Reshaping Stroke Care: Frequently Asked Questions

1. What is being proposed?
   - Stroke is a major health issue. The impact of a stroke can be devastating. Each year around 2,800 people in Northern Ireland are admitted to hospital having suffered a stroke. A further 36,000 stroke survivors live in our communities.
   - There is strong evidence that patients are more likely to be alive, independent and living at home after one year, when they receive Hyperacute Stroke care during the first 72 hours. This is because they are more likely to receive all the key elements of acute stroke care such as swallow tests, early rehabilitation and specialist professional assessments. Professional and clinical guidelines recommend that every stroke patient is admitted to a Hyperacute Stroke Unit.
   - We need to consolidate services on a smaller number of hospital sites with the full range of specialist services and staff available 24/7.
   - Reshaping stroke care in this way would ensure that everyone in Northern Ireland has access to the highest quality care for the crucial first 72 hours of stroke care regardless of where they live or what time of day or night stroke occurs.

2. What are the options?
   - We have identified six options for the configuration of Hyperacute Stroke Care in Northern Ireland. These are summarised in the table below.

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<thead>
<tr>
<th>Option</th>
<th>Configuration</th>
<th>HASU sites</th>
<th>ASU sites</th>
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<tbody>
<tr>
<td>A</td>
<td>5 HASUs</td>
<td>Royal Victoria Hospital (RVH), Craigavon, Altnagelvin, Antrim, South West Acute Hospital (SWAH).</td>
<td>RVH, Craigavon, Altnagelvin, Antrim, SWAH</td>
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<tr>
<td>B</td>
<td>4 HASUs</td>
<td>RVH, Craigavon, Altnagelvin, Antrim.</td>
<td>RVH, Craigavon, Altnagelvin, Antrim. Possible 5th ASU at Ulster</td>
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<td><strong>Phased approach</strong></td>
<td>RVH, Craigavon, Altnagelvin, Antrim</td>
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<td></td>
<td>Stage 1: 4 HASUs</td>
<td>RVH, Craigavon, Altnagelvin</td>
<td>RVH, Craigavon, Altnagelvin, Antrim and Ulster</td>
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<td>Stage 2: 3 HASUs</td>
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</table>

- 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.

- We have now extended the consultation period until 19 July in order to ensure that there is enough time for the public to fully consider the proposals and submit their views to the Department.

3. What’s wrong with our current service? Why do we need to change it?

- Services across Northern Ireland are improving, but there is still significant variation in terms of the time in which patients are seen and the treatment they can access.

- It is known that many patients in Northern Ireland do not receive the highest quality of stroke care. As a result there is a significant number of avoidable hospital admissions, nursing home admissions, disability and deaths as a result of stroke.
• The majority of units in Northern Ireland do not currently see enough stroke patients for staff to maintain and develop expertise according to the recommended minimum of 500 stroke patients per year.

• We currently have vacancies in four of the eight sites where acute stroke services are provided and there is a national shortage of specialist stroke staff. While performance in Northern Ireland has been improving, the workforce shortages increase the risk of the service collapsing if it is not possible to deliver a safe service.

• A smaller number of specialist sites makes it easier to plan and deliver a resilient service that can cope better with fluctuations in workforce. Ultimately, this delivers a more reliable service for patients and a better, more stable working environment for staff.

• All of the options included in the consultation document would require additional investment in the workforce.

4. Why are some hospitals not included in any of the options?

• The National Clinical Guideline for Stroke sets out that people need thrombolysis as soon as possible (at most within 4.5 hours of stroke). Up to 20 per cent of stroke patients may benefit from clot busting therapy (thrombolysis).

• While the current organisation of thrombolysis services scores favourably on accessibility it does not score favourably on clinical outcomes. There is significant clinical variation in thrombolysis rates and door to needle time in patients assessed for stroke in the current thrombolysis sites.

• One factor that sometimes affects how quickly treatment is delivered is the numbers of stroke patients attending each hospital and the experience gained by the local stroke teams. Research indicates that hospitals which admit higher numbers of stroke patients each year are both more likely to provide people with clot busting treatment and to deliver this more quickly. The time taken to deliver treatment was found to be much shorter when services deliver more than 50 treatments a year.¹

• Moreover, the most important factor in stroke care is not the time to hospital. It is the time to expert assessment, brain scanning and treatment that is critical. The

¹ Bray et al (2013) Associations Between Hospital Thrombolysis Volume and Speed of Thrombolysis Administration in Acute Ischemic Stroke http://stroke.ahajournals.org/content/44/11/3129.full
modelling undertaken by the University of Exeter (available on the Department’s website) demonstrates this.

