MINUTES OF THE SCRUTINY REVIEW - STROKE PREVENTION
WEDNESDAY, 8 OCTOBER 2008

Councillors Winskill (Chair), Mallett, Vanier and Alexander

Apologies Councillor

LC10. APOLOGIES FOR ABSENCE

Dr Robert Luder
John Murray

LC11. URGENT BUSINESS

None

LC12. DECLARATIONS OF INTEREST

None

LC13. MINUTES OF PREVIOUS MEETING

Approved

LC14. STROKE ASSOCIATION

Work currently being undertaken is funded by a Section 64 Department of Health statutory grant.
Funded for 3 years.
Project is about getting people to act on their risk factors.
Four pilot areas: Brent, Ealing, Hillingdon and Tower Hamlets. These areas were chosen due to their ethnic diversity and the fact that they have divides in outcomes.
Starting point is mapping local Wards and working out which Wards have a higher prevalence.
Partnership working is key to success in stroke prevention.
Need to find out what health promotion work is going on in the area and ensuring that stroke is covered.
Any targeting needs to be specific and and people need to be careful not to group ethnicities together based on false assumptions.
Some areas have 'Health Trainers' which sit under the Public Health umbrella. The role of the Health Trainers is to educate the population on health and aspects of their lifestyles which impact their health by going into the Community. This is a different role to that of Community Matrons.
It is important to have local ownership to projects.

Examples of Projects:

Healthy Recipe Cards.

- These recipes were put together by students of Thames Valley University.

Patient Toolkit from April 2009.

- This feeds into the forthcoming Vascular Checks.
- Patients will be given a toolkit after they have had their Vascular Check.

- The toolkit is locally owned e.g. it has the PCTs mission statement on it.
- Will include a card with information on Blood Pressure, for example what is 'good' and what is 'high'.
- Will have a range of contact numbers in for example smoking cessation, dietary advice etc. Local GPs are engaged in the process and start by picking out which contact numbers of relevant for each patient.

All projects aim to be sustainable – they will be available regardless of which posts are in place at the Stroke Association.

Strategic Development

- "Assessing need and prioritising
- Engaging with local community organisations, existing networks and the third sector
- Setting up focus groups; talking to stroke survivors and at risk groups about gaps in stroke prevention
- Training:- The recent publication of the National Stroke Strategy talks of the role of primary care and highlights the lack of knowledge even amongst health professionals

- A shift from an NHS centred approach to more involvement from local authorities, with a more "pro-active approach to preventing ill health" (commissioning framework for health and well being)
- Use of terminology:- The difference between 'hard to reach' and 'don't know how to reach'
- Don't expect people to come to you
- What do you/they do once you've reached them?"

(Stroke Association Slide 8)

Nationally 62% of people are able to identify what a stroke is from a multiple choice list. This is believed to be lower in London.
Sickle Cell Aneamia is a big risk factor for stroke. This is especially the case for children aged 2-10years where there is a big risk of multiple strokes.
Teachers should be aware of FAST.

Points of discussion

Pre-registration appointments at Surgeries are a useful tool in identifying risk factors. This includes a Blood Pressure check and questions to assist in identifying risk factors. The check does not have to be carried out by a Dr or a Nurse, it can be carried out by a Healthcare Assistant. Follow ups for a transient population, such as Haringey, are difficult.

Need to ensure that all of the risk factors are known by people. The issues for strokes are the same as those for heart disease and diabetes.

Oberoi Software is being used by a number of practices across the borough. This is a system which identifies those who are at risk by analysing the whole patient register. A letter inviting those at risk in for follow up appointments is then generated.
Issues include:
Some readings may be very out of date as they rely on the last time a person attended.

Resource issues for example the increased workload and possible increase in prescription costs to treat those needing treatment.
There are lots of 'unknowns' – without all fields being populated the system is not as effective as it could be.
Oberoi is not a compulsory system for GPs.

LC15. NORTH CENTRAL LONDON CARDIAC AND STROKE NETWORK

The Panel received a presentation from Jinty Wilson, Director of North Central London Cardiac and Stroke Network.

The North Central London Cardiac and Stroke Network (NCLCSN) is part of the National Improvement programme and aims to assist in the implementation of the Nations Stroke Strategy.

NCLCSN covers Barnet, Enfield, Haringey, Islington and Camden.

The NCLCSN has links with a wide variety of organisations for example the London Ambulance Service, Voluntary and community groups, commissioners, primary care, local authorities etc.
Eager for Primary Care engagement to ensure that there are local solutions to take forward national policy.

Noted that men between the ages of 40yrs and 74yrs are difficult to reach.

Strokes are more likely to happen whilst a person is sleeping.

The London Ambulance service is engaged with an 8 minute target for reaching possible stroke patients.

The reaction for strokes needs to be faster than that for heart attacks. Two hours to get a cardiac patient to treatment e.g. angioplasty is good, but there is a need to faster for stroke patients.
For an ischaemic stroke you have a three hour window for effective treatment – therefore the decision as to whether to thrombolyse needs to be taken within 2 hours.

Need to keep the wider Healthcare for London work in mind for this review as the review will need to complement this.

