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.

<table>
<thead>
<tr>
<th>What we found</th>
<th>What this means</th>
</tr>
</thead>
</table>
| **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. | 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. |
| **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. | 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


Contact
simon.j.turner@ucl.ac.uk

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

This project was funded by the National Institute for Health Research Health Services & Delivery Research programme (Project number 10/1009/09).

The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR, NIHR, NHS, or the Department of Health.

Images courtesy of NHS Photo library