House of Commons

Committee of Public Accounts

Progress in improving stroke care

Twenty–sixth Report of Session 2009–10

Report, together with formal minutes, oral and written evidence

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The Committee of Public Accounts

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The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at http://www.parliament.uk/pac. A list of Reports of the Committee in the present Session is at the back of this volume.

Committee staff

The current staff of the Committee is Sîan Woodward (Clerk), Lori Verwaerde (Senior Committee Assistant), Pam Morris and Jane Lauder (Committee Assistants) and Alex Paterson (Media Officer).

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Contents

Report

Summary

Stroke is one of the top three causes of death and the largest cause of adult disability in England, costing the NHS at least £3 billion a year in direct care costs, with wider economic costs of around £8 billion. In July 2006 our first report on this important subject[1] highlighted serious shortcomings across the whole stroke care pathway, concluding that the human and economic costs of stroke could be reduced by re-organising services and using existing capacity more wisely.

We welcome the demonstrable improvements in stroke care which the Department of Health (the Department) has achieved since our first report. The Department and NHS have increased the priority given to stroke, particularly the speed of the acute hospital response. We also congratulate the Department on the excellent Stroke—Act F.A.S.T. media campaign and the impact this has had on raising staff and public awareness.

However, improvements have not been universal. We find it totally unacceptable that the likelihood of receiving a timely brain scan or accessing specialist care is dependent on where and when you have a stroke. For example, if you have a stroke in London, it is much more likely that you will get a scan within 3 hours and certainly within 24 hours—but in Grimsby, Lincolnshire, too many patients have to wait up to 48 hours—increasing the likelihood of complications and long term disability. Similarly, the proportion of patients treated on a specialist stroke unit, although improving, is still well short of the Department's target of 90%, with some regions showing extremely wide variations.

The improvements in hospital care are not yet matched by progress in delivering more effective support once stroke survivors leave hospital. Many patients discharged from hospital continue to struggle to obtain follow-up care and access to community rehabilitation services remains a post-code lottery. There is also a risk that the current level of services will not be sustained once the funding provided by the Department to help implement the strategy ends next year.

There are a number of systemic problems restricting further development of stroke services, such as a lack of effective joint working between health and social care and limitations in out-of-hours hospital care. There is an opportunity for the Department to consolidate its experience from implementing this strategy and its efforts to improve the quality of care in other disease areas to ensure that these challenges are overcome.

On the basis of a Report by the Comptroller and Auditor General,[2] we examined the Department on how to sustain and improve still further the standards of services for all stroke patients across the whole stroke care pathway and what lessons could be learnt from its experience in developing and implementing the stroke strategy.

1 Committee of Public Accounts, Fifty-second Report of Session 2005–06, *Reducing brain damage: faster access to better stroke care*, HC 911

2 C&AG's Report, Session 2009–10, *Progress in Improving Stroke Care*, HC 291

Conclusions and recommendations

1. **In response to the shortcomings outlined in our 2006 report, *Reducing Brain Damage: Faster access to better stroke care*, the Department has achieved some commendable improvements in stroke care.** We welcome the higher priority that is now being given to stroke care, including the greater awareness of the importance of a fast response. A key development has been the Department's campaign, Stroke—Act F.A.S.T., which has improved public awareness of stroke and the responsiveness of ambulance and hospital staff.

2. **It is not good enough that only 59% of patients are scanned within 24 hours of having a stroke.** Although immediate scanning is vital to achieve the best outcome for stroke patients, too many hospitals are still failing to operate their scanning services 24 hours a day. During 2010–11, the Department should use the *Best Practice Tariff* and the Stroke Improvement Programme to require all hospitals to provide timely access to scanning for all patients who might be eligible for the clot-busting drug, *thrombolysis*. In particular, we expect the Department to make substantial improvements in notably poor performing hospitals, such as Grimsby's Diana Princess of Wales Hospital.

3. **Although treatment on a specialist stroke unit is recognised as the best way to help patients, many stroke patients are still not treated on such a unit.** The Department should require Strategic Health Authorities and Primary Care Trusts to use their performance management arrangements to certify that all applicable hospitals meet its expectation that 80% of stroke patients spend at least 90% of their hospital stay on a stroke unit by March 2011.

4. **There are not enough specialist staff on stroke units and the understanding of stroke by other health and social care professionals who care for people with stroke remains poor.** The Department should work with the Stroke Forum to develop effective training for all hospital staff so that, for example, all patients with aphasia or physiotherapy needs receive safe and effective care.

5. **Not enough hospitals arrange early supported discharge for stroke patients, even though it provides better outcomes for many patients and can save money.** The Department should ask commissioners across the health service to develop business cases for introducing or increasing the use of early supported discharge and should report back to us on the progress it has made within 12 months.

6. **The Department lacks evidence about what types of post-hospital support and long-term care are most effective for stroke patients and does not have a clear plan as to how such care should be funded.** There is a risk that the current level of service will not be sustained once the funding given to local authorities for this purpose ends next year. The Department should develop the evidence-base for post-hospital stroke services by identifying and disseminating examples of good practice. Strategic Health Authorities should track the level of provision across their region, using the metrics currently being developed by the Department. They should seek an

improvement in the quality of long-term care and report on the progress made in 12 months.

7. **Despite 11% of stroke patients being newly admitted to care or residential homes after their stroke, there is little understanding of what services stroke patients need in these settings.** The Department should work with the Care Quality Commission and Skills for Care (the employer-led authority on the training needs of social care staff) to develop proposals for the accreditation and training of care home staff in stroke awareness and care.

8. **Whilst an estimated 4,500 strokes could be prevented each year through better detection and treatment of atrial fibrillation, many people remain undiagnosed or fail to receive the recommended treatment.** The National Institute for Health and Clinical Excellence (NICE) should review whether GPs' incentives are aligned with clinical guidelines so as to reward best practice in the treatment of atrial fibrillation. At the local level, Primary Care Trusts should encourage all healthcare providers to use existing opportunities to check and record patients pulses, for example during flu clinics.

9. **One of the main barriers to more effective stroke services is the persistent failure of health and social care to work effectively together.** We welcome the fact that the Department has asked Primary Care Trusts to work with their local authority to develop local plans for stroke care by March 2010. In addition, by the end of 2010–11, all people who have a stroke should on discharge receive an agreed joint care plan to help them and their carers navigate post-hospital stroke services.

1 Reducing variation in stroke care in hospitals

1. A stroke occurs when blood flow to the brain is interrupted, resulting in damage to brain tissue. The most common causes of the 110,000 or so strokes in England each year were blood clots blocking arteries (Ischaemic) or arteries bursting (Haemorrhagic). Stroke is one of the top three causes of death and one in four people who had a stroke died. It is also the largest cause of adult disability in England, with around 300,000 people disabled as a result of stroke. The direct cost of stroke to the National Health Service (NHS) is at least £3 billion annually with the wider economic cost around £8 billion.[3]

2. In July 2006, we reported that stroke services in England were poor. Vital brain scans for stroke patients were being delayed and a significant proportion of stroke patients were not being treated on a stroke unit. Even though most of the burden of stroke occurred after discharge, post-hospital support services were scarce and difficult to access. Public awareness of the symptoms and impact of stroke, and stroke prevention, was also low. We reported that the cost of stroke, in both economic and human terms, could be reduced by re-organising services and using existing capacity more wisely.[4]

3. The Department recognised that it was vital that stroke patients arriving at hospital soon after their stroke had an immediate brain scan to determine the type of stroke and consequently the most effective treatment.[5] Thrombolysis might reduce significantly the extent of disability for those who arrived at hospital within three to four and a half hours of their stroke, and who had a clot rather than a bleed. Scanning all other patients within 24 hours was important to ascertain whether they should start taking aspirin or not.[6]

4. In 2008, only 59% of patients had been scanned after 24 hours. There remained substantial variation in access to brain imaging, with some hospitals having high average waiting times for scans. The weekday average scanning time at the Diana, Princess of Wales Hospital in Grimsby, for example, was 25–48 hours.[7] Obstacles to providing immediate scanning included some scanners being locked out of hours, even though there were radiographers present who were capable of interpreting the scans, and slow implementation of video link-ups and other technology in areas where scans had to be interpreted off-site. Other barriers included a lack of pre-alert systems to inform hospitals in advance of the arrival of stroke patients, and inefficient location of the scanners with respect to the Accident and Emergency department.[8]

5. The Department of Health (the Department) acknowledged that the waiting times for scans in some hospitals was unacceptable and it announced a number of initiatives aimed

3 C&AG's Report, Session 2009–10, *Progress in Improving Stroke Care*, HC 291

4 Committee of Public Accounts, Fifty –second Report of Session 2005–06: *Reducing brain damage: faster access to better stroke care*, HC 911

5 Qq 7–9, 23, 36–37, 39–40 and 43

6 Qq 8, 11 and 36

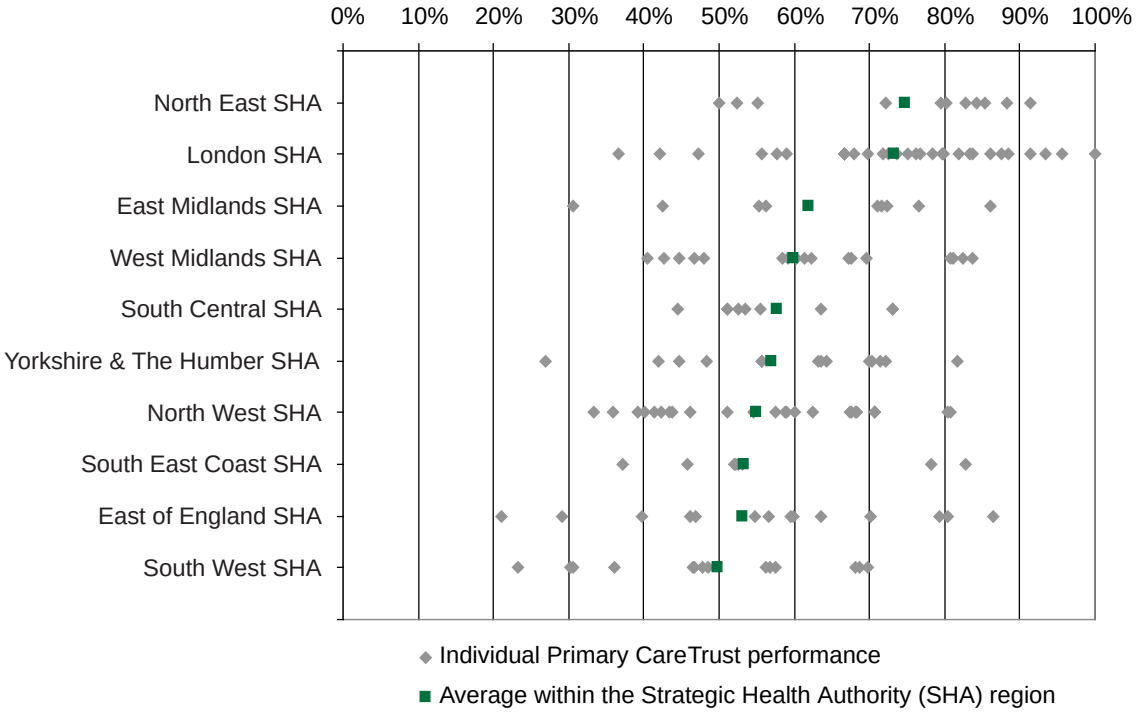
7 Qq 8, 10–11, 29, 38 and 61; C&AG's Report, para 9