A bidding process is currently taking place for Trusts. Some are bidding to become Transient Ischaemic Attack Treatment centres and some for Hyper Acute Stroke Unit Status. The closing date for these applications is 17th November 2008.

Outcomes for Strokes in London are worse than those outside London.

Vascular Risk Assessments are being implemented by PCTs in early 2009. These checks are for 40-74yr olds.
Concern that Older People may be slipping off the radar.

Jinty attended a Health Screening event in Brent Cross which was unundated with people.

Points of Discussion
GPs do not necessarily know where the TIA clinics are, the information is not readily available and it is therefore not clear where they can send patients. Having TIA clinics on Choose and Book would help GPs considerably.

LC16. HARINGEY TEACHING PRIMARY CARE TRUST

The Panel received a briefing from Adrian Hosken, Senior Commissioning Manager, Haringey TPCT.

Haringey has high mortality rates for strokes at the same time there is only 2218 patients on the Stroke Register. With an expected prevalence of 8-9% it would be anticpated that this number would be higher.

Main target for Haringey is VSA14 – Quality Stroke Care (outcome: reduction in stroke related mortality and disability). Haringey is currently rated as red on this target and therefore needs to improve.

Noted that VSA14:06 (proportion of people with TIA who are scanned and treated within 24rs) has a target of 25%. Query as to what the current performance is given that the target appears quite low.

Vascular Risk Assessments (VRA)
The TPCT is currently working on plans for the roll out of the Vascular Risk Assessments with a local implementation group currently being pulled together.
How will people know about them? There needs to be an awareness raising campaign which tells people what exactly they need to do in order to get a VRA.
What is the timetable for the roll out?
Noted that an article in Haringey People would be beneficial and that it should be in at least three key community languages.
Need to carefully consider how to market the VRAs.

Agreed that regular updates would be receievd by the Panel from Adrian.

Points of discussion

To improve outcomes for people who have had a stroke it is anticipated that the acute spend for the NHS would need to increase from £65 million per annum to £85 million per annum. Therefore prevention is important to keep overall costs down in the first place.

Mapping of QOF data may enable people to see whether there are geographical areas with problems.

Noted the difficulties with getting men to attend primary care. Men generally want to be able to access health care ‘then and there’ when they need it.

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LC17. ADULT, CULTURE AND COMMUNITY SERVICES

The Panel received a briefing from Lisa Redfern, Assistant Director for Adults, Adult, Culture and Community Services Directorate (ACCS).

Haringey ACCS is in receipt of a Stroke Grant of £92,000 per annum for three years. This funding will include the recruitment of a Stroke Care Co-ordinator which will be a joing post with the TPCT.

Noted that there needs to be sustainability with this post so that it does not go at the end of the three years.

ACCS is a wide directorate which is able to combine resources e.g. it has parks and leisure under its unbrella as well as social care.

Strong multi-disciplinary pathways are needed for stroke care in Haringey – this is an area which needs to be worked on.

There are a number of projects and initiatives being supported by ACCS, information on these can be found in the attached briefing.

Training

Importance of training staff on FAST and stroke is noted. This needs to be more than a one off training session. There needs to be a mechanism for following up the training e.g. through a Work Force Development plan, jointly with the TPCT.
The training should be about more than recognising symptoms, should also cover recognising risk and knowing what needs to be done in a potentially emergency situation.
Training could include Meals on Wheels staff as they have regular contact with those who are at a high risk.

LC18. NEW ITEMS OF URGENT BUSINESS

None

LC19. DATE OF NEXT MEETING

19th November 2008
18:30-20:30

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Stroke prevention

Homaira Sofia Khan

Stroke Prevention Campaigns Officer

2007 – 2009 Projects

- Primary prevention, raising awareness of high blood pressure and the risk of stroke within African Caribbean and South Asian communities

- Engaging with primary care in order to encourage at risk patients to make lifestyle changes, to avoid the need to take medication.

Pilot Areas

- Brent
- Ealing
- Hillingdon
- Tower Hamlets

Starting point – working with ethnic minority communities

- Mapping local communities
- Providing advice that is relevant to specific communities
- Working with other stakeholders
- Engaging with local health professionals
- Tapping into existing resources; not re-inventing the wheel

Active Intervention – engaging with primary care

- Mapping existing services and health promotion activities
- Identifying gaps in primary health care information around stroke and blood pressure
- Developing tools to encourage lifestyle changes
- Working alongside primary care where possible

Achievements

- Awareness sessions in the pilot areas aimed specifically at ethnic minority groups. Some of these have taken place alongside other organisations such as Diabetes UK and Afiya Trust
- Additional translation of the ‘Preventing a stroke’ leaflet in Somali
- A dvd of vox pops aimed at the Bangladeshi community is in development to be shown at an awareness session in Tower Hamlets
- Health trainers are being trained in stroke prevention
- Healthy recipe cards developed alongside student chefs at Thames Valley University in Ealing
- A patient blood pressure toolkit is being developed with the involvement of the NWL stroke network
- Creation of a network of grass root workers from different charities in order to share best practice

The future

- Sustainability of project work
- Mainstreaming policy around ‘bme’ groups
- Tackling inequalities
- Working alongside national initiatives such as the stroke strategy and the government’s cardiovascular risk assessments

Strategy development

- Assessing need and prioritising
- Engaging with local community organisations, existing networks and the third sector
- Setting up focus groups; talking to stroke survivors and at risk groups about gaps in stroke prevention
- Training:- The recent publication of the National Stroke Strategy talks of the role of primary care and highlights the lack of knowledge even amongst health professionals
- A shift from an NHS centred approach to more involvement from local authorities, with a more **"pro-active approach to preventing ill health"** (commissioning framework for health and well being)
- Use of terminology:- The difference between 'hard to reach' and 'don't know how to reach'
- Don't expect people to come to you
- What do you/they do once you've reached them?

