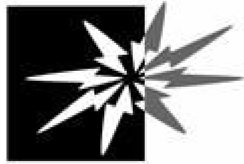


NOTICE OF MEETING

Scrutiny Review – Stroke Prevention

WEDNESDAY, 8TH OCTOBER, 2008 at 16:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Winskill (Chair), Mallett, Vanier and Alexander

AGENDA

1. APOLOGIES FOR ABSENCE

2. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at Item 9 below).

3. DECLARATIONS OF INTEREST

A Member with a personal interest in a matter who attends a meeting of the authority at which the matter is considered must disclose to the meeting the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent.
A Member with a personal interest in a matter also has a prejudicial interest in that matter if the interest is one which a member of the public, with knowledge of the relevant facts, would reasonably regard as so significant that it is likely to prejudice the Member's judgement of the public interest and if this interest affects their financial position or the financial positions of a person or body as described in paragraph 8 of the Code of Conduct and/or of it relates to the determining of any approval, consent, licence, permission or registration in relation to them or any person or body described in paragraph 8 of the Code of Conduct.

4. MINUTES OF PREVIOUS MEETING (PAGES 1 - 6)

To approve the minutes of the meeting held on 3rd September 2008.

5. STROKE ASSOCIATION

To receive a presentation from Homaira Khan, Stroke Prevention Officer, Stroke Association on the work of the organisation and key messages for stroke prevention work.

6. NORTH CENTRAL LONDON CARDIAC AND STROKE NETWORK (PAGES 7 - 8)

To receive a presentation from Jinty Wilson, North Central London Cardiac and Stroke Network.

7. HARINGEY TEACHING PRIMARY CARE TRUST (PAGES 9 - 10)

To receive a presentation from Adrian Hosken, Senior Commissioning Manager, Haringey Teaching Primary Care Trust.

8. ADULT, CULTURE AND COMMUNITY SERVICES (PAGES 11 - 38)

To receive a briefing from Lisa Redfern, Assistant Director, Adult Services, on the stroke prevention work currently undertaken by Adult, Culture and Community Services.

9. NEW ITEMS OF URGENT BUSINESS

10. DATE OF NEXT MEETING

Yuniea Semambo
Head of Local Democracy and Member Services
5th Floor
River Park House
225 High Road
Wood Green
London N22 8HQ

Melanie Ponomarenko
Scrutiny Research Officer
Phone: 020 8489 2933
Melanie.Ponomarenko@haringey.gov.uk

Scrutiny Review – Stroke Prevention Services
Panel Meeting
3rd September 2008

Councillors present: Cllr Winskill (Chair), Cllr Alexander, Cllr Mallett

Others attending: John Murray (Different Strokes), Craig Ferguson (Information Project Manager), Lisa Redfern (AD Adults), Vicky Hobart (Haringey TPCT) Melanie Ponomarenko (Scrutiny – minutes)

Agenda Item	Subject/decision
1.	Cllr Vanier Jinty Wilson Adrian Hosken
2.	**Urgent Business** None
3.	**Declarations of Interest** None
4.	The panel received a presentation from Craig Ferguson, Project Manager (Information Management). MOSAIC is a community profiling database which brings together a variety of data sources and can be used for targeted information provision. Maps can be created using Geographical Information Systems to show the geographical location of data groups e.g. age groups, ethnicity, deprivation indices, income etc. Those from the African, Asian and African Caribbean population are more likely to have a stroke. This population is concentrated in the East of the borough, particularly Northumberland Park, Bruce Grove and Tottenham Green. Those over the age of 55 years are more likely to have a stroke – this population is concentrated in the West of the borough, specifically Muswell Hill and Highgate. Using MOSAIC data it can be shown that those more likely to have hypertensive diseases, smoke more than twenty cigarettes a day and suffer from a stroke or TIA are placed in the East of the

	borough. Noted that the data is not an exact science and that the data fields selected were those 'most likely' in Haringey. This would not necessarily show those who are more likely to have a stroke or TIA above the national population. Data can be over-layed and shown on a Ward level as well as Super Output and post code level. The panel was shown over-layed data to post code level over those over the age of 55yrs who are Black/Black British or Asian and are most likely to have a stroke. This could demonstrate a good starting point for a targeted marketing campaign for stroke prevention. Cared for Pensioners are 5 ½ times more likely than the general population to have a stroke. Noted that there are a larger number of care homes for older people in the West of the borough. Noted that an older person who has spent their life in the East of the borough could be placed in a care home in the West of the borough, they would still be of a greater risk of having a stroke but - this is not picked up using the MOSAIC data base. Data from MOSAIC to be cross matched with data held by Adult Services.
5.	The panel received a presentation from John Murray, Coordinator Different Strokes North London Group. Different Strokes is a charity which was founded in 1996. The North London Branch was founded in 2001 and currently has approximately 100 members with ages ranging from 18 to 70 years. The average age of members is 45 years, with many having had a stroke in their twenties. Aim: *Through active self-help and mutual support, our aim is to help stroke survivors of working age optimise their recovery, take control of their lives and regain as much independence as possible, including returning to work.* Haringey Adult Learning Service provides the main funding. Different Strokes meets on a Monday and a Wednesday morning

	in Wood Green Library, they also have monthly newsletters and outside speakers. Different Strokes is primarily for people of working age, but people continue to attend after this age. 90% of Different Strokes members have been unable to return to work after suffering a stroke. John is a Lay Member of the Stroke Research Network (a national body) and is also a member of the Prevention clinical studies group. John is currently meeting Stroke Physicians to discuss issues and is also arranging visits to stroke units. John will also attend visits for this review. Strokes have a devastating affect on people lives; they are difficult to recover from, have an impact on the lives of family members, can cause physical and emotional changes in a person as well as lifestyle changes – all of which are difficult to cope with. The impact is felt acutely by families as the person who has had the stroke is often 'not with it'. The panel heard John's own personal story of his stroke – this is a clear demonstration of the feelings and processes a person and their family goes through and will be appended in the final report of this review panel. **Key Issue is the lack of awareness;** ▪ of what strokes are ▪ who is at risk ▪ their impact. ▪ that a stroke is an emergency and should be treated in the same way as a heart attack. ▪ how the risk of a stroke can be reduced. ▪ that strokes are preventable ▪ overall with health and social care professionals A Stroke Association MORI poll in 2005 showed that only 50% of people can identify what a stroke is with only 40% being able to recognise certain symptoms and approximately 30% would call an ambulance/go to a hospital. Nearly 1 in 5 GPs in a National Audit Office study said that they do not refer patients who have had a TIA.

