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What are the lessons for major system change from centralising stroke services in London & Manchester?[1]

Research: at a glance

What we know

In 2010, stroke services in London and Greater Manchester were centralised into a small number of specialist 'Hyper Acute Stroke Units' (HASU).[2]

In London, **all stroke patients** were eligible for treatment in a HASU. In Greater Manchester, only patients arriving at hospital **within four hours of stroke** were eligible.

The outcomes of centralisation differed:

- **London**: mortality and length of hospital stay fell more than in the rest of England
- **Greater Manchester**: length of stay fell but no impact on mortality relative to rest of England.[3]

Centralised systems that admit all stroke patients to HASUs, as in London, are significantly more likely to provide evidence-based care.[4]

We examined why services were more fully centralised in London than in Greater Manchester using stakeholder interviews (45) and documents (316) associated with changes.[1]

We assessed how the different approaches to leading change led to significantly different service models being introduced.

What we found

In London:

- System (top-down, region-wide) in the form of the then London Strategic Health Authority & clinical (bottom-up) leadership **combined to introduce change**
- System leadership was **used to overcome resistance** from some hospitals and local commissioners to centralising services.

In Greater Manchester:

- Bottom-up approach led by local hospitals and service commissioners.
- Change was **planned by agreement** among the local organisations involved.
- Programme leaders **lacked power over providers**, meaning that leaders were **less able to challenge resistance** and introduced less radical changes to services.

What this means

Both system (top-down) and clinical (bottom-up) leadership is necessary to enable change.

System leadership can:

(a) provide **authority and power to co-ordinate** local stakeholders to agree to change services over a wide area

(b) capitalise on clinical leadership to develop further support for the goals of change.

Policymakers should consider value of system leadership (**with performance management and financial incentives**) to encourage different stakeholders to forgo their own interests (potentially) and agree to collective change.

References

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Our website

www.ucl.ac.uk/dahr/research-pages/stroke_study

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