The Stroke Association services

As an organisation we offer a number of different services:

- Health promotion
- BME service
- Family and carer support
- Communication support
- Community integration
- People of working age service

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North Central London Cardiac & Stroke Network

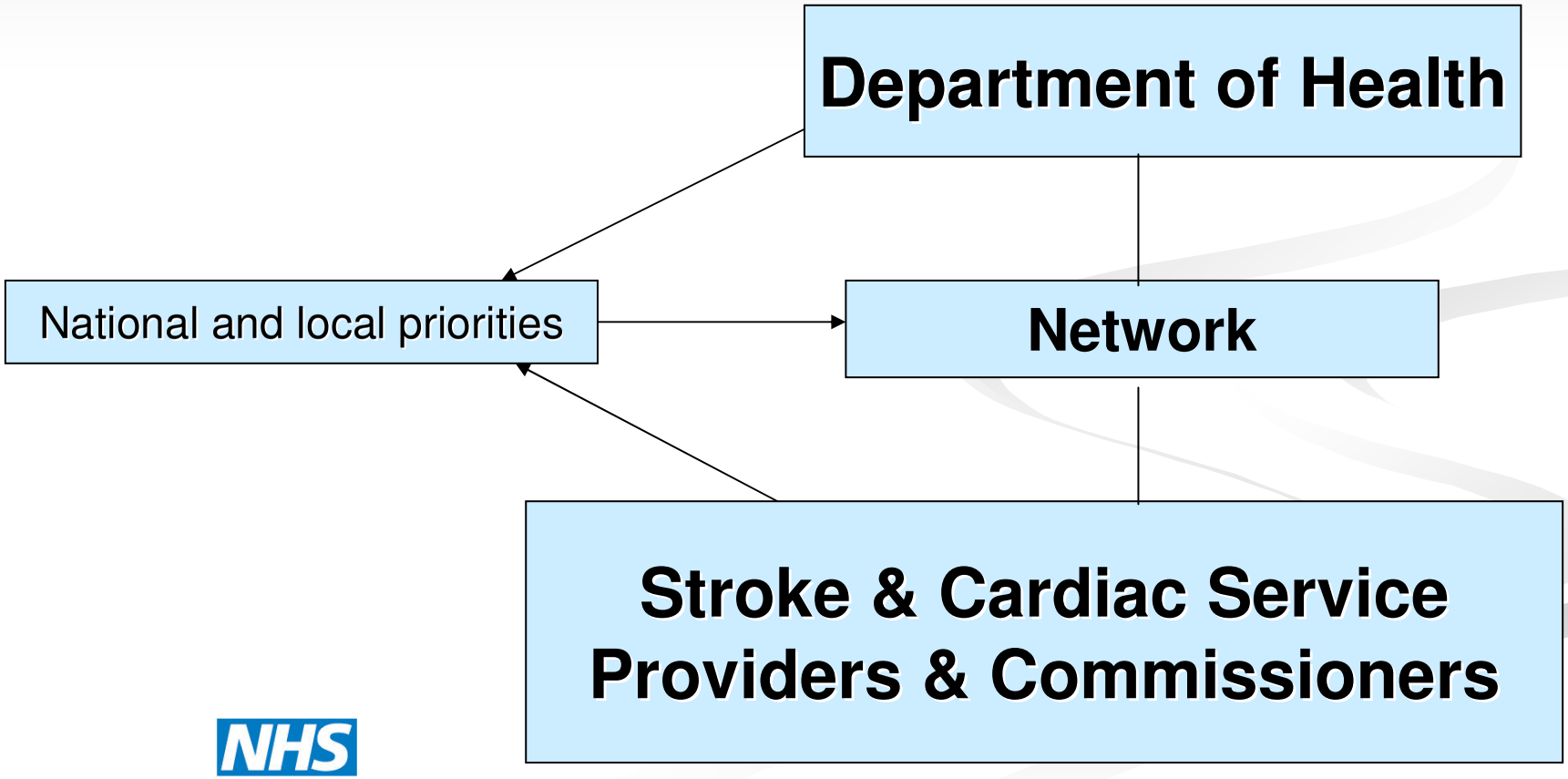
North Central London Cardiac & Stroke Network