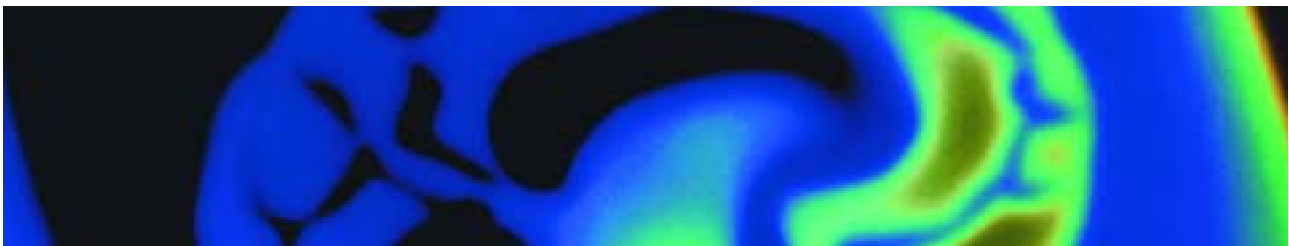
	Important factors to bear in mind: 'FAST' (Face, Arms, Speech Test) is crucial and should be routine. Accident and Emergency must be able to recognise a Stroke or TIA and treat this appropriately within the specified time frame (e.g. Thrombolysis within 3 hrs). This should be recorded and followed up appropriately. Noted that there is frequent pressure from the Department for Work and Pensions regarding their benefits. There is confusion as to what Stroke Service the North Middlesex Hospital has. Possibility of a conference in May 2009 which this scrutiny review could feed in to.
6.	The panel received a presentation from Vicky Hobart, Public Health Consultant: Head of Health Inequalities and Partnerships, Haringey Teaching Primary Care Trust. There is currently an ambitious national vision for strokes; this is set out in the National Stroke Strategy. Pathways are complex and involve a range of providers. Needs assessment data is not currently available. Data requirements for this review therefore need to be discussed. Local data needs to be analysed, interrogated and bench marked. The Well-being Strategic Framework sets out the strategic approach to health issues in Haringey. There is currently approximately 8 years difference in life expectancy between the East of the borough and the West of the borough. ▪ Life Expectancy is 71yrs in the East and 77.6yrs in the West. ▪ The gap is particularly wide for men. ▪ These figures are based on a person at the point of death i.e. people who die in Haringey. Younger people suffering strokes is also an issue in Haringey. An issue in Haringey is that of premature deaths – it is higher than would be 'expected' for the demographics of the population.

	▪ Need to look at comparisons with other areas of a similar demography for strokes. There are a number of risk factors which include the utilisation of and access to services, lifestyle and quality of housing. Thought needs to be given as to how we can effectively intervene. A stroke **IS** a medical emergency and needs to be treated as such. There are a number of effective interventions for someone who has had a TIA e.g. thrombolysis. **Strategic context** The *National Stroke Strategy* is a culmination of all previous data. The UK has comparatively expensive stroke services with comparatively poor outcomes. ▪ There is avoidable mortality. Measuring performance is a challenge. *North London Collaborative Commissioning Group* Haringey TPCT is the lead commissioner for the North Middlesex Hospital. Islington PCT is the lead commissioner for the Whittington Hospital. The PCT's are collaboratively looking at services. E.g. ambulances are not currently commissioned to take suspected stroke patients to a specific hospital. This is an area that is currently being looked at. Primary Care intervention is about reducing the clinical factors. There needs to be a cautious approach to looking at Quality Outcomes Framework (QOF) data as the statistics do not necessarily capture all relevant stokes e.g. when someone has a TIA. They only capture ones where the GP is made aware that a stroke has occurred. Consideration should be given to Stroke registers being held by a wider audience. There is not currently lead GPs for Stroke Care in Haringey. **Pathways** Well-being

	▪ Campaigns and information (including smoking cessation, physical activity, alcohol reduction, obesity etc). ▪ The Well-being Strategic Framework outcomes are being are being delivered across the partnership including all Thematic Boards e.g. the Enterprise Board is helping people get back into employment. ▪ The Well-being pathway is about the environment that we live in – schools, education, social marketing, community development. Primary Care ▪ Input from Community Matrons – a role which could be strengthened in this area. Community Matrons should be central to on-going support models. ▪ Need to define exactly who forms part of the multi-disciplinary team for strokes. ▪ Training for people in contact with those who may suffer a stroke – e.g. residential workers, home carers etc need to be trained in how to spot the signs of a stroke. ▪ Approximately half of GPs in Haringey have a TPCT specific contract (locally defined), the other half have national contracts. N.B. The TPCT can contract GPs to do things differently. Need to raise people's awareness of the symptoms of strokes, not just the people working with potential stroke patients but the people themselves e.g. those in nursing homes, others who are around people who are at risk of a stroke. **Hospitals** ▪ Geographically where are the hospitals which admit Haringey stroke patients? ▪ What stroke services do they have? ▪ Who would be admitted to which hospital e.g. East or West resident? ▪ Are there different outcomes for each of the hospitals? ▪ What is the incidence of a recurrent stroke based on which hospital a person has been admitted to?

Stroke Improvement NHS

Supporting service development with Stroke Care Networks



What is a Stroke Care Network?