8 Qq 15, 25–26, 67 and 69

at addressing this issue. The Department, working through the Stroke Improvement Team's accelerated delivery programme, has required Primary Care Trusts to develop proposals by March 2010 for configuring brain imaging services to give every patient access to scanners 24 hours a day seven days a week.[9] From April 2010, there will also be a financial incentive (with the introduction of a new Best Practice Tariff) for hospitals to provide timely scanning.[10] The Department told us that increased public expectations of what to expect from ambulances and Accident and Emergency Departments would also lead to improvements.[11]

6. The Department agreed that the one intervention that made the most difference was treatment on a stroke unit where patients receive multidisciplinary care from staff skilled in dealing with a stroke.[12] Following the Treasury's Comprehensive Spending Review in 2007, the Department introduced as a 'Vital Sign' Tier One target, the proportion of patients spending 90% of their stay on a stroke unit. Responsibility for delivery of this target rested with Primary Care Trusts and it was included in their operating plans for 2008–09 to 2010–11.[13] While performance against this measure has increased from 47% in the three months from January 2009 to 58% nine months later, substantial progress would be required to meet the Department's expectations of 80% by the end of 2010–11, with some areas falling well below this level (**Figure 1**).[14]

Figure 1: Proportion of patients spending 90% of their time on a stroke unit at the end of 2009



9 Qq 67 and 68

10 Qq 8 and 46–47

11 Qq 15 and 68

12 Q 50

13 C&AG's Report, para 5

14 Q 74; C&AG's Report, para 2.16; Department of Health, *Vital Signs data, 2009–10, October–December*

7. The Department recognised that hospitals started from very different points and acknowledged that the worst performers were an embarrassment.[15] The Department considered that there were sufficient stroke unit beds across the country to ensure that all patients could receive care on a stroke unit, and that it was unacceptable that people were still spending time in Medical Assessment Units or on general wards. The main reasons for patients not being treated on a stroke unit were poor bed management and poor patient prioritisation (triage) protocols. All of these obstacles to treatment on a stroke unit were avoidable. Unlike in coronary care units, sometimes stroke unit beds were occupied by patients with other conditions.[16]

8. The Department expected the introduction of the Best Practice Tariff in April 2010, and Strategic Health Authorities' performance management of their Primary Care Trusts, to improve the results of poor performers.[17] The Department also recognised the importance of the Stroke Improvement Programme, and of the 28 Stroke Networks to drive up improvements in this area.[18]

9. Despite increases in the level of staffing in stroke units generally, some stroke units still had less staff than the Department's expected levels.[19] The Department acknowledged that addressing these shortfalls would not necessarily lead to additional costs as better stroke care usually reduced costs. It considered that some staffing shortfalls, such as in clinical psychology and speech and language therapy, could be partially addressed by training existing members of the stroke team.[20]

10. Early Supported Discharge, whereby suitable stroke patients were discharged from hospital into the care of a specialist multi-disciplinary team based in the community had improved stroke care. It was better for patients and was cost-neutral or cost-saving, as it reduced the length of stay and hence the pressure on hospital beds.[21] There was significant variation in what hospitals deemed to be an early supported discharge programme and only 36% of hospitals offered such a service.[22]

11. The Department acknowledged that a lack of clarity about who should fund Early Supported Discharge services was a barrier to providing them.[23] Although providing Early Supported Discharge could save money in the long-run, it required initial investment to set up the service before the savings, from reducing bed numbers could be realised. The Department recognised the importance of making improvements. It told us that, as the NHS had a 5.5% growth in funding in 2010–11, it has requested that every Primary Care

15 Q 59

16 Qq 9, 15–16, 18 and 74

17 Qq 5 and 6

18 Q 5

19 C&AG's Report, Figure 10

20 Q 52

21 Qq 14 and 48

22 C&AG's Report, para 2.26

23 Qq 14 and 77

Trust identify 2% of its budget to invest in initiatives such as early supported discharge, that could lead to savings.[24]

24 Qq 48 and 77

2 Increasing access to better post-hospital and longer term support

12. Although stroke patients sometimes spent several days or weeks in hospital, it was in the months and years after discharge that they, their families and carers, experienced the full impact of stroke.[25] Access to long-term support services and rehabilitation for stroke patients and carers remained a postcode lottery.[26] The National Audit Office found that less than a third of patients and carers surveyed considered that emotional support, including counselling, respite care and training for carers to help them support people in their homes, was very poor.[27] The Department acknowledged that there was a lack of guidance on what worked, for example, on the impact of psychological and social support, due to a lack of evidence. The Department told us it had not addressed this shortcoming due to limitations in its resources but that it planned to turn its attention to this issue over the next 12 months.[28]

13. The Department planned to use the findings of the *Collaboration* for *Leadership in Applied Health Research and Care* (CLAHRC) to develop its future work programme. CLAHRC was a national programme established to undertake research on patient needs and to support the translation of research evidence into practice in the NHS.[29] The Department considered that evidence should also be improved through dissemination of the Stroke Improvement Programme's work at pilot sites.[30]

14. The Department had set aside £100,000 for each local authority every year for three years to pump-prime investment in long-term support, starting in 2008.[31] There was a risk that once the funding ends, even the current level of provision would not be sustained. The Department had no direct leverage over Local Authorities but in its experience of previous programmes, local authorities continued to fund services after ring-fenced funding had ended.[32] The Stroke Improvement Programme was also going to set out a series of measures which the Department planned to use, to monitor whether investment in long-term services continued.[33]

15. Around 11% of stroke patients were admitted to care or residential homes after their stroke and at least a quarter of care home residents have had a stroke. There were no requirements, however, for care home staff to be trained to meet the specific needs of

25 C&AG's Report, para 3.1

26 Q 12 and 81; C&AG's Report, para 3.13, Figure 17

27 Q 81; C&AG's Report, para 3.14, Figure 14

28 Qq 12 and 79

29 Q 79

30 Q 81; Stroke Improvement Programme, *National Projects 2009–10*, www.improvement.nhs.uk/

31 C&AG's Report, Figure 4

32 Qq 13 and 48

33 Q 49

stroke patients, and care home staff had a lack of understanding of stroke, although the Department's Stroke—Act F.A.S.T. campaign may have helped address this issue.[34]

16. The Department recognised that shortcomings in care homes could be addressed through the recently completed stroke-specific educational framework, which sets out the core competencies for health and social care professionals, including care home staff. The Department told us that the Care Quality Commission (the Commission) was analysing the entire post-acute care pathway for stroke across England including nursing homes, and that the Commission could use its regulation and information collection powers to improve services, including the alignment with social care. The Department was working with the Commission to develop proposals for accrediting staff who care for people with stroke in care homes, requiring them to have qualifications in stroke.[35]

34 Qq 81 and 82; C&AG's Report, para 3.15

35 Qq 71 and 82–83

3 Improving public awareness and understanding of stroke

17. The Department recognised the importance of raising public awareness and understanding of stroke, not only to increase the likelihood that people would call for an ambulance if they were having a stroke, but also to help develop services.[36] In February 2009, the Department launched the Stroke—Act F.A.S.T. campaign, which has been very effective in improving the public's recognition of the symptoms of stroke and, as a result, the number of stroke-related ambulance calls.[37] The Department's campaign was easy to understand, making it more likely that members of the public would get someone they thought might be having a stroke to hospital quickly. The campaign had also changed the profile and understanding of stroke for health care professionals and GPs' receptionists, and the way that Accident and Emergency Departments work.[38]

18. An important aspect of improving understanding of stroke was to prevent strokes from occurring in the first place, by increasing public awareness of the risk factors. These include high blood pressure and cholesterol, smoking, unhealthy diet and lack of exercise.[39] The Department acknowledged that prevention was the biggest issue for patients and their carers and that progress had been slow.[40] One in five stroke patients were not aware, for example, that lack of exercise increased their risk of a further stroke.[41] The Department told us that in order to prevent a further stroke, it was important to prescribe Aspirin to reduce the risk of blood clotting. Prevention was especially important with increased emphasis on managing high blood pressure, reducing obesity, giving up smoking, and reducing cholesterol levels.[42]

19. Atrial fibrillation (irregular heart rhythm) was another major risk factor for stroke. NHS Improvement estimated that appropriate treatment of all people with atrial fibrillation would prevent around 4,500 strokes each year, and would do so cost-effectively.[43] However, doctors were reticent about putting patients on the recommended drug (warfarin) even when there were no contraindications, as it involved regular monitoring. Some elderly patients had not been prescribed warfarin due to doctors' perception that it increased the impact of falling. However, recent evidence suggested that even elderly people at high risk of falls were safer receiving warfarin than being left untreated.[44]

36 Q 68

37 Qq 15, 23 and 30; C&AG's Report, para 2.3, Figure 8

38 Qq 15, 18 and 71

39 C&AG's Report, para 3.17

40 Q 54

41 C&AG's Report, para 17

42 Qq 54 and 55; C&AG's Report, paras 3.17 and 3.18

43 C&AG's Report, para 18

44 Q 21

20. Using a simple pulse test on those considered to be at high risk had the potential to improve the diagnosis and treatment of atrial fibrillation within primary care. The Arrhythmia Alliance had raised awareness through its *Know your Pulse* campaign and the Department's Stroke Improvement Programme had developed a free-to-use tool to help identify patients who could be treated with warfarin.[45]

45 Qq 21 and 86

4 Learning lessons to help deliver improvement in stroke

21. In 2009, the Department set out its intention to improve the standards of services across its national priorities, including stroke, over the following five years based on the approach it had used to reduce waiting times.[46] To help improve stroke care, the Department had also used lessons learned from its experience of implementing other national strategies and programmes.

22. A barrier to improving stroke care is a lack of joint working between health and social care organisations.[47] This issue has already been raised in our other health related hearings on Dementia, End of Life Care, Autism and Alcohol.[48][49][50][51] As part of the Department's accelerated development programme, Primary Care Trusts were told, in November 2009, to submit by March 2010, local plans for stroke care, which should be developed jointly with their local authorities.[52] The Department told us that, it also expected all patients to receive a joint care plan on discharge from hospital which should cover both health and social care needs. The care plan should also be shared with all relevant organisations involved in that individual's care.[53]

23. The Department acknowledged that it had a range of tools available to facilitate better joint working. These included providing support from its Stroke Improvement Programme in two ways: through Local Area Agreements which include all of the Department's highest tier performance indicators; and by permitting greater flexibility in joint budgeting across organisations. There were also opportunities to improve joint working through Stroke Networks, which bring together all local stakeholders and through the Commission's oversight and monitoring of progress in coordinating health and social care.[54][55]

24. There was also scope for the Department to transfer the successful elements of the stroke strategy to other areas. The Department recognised that many elements of the stroke strategy had contributed to progress being made, including leadership, organisational and cultural changes. These included setting up Stroke Networks, and aligning incentives to the

46 Department of Health: *NHS 2010–2015: from good to great. Preventative, people-centred, productive*, December 2009

47 C&AG's Report, para 1.15

48 Committee of Public Accounts, Nineteenth Report of Session 2009–10, *Improving Dementia Services in England—an Interim Report*, HC 321

49 Committee of Public Accounts, Nineteenth Report of Session 2008–09, *End of life care*, HC 99

50 Committee of Public Accounts, Fiftieth of Session 2008–09, *Supporting people with autism through adulthood*, HC 697

51 Committee of Public Accounts, Forty-seventh Report of Session 2008–09, *Reducing Alcohol Harm: health services in England for alcohol misuse*, HC 925

52 Qq 63–66

53 Q 28

54 Qq 20, 26 and 84

55 Q 83

required improvements. Key elements in the development and implementation of the stroke strategy were that its timing aligned closely to the Treasury's development of the 2007 Comprehensive Spending Review and that the Department identified it as a national priority in its NHS Operating Framework.[56]

56 Qq 2–4, 35, 84–85 and 87

Formal Minutes

Monday 22 March 2010

Members present:

Mr Edward Leigh, in the Chair

Mr Ian Davidson	Mr Austin Mitchell
Nigel Griffiths	Dr John Pugh

Draft Report (*Progress in improving stroke care*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 24 read and agreed to.