An introduction

Network Purpose

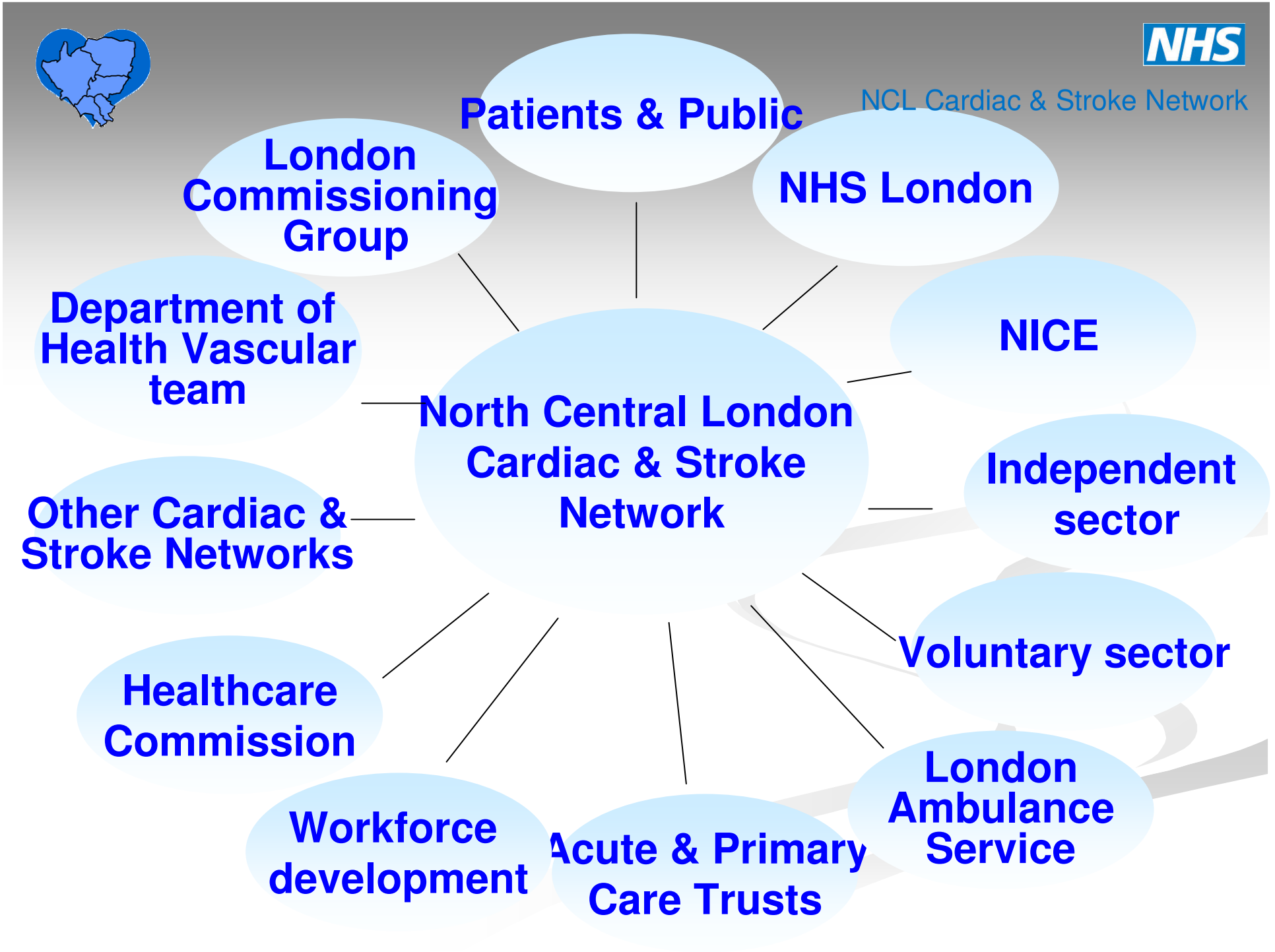
'Connections across disciplines which provide integrated care across institutional and professional boundaries, raising clinical quality and improving the patient experience'

(DoH, A network toolkit, 2004)

