Our ref: TO00000169878

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12 January 2006

Dear Mr Alexander,

Thank you for your letter of 6 December to Rosie Winterton about stroke services. As you will appreciate, Ms Winterton receives a large amount of correspondence and cannot answer all of her mail personally. Your letter has been passed to me for reply and I hope you find the following information helpful.

Below, I have reproduced the points raised in your letter and provided the Department of Health's response:

National Service Framework for the Elderly - Section 5

1) The NSF is now well behind the times and the DH should not be promoting it as the main guidance for the treatment of people with stroke. This is because it sets a standard for scans to be carried out within 24 hours of symptom onset, a target that is well out of date and has been replaced by the three hour best practice target. However, many Trusts still rely upon the NSF because it is still promoted by the DH as national guidance (NINDS rt-PA Stroke Study Group. Generalized efficacy of t-PA for acute stroke. Stroke. 1997; 28: 2119–2125).

Our previous letter to you referred to the *Older People's National Service Framework* (NSF) *Chapter 5* to outline existing work prior to the National Audit Office (NAO) Report. As the NAO report points out, the NSF has helped kick-start the widespread development of specialist stroke services. Where specialist stroke services were uncommon ten years ago, they are now in place everywhere. The Department is developing an NSF-style stroke strategy with six expert project groups: prevention and public awareness; transient ischaemic attack and minor stroke services; emergency response; hospital care; post-hospital care: and Workforce. The strategy is due to be published in autumn this year.

The Department is also working with the Royal College of Physicians, which is producing updated clinical guidelines for stroke by 2008.

Furthermore, the National Institute for Health and Clinical Excellence (NICE) is preparing guidance on acute stroke, also due to be completed next year.

2) A 'specialist stroke service' is not a 'stroke unit' and may be quite rudimentary. Similarly, a 'stroke unit' might be a fully staffed 24/7 unit providing scanning and treatment within 3 hrs of symptom onset, or might be very basic providing few beds and scanning within 24 hours. We understand that after 3 hrs has elapsed, thrombolysin cannot be used because it could cause a fatal bleed.

There are two types of stroke: acute ischaemic stroke and haemorrhagic stroke. Thrombolysis can only be used for the treatment of acute ischaemic strokes, which are caused by a blood clot forming in the brain. Thrombolysis treatment dissolves the blood clot. This therapy is most effective in reducing brain damage within the first three hours of onset of symptoms. Therefore, it is not recommended for use after this time period.

A haemorrhagic stroke is caused by bleeding on the brain so thrombolysis is not used as it would only cause further bleeding.

3) The DH's stroke strategy is age related: "By 2010 the Government aims to reduce the death rate from Stroke, CHD and related diseases in people under 75 by at least 40% even though their main policy on stroke is contained in the NSF for the elderly. Isn't it time to change this so that it applies to the over 75s who are most affected by stroke? (http://tinyurl.com/mj9k7)

The above target was set by taking into account a range of factors, including:

- the advice of experts, based on their knowledge of the range of interventions available and their likely impact over the period until 2010,
- an analysis of international data – showing what has been achieved in the best performing countries and how quickly; and
- an extrapolation of recent trends in this country.

Implementation of Best Practice on Stroke Care

It is baffling that although you have the power to oblige all PCTs to commission a 24/7 service for scanning and treatment within 3 hrs that you refuse to use this power to save hundreds of lives. We do of course welcome the appointment of Professor Boyle to lead on stroke care.

Since 2003, financial control and responsibility has rested with the local NHS service commissioners. However, to help local providers to improve their stroke services, we published an evaluation toolkit. As mentioned in our previous reply, the toolkit, ASSET, is designed to help health providers understand how they can improve stroke services by reviewing performance compared with other providers, and identifying the positive impact on patient outcomes and efficiency from four specific service interventions. I have been informed that stroke teams are using this resource locally to persuade managers to invest in important improvements. Furthermore, the Department has just launched ASSET 2, which shows Primary Care Trusts (PCTs) and GPs that, by using their own statistics, improved care will save money in the long

run, reduce hospital bed days, and save lives.

National Audit Office Report

Can you let us know what progress has been made by the DH with implementation of NAO recommendations?

The Department will not be publishing a report on implementing the NAO report recommendations. Considerable progress has already been made and the Department has asked NICE to produce a clinical guideline on acute stroke and a technology appraisal on thrombolysis, and has provided a toolkit and guide on stroke for commissioners.