- In smaller units, it is more difficult to provide the specialist staff, and more expensive to deliver high quality services, in a sustainable way, over seven days. Furthermore, where the number of stroke patients attending a hospital is small, stroke may not be recognised as a distinct speciality and patients are often admitted to the care of general medical or elderly medicine consultants.

- The Stroke consultation is about ensuring that as many patients as possible receive the best outcomes after a stroke and this requires us to plan to develop services that are accessible, effective, efficient and sustainable. For these reasons we need to plan to have fewer sites involved in Hyperacute Stroke Unit (HASU) care.

5. The plans do not meet the Golden Hour. What if it takes longer for me to get to hospital than it does currently? Will I be at risk?

- The ‘Golden Hour’ is not a recognised term in stroke care. In our healthcare system, 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. It is based on evidence of what delivers the best outcomes for stroke patients.

- The guideline sets out that people need thrombolysis as soon as possible (at most within 4.5 hours of stroke). Up to 20 per cent of stroke patients may benefit from clot busting therapy (thrombolysis).

- The most important factor in stroke care is not the time to hospital. It is the time to expert assessment, brain scanning and treatment that is critical. The modelling undertaken by the University of Exeter demonstrated this.

- The proposals do mean that some patients may have to travel further than is currently the case. However, they will arrive at a service that is fully resourced with dedicated staff and scanners available 24 hours a day 7 days a week. This means that no matter what time of day patients arrive at the service, they will be able to receive the most effective brain imaging and treatment as quickly as possible.

- There is a small number of people who die within a few hours of a stroke. Sadly, very little can be done for these patients and they would very likely have the same outcome wherever they are.
The majority of deaths from stroke happen in the days and weeks afterwards, often due to complications of the original stroke. Hyperacute stroke units have been proven to be better at preventing these complications and reducing deaths. In Greater Manchester it is estimated that 69 extra lives are being saved each year thanks to hyper acute stroke units. In London around 100 extra lives a year are being saved.

6. Why can’t thrombolysis continue to be provided at smaller hospitals?

- Thrombolysis should only be given in units where staff are trained and experienced in the provision of stroke thrombolysis, with a thorough knowledge of the contraindications to treatment and the management of complications.

- Emergency medical staff, if appropriately trained and supported, should only administer thrombolysis provided that patients can be subsequently managed on a hyperacute stroke unit with appropriate neuroradiological and stroke physician support.

- It may be possible to continue to administer thrombolysis at smaller hospitals through a networked approach with emergency departments. However, it would have to be clearly demonstrated that teams could deliver a door to needle time of within 40 minutes. Without this assurance, there would be little or no benefit to patients who would be better to travel immediately to the nearest hyperacute Stroke Unit.

7. What about rehabilitation? What happens when I leave hospital?

- Stroke rehabilitation usually begins in hospital in stroke unit and continues after hospital discharge by either a community stroke team or an early supported discharge team.

- Under the proposals, patients would follow a very clear journey:
  1. At first patients will stay on the hyper acute stroke unit for about 3 days (depending on each individual patient and their needs).
  2. Then if they are well enough they will go home, or go to the acute stroke unit (at the same hospital) until they are well enough to go home.
  3. Around two thirds of stroke survivors will require some continued support or rehabilitation in a community setting. Rehabilitation will be tailored to each patient’s needs and provided in or as close to their home as possible.
8. Is this really about saving money?

- Absolutely not. The focus of the proposals is introducing a better model of care that will deliver improved patient outcomes.

- All of the options included in the consultation document would require additional investment in terms of staff, services and equipment.

9. Where can I get more information?

- More information is available on the Department’s website which contains a copy of the full consultation document as well as some of the key pieces of research underpinning the proposals. It is available at [https://www.health-ni.gov.uk/reshaping-stroke-care](https://www.health-ni.gov.uk/reshaping-stroke-care).

- All stroke services across the UK provide regular performance information to the Sentinel Stroke National Audit Programme (SSNAP), run by the Royal College of Physicians.

- They publish data quarterly and annually. The following links may be helpful to access the SSNAP data for Northern Ireland:
  - Regional reports [https://www.strokeaudit.org/results/Clinical-audit/Regional-Results.aspx](https://www.strokeaudit.org/results/Clinical-audit/Regional-Results.aspx)
  - Interactive maps [https://www.strokeaudit.org/results/Clinical-audit/Maps.aspx](https://www.strokeaudit.org/results/Clinical-audit/Maps.aspx)