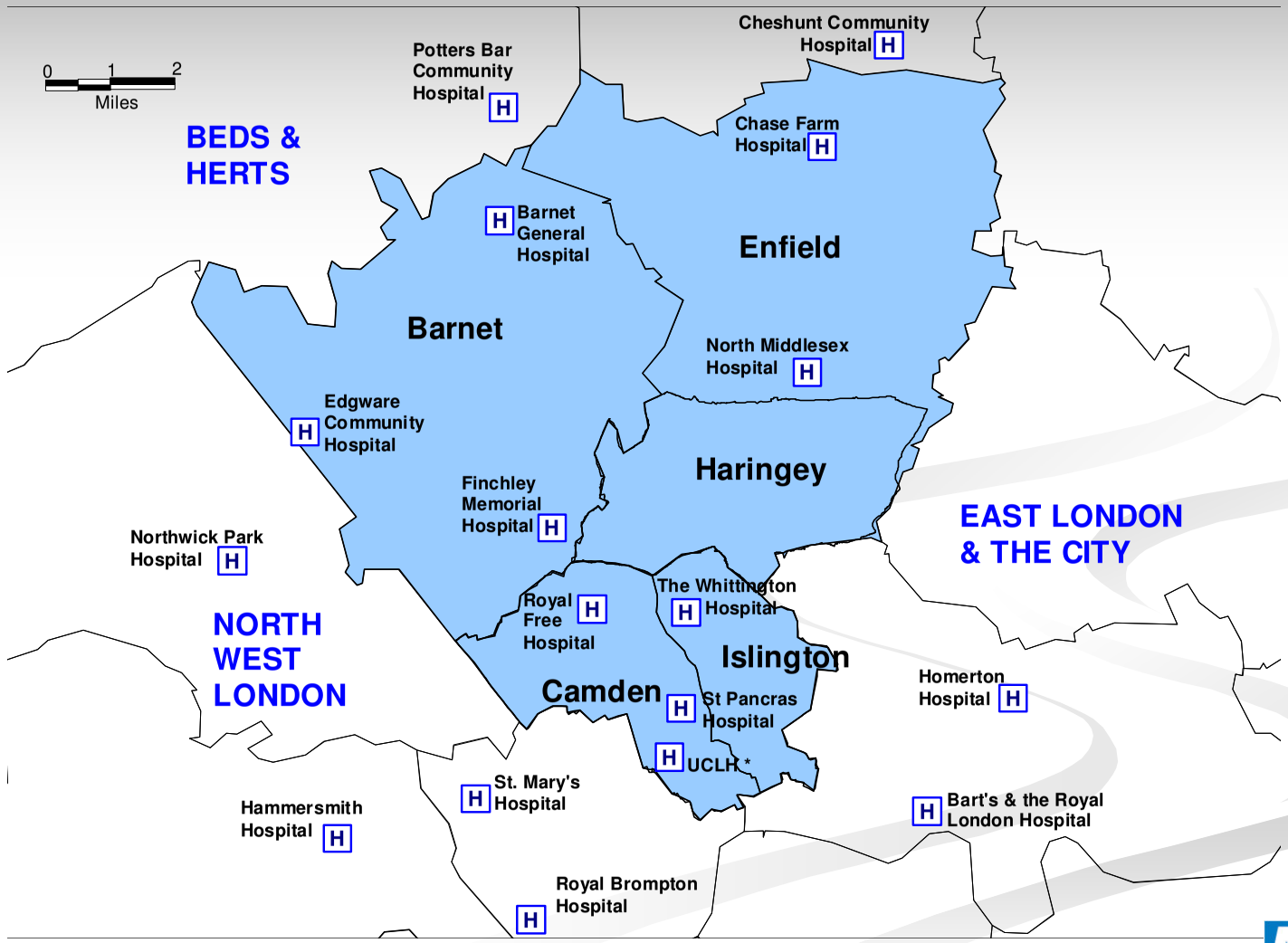


NHS

NCLCS Network


NHS
NCL Cardiac & Stroke Network
Patients & Public
London Commissioning Group
NHS London
Department of Health Vascular team
NICE
North Central London Cardiac & Stroke Network
Other Cardiac & Stroke Networks
Independent sector
Voluntary sector
Healthcare Commission
London Ambulance Service
Workforce development
Acute & Primary Care Trusts