A Stroke Care Network is an alliance of services and patients whose common purpose is to improve the care of people experiencing stroke and TIA. It is a cooperative association of those providing and receiving care who work together to ensure that stroke and TIA care is the best that is can be.

The services included in the network are all those contributing to the stroke and TIA care, such as healthcare staff (doctors, nurses, ambulance personnel, speech and language therapists, psychologists etc.), social care staff, and voluntary and charitable organisations.

Those experiencing stroke or TIA, their families and carers, are an integral part of the network and, as partners in the network, guide and support its aims and activities.

How can Stroke Care Networks help improve services?

Establishing stroke care networks will support the implementation of the stroke strategy and the delivery of improved services for stroke patients and their families.

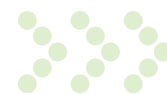
Experience in other services, such as those for coronary heart disease and cancer, has demonstrated that networks are of great value to the organisations which comprise them. Networks can support development in individual services as well as improve cooperation and coordination between different organisations involved in the same care ‘pathway’. This latter function is essential to guarantee the prompt, safe, efficient and high-quality delivery of care.

Networks are also of huge benefit to patients. Networks can help move from a series of disconnected episodes of care from apparently disjointed services, to seamless, co-ordinated care across health services, social care and the voluntary sector. This is particularly important when leaving hospital and planning support and ongoing care in the community.

What will Stroke Care Networks do?

Stroke Care Networks will have three central themes to their work, all of which will build cooperation within local services and support development. These are to:

- promote cooperation and working across service boundaries. This will be achieved by developing the self awareness of the local stroke ‘community’ - clinical and managerial staff, patients, carers, commissioners, social care and all others involved the provision of services for stroke patients - and encouraging improved understanding, closer cooperation and joint working;
- facilitate necessary improvements to service delivery and coordination. Supporting and undertaking a programme of service improvement work should initially address development priorities within and between services as well as form the foundation for ongoing focus on quality of services and continuous service improvement;
- ensure commissioning processes underpin high-quality services. Providing expert advice to ensure that the commissioning process is fully informed of the complexities of stroke services and understands the perspectives of clinicians and patients.



The initial work of the network will be implementation of the stroke strategy. By drawing together the care community, patients and carers, the network should initially consider the current state of local services against the strategy, and identify a work programme to address local needs.

How do we set up a Stroke Care Network?

Each local stroke network will require a small team to coordinate and support the functioning of the network, comprising a lead clinician and/or social care lead, a manager, one or two service improvement workers and some administrative support. The structure of the network and how it operates will bear broad similarity to other networks, although the form of the network should follow its desired function, rather than be constrained to any particular model.

The boundaries of individual stroke networks should mirror the functional footprint of services, incorporating the 'hub and spoke' model but also including broader services (e.g. primary care, social care, ambulance service etc.) that contribute to the local care pathway.

In many areas, these boundaries will roughly coincide with existing networks, such as cardiac. However, a pragmatic approach should be taken to defining the area covered by an individual networks. The focus should be on developing a 'membership' organisation defined by those who have an interest in working together to the benefit of the people whose care they contribute to.

As funding is identified to support stroke networks, the first steps should be to gather together representatives of the stroke care community and discuss the key principles of the network. This meeting, supported by local discussions with key stakeholders, should aim to identify clinical/care leads to guide and champion the development of the network.

How do Stroke Care Networks relate to cardiac networks?

Cardiac networks have expertise in service improvement techniques and extensive experience in helping different organisations work together, which may be helpful in supporting stroke services. In some areas, the scope of existing cardiac networks has been expanded to cover both heart disease and stroke. Whether this becomes more widespread should be decided at local level. However, all cardiac networks should offer their support, and the learning from the developmental journey they have undertaken, to their stroke colleagues.

How will Stroke Care Networks be supported? Substantial assistance is available through the cardiac network system. In addition, a national team is being established to coordinate and support Stroke Care Networks through a variety of avenues including training and development for stroke network staff; coordinating regional or national forums; hosting national meetings and organising improvement events and conferences to ensure shared learning and understanding of national perspectives.

A number of national projects will be offered to networks based on the priorities identified in the stroke strategy. Participating in these projects will accelerate improvement progress at local level and contribute to the growing body of knowledge on developing stroke services.

Appendix A

PRIMARY CARE

Quality and Outcomes framework 2007/08, produced per kind favour by Mahnaz Shaukat, Public Health Strategist, Islington PCT

The following data has been shared by the public health intelligence leads in each PCT, and put together by Islington PCT. Please note that the data has been extracted from the QMAS system as at the end of March 2008 and may be subject to change when published nationally in June.

NB: 4 Camden practices were excluded from the minimum, maximum score as these practices have very specific populations (homeless, students etc) and hence skew the range.

Prevalence

Table 1: Number of patients on the CHD, Stroke and Heart Failure register and crude prevalence using GP list size as of February 2008.

Register	Islington Crude prevalence % (number on register)	Camden Crude prevalence % (number on register)	Enfield Crude prevalence % (number on register)	Haringey Crude prevalence % (number on register)	Barnet Crude prevalence % (number on register)
CHD	**2.0%** (3,913)	**1.97%** (4,519)	**2.58%** (7,555)	**2.09%** (5,731)	**2.8%** (10,338)
Stroke	**1.1%** (2,169)	**0.98%** (2,252)	**1.09%** (3,197)	**0.84%** (2,317)	**0.94%** (3,428)
Heart Failure	**0.60%** (1,202)	**0.50%** (1,152)	**0.54%** (1,589)	**0.45%** (1,245)	**0.59%** (2,167)

Table 2: Average percentage achievement for CHD indicators and range of achievement by practice.