The Department published a formal response to the Public Accounts Committee report on stroke which sets out the Department's position in more detail at:

NHS Direct

Whilst we are pleased that NHS Direct provides advice about the diagnosis of stroke, we doubt very much whether a diagnosis could be made by phone without seeing the patient. It worries the Forum that NHS Direct think they can distinguish between an urgent and emergency case on the phone. Also delays in accessing NHS Direct are often far too long to allow treatment to begin within three hours of onset. Immediate and rapid referral of all 'possible' strokes by ambulance to a stroke unit, for immediate scanning and diagnosis is the only adequate service. Would you commit yourself to this?

NHS Direct is represented on our national stroke strategy emergency response project group and the Department is aware of the problem of delays. Work has recently been undertaken with NHS Direct to prove the algorithms they use so that an emergency response to stroke is triggered.

Scanners

1) How many additional CT scanners have been installed since 2000 (apart from the replacement scanners)? How does this increase compare with annual increases in other developed countries?

Of the 217 new and replacement scanners that have been installed since April 2000, 88 are additional.

2) How many additional radiologists have been trained since 2000 to read CT scans of the brain? We understand that only specially trained radiologist (not radiographers or neurologists) can read these scans and that a huge training programme would be needed to ensure 24/7 cover. What is badly needed is a sufficient number of radiologists to read CT scans of the brain. What is your plan to ensure that the NHS has a sufficient number of fully training neuroradiologists?

The Department does not currently have details of radiologists trained to read CT scans of the brain but will have this information following the specialist review mentioned earlier. Options such as teleradiology (interpretation of scans on another site) will be explored. In general, patients suffering stroke currently get a CT scan. The focus of our work is on bringing the timing of the scan forward so that patients can benefit from thrombolysis if suitable.

3) How effective and how developed is the PACS system for examining scans remotely. Where is the system is being used and is the system affected by the problems with the NHS computer system?

Over half the Trusts in England now have PACS solutions covering all geographical regions. NHS Connecting for Health has implemented internationally-proven PACS solutions in over 65 Trusts. The Department is planning to complete PACS deployments in every Trust by the end of 2007.

Direct Access for the Ambulance Service

'Taking Healthcare to the Patient' emphasised the need to develop local agreements for the rapid and direct transfer of patients to specialist stroke units by ambulances services. It is undisputed that earlier diagnosis and treatment is essential for effective stroke care. Will you therefore agree to ***require*** *ambulances services to establish local agreements with NHS Trusts, deliver stroke patients direct to specialised acute stroke units, which have the capacity to provide appropriate care within three hours.*

Leaving people to deteriorate in an A&E department, losing vital minutes, surely cannot be justified.

The Department published *Mending hearts and brains - clinical case for change*, a Report by Professor Roger Boyle, National Director for heart disease and stroke on 5 December 2006. This report shows that the emphasis has shifted so that paramedics should, using the FAST (Facial Arm Speech Test) discover quickly if the patient is having a stroke. The patient should then be taken straight to the stroke unit for scanning and appropriate treatment. It is likely that the national stroke strategy will recommend exploring models for 'hub and spoke' stroke treatment to enable this.

However, the report also highlights that services will need to be organised according to geography as needs will vary. This will be where local decision-making comes in

2) Would you agree that the Healthcare Commission should be monitoring NHS Trusts to make sure that all stroke patients are getting scanned and treated within 3 hours of symptom onset? Will you ask the HCC to do this?

When the stroke strategy is published, the Department will be working with the Healthcare Commission to develop appropriate indicators to monitor its implementation.

The current system in which you expect local PCTs and NHS Trusts to implement best practice is clearly failing patients in some cases. The Forum believes that you are supporting post-code access to treatment despite your previous attack on this system.

Would you agree to tell the NHS that the best practice standard of treatment required for the adequate treatment of stroke patients should be mandatory by April 1st 2007 and available to all patients?

There are a range of levers for making change happen – from commissioning arrangements and inspections through to patient power and internal pressure from frontline staff working in stroke teams. The Department will be looking at which mechanisms are most suitable to achieve the range of objectives recommended by the expert project groups helping us to develop the strategy.

I hope this reply is helpful.

Yours sincerely,

Stephen Atkinson
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Department of Health