Geographical Area: 1.2 Million



NCLCS Network

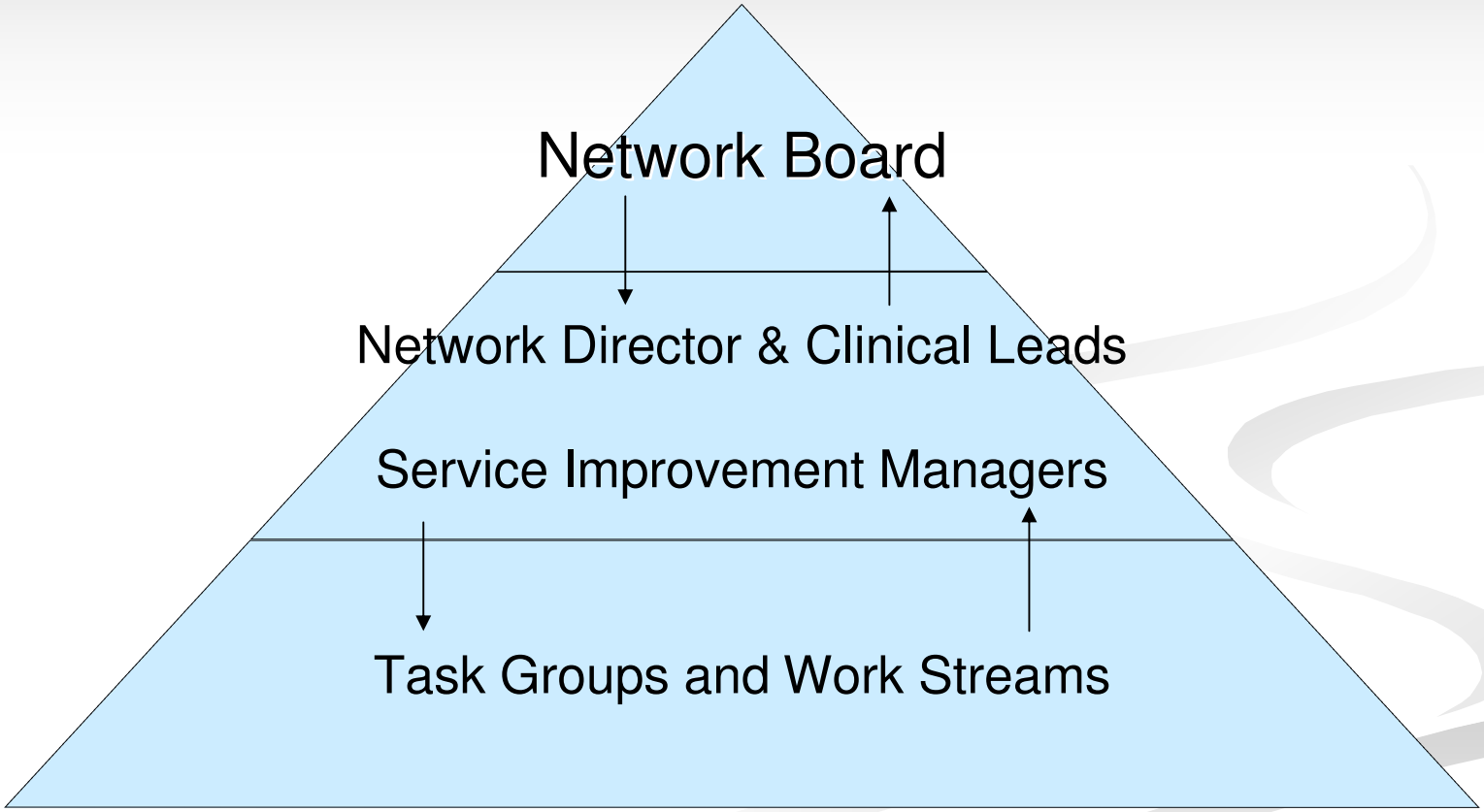
Stakeholders

- Barnet & Chase Farm Hospitals NHS Trust
- North Middlesex University Hospital
- The Whittington Hospital
- Royal Free Hampstead Hospital
- UCLH: including Queen's Square and The Heart Hospital

- Barnet PCT
- Camden PCT
- Enfield PCT
- Haringey tPCT
- Islington PCT

NHS
NCLCS Network

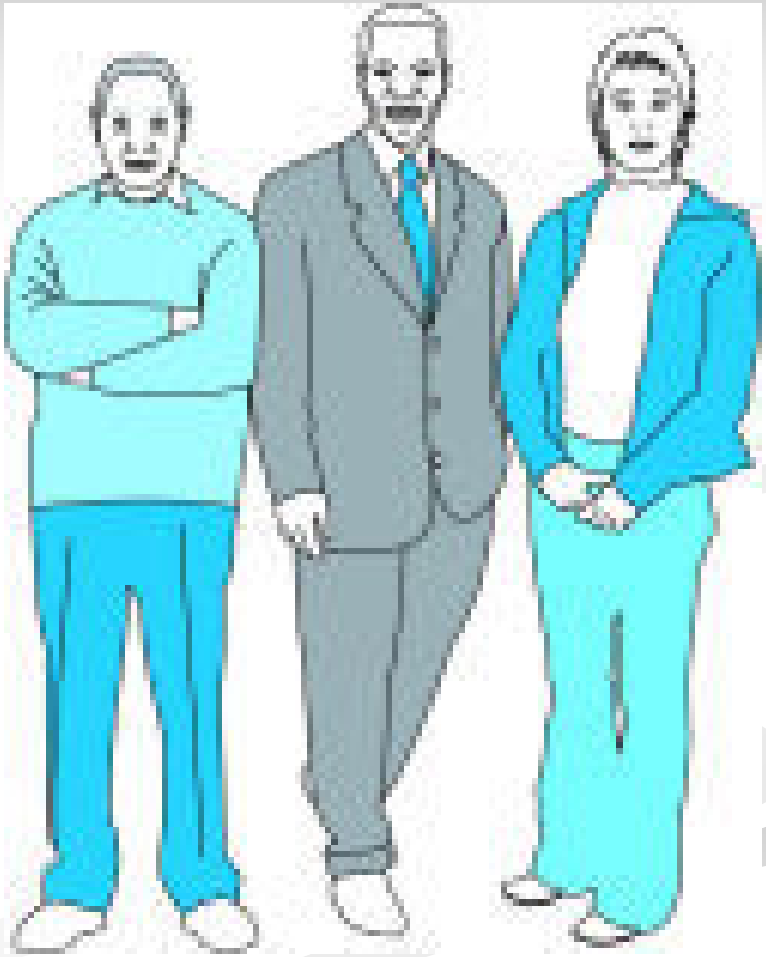
Network Structure



NCLCS Network

Task Groups

- Majority of improvements delivered through Task Groups
- Focus: Equal Access and Good Standard of Care Delivery
- Who is involved:
  - Consultant Cardiologists and Consultant Neurologists,
  - Nurses
  - Commissioners,
  - Service User,
  - Managers,
  - Public Health Professionals,
  - Joint Commissions,
  - London Ambulance Service.



Current Priorities

- Stroke – urgent care
- Life after Stroke
- Patient and Public Involvement
- 18 weeks
- Heart Rhythm Abnormalities (arrhythmia)
- Heart Failure
- CVD Prevention
- Inter-hospital Transfers

Contact Details

- North Central London Cardiac & Stroke Network
  - www.nclcn.org.uk

- Network Director:
  - Jinty Wilson

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Haringey NHS
Teaching Primary Care Trust

Briefing: **Stroke**

Stroke is the second most common cause of death in London and the single largest cause of physical disability. In 2006, 976 Londoners under the age of 75 died of a potentially avoidable stroke. Nearly 1% of Londoners has had one or more previous strokes and in 2005/6 over 11000 Londoners were admitted to hospital with a stroke. About a third of people who have a stroke will die as a result of it.

