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

Introduction

On Friday 2 February 2018, the NHS in Kent and Medway, Bexley in south east London and the High Weald area of East Sussex, launched a public consultation on the future of urgent stroke services in Kent and Medway. The NHS is asking for people's views on proposals to establish new 24/7 hyper acute stroke units in Kent and Medway. The consultation runs from Friday 2 February 2018 for 10 weeks until midnight on Friday 13 April 2018.

Full details are 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 are proposing to establish hyper acute stroke units in Kent and Medway, and the proposals recommend establishing three units. The proposals also set out a five options for where these three units could be located across Kent and Medway.

Under the proposals, hyper acute stroke units 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 runs from Friday 2 February until Friday 13 April 2018. All details are 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 would 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 would need to invest up to £40million in hospitals and recruiting more staff. The proposed 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 proposed changes were made, the better outcomes for patients would also mean a reduction in the overall cost of stroke services. The reduction would 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 would 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 would 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.

Question: What about the 'golden hour' for treatment? Won't the longer journey times mean this isn't achievable?

The study from which the so-called "golden hour" comes was carried out in America nine years ago and is not based on up to date evidence. As the NHS, we work to the National Clinical Guideline for Stroke, which is the definitive source of how stroke care should be delivered in the UK to give the optimum outcomes.

This national guideline says that patients should get clot-busting drugs, if they need them as soon as possible, ideally within 3 hours of symptoms starting (and at most within 4.5 hours of stroke). Between 10 and 20 per cent of stroke patients may need clot busting therapy (thrombolysis).

In the South East, we have set ourselves the even more stringent standard of patients getting clot-busting drugs, if they need them, 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.

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 99.9% 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 seconds 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 would be able to 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?

Answer: 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. The Queen Elizabeth the Queen Mother and the Kent & Canterbury hospitals have been excluded from all the shortlisted options.

Both hospitals are run by the East Kent Hospitals University NHS Foundation Trust; who also run the William Harvey Hospital. We have worked closely with the Trust to look at each site's potential to be a hyper acute stroke unit:

- Kent & Canterbury Hospital – does not currently provide a stroke service or the range of other emergency and urgent care services that are needed to support a hyper acute stroke unit. This meant it did not pass the 2nd stage of our evaluation process.
- Queen Elizabeth the Queen Mother Hospital – does have the emergency and urgent care services needed to support a hyper acute stroke unit, but does not have a range of other services that are desirable to have alongside a hyper acute stroke unit. This meant that while it was included in our medium list; it was evaluated less favourably than the William Harvey which has both the needed and desirable services.

We also asked the Trust whether it could develop 2 hyper acute stroke units. They concluded that it would be very difficult to attract enough specialist stroke staff to run 2 units; so options including both the Queen Elizabeth the Queen Mother and William Harvey sites were evaluated more poorly and did not make the shortlist that is part of this consultation.

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 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.