QOF 2007/08		Islington	Camden	Enfield	Haringey	Barnet
CHD 2	Patients with newly diagnosed angina	**95%** (40%-100%)	**93%** (60%-100%)	**90%** (0%-100%)	**80%** (6%-100%)	**94%** 95%-100%)
CHD 5	Record of blood pressure in the last 15 months	**98%** (94%-100%)	**97%** (88%-100%)	**98%** (68%-100%)	**97%** (82%-100%)	**97%** (80%-100%)
CHD 6	Last blood pressure record is <150/90	**91%** (78%-100%)	**86%** (73%-100%)	**90%** (63%-100%	**88%** (55%-100%)	**89%** (71%-100%)
CHD 7	Record of cholesterol in the last 15 months	**94%** (86%-98%)	**91%** (57%-100%)	**92%** (33%-100%)	**91%** (48%-100%)	**93%** (51%-100%)
CHD 8	Last cholesterol is <5.0ml	**83%** (69%-97%)	**79%** (42%-96%)	**78%** (26%-96%)	**78%** (39%-100%)	**80%** (48%-98%)
CHD 9	CHD patients on antiplatlet therapy/anticoagulation	**95%** (88%-100%)	**93%** (68%-100%)	**95%** (74%-100%)	**93%** (71%-100%)	**94%** (71%-100%)
CHD 10	CHD patients treated with a beta blocker	**75%** (37%-100%)	**70%** (30%-90%)	**73%** (30%-100%)	**70%** (36%-100%)	**68%** (41%-100%)
CHD 11	Patients with a history of MI who are currently treated with ACE inhibitor	**94%** (80%-100%)	**88%** (50%-100%)	**91%** (57%-100%)	**90%** (33%-100%)	**88%** (71%-100%)

Table 3: Average percentage achievement for Heart Failure indicators and range of achievement by practice.

QOF 2007/08		Islington	Camden	Enfield	Haringey	Barnet
HF 2	Patients with a diagnosis of heart failure confirmed with ECHO	**98%** (75%-100%)	**96%** (75%-100%)	**89%** (0%-100%)	**94%** (0%-100%)	**96%** (0%-100%)
HF3	Patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contra-indication.	**92%** (80%-100%)	**89%** (67%-100%)	**90%** (0%-100%)	**90%** (0%-100%)	**90%** (0%-100%)

Table 4: Average percentage achievement for Stroke indicators and range of achievement by practice.

QOF 2007/08		Islington	Camden	Enfield	Haringey	Barnet
Stroke 5	Record of Blood Pressure in last 15 months	**98%** (91%-100%)	**96%** (75%-100%)	**98%** (72%-100%)	**96%** (67%-100%)	**96%** (80%-100%)
Stroke 6	Last BP is < 150/90	**90%** (74%-100%)	**85%** (72%-100%)	**89%** (67%-100%)	**86%** (57% - 100%)	**88%** (70%-100%)
Stroke 7	Record of cholesterol check in last 15 months	**92%** (76%-100%)	**89%** (65%-100%)	**89%** (50%-100%)	**87%** (33% -100%)	**90%** (33%-100%)
Stroke 8	Last record of cholesterol is <5.0m/ml	**77%** (65%-100%)	**75%** (54%-94%)	**72%** (25%-92%)	**71%** (25% -100%)	**74%** (33%-100%)
Stroke 11	New stroke patients referred for further investigation	**92%** (0%-100%)	**91%** (67%-100%)	**84%** (0%-100%)	**88%** (0% -100%)	**93%** (50%-100%)
Stroke 12	TIA/Ischaemic Stroke on antiplatlet/anticoagulation	**95%** (80%-100%)	**93%** (75%-100%)	**95%** (75%-100%)	**94%** (57% -100%)	**94%** (75%-100%)

Briefing Note – Summary of Stroke Prevention work in Adult Services for Overview and Scrutiny Review 30th September 2008

1. Introduction

In Haringey, we have a coordinated stroke care pathway and offer a range of stroke care prevention services. Adult Services work closely with Haringey Teaching Primary Care Trust (HTPCT), the third sector and with internal partners: Leisure and Adult Learning to maximise an individual's rehabilitation following a stroke. Stroke care prevention needs to be seen in the context of Haringey's Wellbeing Strategic Framework[1]. A stroke prevention project group now meets monthly and the Department of Health (DH) has allocated a new grant of £92k for agencies to spend on stroke care[2]-please see attached Annex 1 for the group's initial thoughts regarding the priorities for this year's grant allocation.

2. Key policy drivers

Apart from those mentioned in the introduction other key national policy regarding stroke care includes: The National Service Framework on Long-Term Conditions[3] and The Darzi Report[4].

3. A Summary of current work and stroke prevention projects in Haringey

The third sector:

Haringey Stroke Clubs

Haringey Stroke Clubs are run by Age Concern Haringey to support people living with long term health conditions following a stroke.

Three clubs are run across the borough and they operate for 40 weeks a year. Members' requirements for accessible transport are met; we provide lunch and a programme of activities.[5] We also benefit from, and much appreciate the help given by, our volunteers. They offer additional support to the members.

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[1] http://harinet.haringey.gov.uk/index/social_care_and_health/health/well-being_framework.htm

[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/AllLocalAuthority/DH_084593

[3] http://www.dh.gov.uk/en/Healthcare/Longtermconditions/index.htm

[4] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

[5] The clubs are located at Abyssinia Court, Mayfield Rd, N8; Braemar Avenue, N22 & Claudia Jones House, Gederny Rd, N17

Having reviewed the clubs to identify how best to meet the needs of our members a new, 'person centred' approach in line with the government's cited new direction in community health was identified.[6]

We piloted this new approach successfully helping new members recently discharged from hospital to make and meet realistic goals. Whist the pilot was successful it was also challenging - with no extra staff or resources.

Implementation of the review recommendations are however progressing with a steering group involving members, 'expert patients' and representatives from North Middlesex Hospital and London Borough of Haringey's Adult, Culture and Community Services Department.