In Haringey, there are between 425 and 525 strokes occurring each year. Data from local hospitals (which do not deal exclusively with Haringey residents) indicate that there were 598 emergency admissions for stroke (353 admissions at North Middlesex Hospital and 245 admissions at the Whittington Hospital) in 2005/6). It is difficult to obtain reliable prevalence data, though nationally, this is estimated to be 9% among men and 8% among women. There is widespread recognition of the underreporting of stroke. This is reflected in local GP stroke registers, which indicate that in 2007/08 there were 2218 (across 59 practices/Average 37.5 patients per practice) which equates to less than 1% of the population.

Stroke Services in Haringey – targets
There is one main target for stroke care: VSA14 Quality stroke care (outcome: Reduction in stroke related mortality and disability)
Haringey is currently ragged as Red against this target.

The target is then made up of six indicators (those in bold being the main two):
VSA14:01 Number of people who have a stroke who are admitted to hospital – target 44 per month
VSA14:02 Number of people who spend at least 90%of their time on a stroke unit – target 22 per month increasing to 29
VSA14:03 Proportion of people who spend at least 90% of their time on a stroke unit – target 50% increasing to 66%
VSA14:04 Number of people who have a TIA who are at risk
– target 12
VSA14:05 Number of people who have a scan and are treated within 24hrs – target 3
VSA14:06 Proportion of people who have a TIA who are scanned and treated within 24hrs - target 25%

Stroke Services in Haringey – hospital services
The North Middlesex University Hospital (NMUH) and the Whittington Hospital both provide acute stroke services for people living in Haringey. A summary of key stroke services provided through these hospitals is provided in the table below:

Stroke service at the Whittington and NMUH 2005/6		
	Whittington Hospital	NMUH
Stroke Unit	Combined acute (6 beds) / rehabilitation (12 beds)	Dedicated Acute unit 8 beds (increasing to 16)

Stroke Services in Haringey – Primary Care
Upon discharge from hospital, the management and care of stroke patients is primarily undertaken through the GP. The performance of GPs in managing stroke patients (secondary prevention) is measured through the Quality and Outcomes Framework. This data indicated that in 2006/7 there were 2,259 patients on GP stroke registers and 2218 in 2007/08.

For Haringey as a whole, these patients would appear to be well managed by their GP through regular blood pressure and cholesterol monitoring, provision of anti blood thinning/ thickening treatments.

Quality and Outcomes framework (QOF)

There are 8 indicators:

Records:

1. The practice can produce a register of patients with a stroke or TIA.
2. The % of new patients with a stroke who have been referred for further investigation.

On-going management:

3. The % of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months.
4. The % of patients with a history of TIA or stroke whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less.
5. The % of patients with TIA or stroke who have a record of total cholesterol in the last 15 months.
6. The % of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less.
7. The % of patients with a stroke shown to be non-haemorrhagic, or have a history of TIA, who have a record that an anti-platelet agent (aspirin, clopdogrel, dipyridamole or a combination), or an anti – coagulant is being taken (unless a contraindication or side effects are recorded).
8. The % of patients with TIA or stroke who have had influenza immunisation in the preceding 1st Sep-31st March.

The table below shows 2006/7 QOF performance against our NCL sector neighbours

PCT Code	*PCT Name*	*Number of Practices*	*Stroke Total Points Achieved /Available %*
5A9	BARNET PRIMARY CARE TRUST	76	96.7%
5C1	ENFIELD PCT	58	94.7%
5C9	HARINGEY PCT	59	92.6%
5K7	CAMDEN PRIMARY CARE TRUST	44	91.3%
5K8	ISLINGTON PRIMARY CARE TRUST	41	98.3%

The table below shows 2007/8 QOF performance against our NCL sector neighbours

PCT Code	*PCT Name*	*Number of Practices*	*Stroke Total Points Achieved*	*Stroke Total Points Achieved /Available %*
5A9	BARNET PRIMARY CARE TRUST	73	1,704.2	97.3%
5K7	CAMDEN PRIMARY CARE TRUST	42	967.9	96.0%

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5C1	ENFIELD PCT	62	1,423.2	95.6%
5C9	HARINGEY PCT	58	1,330.2	95.6%
5K8	ISLINGTON PRIMARY CARE TRUST	39	928.9	99.2%

Stroke Services in Haringey – Rehabilitation

A range of rehabilitation and intermediate care services are provided by local health and community care services and utilised by those people recovering from a stroke in Haringey. These include:

- Green Trees at St Ann's Hospital (50+ residential stroke care)
- Integrated community therapy team (rehabilitation in the clients home)
- Step down beds (to support community discharge)

What are the risk factors associated with stroke?

There are a number of risk factors which are associated with stroke which include demographic factors (e.g. age, gender and ethnicity), lifestyle (e.g. smoking, diet) as well as the existence of other health conditions (e.g. previous stroke, diabetes & heart disease). A table of the relative risk of these individual risk factors is shown below.