Conclusions and recommendations 1 to 9 read and agreed to.

Resolved, That the Report be the Twenty-sixth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Wednesday 24 March at 3.30 pm

Witnesses

Wednesday 24 February 2010

Page

List of written evidence

List of Reports from the Committee of Public Accounts 2009–10

First Report	A second progress update on the administration of the Single Payments Scheme by the Rural Payments Agency	HC 98
Second Report	HM Revenue and Customs: Improving the Processing and Collection of Tax: Income Tax, Corporation Tax, Stamp Duty Land Tax and Tax Credits	HC 97
Third Report	Financial Management in the Foreign and Commonwealth Office	HC 164
Fourth Report	Highways Agency: Contracting for Highways Maintenance	HC 188
Fifth Report	Promoting Participation with the Historic Environment	HC 189
Sixth Report	Train to Gain: Developing the skills of the workforce	HC 248
Seventh Report	Young peoples sexual health: the National Chlamydia Screening Programme	HC 283
Eighth Report	Department for International Development: Aid to Malawi	HC 282
Ninth Report	The procurement of legal aid in England and Wales by the Legal Services Commission	HC 322
Tenth Report	Services for people with rheumatoid arthritis	HC 46
Eleventh Report	HM Revenue and Customs: Dealing with the tax obligations of older people	HC 141
Twelfth Report	Maintaining financial stability across the United Kingdom's banking system	HC 190
Thirteenth Report	Excess Votes 2008–09	HC 360
Fourteenth Report	Department for Transport: The failure of Metronet	HC 390
Fifteenth Report	Equality and Human Rights Commission	HC 124
Sixteenth Report	Regenerating the English Coalfields	HC 247
Seventeenth Report	Department for Business, Innovation and Skills: Venture capital support to small businesses	HC 271
Eighteenth Report	Vehicle and Operator Services Agency: Enforcement of regulations on commercial vehicles	HC 284
Nineteenth Report	Improving Dementia Services in England—an Interim Report	HC 321
Twentieth Report	Department for Work and Pensions: Management of Benefit Overpayment Debt	HC 444
Twenty-first Report	The Decent Homes Programme	HC 350
Twenty-second Report	The sale of the Government's interest in British Energy	HC 356
Twenty-third Report	Ministry of Defence: Major Projects Report 2009	HC 338
Twenty-fourth Report	HM Revenue and Customs: Handling telephone enquiries	HC 389
Twenty-sixth Report	Progress in improving stroke care	HC 405
Twenty-seventh Report	Ministry of Defence: Treating injury and illness arising on military operations	HC 427

Oral evidence

Taken before the Committee of Public Accounts

on Wednesday 24 February 2010

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Nigel Griffiths
Angela Browning	Mr Austin Mitchell
Mr Paul Burstow	Geraldine Smith

Mr Amyas Morse, Comptroller and Auditor General, **Mr Rob Prideaux**, Director, Parliamentary Relations and **Karen Taylor**, Director, National Audit Office, were in attendance.

Mr Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, was in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
DEPARTMENT OF HEALTH
PROGRESS IN IMPROVING STROKE CARE (HC 291)

Witnesses: **Sir David Nicholson KCB CBE**, Chief Executive of the National Health Service, **Professor Sir Bruce Keogh**, NHS Medical Director, **Professor Roger Boyle CBE**, National Director for Heart Disease and Stroke, Department of Health and **Dr Damian Jenkinson**, National Clinical Lead—Stroke Improvement Programme, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, gave evidence.

Q1 Chairman: Good afternoon, welcome to the Committee of Public Accounts. Today we are considering the Comptroller and Auditor General's Report *Progress in improving stroke care*. We welcome back to our Committee Sir David Nicholson, who is the Department of Health's Accounting Officer and Chief Executive of the National Health Service. Could you please introduce your colleagues Sir David?
Sir David Nicholson: Professor Roger Boyle, Professor Sir Bruce Keogh and Dr Damian Jenkinson.

Q2 Chairman: As you know, the Committee has long since taken an interest, ever since the NAO's groundbreaking Report in 2005. We are very proud of the pressure we have put on you and obviously you have made progress, so congratulations on the progress that you have made, although of course there are still some regional variations and concerns about post-hospital care, how soon you get a brain scan, all these issues which we want to investigate with you during the course of this afternoon. However, congratulations on the progress you have made. What are the elements of the stroke strategy or the priority given to it which have enabled you to make good progress?
Sir David Nicholson: The first thing is that we spent quite a bit of time getting the strategy right and it took us quite a bit of time to do that. One of the benefits of that is that we bought in a lot of support from around the service, from patient groups, from clinicians and from managers around what was actually required and what was needed. So when the strategy was finally published it had real buy-in across the system as a whole and that is really important. The second issue in terms of timing was that we were able to publish the strategy just at the time we were doing the comprehensive spending review, so we were able to use the development of the strategy as an opportunity to get money through the Treasury in order to support it. Thirdly, because of that, we were then able to make a national priority for stroke services. As you know, it is a Tier One priority for the operating framework and we identified both national money and local money to support it. They are the things which helped us make the progress we have.

Q3 Chairman: So it is important that it is a Tier One priority obviously.
Sir David Nicholson: Absolutely it is a Tier One priority.

Q4 Chairman: So if that is such an important ingredient of improving stroke care, why have you not made dementia a Tier One priority?
Sir David Nicholson: I hopefully explained that last time and I will explain again. The issue about the stroke one is that we were able to do it at the time of the comprehensive spending review, when we identified the national targets for the next three years. Dementia came after the spending review and therefore was not part of that process. That is not to say it will not be in the future, but certainly at this time in a sense the timing of the stroke review was particularly significant.

Q5 Chairman: If we look at figure nine in this Report, we can see that there are very wide variations between regions and hospitals. What are you going to do to try to bring the performance of the laggards up to the best practice?

Sir David Nicholson: You have to understand—I am sure you do—that when we started off people were in very different places. We have to understand that as we go forward; they were in very different places and it does take time to get everyone up to those kinds of standards. What we have done of course is to identify it as a Tier One priority. As we speak, every PCT is currently putting its plans into the strategic health authorities by the end of March to set out how they are going to get to the standards required in the strategy by the end of 2010–11 and we are supporting it by 28 stroke networks which Dr Damian Jenkinson is leading as well.
Professor Boyle: We were dealing with a lot of very different starting points and the issues are different in different parts of the country. For example, in some of the urban areas, particularly Greater Manchester and London, there has been a real process of re-designing how stroke is managed altogether, which has required public consultation and that takes time then for the new services to be established. They are now established in London and Greater Manchester and beginning to work and we will see therefore substantial improvement.

Q6 Chairman: May I interrupt? You have this target of 80% of patients spending 90% of their time on a stroke unit. What sanctions can you impose on units which are not meeting this target?
Professor Boyle: We do this down the performance management route, working with the performance directors in the strategic health authorities. We have added to that, as from the coming April, a new way of incentivising through a best practice tariff which will incentivise trusts not only to do much more urgent scanning but also directly admit patients into the stroke unit and keep them there for the duration of their stay in hospital.

Q7 Chairman: Obviously what is absolutely vital is to have a scan quickly, is it not?
Professor Boyle: Yes; indeed.

Q8 Chairman: If we look a paragraph 2.11 of this Report, we see that 59% of patients are scanned within a day of having their strokes. That means that a lot of people are not being scanned within 24 hours, which is very worrying.
Professor Boyle: Yes, that is where this best practice tariff will also begin to impact. For those people who present within the time window to be considered for thrombolysis, therefore requiring an immediate scan, 24 hours even is not sufficient. We need to be much more ambitious than that.

Q9 Chairman: We have an excellent memorandum, as always, from The Stroke Association and we are very grateful for the work they have done with us over the years in bringing this to the public's attention. They tell us "In particular it is unacceptable that only 17% of stroke patients are admitted to a stroke unit within four hours of arrival in hospital. There are also continuing problems with access to brain scanning with only 1 in 5 eligible patients having a scan within three hours of their stroke". Do you accept their point of view that this is unacceptable, especially as they were key recommendations in our Report in 2006?
Professor Boyle: Yes. We do find that patients are still being migrated into medical admissions units rather than direct to a stroke unit and this is a major plank of our work plan for this coming financial year; we are setting up an accelerated delivery programme to make really sure we get every single trust across the country. That is absolutely vital.

Q10 Chairman: Some of these figures are very alarming. If you look at the two hospitals which serve my constituents, Lincoln County Hospital and Diana Princess of Wales Hospital at Grimsby, also serving Mr Mitchell's constituents, even within these hospitals there is an enormous variation. It is shocking that the weekday average scanning in the Diana Princess of Wales Hospital in Grimsby is between 25 and 48 hours. This means that if you have a stroke in Grimsby or in the rural areas—I live 14 miles from Grimsby—you might have to wait 48 hours to get a scan.
Professor Boyle: The importance of the scan in that early first day is for most patients really to decide whether they should commence Aspirin or not and there is a timing issue as to whether it is crucial whether that is within the first day or day or two. The one thing we really need to get right is that we need to be scanning the people who present within four and a half hours or three hours, that sort of time window, from the onset of symptoms; much more quickly than within 24 hours.

Q11 Chairman: What worries me is that someone who develops stroke symptoms in this part of London—look at figure nine, there is even a wide variation within London—I suspect would have a very good chance of having a brain scan, even within three hours, but somebody living in Lincolnshire might have to wait up to 48 hours. What would you say personally to somebody you knew had had to wait over 24 hours for a brain scan and as a result was disabled for the rest of their life?
Professor Boyle: It happened to my sister. I have had personal experience with a family member who had the same difficulty. It is not acceptable in the long term, but it does require a big culture change and that is difficult to bring about in the National Health Service. If you take the East Midlands in particular, Lincoln is a focus to become a hyper-acute centre as the East Midlands plan unrolls, but that has taken a lot of consultation, which is still not quite complete across the East Midlands, to make sure that this new model of care for the East Midlands is put into place. Grimsby is an outlier which we recognised and picked up in our research before coming to this Committee. We know that there is still plenty of work to do to get consistency. My experience in doing similar work in the heart programme, dating back to 2000, was that it takes up to five years before you can really get that consistency across the piece and then have it embedded and sustainable over

future years. We now have that in the heart programme and I think we have to accept that it takes time for some of these organisations to catch up with the pace of the best.

Q12 Chairman: Let us look at all the support services after you leave hospital. This is very varied as well. If we look at pages 35, 36 and 37, this is very patchy, is it not? Why have you allowed support services to remain such a lottery around the country?
Professor Boyle: Because that is the most difficult bit of the pathway to deal with. While there is variation in the provision of services on the acute side, we have seen ever more variation in the long-term support services and the long-term rehabilitation. We have certainly had issues of human capacity to deal with this whole pathway simultaneously and where we have the best evidence of where clinical outcomes will be substantially improved, most of the evidence about that is around the acute section of the pathway, in other words getting stroke units properly equipped, staffed and capable to do the first part. We are now turning our attention in this next delivery period over the next 12 months to look at that longer term part of the pathway and to develop the metrics which will show us whether or not we are gaining the same sort of improvements that we have seen in most areas for the acute pathway.