A volunteer 'buddying' scheme is proposed and discussion underway with Haringey Teaching Primary Care Trust's (HTPCT) Assistant Director for Strategic Commissioning as to how to resource this development. A commitment to 3 year funding for Haringey Stroke Clubs would enable us to significantly further our work enabling and empowering stroke survivors to better manage their health condition(s) with:

- Information, advice and support
- Long term care & support
- Participation in community life

Between April 2007 – March 2008 total of 1,288 attendances were achieved (1,277 06/07) over 114 sessions.[7]

CLUB	TOTAL ATTENDANCE	NO OF SESSIONS
NORTH TOTTENHAM	471	37
WOOD GREEN	429	38
HORNSEY	388	39
TOTAL	**1288**	**114**

[6] Stroke Club Review – launched March 2007 available on request
[7] See summary statistics Apr 07 to March 08 attached

ETHNICITY	AGE		SEX	Referral source
	40 - 49	1		
AFRO/CARIB	50 - 59	2	MALE	PCT / GPs/Self
UK/EURO	60 – 69	19	FEMALE	Intermediate Care
IRISH	70 – 79	14		Hospital
ASIAN	80 - 90	6		
BLACK AFRICAN	90 +	1		

Also please refer to Annex 2 for a full review report of Age Concern's Stroke Care work.

Alongside the more intensive stroke rehabilitation programmes provided by the acute and primary care trusts, we also provide an array of specialist stroke services, for example:

- We provide 'enabling' and ' rehabilitative' home care post discharge from hospital;

- Our leisure services provide a 'phase for cardiac rehabilitation programme' ;

- Our Adult Learning Division uses work actively with 'Different Strokes', an organisation concerned with the rehabilitation of stroke victims. The group provides regular massage sessions within our libraries which are publicised via our 'What's On' publication. Our Adult Learning Division uses Different Strokes in a tutorial capacity to provide courses that enable users to concentrate on small but significant steps towards:
  - improved physical mobility;
  - regaining self confidence;
  - Share and address in a supportive environment the personal issues around professional identity that is often shaken by suffering a stroke;
  - Reclaiming and re-building process post stroke;
  - Networking and learning from individuals with similar experiences;
  - Regular social and learning link to the wider world through shared activities and interests; and
  - Opportunities for life long learning.

  We provide information in relation to stroke prevention. Different Strokes is again a key partner in this process although we involve many other partner bodies and provide our own blood pressure monitoring, stress counselling and weight care and exercise programmes.

- We have invested in a variety of stroke projects – using the new stroke care grant, for example:

- Appointment of a joint Stroke Coordinator for 3 years to work across health and social care. Elements of this role will involve improving care pathways from Acute Services into rehabilitation – including social care within the community and in care homes;
- Support for existing initiatives – specifically the Age Concern Stroke Clubs;
- Support the Council's 'Welfare to Work' strategy to the 'Winkfield Resource Centre' to support outreach work to help working age adults return to work;
- Enhance the establishment of the 'Haven Day Centre' by 1 worker to enable more intensive work with older people who have returned to the community & could benefit from further intermediate care.

Stroke Club Review

December 2006

Silvia Schehrer

Age Concern Haringey

Stroke Clubs Review

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Appendices

A Stroke Club Activities
B Stroke Club Attendance 2005-06

The aim of this review is to evaluate the work of the Stroke Clubs run by Age Concern Haringey in the context of national and local priorities to present options for their future development.

Stroke Club Review

1. Executive summary

Haringey Stroke Clubs have a track record in enabling people with long term health conditions from age and ethnic diverse communities to maintain social networks and access peer-support.

The National Service Framework Older People[1] (NSF standards 5 & 8) and HTPCT's local Community Rehabilitation Strategy[2] provide the opportunity for changes to the management of the service to pilot a rehabilitation focussed 'club' enabling individuals to

- rebuild confidence
- work towards identified goals
- improve mobility and developing new interests and activities
- develop skills, knowledge and confidence to manage their condition and care effectively[3].

Sustained commissioning will enable this to be developed.

The report makes the following recommendations:

- To discuss with funding partners the future direction of the Stroke clubs.
- To set up a Steering group with partners in health and social care and users to develop a new service model and to pilot a rehabilitation focussed 'club'.
- To facilitate greater user involvement in the development and running of the Stroke Clubs.
- To clearly link the Stroke Clubs to the priorities identified in the Age Concern Haringey business plan and the development of the Resource centre.
- To seek funding to incorporate the user engagement techniques and training of the Expert Patient Programme into the Stroke Clubs
- To identify and develop volunteer roles strengthening links to other services both within and outside of Age Concern Haringey.

2. National Context and policy developments

[1] See especially standard 5: Stroke and standard 8: Healthy Living
[2] Following HTPCT/LBH 30th Oct 06 Community Rehabilitation Strategy Workshop
[3] Department of Health: Self Care – A Real Choice, 2005

Stroke has not its own National Service Framework, but is dealt with in the National Service Framework – Older People with a dedicated chapter Standard Five.

The stated aim of Standard Five is to 'reduce the incidence of Stroke and to ensure prompt access to integrated stroke services'. Given the high incidence of second and subsequent strokes secondary prevention and rehabilitation are also identified as priorities.

Stroke is the single biggest cause of severe disability and the third most common cause of death in the UK. Each year 110,000 people in England and Wales have their first stroke, and 30,000 people have further strokes. Around 30% of people who suffer a stroke die in the first month and of those that survive 35% are significantly disabled or need considerable help with daily tasks. Some 5% of all stroke survivors are admitted to long-term residential care[4].

The effects of the stroke differ depending on the part of the brain affected. They range from difficulties in movement, balance, walking, swallowing, speaking, writing, understanding the spoken or written word, to support needs with activities of daily living including dressing and preparing meals as well as vision and mood. Patients can recover functions for several years after the initial stroke, which makes ongoing support and rehabilitation so valuable.

A National Audit Office (NAO) report published in 2005 identified a number of areas for improvements in stroke services. The Government has since announced an 18 month work programme to produce a national strategy to modernise service provision and deliver the newest treatments for stroke. By 2010 the Government aims to reduce the death rate from stroke, CHD and related diseases in people under 75 by at least 40%.

To facilitate the development of a national strategy a National Stroke Strategy Conference was held in March 2006.

