Transforming health and social care in Kent and Medway

NHS

9 February 2018

Dear Charlotte,

Re: your 22 January blog as Labour mum

Thank you for your passionate concern about stroke patients in east Kent. We, the NHS, absolutely share your desire for local people to get the best possible care.

However, your blog draws some misleading conclusions from the Freedom of Information response that you received from South East Coast Ambulance Service NHS Foundation Trust about ambulance response times in east Kent. We thought it would be helpful to explain what these are so you can correct them.

In your blog you say: "The data, released yesterday reveals that patients in the Dover (CT16) area suffering from a suspected stroke, had the longest wait for an ambulance across East Kent in the month of December, with an average wait time of 41 minutes. Patients in the CT2 area of Canterbury suffering from a suspected stroke had an average wait time of nearly 27 minutes last month, whilst stroke call outs to Whitstable (CT5) and surrounds took an average of half an hour to arrive."

This is absolutely correct. However, it does not convey to the average reader that stroke patients may require different levels of response, depending on their symptoms and the amount of time that they have been experiencing them for.

The national target to get an ambulance to someone who is experiencing the typical F.A.S.T. symptoms, and has just started experiencing them, is an average of 18 minutes. However, someone who experienced the symptoms yesterday, or last week, is not going to require a time-critical response, because the moment for time-critical treatment has passed. An ambulance will be sent to them, but it will not be required to get to them within 18 minutes.

In addition, as the FOI response to you explains, these are response times for a wider category than just stroke, namely stroke/neurological.

At the moment, the paragraph gives the impression that the times you cite are for responses to acute stroke patients – those who could expect a response within 18 minutes. We would be most grateful if you could amend your blog to reflect the fact that the times cited are averages for all types of response to people with suspected stroke and also all types of response to people with other neurological conditions, where treatment may not be time-critical.

You also say: "With the ongoing consultation about stroke services proposing to make the William Harvey Hospital in Ashford the only specialist centre for stroke treatment in the region, those in the CT16, CT2 and CT5 postcodes should not be alone in being very worried indeed. With travel times from

central Dover to the William Harvey hospital being 30 minutes on a good, traffic-free run, the combination of ambulance wait-times and travel times means that any stroke patient from that area has a very poor chance of being seen by a specialist team with the 'golden hour' for treatment."

"The outcomes for stroke patients in Whitstable are likely to be even worse. With the aforementioned average half hour wait for an ambulance combined with the average drive time of 45 minutes to the William Harvey hospital, the *average* stroke patient will arrive at hospital after 1 hour and 15 minutes."

The study that you link to on the so-called "golden hour" is a single piece of research which was carried out in America nine years ago and is not based on up to date evidence.

Stroke outcomes in the UK are significantly better than in the US. As the NHS, we work to the National Clinical Guideline for Stroke, which is the definitive source of how stroke care should be delivered in the UK to give the optimum outcomes. It is based on systematic reviews and meta-analysis of what delivers the best outcomes for stroke patients: 670 papers were considered in the development of the 2016 stroke guideline.

The guideline sets out that people need thrombolysis as soon as possible (at most within 4.5 hours of stroke.)

In the south east, we have set ourselves the even more stringent standard of patients getting clot-busting drugs, if they need them, within two hours of calling for an ambulance. Between 10 and 20 per cent of stroke patients may need clot busting therapy (thrombolysis).

To achieve this two hour standard, the South East Stroke Clinical Advisory Group set a target for patients to reach hospital within an hour of the 999 call, to allow an hour at hospital for patients to have a scan and be given clot busting drugs if needed.

People having a stroke (acute stroke patients) who dial 999 would always be conveyed by blue-light ambulance to the hyper acute stroke unit for their area, and the travelling times we set out in the stroke consultation are realistic for blue-light ambulances, no matter how frustrating the traffic for other road users.

Because hyper acute stroke units have dedicated teams on hand to receive the patient, they can often respond faster when a patient arrives at hospital than A&E departments without a hyper acute stroke unit. This cuts down the overall time between calling 999 and getting treatment, even if the patient has travelled further.

To improve even further, the ambition is for the hyper acute stroke units to be able to deliver brain scans, and thrombolysis where needed, within 30 minutes of arrival at hospital.

The evidence, from elsewhere in the country where similar changes have already been made, shows that patients who are treated in a hyper acute stroke unit have a much better chance of surviving and making a good recovery, even if they travel further to get there.

You say: "The above statistics are, of course, only the averages. Shockingly, in December someone in Dover suspected of having a stroke had to wait nearly 3 and a half hours for an ambulance to arrive. In October and November, patients in Canterbury suffering from respected strokes had to wait well over two hours for their ambulance to arrive. In 2017, there was one report from the Folkestone area of a suspected stroke patients waiting over 5 hours for an ambulance to respond to their emergency call out."

None of the longest waits cited in this paragraph included any acute stroke patients – that is, those needing time-critical treatment. Half of the patients who had the longest waits, when assessed by paramedics on the scene, were not taken to hospital because they actually did not need inpatient care. Again, it would be helpful if you would please clarify this.

You say: “Health chiefs in the area must take account of ambulance response times as part of their consultation into the reconfiguration of stroke services. With the ‘average’ patient from Blean, Whitstable, Herne Bay, Dover, Deal, Sandwich, the CT2 region of Canterbury and all of Thanet being unable to make the William Harvey Hospital within the ‘golden hour’ for stroke treatment, they must look again at how proposed provision can best accommodate successful outcomes for all. We are very worried that a Conservative government led cost-cutting agenda, imposing poor Sustainability and Transformation Partnerships on hospital trusts across the UK is putting money before lives.”

Again, we ask you to clarify that there is no golden hour – it is about achieving the South East best practice standard of access within 120 minutes to treatment for blood clots, for those patients who need them. Currently, only half the patients in Kent and Medway who need it get thrombolysis within the recommended time because patients are taken to busy A&Es where they may wait to be seen. This would not be the case with dedicated hyper acute stroke units with sufficient staff and scanning facilities to meet patients as ambulances arrive, and speed them through for their brain scan.

In addition, for all stroke patients including the 80 to 90 per cent for whom clot-busting drugs are not appropriate, the most significant factor to support their recovery is being treated in a hyper acute stroke unit, particularly in the first 72 hours after their stroke, with a specialist team of doctors, nurses and therapists able to give them intensive therapy, care and treatment 24 hours a day, seven days a week. We know from the evidence that this is the influential factor in reducing long-term disability and enhancing recovery.

It is worth highlighting that, while South East Coast Ambulance Service (SECAmb) is facing challenges and is working hard to improve, in December 2017 it was ranked second best in the country for the new ‘Category two’ calls, which include calls to acute stroke patients in need of time-critical treatment.

Furthermore, the stroke review business case includes £1million investment for SECAmb as part of a detailed implementation plan for the stroke proposals involving up to £40million of investment. Implementation would not be ‘overnight’ but over at least 12 to 18 months from the date of the decision on the future shape of hospital-based urgent stroke services in Kent and Medway, which is expected this autumn.

We hope you find this information helpful. Please contact us at km.stroke@nhs.net if you would like further detail on stroke services or the stroke consultation.

Dr Mike Gill, Chair of the Joint Committee of Clinical Commissioning Groups for the Kent and Medway Hyper Acute and Acute Stroke Services

Dr David Hargroves, senior stroke consultant at East Kent Hospitals University NHS Foundation Trust and clinical lead for the stroke review