Q13 Chairman: What happens when this ring-fenced funding to local authorities for support services stops? What are your plans?
Sir David Nicholson: It was always given to local authorities on the basis that it was pump priming for three years; £100,000 for each local authority every year for three years. They have spent it in a variety of ways. Our experience and our expectation is that the local authorities will continue to fund it after the period ends; we made it very clear that we do not propose to continue this pump-priming money. Our experience is that the local authorities do respond in these circumstances. The most obvious example was the older people's programme that we have just pump primed for local government and all but three local authorities have actually taken up the long-term funding of that. So our expectation is that local authorities will do it. I have no leverage directly over local authorities to make them do it but our expectation and experience is that they do.

Q14 Chairman: My last question is about early discharge. If you look at paragraph 2.26, there is some evidence that getting early discharge with proper support services is the best thing but, again, it is very patchy, is it not? Why are you not doing more to insist that hospitals have a better coordinated plan for early discharge with proper support?
Dr Jenkinson: The stroke improvement programme and the network of 28 across England have played and will play a major role in changing the services. The figures you referred to are completely valid as criticism. The major focus of our further work will be ensuring that all patients go through stroke units in a timely way and have a timely scan and as many people as possible have access to early supported discharge. The issue around early supported discharge—and, to take your figures, it has increased by 15% of sites in the past couple of years which is significant in itself—is that there have been barriers perceived around the funding and costing of early supported discharge which at face value appear to be in addition to monies that primary care trusts are paying through the tariff. We know however that if it is properly done with a properly specified service it is not only better for patients but it works out in a cost neutral, perhaps even cost-saving way for health communities. It is part of the work of the stroke programme to address those sometimes cultural barriers and resistance across the nation and increase the percentage of eligible patients going through early supported discharge.

Q15 Angela Browning: May I add my congratulations to Sir David because we sometimes give you a hard time in this Committee. I actually think that the progress you have made has been very good and I particularly think that the FAST advertising campaign that you have engaged in is one that is easily understood by the lay public, is easy to remember and I am sure will make a huge difference to people getting a relative or somebody they think is a bit poorly or not very well to hospital quickly. I do congratulate you on that and I think it is excellent. However, I do of course have some concerns. I just wonder why it is that when we look at the number of stroke patients who are reaching hospital and then have a long wait before being scanned—I assume most of these people will be admitted through A&E—that what is happening at the triage stage when they first arrive in A&E is that the triage nurse is not picking up that this is somebody for whom there is a very clear pathway and that that person should not be sitting around waiting. The triage system is clearly not working properly.
Sir David Nicholson: Yes, this is undoubtedly a major issue for us to tackle. It is a kind of cultural issue in the way some of these services are organised and it can happen that an ambulance paramedic can diagnose a stroke, the patient then goes to A&E, they want to diagnose it, they assess and diagnose it, then he goes to an MAU, they diagnose it and then he goes to a stroke unit. That is clearly unacceptable but it has been quite difficult to change the way some hospitals work.
Professor Boyle: I visited University College Hospital yesterday where they now have a system where there is a pre-alert from the London Ambulance Service from the paramedic who has done the FAST assessment. They use that as the trigger to alert the scanner that they need to have an immediate slot. They have reduced their call-to-needle time, that is the call to the Ambulance Service, to the delivery of the thrombolysis drug, from 90 minutes down to about 30 minutes just by looking at the internal processes and mapping how many hand-offs you have to get through before you

actually get to the scanner and get pictures and then have them interpreted. It is all about those simple things which we have been learning through our experiences with the networks and the stroke improvement programme. The challenge now is to get that learning spread right across the NHS so that everybody can have the best processes in place and the most rapid ones.

Q16 Angela Browning: I hope you are going to spread that out. It seems to me that the triage was a very important implementation a few years ago but if triage nurses are not locked into this then it does not make a lot of sense really. May I just ask you about my own area as I am sure we are all going to do? I live midway between the Taunton and Somerset Foundation Trust and the Royal Devon and Exeter Hospital. I have been a patient at the Royal Devon and Exeter, as I have been, I have to say Dr Jenkinson, in your excellent hospital. I received very good service there. However, there is a huge difference between the Taunton and Somerset and Royal Devon and Exeter. Given that in Devon that hospital serves a large catchment area along that south Devon coast as a general hospital, Sidmouth, Budleigh Salterton, a huge retired population. Why is it that a hospital which is serving a particularly elderly population has such disproportionate figures? I live half way between the two and I know which direction I am going to ask the ambulance to go in, if I am able to speak.
Professor Boyle: You will have to leave a note under your pillow.
Angela Browning: Do not worry; my husband will make sure it is all done satisfactorily.
Mr Bacon: Get a tattoo.

Q17 Angela Browning: Yes, I will get a tattoo saying "Take me to Bournemouth".
Dr Jenkinson: At the request of Sir Ian Carruthers we did a review across the entire south-west and all of the 17 acute provider trusts, so we have been to each of those hospitals and actually been in them and I understand the issues you are referring to. A lot of it is around clinical leadership and one of the sites to which you refer has had difficulty in appointing senior clinicians to help run and move that service forward, whereas the other one has a national class figure. I know, however, that those issues have been resolved more recently, so I would expect that other site to improve and they are all part of the Peninsula network in the south-west there and they are all following similar protocols across the region. We would expect to see the variances between those sites diminish.

Q18 Angela Browning: I am a little bit more encouraged. Obviously now I have seen these figures I shall be writing to the chief executive and no doubt she will give me a more detailed blow-by-blow account of why I should not be nervous about the hospital's performance because clearly it has been very unsatisfactory. Is it the case that areas which do serve a large catchment of elderly people—I know stroke is not exclusive to elderly people—have got into a pattern of dealing with elderly people, a matter which has been discussed in this Committee before. I worry that when elderly people present, they are shuffled off in a certain way which perhaps does not address the importance of their symptoms on admittance.
Dr Jenkinson: I think you are completely correct and part of the cultural problem is that many people who have worked in stroke over the years, for instance myself, have acquired a learned expectation that nothing much was going to happen and when the stroke strategy and all the leverage that came with it actually arrived, there was some resistance amongst them to moving forward. I think you are right but I think also that the FAST campaign and public awareness has completely changed the profile of stroke for the public and also for healthcare professionals. The trick we must play now is to make the very most out of that.

Q19 Angela Browning: May I go to the other end when somebody has been discharged from hospital? After we did our initial Report on the NAO Report on strokes, I did go to visit one of the small units in my own constituency which actually takes patients from the Royal Devon and Exeter Hospital and see how they were being rehabilitated ready for home discharge. My worry there—and I have raised this before—was that yes, there was some excellent work being done, but actually the state people are in when they arrive through their own door is not satisfactory compared with the progress that has been made to date. There are certain key things. To recover from a stroke—as with many other conditions but strokes particularly—ongoing physiotherapy is very important and there are gaps of nine, 10 weeks before there is a home assessment and a programme put in place; speech therapy also. Can you just give us some indication as to where we are with physiotherapy and speech therapy for stroke patients once they have got back home?
Dr Jenkinson: Talking about the particular area you are speaking of, I know that within the business case for the Exeter hospital they had a fully comprehensive and fully specified early supported discharge programme which they had not had previously and have clear plans on improving access to the therapies you are describing. You are also correct in saying that at the moment, as it exists, access to the professions for all patients across England is not good. Part of the major emphasis of the work we are going to take on from this point is focusing on that part of the pathway, addressing that.

Q20 Angela Browning: My final point is that it seems to me, from what I saw and heard, excellent work, but once they are at home the progress is not as good as it might be in order to get better, more mobile, able to cope independently. Of course it then starts to be that transition of responsibility from health to social services and again we are back to these old questions which we have discussed before of silos of

money and responsibility. I just do not understand why for years we have been talking about the need for health and social services to work together which is a very good thing and essential, but they do not. Can anybody do anything about these silos which prevent that happening?

Sir David Nicholson: There are lots of examples in the country where they do work really well together. I am sure you can all think of places—and I can—where they work really well together. We have thought long and hard about whether this is a structural issue, whether changing structures would change it but what we think is maximum flexibility from the centre. So we should take many of the controls off people's ability to move money from one part of the public sector to the other and pooled budgets and all those sorts of things; a very important part of that which we are doing, encourage people, support it and all the rest of it and make sure that people do actually, through joint commissioning, make these things work. There is no simple way of doing it; it is a matter of people working together to make it happen. There are some really good examples around the country and there are more to make it a reality.

Q21 Geraldine Smith: I am quite interested in the number of people who could potentially have a stroke but who are not on Warfarin or blood-thinning drugs for it. What can you do about that? Is it quite as simple as it looks when I read a figure of only 24% on these drugs? Is it because maybe looking at strokes you are looking in isolation and you are not looking at the potential harmful effects of people taking these drugs?

Professor Boyle: We have this as another major work plan which we have been working on over the last year and we will be doing that over the next year or two because it is going to take a couple of years to get to where we need to be on this. When NICE produced their guideline on the management of atrial fibrillation, which is one of the big risk factors for developing stroke, they thought that probably only about half of the eligible population who would be at high risk from a blood clot coming from the heart to the brain were adequately anti-coagulated with Warfarin. There is a considerable resistance to putting a largely elderly population onto Warfarin. GPs are reticent because it is a big logistical exercise to do the regular blood tests and make sure the drug is being taken in a safe fashion. More recent evidence has emerged from the trial done in Birmingham which shows that even in the elderly population it is a much safer thing to do than to leave untreated. People have suggested that the risk of falls was so great and therefore the risk of serious bruising would not justify the risk of taking Warfarin. The trials showed conclusively that that was not the case and that overall benefit was much greater than using Warfarin. We have to change the mentality in terms of recognised cases. We have developed, through our stroke improvement programme, some software which is available free to every practice, which will interrogate the practice system to find the people with high risk of atrial fibrillation so they can then reconsider the treatment options. Then we have a second big raft of work which is looking at better ways of identifying people who have atrial fibrillation but have not been diagnosed. Those are the two big rafts of work which we are trying to put into place.

Q22 Geraldine Smith: Is there not a new drug ahead of Warfarin which stops side effects?

Professor Boyle: There is a new drug just about to emerge and we are not yet certain whether it is going to be cost effective. It depends on the pricing and it has not yet been widely tested in this group, particularly the elderly population who are at most risk, to see whether it would be an effective drug in that population, although the current trial data does look quite encouraging. It is going to be a question for NICE to consider and we have commissioned them. I chair the group which selects the topics and they are working on that very much.

Q23 Geraldine Smith: May I also congratulate your team on the advertising and everything? It has led to a real sea change and it was very simple, very clear and extremely effective. Really well done on that. The next stage, if someone has a stroke, is getting to hospital, getting the brain scan and getting the blood clotting drugs. Can those blood clotting drugs be harmful in certain strokes? Is that the reason why you would not give them to everyone who presented with symptoms?

Sir David Nicholson: Yes, it is absolutely the case that thrombolysis is a potentially quite dangerous thing and planning, organisation and training is not something you can switch on tomorrow in a hospital. Quite a lot of work needs to be done before you are in a position to do it.

Professor Boyle: It is certainly an effective treatment and reduces the extent of disability if it is given in a prompt fashion but only to those people who have the thrombotic strokes. If you gave it somebody who had had a cerebral haemorrhage that would be almost a death sentence. At the moment it is only licensed for people under the age of 80. It is only thought to be effective if you can a treat a patient within four and a half hours of the onset of symptoms. Only a proportion of patients who are admitted will be eligible to have the treatment.