3. Haringey's Priorities

Long term conditions of which stroke is one are a significant factor for Haringey. It is estimated that there are 17.5 million people in the UK with long term conditions, equating to around 75,000

[4] NAO:Reducing Brain Damage Faster access to better stroke care; 2005

people in Haringey. The incidence of stroke in the borough is relatively high compared with the national average[5]. Given the increased dependency of patients identified above 2 there is significant social care as well as health care costs associated with stroke. Stroke is one of the major causes of death in Haringey and a particular problem in the African Caribbean population and unskilled manual workers where the incidence of Stroke is higher than in the general population[6].

Although the risk of stroke increases with age, there is also a significant minority of people under 55 years, who suffer from a stroke. It has been estimated that there will be about 50-70 stroke survivors in a general practice list of 10,000 of which about half will be independent and the rest will have varying degrees of dependence. Each year there are likely to be 20 admissions with a primary diagnosis of stroke[7]

Within Haringey, there are significant health inequalities between different wards. From the 2001 Census we know that the percentage of people reporting a limiting long-term illness was significantly higher in the north east of the borough than in the west.

The Haringey's Long Term Conditions Programme[8] was identified as a priority for the borough. Whilst achieving financial balance as key priorities were identified:

- To improve the management of long term conditions
- To improve health and reduce inequalities in Haringey
- To provide timely and responsive care in the right setting
- To improve patient experience

Haringey is also working towards the following stroke specific Performance Indicators:

- To reduce mortality rates from heart disease, stroke and related diseases by at least 40% in people under 75 by 2010.

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[5] Enfield & Haringey Health Authority: Management of Stroke 2000
[6] Data from the Health Survey for England show that amongst African-Caribbean and South Asian men the prevalence of stroke was between about 40% and 70% higher than that in the general population. People in socio-economic group V (unskilled manual workers) have a 60% higher chance of having a stroke than those in socio-economic group I (professionals).
[7] Enfield & Haringey Health Authority: Management of Stroke 2000
[8] Haringey Local Healthcare Community Benefits Realisation Plan; Long-term conditions Integrated Change Plan; March 2006

- To reduce the inequalities gap between the fifth of areas with worst health and deprivation with the population as a whole by 40%.
- To establish systematic treatment regimes for majority of patients at risk of CHD, particularly those with hypertension, diabetes and BMI greater than 30.
- To reduce adult smoking rates to 21% or less in 2010 from 31% in 2002, particularly targeting patients with coronary heart disease, diabetes or stroke.[9]

These targets are ambitious and only achievable, if stroke patients are supported and given information advice about their condition and how to best manage it.

4. The Stroke Clubs

The three Stroke Clubs run by Age Concern Haringey have been offering boroughwide support for over 15 years. They are based in Supported Housing Schemes in Wood Green, Tottenham and Hornsey.

The aim of the Haringey Stroke Clubs is to provide self-care support to ensure that members:

1. are alert to the early symptoms that might suggest repeat incidence of acute ill-health.
2. learn about their long-term health condition.
3. obtain peer support and socialise
4. are empowered to gain timely access to primary care services.

As well as providing respite the clubs support family and friends caring for members.

The clubs are run by the part-time Stroke Clubs co-ordinator with the help of a part-time care assistant and four volunteers. The clubs offer a light lunch followed by a programme of activities ranging from exercises and games to mental stimulation and health talks. (See Appendix B) A tutor from the College of North East London (CONEL) offers keep-fit sessions at the club in Tottenham, all other activities are facilitated by the Stroke Clubs Co-ordinator. All members are encouraged to take part and help

[9] Haringey Local Healthcare Community Benefits Realisation Plan; Long-term conditions Integrated Change Plan; March 2006

with choosing activities to suit their needs and to the assist them in maintaining independent lifestyles.

The clubs meet for 40 weeks in the year (term-time only) recording 1,696 attendances from April 2005 to March 2006. As most members are unable to use public transport accessible transport is provided by a combination of Age Concern's minibus drivers/escorts and Dial-A-Ride.

Regular outings feature as well as visits from a named Community Matron (formerly Health Advisor) linked to each group. (We understand the Community Matrons will focus on avoiding Accident & Emergency visits and admissions by people with long-term conditions and will not be able to continue to provide the same service to the stroke clubs in the future.) Members also receive regular magazines from the Stroke Association and have access to their factsheets and information on a wide range of issues from healthy eating and alternative therapies and help with moving to sheltered accommodation. The co-ordinator also provides information and referrals to other Age Concern Haringey services such as their Welfare Benefits advisor and the Handyperson service. Referrals are also made to Social Services and the Sensory Impairment Team.

Capacity is limited and as users have been coming to the club for many years a waiting list exists. The following table illustrates the current waiting list:

Venue	Hornsey	Wood Green	Tottenham
Number of people	2	2	6

Current waiting list as at Nov 06

4.1. The User and Carer experience

Between April 2005 and March 2006 the stroke clubs supported a total of 57 members of which 33 are female and 24 male. Although (90%) members are over sixty (19 between 60-69,10 between 70-79 and 12 between 80-89 with one member over 90) there are 6 members between 50 and 59 years old. The clubs are ethnically diverse with 24 members of Afro-Caribbean background, 19 UK/European, 3 Irish, 5 Asian, 5 African and one Turkish Cypriot.
For the purpose of this review we sampled opinion from some 25% of participants (14 out of the 57 members) using the members of

the club in Wood Green for our survey. Participants were asked to answer a range of questions about their health, the services the clubs offer currently and how they would like to develop the clubs in future. [10]

The vast majority of members (12 out of the 13 surveyed) had their Stroke over two years ago and out of those four had been affected by a stroke more than 10 years ago. Unsurprisingly four members had attended the club for over 10 years and one between 5 and 10 years only two members had joined the club in the last two years. The majority had attended the club between five and ten years.

