options which require the fewest additional consultants more highly. It is also better for us to concentrate these scarce doctors in fewer hospitals to provide the highest quality care around the clock, rather than spread them too thinly across a more hospitals.

If these proposals go ahead, we will develop a detailed staff development and recruitment plan as part of establishing hyper acute stroke units. We know from other areas around the country that hospitals with hyper acute stroke units find it easier to recruit stroke consultants and other specialist stroke staff because they offer better opportunities for professional development, and allow staff to care for patients in line with national best practice.

Question: Under the proposals, what would happen to staff at existing stroke units not chosen to be a HASU?

Answer: We know from staff feedback that specialist stroke staff support the development of hyper acute stroke units to improve the quality of care for patients. At the moment we face staffing challenges with significant vacancies in the stroke services at all six current sites. We believe that setting up three hyper acute stroke units would improve recruitment and retention in the medium to long term, however, there may be short term disadvantages.

The changes would mean that some existing staff would be asked to change where and how they work. For some staff this would mean longer travel times to work, different shift patterns, working with different people and in a different environment. All organisations across Kent and Medway will use best endeavours to support staff in making the transition so we retain our existing staff within the stroke units, but for some the impact of these changes on work and home life may not be acceptable and we may be at risk of losing some of our talented and dedicated stroke staff. However, if changes were unsuitable for individuals, we expect that most would be offered alternative roles allowing them to stay on the same site.