Q24 Geraldine Smith: So any patient over 80 would not be eligible for that treatment.

Professor Boyle: It is still used off licence by clinicians, after discussion with the patient or their family if they are not able to communicate, at discretion and after explanation. It does not exclude the over-eighties from access to the drug but at the moment the licence does not actually sanction that approach.

Q25 Geraldine Smith: Obviously there are more problems in rural type areas like my own constituency. I notice in our area Blackburn does very, very well with strokes but I want to see my area

be as good. I know one of the things the network is looking at is video link-ups, some sort of video so they can link up with the consultant who can see the scans. Can you tell me a little bit how that is progressing?
Professor Boyle: You have already received the report from the Cumbria and Lancashire Health and Stroke Network, from Sally Chisholm.

Q26 Geraldine Smith: Again may I put on record my thanks for the time she took and the effective manner in which she came and presented all the work they are doing. Could you pass on my thanks to her?
Professor Boyle: She is a classic demonstration of the capability of these networks to look across organisational boundaries and across a bigger geography than just a single primary care trust and really make some significant changes. Yes, there is a serious geographic challenge in your area. My mother lives in Cumbria and I am very interested in it myself. The tele-medicine solution is being developed which allows a clinician remote from the site where the patient is and where the scan has been taken to guide the local clinician, who is not necessarily a stroke expert, into making the right decisions and making sure that they have at least equal access to the right treatments as everywhere else. It still requires in those local hospitals for the stroke unit to be properly staffed, equipped and skilled to monitor those patients afterwards. That has been the time limiting factor in terms of getting everybody up to that level of care.

Q27 Geraldine Smith: In the long run that must be cost effective because the better you can treat someone initially, the less aftercare they require.
Professor Boyle: Yes; absolutely right.

Q28 Geraldine Smith: May I also say from my own experience, someone I have seen who had had a bad stroke, that the life-changing effect on a family is very, very distressing to watch. Can you say a little more about the aftercare, the post-hospital support because that is another area where people feel more can be done?
Professor Boyle: What we are trying to develop at this current stage of our progress is a system whereby at discharge from hospital a joint care plan is developed which deals with both health and social care issues. That is then shared with the patient and their carer, if there is one, to make sure that everyone is clear, including the general practice that is responsible for them, about what the full plan is and what should be in place. At least then, if the support services do not arrive on time, you are quite clear what it is that is missing and who should be contacted to make sure that gap is filled. Not only that, but if the whole plan is then reviewed much more systematically at six weeks and at six months and then annually thereafter, so that people do not drop between the various holes which exist, as we have discussed, between health and social care, so that there is this drive at least from the individuals and the families to make sure that there is better joined-up care for the longer term. That is part of our development plan for the next 12 months.

Q29 Geraldine Smith: To have a stroke is a terrible thing to happen. Where would you get the most effective care in the country and where would you get the least?
Professor Boyle: We heard about the Grimsby issue. At the moment in London the most effective unit appears to be King's College Hospital and that is partly because the Ambulance Service has latched onto the notion that there they will be greeted by a nurse trained to do the early assessment, that the X-ray department is immediately adjacent to the A&E department and that the radiologists and radiographers there will accept a referral from the nurse, so they have a very rapid transfer through the system. They then have a very well trained and skilled workforce in the stroke unit. The local authority appointed dedicated social workers who visit the unit and assess every patient so that they provide the link back out into the community. For example, in Southwark PCT they have pooled budgets between health and social care for dealing with these people with long-term needs. That is a model we would want to take and share around the country.
Geraldine Smith: I wish you luck. It is not an easy task but it is important, particularly, as you have already said, for rural areas and people living in North Lancashire and Cumbria, my own area.

Q30 Mr Mitchell: I think the adverts were very effective, but that is presumably the £11 million referred to in the Report. It tells you what the symptoms are and what is happening but it does not tell you what you should do if you witness those symptoms. Should they tell us that?
Professor Boyle: Dial 999. It says call 999.

Q31 Mr Mitchell: It says that but is there anything else you can do?
Professor Boyle: No, there is not much that a lay person can do other than standing by. Fortunately our ambulance services across the country have shown themselves very interested in this condition and have been very responsive.

Q32 Mr Mitchell: Yes, I think their standards are improving considerably.
Professor Boyle: Absolutely.

Q33 Mr Mitchell: It is more dangerous for a lay person to interfere and to do something.
Professor Boyle: There is a very limited amount that you can do to help a stroke person in those early stages.

Q34 Mr Mitchell: Returning to the statistics to which the Chairman referred, I was horrified to look at the statistics for Grimsby, in fact I am wondering whether I should go back and fight the election there or stay in London and be cosseted by the Health

Service. Since they are so bad, let me ask who is driving any improvement. What pressures are being brought to bear on the trust to improve matters?
Professor Boyle: The strategic health authority has now developed a comprehensive plan across the whole of Yorkshire and Humberside to address these issues.

Q35 Mr Mitchell: That is a regional effort.
Professor Boyle: Yes. They also have a responsibility through these vital signs which we mentioned in terms of performance managing the trust. It will meet regularly with the trust to discuss their performance against those vital signs and that is one lever. We hope also this best practice tariff will impact on them. We know also from the Sentinel stroke audit data, which has been so useful in telling us about the trends of improvement over the last 10 years. We will also be able to benchmark them in the current data collection which is going on this year. That all gets pretty well out into the public domain so that is something for their reputation. Ultimately the regulator will have a view on the performance of the trust and will use this information for their assessment purposes.

Q36 Mr Mitchell: Push them hard. I could not quite understand what you were saying about the importance of a scan. It is important to have a scan within the first three hours so you can diagnose what to do or later. What is its importance later?
Professor Boyle: The importance early on is to see whether you are eligible for the clot-busting drug and injection. After the first four and a half hours, then the decision is a different one. The decision on the basis of the scan is whether this is really a stroke or something pretending to be a stroke, perhaps a brain tumour or something else.

Q37 Mr Mitchell: Will the scan detect that?
Professor Boyle: The scan will detect that. The clinical decision, in terms of treatment, is whether or not to commence Aspirin to prevent further clots from forming. That is the decision we want to make sometime in the first day or two.

Q38 Mr Mitchell: The average waiting for scans in Grimsby is 25 to 48 hours and then 48 hours for a weekend. It looks as though they have knocked off for the weekend. Why would that be the case?
Professor Boyle: There has been a culture in some hospitals to lock the scanner out of hours.

Q39 Mr Mitchell: It just stops.
Professor Boyle: Yes.

Q40 Mr Mitchell: It should be open all the time presumably.
Professor Boyle: There almost certainly will be a radiographer in the hospital who is capable of using the machine, who is doing the other emergency X-ray duties. It may require some additional staffing hours and therefore there is a cost attached to it which is then the deterrent to that hospital's chief executive and finance director in the long term.

Q41 Mr Mitchell: What is thrombolysis? I do not quite know what that is.
Professor Boyle: This is a process just like when you have a heart attack and the artery to the heart is blocked by a blood clot. It is having a treatment which will remove that blood clot and dissolve it.

Q42 Mr Mitchell: Is it an injection?
Professor Boyle: Yes, it is an injection, an infusion.

Q43 Mr Mitchell: Why do ambulances not carry it then?
Professor Boyle: Because they cannot do the scan to determine which type of stroke they are dealing with.

Q44 Mr Mitchell: So it is not a universal application.
Professor Boyle: No; no.
Sir David Nicholson: It can be fatal, given to the wrong patient.

Q45 Mr Mitchell: You have granted this money and it seems to be working well and there has been a discernible improvement. How do you stop it leaking into other services? If I were running a hospital trust and you gave me a lump sum for this or that or the other, I would fiddle bits of it into other categories of medicine. How do you keep it ring-fenced for strokes?
Sir David Nicholson: We do not keep it ring-fenced for strokes; there is no ring-fencing on the money, but they have to report what they have spent it on. We believe that transparency and publication is a more powerful lever for change than is ring-fencing the resources.

Q46 Mr Mitchell: So it is accountancy really.
Sir David Nicholson: It is accountancy. The other thing is that Professor Boyle talked about the best practice tariff. What that means is that if you treat a patient with stroke and you treat them in the way, for example, you might do for some of your constituents in Grimsby, they will get less money than they would if they treated following best practice. It gives an incentive for them to change their organisation to make it work better and if they need extra resources for the extra scanning, they can get that out of the extra money they get for the best practice tariff. It is the first time we have used it in the NHS and we are hopeful it is going to make a big difference.

Q47 Mr Mitchell: Are you happy that it is working?
Sir David Nicholson: We are literally just about to start it.
Professor Boyle: It starts in April.

Q48 Mr Mitchell: I am happy to hear that. What happens? You have been going around telling them they have to prepare for this level of cuts and that

level of cuts and terrifying everybody in the Health Service. What happens when this specific funding runs out?
Sir David Nicholson: I am not trying to terrify people I am just trying to get them into the place where they start to think about how they are going to work through. There is no doubt that, when we reflected on the NAO Report and recent work, we think a bit more urgency needs to be put into the stroke strategy at the moment, hence Dr Jenkinson talked about the accelerated development, because in 2010–11 we still have 5.5% growth, so we do have the ability to invest resources. It is critical that we get those stroke plans right for that period. There are other opportunities in stroke that actually save resource. The early supported discharge would of course mean you needed fewer stroke beds so you would actually need to invest less in hospital and more outside. So you can transfer that and make savings when you do it. There are opportunities down the road in the stroke service of saving resource as well as spending it.

Q49 Mr Mitchell: You are satisfied that the improvement that has been gained so far will be sustained.
Sir David Nicholson: Yes; absolutely. Dr Jenkinson and his colleagues are setting out a series of metrics, of detailed measures, so that when organisations publish their accounts we can track that they are continuously improving stroke services.

Q50 Mr Mitchell: Another area where we seem to be deficient, in my constituency certainly, figure nine, page 25, proportion of patients spending 90% of their time on a stroke unit, which is the lowest in Yorkshire and Humberside. Why is that important? Why is it so low there?
Professor Boyle: The one intervention which makes the most difference to outcome is admission to a stroke unit. You then get the multidisciplinary care from people who are skilled in caring for people with a stroke. If you go into a general ward, a well-meaning ward orderly may come along and say "Would you like a cup of tea, dear?". The answer would be yes, they would sip the tea, if they could, and it would go down the wrong way because they had not had a swallowing assessment and they would immediately get a really bad outcome. Right from the first hour of admission we really need to get these vulnerable people into the place where the right skills are and that is our big ambition for this coming year. We have made some progress, but we have to go a lot faster and do better still.

Q51 Mr Mitchell: Figure 10, page 27, why are our actual staffing levels in England so much lower than the minimum recommended level in Australia.
Professor Boyle: I visited Australia in the early part of last year and these are recommendations, they have not been achieved even in Australia.

Q52 Mr Mitchell: Those are the minimum.
Professor Boyle: Yes, but we have seen substantial improvements in the numbers of staff in all the staff groups in this country and that is a trend which hopefully will continue if they are focused in the right way. We can still do that in a cost-effective envelope and actually save money. Coming back to your previous point, we do know from modelling that the National Audit Office did in their original Report, that actually better stroke care is cheaper care. We know that historically we have spent more on stroke than equivalent countries to us and yet have worse outcomes. It is just making sure that we focus the attention of existing staff on doing things differently and more efficiently and more effectively and getting better outcomes, then everybody wins.