Risk Facto	Relative Risk
Age (per decade)	2.2
Male gender	1.4
BP (per 10mmHg diastolic)	2.3
BP (≥ 160mmHg systolic)	2.5 – 4
Atrial fibrillation	5
Diabetes mellitus	2 – 3
Ischaemic heart disease	2.5
Heart failure	2.5 – 4.4
Peripheral vascular disease	2
Previous TIA	7
Previous stroke	9 – 15
Warfarin treatment	7 – 10
Smoking	2
Alcohol (> 30 units/week)	2.5 – 4
Family history	1.4 – 2

(From Kwain, 2001)

What can be done to prevent stroke?

Whilst there are a number of significant predisposing factors which may increase an individual's risk stroke is still considered to be largely preventable. Indeed, it has been estimated that first event of stroke may be reduced by up to 50% through population and primary care prevention alone.[1] Stroke prevention however needs to be balanced between primary prevention (first event) and secondary prevention (reoccurrence) as both of these strategies have been shown to have a considerable impact in reducing the overall incidence of stroke.

Given the similarities in risk factors, strategies for the primary prevention of stroke strongly correlate with those strategies to prevent coronary heart disease and diabetes. Common components in these strategies include educational interventions (e.g. awareness) and behaviour modification (e.g. changes in diet or exercise). There is evidence to suggest that these strategies are also effective at reducing the risk of stroke[6]:

- Reducing salt intake as effective as medication for reducing blood pressure

[1] Epidemiology of Stroke (J Kwain) Journal of Geriatric Medicine, 3 (3) 94-98 2001

- Increased physical activity reduce stroke risk by 25-60%
- Smoking cessation reduces risk of stroke to that of a non smoker within 5 years
- Reducing blood pressure to normal levels reduces risk of stroke by 40% in all ages

Given the significant risks of a reoccurrence of a stroke, secondary prevention is important to include within stroke prevention strategies. Patients who have suffered a stroke remain at an increased risk of a further stroke of between 30% and 45% within 5 years of the first event, therefore require ongoing review and management of their stroke risk factors. The Quality & Outcomes Framework (QOF) provides inducements for GPs to monitor and manage these risk factors in their practice caseloads.

In April 2008, a national programme of vascular checks was announced to ensure that all those aged between 40 and 74 are routinely and systematically offered checks for stroke, coronary heart disease, diabetes and kidney disease.[2] We will develop strategies to ensure that vascular checks are available through primary care and a broader range of providers within the community i.e. Pharmacies

Work undertaken by the London Health Observatory would appear to underline the need to develop stroke prevention through community wide action and primary care services. Given the relative costs of different stroke prevention strategies (below) it is evident that the most efficient methods of reducing the risk of stroke are centred within community and primary care based approaches given the relative costs of other clinical based alternatives.

Cost of preventing 1 stroke per year[6]	
Measures	£
Quit smoking independently	Nil
Quit smoking with NRT	£12,000
Aspirin for those at increased risk of stroke	£600
Treatment of high blood pressure	£1,000-£7,000
Anti-coagulation	£9,000
Statins (cholesterol reducing)	£20,000-£25,000
Cartoid surgery (removal of plaque from arteries)	£162,000-£232,000

Although evidence would appear to suggest that stroke prevention strategies should be focused through primary care, such strategies face a number of distinct challenges particularly those based in London and other major conurbations. We need to ensure that stroke prevention strategies address primary care issues pertinent to these areas, particularly:

- Transient populations
- Ethnically and culturally diverse populations
- Culturally sensitive in primary care services
- High level of un-registered populations
- Uneven distribution of primary care services and workers
- Variable quality of primary care services

Current service issues and gaps:

Nationally there are number of well documented concerns about the nature, organisation and capacity of services to support those people who have had, or at risk from, a stroke. These concerns encompass the whole spectrum of stroke service provision:

- Poor identification of stroke risk factors (i.e. hypertension) in the community
- Variable support and management of those with underlying stroke risk factors
- Poor access to emergency brain scans

[2] Putting Prevention First Vascular Checks, risk assessment and management DoH 2008

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- Limited capacity within dedicated stroke units and the specialist care available through these units
- Few patients receive rehabilitation through specialist multi-disciplinary teams in the community.

Suggestions for development

1. Local implementation group(LIT) for Stroke
2. Development of local stroke strategy
    - Raising awareness – improve public knowledge of stroke and its symptoms.
    - Prevention of stroke – action to promote healthier lifestyle and reduce vascular risk.
    - Patient and carer involvement – effective communication and planning of care.
    - Acting on warnings – ensure assessment of those with TIA within 24 hours.
    - Stroke is an emergency – getting stroke patients to appropriate hospital care quickly.
    - Stroke unit quality – develop capacity and access to specialist stroke units.
    - Community rehabilitation – expand specialist multidisciplinary care in community.
    - Community participation – assist stroke survivors back in to community life.
    - Workforce – ensure that the workforce is appropriately stroke skilled.
    - Service improvement – research & evaluation to support service development
3. Stroke register
4. Stoke handbook
5. Increase capacity at Greentrees

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