When members were asked to identify the activities of the clubs most important to them the following ranking emerged:

Rank	**Activity**
1	Socialising
2	Transport
3	Physical Exercise
4	Information
5	Access to Health Advisor
6	Mental Stimulation
7	Support for carers
8	Referral to other services
9	Respite

Members survey response

Socialising scored the highest closely followed by transport and physical exercise. Respite scored the lowest, which is probably unsurprising given that there was only one carer among the 14 surveyed. Overall there seemed to be two distinct groups:

- First and larger group, which included those in the older age groups and with more severe impairments valuing the socialising and peer support element of the groups most. One member put it like this:

'I want people to acknowledge my age. This is my chance to meet people.'

[10] A detailed breakdown of questionnaire and its evaluation is enclosed in Appendix C.

- Second smaller group, including mainly the younger members favoured more physical exercise and work on particular tasks. One user summed this up like this:

> '***What I want is to be able to walk to the other side of this room without my stick or any help.'***

Members of the group had a variety of other conditions with 4 suffering from diabetes, 2 with a heart condition, 2 with asthma and one member suffering from each of the following: arthritis, rheumatism, high blood pressure and epilepsy respectively.

Although one respondent felt the club made no difference, half of all respondents rated the Stroke clubs as very important and a third as important in helping them to self-care.

When asked what other services they would like to see in their area members had the following suggestions:

- shopping and theatre trips,
- physiotherapy,
- occupational therapy and equipment,
- volunteer to take them out,
- the acknowledgement of old age
- more social clubs.

The second part of the questionnaire asked participants opinion on what kind of activities a more rehabilitation focused stroke club should have. Twelve of those surveyed felt there was a need for such a service, the other two participants did not answer this question.

Participants were then offered a list of potential activities for the new service and asked to tick those they would like to see included. The following chart shows the number of users supporting each activity:

Activity	Score
Health Checks	11
Improving mobility	10
Develop new interests/activities	9
Rebuild confidence	8
Re-establish social contacts	7
Peer Support	7

Linking into other services	6
Practising minor household tasks	5
Work towards goals set by patients	5

Members survey

This clearly shows that members of the club are interested in monitoring and improving their condition as well as developing new interests and social networks.

When asked what additional activities they would like to see included members suggested more exercise, cooking, physiotherapy and help with self-help as well as alternative therapies like reflexology and massage.

> ***'We could prepare our own lunch – practise using the tools we got from the therapists and enjoy doing something together'***

suggested one member. Another member was keen to improve his walking to enable him to play with his grandchildren.

Members were also asked if they wanted to get involved in developing and running time-limited 'rehab groups'. Encouragingly a third of those responding to this question felt they wanted to get involved with two offering to be part of a Steering Group and two offering to help with publicity and to encourage referrals.

4.2. Feedback from Health and Social Care Professionals

To gauge feedback from Health and Social Care professionals a similar survey to the one completed by users was circulated via e-mail to senior staff members in hospitals, Social Services and the Primary Care Trust. In total 15 responded with 7 from Acute Trusts, three Primary Care Practitioners and 5 describing themselves as other including two Social Care Managers, 1 nurse and 1 physiotherapist.

Out of the total sample, 9 were aware of the work of the Stroke Clubs, but only 1 had made any referrals to the clubs. This is at least partly explained by the fact that the survey was mainly circulated to senior members of staff in health and Social Services rather than front-line staff making referrals. It does however highlight the need for more information and publicity from the Stroke Clubs about their work.

Respondents were asked to rate the current activities of the Stroke clubs in order of priority producing the following order:

Rank	Activity
1	Information
2	Physical Exercise
3	Mental Stimulation
4	Support for carers
5	Socialising
6	Respite
7	Access to Health Advisor
8	Referral to other services
9	Transport

Health / Social Care Practitioner survey

Although this list is fairly compatible with the priorities of the user group it is worth noting that users rated transport as the second most important whereas it comes last for professionals and the most important for users socialising only comes fifth for professionals.

More than three quarters of health and social care professional responding rated the clubs as very important (12) and three as important in enabling users to self-care.

When asked what other services they refer to a wide range of health, social services and voluntary sector services were listed. As particular gaps in provision respondents identified better access to traditional therapies (physio, speech and language, OT and dietetics) as well as counselling and alternative therapies (relaxation, massage, aromatherapy, music activities). A number also reported a gap in services for younger people offering support to return to work or learn to drive again. Better support for carers and families as well as more community groups and clubs was also mentioned. Getting out and about for entertainment and to be able to go on holidays was also identified. One highlighted the potential for better links to Haringey's Expert Patient Programme.

All 15 professionals responding to the survey supported the idea of a time limited rehabilitation focussed service. The professional group was also asked to prioritise the various activities of the rehabilitation. Interestingly the order was almost the reverse of the

one given by users apart from improving mobility, which scored highly in both groups. Whereas the users scored Health Checks and developing new interests in their top three, professionals scored this last.

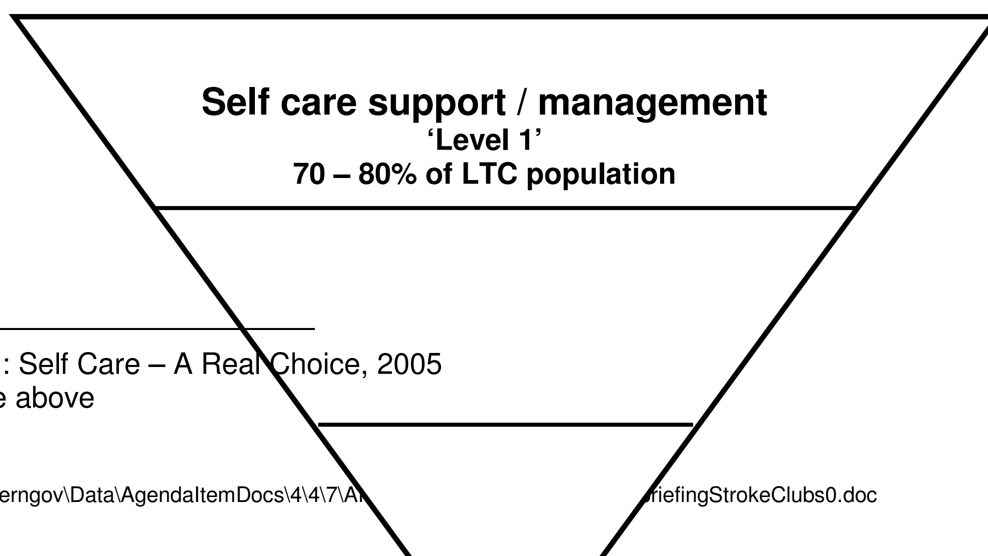
When asked what else they would like to include in the programme relaxation, massage and aromatherapy were mentioned as well as return to work support for younger people and cooking simple meals. More involvement of family and carers and their support as well as counselling and psychological support for users and carers was also identified. One respondent highlighted the need for a more client centred approach and the prevention further strokes.
When asked if they could offer support in developing or running the service many responded positive. Four people offered to be part of the Steering Group, two to develop individual rehab plans, 4 to provide training session and 7 offering information sessions and help with publicity and referrals.