Q53 Mr Mitchell: Am I more likely to have a stroke if I have had a stroke?
Professor Boyle: Yes.

Q54 Mr Mitchell: Why is there such a gap in the coordination with social services for aftercare in speech therapy and in six-week and six-month reviews of my improvement after I have had a stroke? It is the biggest weakness in the system.
Professor Boyle: The long-term risk issues are the biggest issues for the patients and their carers, there is no doubt at all. In terms of protecting you from a further stroke, the important thing to do is to make sure that addressing the stickiness of your blood is one particular issue, so Aspirin and another drug, Dipyridamole, to reduce the risk of further clotting taking place and making sure that your blood pressure is appropriately treated and, coming back to my other hobby horse, statins, making sure that all the secondary prevention opportunities are taken. Although there has been improvement on that, we have seen that, in terms of the behaviour of primary care in reducing risk to stroke victims historically, we still have more to do in improving that aspect of preventive care in the coming years.

Q55 Chairman: So statins are quite useful, are they?
Professor Boyle: Yes.

Q56 Nigel Griffiths: Dr Jenkinson, I want to congratulate you for being part of the Hospital Doctor's Team of the Year, for winning the Team Innovation Award and in particular for ensuring your local stroke services have achieved recognition as an NHS Beacon Service. You are one of the reasons why I believe in centralised NHS budgets and delivery and what Sir David said earlier was music to my ears on the subject of budgets. What do your team's achievements mean in terms of the impact of treatment on the quality of stroke victims' lives?
Dr Jenkinson: Are you talking about my work in my own trust?

Q57 Nigel Griffiths: Yes.
Dr Jenkinson: The most important thing about the way that we have worked at the Royal Bournemouth Hospital is that I believe we are genuinely patient

centred, that we understand the needs of our local population and we have incorporated people with strokes and carers in the planning of our services. Leadership in all the different disciplines and at all different levels is critically important and I think that frontline staff need to be given permission and the tools to be able to move services forward. There is plenty of leverage in the system, there is money in the system to improve stroke services but it needs leadership at a local level and that needs commitment and resources within organisations, so organisations have to be signed up to it as well. It is a combination of factors about having a vision in a trust, a leadership, a conducive atmosphere, understanding the needs of your local population and responding to those in an evidence-based way.

Q58 Nigel Griffiths: So it is your experience that basically the funding is there but it is the leadership and then the operation at a local level.
Dr Jenkinson: Yes; absolutely right. Sir David talked today about the ring-fenced £105 million which was clearly the icing on the cake. There was an increase in the allocations to primary care trusts to commission better cerebrovascular or stroke services but that depended upon people in localities taking the initiative and leadership to have that vision and move their services forward and some move faster than others.

Q59 Nigel Griffiths: Are you very frustrated with the ones which are the laggards?
Dr Jenkinson: Yes; hugely. It is an embarrassment.

Q60 Nigel Griffiths: Professor Boyle said earlier that the changes in the heart programme took five years, mainly for cultural reasons. Why is it that it may take another five years to achieve what Dr Jenkinson and other top clinicians have achieved when we are dealing with the finest minds in the United Kingdom in charge of it?
Professor Boyle: I do not think we have five years. Because the financial pressures are going to hit us in another 18 months or so, we really have to make sure that we get this consistency in place during the next 12 months. We are not going to rest; we are going to make this absolutely our number one priority, to get consistency across a range of markers and challenge everybody to join in this process. We will be collecting the data which will inform us about whether or not we are making progress and we will be making that pretty explicit to the public and others to make sure it happens.

Q61 Nigel Griffiths: That is rather encouraging because my next question was why taxpayers in Grimsby should put up with a second-rate service and you are saying that in 12 months' time they will not.

Professor Boyle: We have made special note of Grimsby.

Sir David Nicholson: We would expect substantial improvements. The first thing is that the primary care trust in Grimsby is currently putting its plans into the strategic health authority to show how it can deliver top-drawer stroke services by the end of next year. We will examine those plans to satisfy ourselves that they are okay and we will expect them to deliver on them the year after. That is exactly what we need to do.

Q62 Mr Mitchell: I will go back in three years' time.
Sir David Nicholson: I am sure it is better now.

Q63 Nigel Griffiths: Professor Boyle you gave us a very good illustration in Southwark where you said they have a joint care plan for health and social services. Why is this not mandatory throughout the country?
Sir David Nicholson: What? That there is a joint plan?

Q64 Nigel Griffiths: An effective one.
Sir David Nicholson: Essentially it is and that is what the arrangements through the planning process are doing at the moment. We expect those plans that come in to be joint between local government and health. It is not the law that they should be, but we would expect it. In fact they could not give us a credible plan unless it was joint. That is what we will be examining with them over the next few weeks as we accept or reject the plans which have been put in.

Q65 Nigel Griffiths: Are you going to remove all the money for stroke care from those who either fail to submit a plan or submit an inadequate plan?
Sir David Nicholson: No, we will not do that, but there is a whole series of interventions that we can make: Dr Jenkinson and his team can be sent in to help them do it; we have NHS Improvement who are doing a lot of work; we have people and facilities we can put into those areas to make sure they can deliver a plan which is acceptable.

Q66 Nigel Griffiths: When did this work stream come about?
Sir David Nicholson: The accelerated development programme is just about finished. We told PCTs in November/December of this year what we expected by March, so they have been working on that over the last three or four months.

Q67 Nigel Griffiths: Have you told PCTs to unlock scanners at the weekend?
Sir David Nicholson: PCTs would say they do not lock them up in the first place, that the hospitals do that. A part of their plan is that they have to show how they are going to provide access to CT scanners. That may not mean that every organisation provides all of the services 24 hours a day. It may be that in some places we concentrate on particular hospitals in urban areas and others to make it happen but what we want is to make sure that everybody, every person, every member of the population has access to that service.

Q68 Nigel Griffiths: How long do you think that is going to take effectively?
Sir David Nicholson: Our ambition is to deliver it by the end of next year but we know that is an incredibly tight and difficult thing to do. We do not want to back off from that at the moment because we want to keep the pressure on the system to get the improvements as quickly as we can. If we are dealing with a culture problem which takes a long time to change, what is your most effective way of persuading colleagues to catch up really?
Dr Jenkinson: The most powerful tool we have is the awareness of the public and we need to make the very best use of that. You will know that awareness has gone from 15% to 82% and there are all sorts of potential benefits which can come out of there and not just acute illness behaviour when someone is having a stroke, but also their involvement in local services and demanding the highest calibre service in the locality, being involved in implementation groups and describing the services. I genuinely believe that is the strongest tool we have at the moment.

Q69 Nigel Griffiths: Professor Boyle, in another informative intervention you mentioned that the A&E being next to the X-ray department was a particularly helpful model. Is this now required for all new hospitals?
Professor Boyle: Yes, I think it is built into the NHS Estates' advice about co-location and it is also true that you need to have your emergency acute services, things like coronary care and stroke care, very closely linked to the A&E department. You do not want to linger in an A&E department; it can be a bit like sticking paper. This is why you need to clarify the immediate triage issues and the pre-alert systems which are present in many more districts now than was the case, so that the view of the Ambulance Service is taken seriously and is not then double-checked unnecessarily.

Q70 Nigel Griffiths: If a health authority is building a new hospital today, is there an option for them not to use that model?
Professor Boyle: No.

Q71 Nigel Griffiths: Good. I notice that training is an issue highlighted on page 26 or rather the lack of training in terms of recognising the symptoms of stroke. How has that been addressed?
Professor Boyle: The FAST campaign, although it was directed at the public in general, has actually been very informative to staff as well. Effectively a lot of them, lay staff, people like GP receptionists, need to know these simple messages as well and that has had a very great impact. It has had a big influence on the way A&E departments behave because they would pay more attention to somebody with chest pain or major trauma than they would to somebody with a stroke. We know that the impact of treatment for somebody with a stroke is just as effective as managing a heart attack, if it is done properly.
Dr Jenkinson: On the training issue, part of the work which flowed out of the creation of the stroke strategy was the creation of an educational framework which is stroke specific and that work is now done. It describes the skills and competencies of any member of a workforce whatever discipline they come from to meet the needs of people with strokes along the entire pathway. That includes within it core competences which would include any member of staff—and Professor Boyle describes the domestic who gives a person with a stroke a glass of water which could be catastrophic—to ensure that they understand issues around dysphagia that a paramedic would know that, somebody in radiology and in primary care as well. That piece of work is now complete and that information and resource is now nested within a new host, the United Kingdom Stroke Forum and they are just coming on stream with that. In the future, in the coming few months, you will see them accrediting courses and accrediting individuals to enable people in stroke to get specialised training, core competences and extended competences, to enable the staff to have a career progression. It will be better for patients and it will enable transfer between units of specialist staff as well.

Q72 Nigel Griffiths: I had a constituent, Jim Hill, whose quality of life was immeasurably improved after a stroke by the TENS project, the electrical stimulation. Is that rolled out nationally?
Dr Jenkinson: I am not aware of clear evidence that TENS make a difference. I can look into that and bring information to you. There is evidence for what is called functional electrical stimulation, which is the stimulation of nerves in a limb which is paralysed because the brain has failed to function and drives the limb to work. Certainly for walking, functional electrical stimulation can make a difference in terms of speed of walking and quality of life. I am not sure of the evidence base on TENS.

Q73 Nigel Griffiths: Do you recommend that people who do not have stomach associated problems take Aspirin; men over the age of 50?
Dr Jenkinson: No, there is not good evidence, if you have not had a vascular event, for taking Aspirin. If you have had a vascular event, heart attack or stroke, it brings undoubted benefit but that is not clear for people as primary prevention.
Chairman: Sorry to spring all this free medical advice on you.

Q74 Mr Burstow: I just want to come back to some of the issues around the must-do targets of 90% of patients spending the majority of their time in the stroke unit. Professor Boyle talked earlier on about the financial pressures placing a great imperative on getting things completely right in the next 12 months. How long do you think realistically it will take to get beyond the 90% towards the 100%?
Professor Boyle: It is not going to be very long. We know that on any one day the number of patients in hospital with a stroke matches the number of stroke

beds there are. It is more a question of how those beds are used and a question of bed management. Very often patients with other conditions end up in a stroke unit for some other reason, pressure on the beds in general, but that does not happen in coronary care units, so why should it happen in stroke units. That is the message we are really trying to major on at the moment.

Q75 Mr Burstow: Are the levers now in place to make sure that over the next 12 months those changes in management of beds actually deliver that?
Professor Boyle: Yes. We have all the levers we can hope for in the present climate and quite how we are going to do these measures and track each hospital over time is something we are going to be planning tomorrow afternoon. Probably we will get some monthly progress reports on whether or not this initiative is being followed through sensibly.

Q76 Mr Burstow: So if the NAO did another piece of work of this sort in 18 months or two year's time, you would be confident.
Professor Boyle: That is certainly our ambition. Some of the hospitals do not know that yet but they will find out soon.

Q77 Mr Burstow: That is good. May I pick up the cash as well as care benefits which arise out of funding early supported discharge services which you were talking about just now? Given that fact, why is it so difficult to identify who will pick up the bill of actually setting them up?
Sir David Nicholson: The issue is that what tends to happen in these circumstances is that the theory is that if you put the supported discharge in place you would need fewer beds but what comes first? Very often it is the fewer beds which fund the supported discharge. What we have said for 2010–11 is that every PCT should identify up to 2% of its budget that it can use to invest to make these kinds of upstream things happen. We said "Don't allocate that money in 2010–11 but use it for this kind of thing. So every PCT should have the opportunity to have money in 2010–11 to make the investment to early discharge before it closes the bed. We think that is a much better way of doing it. It is having the confidence and understanding to do that which has been the restriction.

Q78 Mr Burstow: Back to the question earlier, within the next 12 months that is something where we will see a significant change.
Sir David Nicholson: You should see that over the next 12 months.

Q79 Mr Burstow: One of the things the Report talks about on page 34 is around long-term care and support. It makes the point that there is a host of recommendations in many areas but there is a lack of clear guidance around what works best when it comes to post-hospital care. What can you do to try to provide some clarity there so services can be better tailored and developed?
Sir David Nicholson: It is absolutely true; it is the part of the strategy which has the least evidence underpinning it. Because of that, it has been some of the most difficult bits for us to do. I know there is quite a lot of work going on in this area.
Dr Jenkinson: The evidence base is relatively poor there compared with the rest of the stroke pathway. We know what patients experience and what they want. We know aspects of secondary prevention and what can be done in that regard but clarity around psychological and social support and evidence for that is not clear. Work is going on through a national programme called CLAHRC, *Collaboration for Leadership in Applied Health Research and Care,* which is clarifying those issues and we are going to incorporate those findings into what our programme will be doing over the coming months.

Q80 Mr Burstow: Part of the patient's experience is the carer's experience.
Dr Jenkinson: Absolutely.

Q81 Mr Burstow: The Report highlights emotional support, particularly counselling, access to respite care and training on how to support the person at home, as being areas where there has been a fairly substantial number of people saying this is poor and in some cases very poor. What more are you doing to make sure that that really begins to shift so that if we saw another of these Reports in 18 months' time the numbers of people indicating those were poor would not be poor?
Dr Jenkinson: Certainly the stroke programme has run accelerated work in nearly 60 pilot sites with five different programmes of work over the past year. Our learnings from that are coming out now and our intention will be to disseminate that across the country; that includes work in rehabilitation, transfer of care and longer term care. It is important to note—I am not for a moment saying it should be done for nothing—that there are examples, for instance across the south-west, where a major project was undertaken by an organisation called Connect, which is a charitable organisation, along with a primary care trust and the provider trust at Truro to help bring long-term support for people with stroke who had communication problems. That pilot ran for two years and it was clearly successful by hard outcomes and also by how patients and carers judged that. It is now being commissioned to continue. We would take learning from major pieces of work like that and many of the services which will help support people with stroke already exist; it is about providing signposting and enabling those organisations to recognise particular issues for people who have had a stroke.

Q82 Mr Burstow: On the issue of training, there is reference in the paperwork to care homes and residential homes and about 11% of stroke patients go there once they are discharged. There appears to

be quite a serious issue about lack of awareness, part of which I suspect has been addressed by the FAST campaign, but nevertheless a lack of awareness and recognition of the symptoms and a lack of training around how to manage people with stroke properly in that setting. You referred just now to a new piece of workforce training development that is being done. Does that include care home staff?

Dr Jenkinson: Yes, it does. It includes the skills and competences that would be core and also extended for that part of the pathway. You may know that the Care Quality Commission is at the moment describing and analysing the entire post-acute care pathway for everyone with stroke across England and that would include people in nursing homes. It is our intention to work with them and in the future to look perhaps towards accrediting staff who care for people with stroke in care homes and requiring them to have qualifications in stroke, as they do for people with cognitive impairment.

Q83 Mr Burstow: It did occur to me, apart from the fact that there would not be enough space at the table, that in some ways the absence of the CQC at the table was actually quite important here because they clearly hold some of the levers to drive not just this issue about training in care homes but also the other issue which has come up in a number of questions which is this issue of the lack of alignment with social care. I was wondering whether you could say a little bit more about what the Department are doing in relation to that issue of getting the local government part of this equation fully aligned with the strategy and what discussions there have been with the Department for Communities and Local Government.

Sir David Nicholson: There have been extensive discussions, as you might expect, not least of all because of all the debate going around the national care service and the funding of long-term care by the Government in general. We have been having lots of discussions with them about all of that. The issue has been how to increase and improve integration between services and it seems to me that is the central point. We have come to the conclusion that structural change is not what is required in these circumstances but getting the incentives aligned and getting them right. You are absolutely right that the CQC is a crucial part of that. It does go across that boundary and the way in which they regulate the system, they collect information, the things they do, will be critical to make that happen.

Q84 Mr Burstow: One of the tools in that particular box is local area agreement. Is that one of the things which is now actively being encouraged?

Sir David Nicholson: Absolutely. As you know, the Tier One Vital Signs are all part of the local area agreements that we talked about.

Q85 Mr Burstow: My final question is returning to where I began around the must-do targets and a session which you say took place about a month ago now around dementia. Not so much to come back to that issue specifically but what has been interesting has been some the points which have been made in this session about lessons from this strategy. What general lessons would you draw that could and should be applied to the roll out of other strategies?

Sir David Nicholson: I think that the stroke strategy is ahead of dementia in that sense. The lessons we learned from stroke were first of all to get the strategy right and get people bought into it. That is why in a sense we have spent so long getting the dementia strategy in the right kind of place because we know that the power of buy-in across health and social care and patient groups is vital if you are making this change happen. Get the strategy absolutely right. You need relatively small amounts of seed corn, pump-priming money nationally and you need to make sure that the service sees it as a major priority. They are the kinds of things and the development of networks around the system and some kind of improvement capacity.

Dr Jenkinson: I would say the tricks are: raised awareness, if the public understands the issues and biases about dementia and stroke are taken away and there is a true understanding of what good care looks like, that helps move it forward; strong leadership and that means resources and time to give people headroom to do that both nationally and at the local level; genuine leverage in the system has made a difference for stroke care.

Q86 Angela Browning: Right at the beginning of this session you mentioned the need to try to improve on the diagnosis of atrial fibrillation because it is undiagnosed. When the heart loses sinus rhythm the physical symptoms associated with that can mean people then seek medical attention, but people can have atrial fibrillation for a very long time without knowing they have it. If you were to apply a Holter monitor to them, you would pick up the sinus rhythm imperfections without them necessarily knowing they have it. But you cannot apply the Holter monitor until you have some indication that this is what it might be. How are you going to improve the diagnosis of atrial fibrillation in those people who do not present with dramatic symptoms?

Professor Boyle: We need to get all the health professionals a little more adept at doing a very simple diagnostic test which is feeling the pulse of the person in the room. *Know your Pulse* is a campaign which the Arrhythmia Alliance have campaigned on in this building. It is something you can do yourself also. Sometimes there are other irregularities which are quite difficult to differentiate from atrial fibrillation so we are also quite keen to improve simple access to diagnostics in primary care. You can do this now with very simple tele-medicine devices, central reporting, which does not require great expertise in the practice. We have also explored with some PCTs the notion that you could, when giving the flu jab, because it is the same high risk group that will be called in for seasonal flu protection, also check the pulse and identify people that way. So we

have a lot of learning through our networks on that particular approach which we are pursuing and spreading across the country.

Q87 Chairman: Professor Sir Bruce Keogh, I never like to see a witness sit through an entire hearing not saying a word. You are obviously a very distinguished Medical Director of the NHS. What do you think are the wider lessons for the NHS that we can learn from the implementation of the stroke strategy?

Professor Sir Bruce Keogh: It goes back to one of the previous questions about how strategies interrelate. Roger Boyle was responsible for implementing the national service framework for coronary heart disease and in many senses there is great similarity there. There is similarity in the pathology because it is vascular, it is simply that stroke affects the brain, heart disease affects the heart. We learned quite a lot from there about the disease processes, about how they are treated, about the importance of coronary care units which has led us to understand the importance of stroke units. We have learned about the value of networks, we have learned about the value of collaboratives, we have learned about the value of national audits and the use of data when it is collected and used effectively by those people who actually deliver the service and we have learned, most importantly, about how to start building the consensus for a strategy from the bottom up. There is a history of people sitting in darkened rooms thinking they know how a service should be delivered and that history has demonstrated that those initiatives have faltered time and time again. One of the things I think we learned fairly early on with some of the national service frameworks was that there is a great synergy in a kind of tripartite relationship between those people who receive and deliver the service, coupled with those who actually administer the service, such as the Department of Health and the administration of the NHS, linked into the Treasury, in other words the people who have to pay for it. The bit I think we are building on more and more is a deep understanding that involvement of those who deliver the service is important. Actually the intellectual capacity for solving the sorts of problems which we have to address does not reside necessarily in this building or in Richmond House: it resides with those people who engage with patients on a day-by-day basis and who feel the frustrations of those patients, and share some of their emotions. Those are the people who, in my view, are best equipped to advise on how services should be best delivered and how they should be changed. One of the difficulties we have is how we interpret that desire for change and ultimately effect it into policy and strategies. The stroke strategy probably represents among our strategies the pinnacle of that endeavour but we are still learning from the stroke strategy so I think subsequent ones will be even better.

Chairman: Thank you very much for that. It is a very good answer and I do not even need to summarise the hearing. Thank you.

Memorandum from The Stroke Association

NATIONAL AUDIT OFFICE STROKE FOLLOW-UP REPORT: PROGRESS IN IMPROVING STROKE CARE

About The Stroke Association

The Stroke Association is the only UK wide charity solely concerned with combating stroke in people of all ages. We fund research into prevention, treatment and better methods of rehabilitation and help stroke survivors and their families directly through our website and national helpline.

We also provide a range of community services including support for people with communication difficulties as a result of stroke, family support, information services and welfare grants. In addition we campaign, educate and inform to increase knowledge of stroke and act as a voice for people affected by stroke.

Stroke Facts

A stroke is the brain equivalent of a heart attack caused by an interruption of blood supply to the brain.

Stroke is one of the top three causes of death in England and the largest cause of adult disability. Around 300,000 people in England are living with moderate to severe disability as a result of stroke.

Stroke is also one of the most expensive conditions, with direct care costs to the NHS of £3 billion every single year, within a wider economic cost of £8 billion.

Executive Summary

In 2005 the groundbreaking National Audit Office report *Reducing Brain Damage* exposed the shameful state of stroke services in England.

Five years on we are pleased that the NAO's follow up study concludes that the subsequent actions taken by the Department of Health have improved value-for-money in stroke care and resulted in better outcomes including a reduction in the chances of dying after a stroke. The Stroke Association welcomes this conclusion and congratulates the Department, and all those others who have contributed to this success.

However, despite improvements we would also like to caution against stroke care now being seen as a "done deal". The NAO make it clear that there remain areas of serious concern and significant threats to achieving continued improvement and value for money in stroke care over the medium to long term.

In particular the NAO are keen to point out that the welcome improvements in acute stroke care are not yet being matched in longer term support for survivors and their carers in the community.

The study also exposes the threat posed to stroke support services by the current financial pressures facing the NHS and Local Authorities and the end of additional funding for implementation of the National Stroke Strategy in 2010–11.

Although the Department of Health's ring fenced funding for Local Authorities has significantly increased access to longer term stroke support from organisations such as ourselves, we have serious concerns about the sustainability of such services and the level of support we will be able to offer to stroke survivors and their carers after the funding period ends.

We fully agree with the NAO's recommendation that NHS Organisations and Local Authorities must now plan how they will sustain these services and we need a commitment from the Department that these improvements will continue in the long term.

Although the NAO are right to emphasise the great improvements made in emergency and acute care since 2005 there are also areas in this part of the pathway where progress has been too slow.

In particular it is unacceptable that only 17% of stroke patients are admitted to a stroke unit within four hours of arrival in hospital. There are also continuing problems with access to brain scanning with only one in five eligible patients having a scan within three hours of their stroke. Both of these areas were the subject of key recommendations by Committee of Public Accounts in 2006.

Despite the great strides that have been made we feel that the concerns and threats to the sustainability of recent improvements outlined by the NAO and the slow progress in improving longer term support means that the true picture of improvement in stroke care remains incomplete.

We would therefore recommend that as with the Dementia Strategy the Committee of Public Accounts should request a further review of progress in stroke care within three years to ensure that developments in stroke care continue to provide maximum value for money to the tax payer.

Post-hospital and Longer-term Support

1.1 Post-hospital and longer term support in the community has traditionally been the weakest element or care for many stroke survivors and the NAO find that the improvements in acute stroke care in recent years are not yet matched by progress delivering more effective post hospital care and support.

1.2 The NAO follow up report includes five recommendations on post hospital longer term care compared to two in the original 2005 report. We welcome the increased profile that the NAO now gives to this area of support.

1.3 The 2005 NAO report acknowledged that voluntary and community organisations can provide effective long term support for stroke survivors and recommended that the Department of Health encourage this.

1.4 The Stroke Association has taken up this challenge and the ring fenced funding for Local Authorities attached to the National Stroke Strategy along with increased investment from PCTs has led to a massive increase in the number of support services we are able provide to stroke survivors.

1.5 The additional funding has also allowed significant innovations in the services we provide including moving beyond our long running Information, Advice and Support and Communication Support services to increased health promotion services, work supporting re-enablement and social inclusion and targeted support for high risk groups.

1.6 Our new model of provision for stroke survivors, Life After Stroke Services, puts stroke survivors and carers at the centre and offers services to meet individual needs; it also sign posts stroke survivors to other services. We believe this service will encourage integration and joint working between health and social care systems and other services such as benefits and employment support as identified by the NAO report as one of the key areas of concern.

1.7 Once the current level of our services reach full capacity, one in two eligible patients will be able to access them, compared to one in five in 2005. The Stroke Association can also report that the growth of our services has been greater in areas where access has previously been relatively low.

1.8 However, there are still regional variations in the services that we offer and problems with access to services in rural areas. We hope to continue to develop these services and ensure a more uniform distribution across the country.

The value of longer-term support

1.9 We believe our services offer effective support for the post hospital needs of stroke survivors and their carers but accept that it is sometimes difficult to demonstrate their cost effectiveness. We do however monitor their impact on people who use our services.

1.10 The report *Changing Lives—The Stroke Association Impact Survey* showed that as result of using our services 85% of people felt more in control and 75% felt that stroke dominated their life less. Anecdotal evidence shows the economic benefits that arise, for example through enabling early discharge, helping people back to work and avoiding readmission to hospital.

1.11 The Stroke Association is investing £150,000 in researching the effectiveness and value of our services. We believe this will provide an evidence base to demonstrate the value and effectiveness of these services as well as their obvious social value to stroke survivors and their families.

1.12 We welcome the NAO recommendation that the Department of Health should evaluate the effectiveness of the Local Authority stroke grants during 2010–11 and hope that this will help improve the evidence base for longer term support.

1.13 The Department of Health should commit to evaluating the effectiveness of the Local Authority stroke grants during 2010–11.

1.14 The Department of Health should take action to improve the research based evidence and guidance on the costs and benefits of clinical and other support for long term stroke care.

The risk to support services

1.15 The NAO report shows that 76% of Local Authorities surveyed have used the Department of Health's ring fenced grants to develop services such as the provision of information training and support for stroke survivors with The Stroke Association.

1.16 However, this funding is only guaranteed until 2010–11 and we are seriously concerned that with increased pressure on Local Authority budgets these services may be at risk of closure when grants end. We agree with the NAO that action must be taken now to plan how to sustain support services.

1.17 The Department of Health should take action to help ensure that those services currently funded through the ring fenced grant to Local Authorities are sustained beyond 2010–11.

Outcome measures for longer term support

1.18 One of the reasons for the difficulty in assessing the effectiveness of longer term care is that there is a lack of agreement on outcomes measures to assess the quality of long term care.

1.19 We support the NAO recommendation that the Department of Health should develop a set of indicators of high-quality long-term stroke care. We also support the suggestion that the longer term care aspects of the Strategy should be re-examined with a view to develop more measurable quality markers and a set of specific milestones for improvement. We would like to see providers of longer-term support services, stroke survivors and carers directly involved in this process.

1.20 The Department of Health should involve providers, stroke survivors and carers in discussions about how best to define and measure good quality long term care.

Ongoing review and support of stroke patients after discharge

1.21 The NAO state that 30% of patients were not given a follow up appointment within six weeks of discharge as required by the Stroke Strategy.

1.22 Without an effective review system stroke survivors and carers may be denied access to those services that could have a major impact on their quality of life.

1.23 The Department of Health must take action to ensure that an effective review system is put in place that can identify the long term needs of stroke survivors.

Public and Professional Awareness of Stroke

2.1 We welcome the Department's major advertising campaign focusing on stroke symptoms and the fact that stroke is a medical emergency. It is pleasing to see its success as demonstrated by the increase in the number of calls registered by ambulance trusts. However, the true measure of success will be if the key messages (recognition of symptoms and dialling 999) are retained and acted upon when a stroke occurs.

2.2 The Department of Health must make plans to continue the campaign to improve awareness of stroke over the medium to long term.

2.3 The Committee of Public Accounts in its previous report recommended that the awareness campaign should particularly focus on those groups at higher risk of stroke such as people from Afro-Caribbean and South Asian ethnicity.

2.4 The Department of Health should outline what work has been done to explicitly target higher risk groups with key messages on stroke symptoms and commit to continuing this over the medium to long term.

2.5 The NAO suggest that a lack of training within A&E and Medical Assessment Units for recognising symptoms of stroke is acting as a bar to patients accessing specialist stroke units.

2.6 The Department of Health should ensure that stroke training is provided to all staff involved in the management of stroke patients whether or not they are working on a stroke unit.

Improving Acute Care

3.1 We welcome the transformation in acute care which has taken place in most parts of England since the last report. However, the NAO suggests that the extent of progress is variable around the country and warns that future reorganisation of services to provide better care could be complicated by the challenging economic climate. The NAO highlight the following issues that must be addressed to ensure continued improvement and value for money:

Emergency Assessment and Treatment

3.2 A brain scan is the only way of identifying if a patient is experiencing a hemorrhagic (caused by bleeding) or ischaemic (caused by clotting) stroke and deciding the appropriate action to take.

3.3 Thrombolysis (treatment with clot busting drugs) can reduce mortality and morbidity in eligible patients but needs to be administered within three hours and is dangerous for patients with hemorrhagic stroke making scanning essential.

3.4 Although access to brain scanning has improved only one in five eligible patients had a scan within three hours of their stroke and only 59% within 24 hours.

3.5 Although the number of sites in England offering thrombolysis has increased greatly from 18% in 2006 to 71% in 2009 the number of patients treated is small and only one in four sites provide thrombolysis at night and at weekends.

3.6 The Department of Health must take action to encourage the rapid assessment, imaging and treatment of patients with suspected stroke throughout the 24 hour period, seven days a week.

Access to Stroke Unit Care

3.7 Stroke unit care is the single most beneficial intervention that can be provided after stroke.

3.8 We welcome the fact that the proportion of patients spending 90% of their stay on a stroke unit increased to 57% in 2009 but it is important that all patients should be treated this way.

3.9 The failure to admit directly to an acute stroke unit remains the most important barrier to improving acute stroke care. The report shows that only 17% of stroke patients were admitted within four hours of arrival at A&E.

3.10 The Department of Health must take action to ensure all patients are admitted directly to an acute stroke unit and that they spend the majority of their time at hospital in a high quality specialist stroke unit.

Staffing

3.11 The unavailability of the full range of appropriately trained staff is identified as a weakness in the report. Although the number of stroke consultant sessions has increased it is still well below the recommended minimum level of two per 250,000 and there are particular problems with access to psychological support.

3.12 The Department of Health should consider what action is required to meet the necessary staffing levels in stroke units to implement the Stroke Strategy.

Treatment of TIA (Transient Ischaemic Attacks or Mini Stroke)

4.1 It has been estimated that improving the treatment of TIA (mini stroke) could prevent 1,200 strokes and save the NHS £37 million.

4.2 The NAO find that specialist assessment of suspected TIA has improved especially in the number of sites with systems in place for higher risk patients to be seen and treatment initiated within 24 hours.

4.3 However, we understand that the Vital Signs measure chosen to assess improvement (the proportion of higher risk patients treated within 24 hours) has unfortunately created some difficulties and confusion and may have become a disincentive to delivering best practice in this area.

4.4 We would therefore like to see other efforts being made to drive the development and spread of good practice on delivering treatment within 24 hours for those higher risk TIA cases.

4.5 We are also concerned that 51% of hospitals have a waiting time of over two weeks for carotid endarterectomy, one of the main procedures for TIA. Providing such surgery within two weeks could prevent around 250 strokes at a net saving of £4 million to the NHS.

4.6 The Department of Health should take further action to encourage the widespread use of best practice in the management of TIA.

Preventing further Strokes

5.1 The report notes that the best way to reduce the human and economic costs of stroke is through prevention.

5.2 We would like to see further emphasis on the management of risk factors for stroke and in particular the effective treatment of atrial fibrillation (irregular heart rhythm) which could prevent 4,500 strokes annually.

5.3 The risk of having another stroke or TIA is very high so ongoing monitoring and support of secondary prevention is important. The report shows that only half of stroke survivors were given advice on further stroke prevention on leaving hospital and many were not aware of the common risk factors.

5.4 Alongside improvements to the ongoing assessment of secondary prevention the Department of Health must take a lead at the national level to refer explicitly to stroke in more public health campaigns.

Contrast with Dementia Strategy

6.1 The recent follow up report from the NAO criticising progress on the Department's dementia strategy highlighted a number of levers for change missing in that strategy which have contributed to the success we have seen with the implementation of the National Stroke Strategy.

6.2 Unlike dementia, the position of stroke as a national priority for the NHS was supported by its inclusion in the NHS Operating Framework as a Tier One "must do" indicator.

6.3 The existence of a National Clinical Director for Stroke has also been a key factor in driving change, a position that wasn't filled for dementia until a year into the Strategy.

6.4 The lack of extra funding for councils to help improve services was also highlighted as a problem in the NAO's dementia follow-up. The NAO stroke report showed that there has been an increase in long term support services for stroke survivors as a result of ring fenced grants for Local Authorities.

6.5 The Department of Health must ensure that stroke care remains a national priority for the NHS with strong leadership and adequate funding.

Request for further Review by the National Audit Office

7.1 Despite the great progress that has been made since 2005 we agree with the NAO that there are ongoing concerns to be addressed if the National Stroke Strategy is to achieve its objectives in the medium to long term.

7.2 The future financial climate the NHS must operate within and the end of the period of additional funding that accompanied the Stroke Strategy also raises questions about the sustainability of progress and further development of both acute and longer term stroke care and support.

7.3 The slower movement on improving longer term support for stroke survivors and the lack of evidence on the cost effectiveness of such support means that the assessment of progress to date does not give a full picture of improvement across the whole care pathway for stroke.

7.4 We recommend that as with the Dementia Strategy the Committee of Public Accounts should request a further NAO review of progress in stroke care within three years to ensure that developments in stroke care continue to provide maximum value for money to the tax payer.

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