5. Models for future provision

Supporting people with long-term conditions is one of the key challenges for the NHS as a whole and the local care economy in Haringey.

'Care for long-term conditions accounts for 60% of bed days in hospitals and 80% of GP consultations'[11]. In addition to this the incidence of long-term conditions in the over 65 is set to more than double in the next 25 years.[12]

The model for managing long-term conditions and therefore stroke in the NHS is described in the inverted pyramid diagram below:



[11] DH: Self Care – A Real Choice, 2005
[12] see above

Stroke Club Review

Disease/Care Management
'Level 2'
High risk

High Complexity
'Case' Management
'Level 3'

Fig 1. Inverting the triangle of care
(after DOH Self-Care 2005)

Self care support / management - Level 1: Supported self care – collaboratively helping individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively.

Care management - Level 2: Disease-specific care management – This involves providing people who have a complex single need or multiple conditions with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways, such as the National Service Frameworks and Quality and Outcomes Framework.

'Case' management – Level 3: requires the identification of the very high intensity users of unplanned secondary care. Care for these patients is to be managed using a Community Matron or other professional using a case management approach, to anticipate, co-ordinate and join up health and social care.

The aim of paragraph 5.1 below is to link the Stroke Clubs into this continuum and Model of Care for long-term conditions while offering users and professionals in the local care economy the outcomes they wish.

5.1. Supporting people with long-term conditions

As is evident from our user survey a significant number of members of the stroke clubs (85%) also suffer from other long-term conditions like diabetes, heart condition, high blood pressure, asthma, arthritis and rheumatism and epilepsy. This means the stroke clubs have a role to play in the disease management as well as the support of self-care of members.

The fact that users rated Health Checks as their top priority for the new service also indicates that users are aware of their conditions and are keen to be involved in their own monitoring. The Stroke clubs already offer some of this support through the regular visits by the Health Advisors. As the role of Health Advisors is now changing to that of Community Matrons, who according to government guidance have a clear focus on supporting people with long-term conditions, it would be opportune to further develop this in conjunction with the Community Matrons. Links with other specialist services like Diabetic nursing and Occupational Therapy and Speech & Language Therapy could also be developed to provide better support both for stroke and the other conditions that Stroke Club members present with.

Developing these links and establishing a more focused programme for the stroke clubs has considerable resource implications in terms of the co-ordinator's time which have to be considered. Furthermore this requires partnership working with colleagues in other services to develop and run the stroke clubs. As is evident form the survey of health and social care professionals there is enthusiasm for developing such a partnership.

Recommendation:

To establish Steering Group representing professionals as well as users and carers to facilitate greater partnership working and to develop a new service model

5.2. Rehabilitation focus

Rehabilitation has many different meanings and interpretations depending on the setting and people involved. For the purpose of this paper we are using the term of Community Based Rehabilitation (CBR), which according to three United Nation Agencies, ILO, UNESCO, and the WHO, may be defined, as

> "(a strategy) within community development for the rehabilitation, equalization of opportunities, and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves,

> their families and communities, and the appropriate health, education, vocational and social services" [13]

Working with this definition of rehabilitation it is clear how the Stroke Clubs play a part in the Rehabilitation of Stroke patients and how this role could be developed and expanded.

Aspects of rehabilitation that community services can specialise in include "monitoring patients at home, facilitating social re-integration into local communities, managing common problems effectively, and preventing complications."[14]

Facilitating the re-integration into the community is something that Age Concern Haringey has experience in and that would sit well with other services provided by the organisation such as Information and Advice, volunteering opportunities and the Resource Centre. Restructuring the Stroke Clubs as a vehicle for re-integration into mainstream activities also enables the clubs to free up capacity for patients recently discharged from hospital.

A need for additional support to enable people to access mainstream services has already been identified by the Speech and Language Therapies Team in Haringey. Building users confidence and supporting them individually to access mainstream services as well as educating other service providers about the particular needs of stroke suffers (e.g. communication difficulties) is vital.

As improving mobility scored the second highest of all the activities for the new service in the user survey there is clearly a need identified by users to continue their rehabilitation after they have been discharged by therapists.

The therapists themselves have identified a particular gap between the practising of skills and techniques that they teach people in therapeutic settings to real (everyday life) situations. The suggestion by one user to prepare their own lunch, for example, could, if planned with OT, SLT or dietetics input be a practical example of 'bridging the gap' between therapy and community.
With additional training identified by qualified therapists and with clear guidelines other 'gap-bridging' examples could be developed. Again additional time would be needed by the co-ordinator to take

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[13] Joint position paper by ILO, UNESCO and WHO: Community Based Rehabilitation, CBR, 1994.
[14] Wade 2001

on these developments and make the appropriate links with therapy professionals.

Preventing complications through information giving and visits from Health Advisors is already part of the programme of the Stroke Clubs and this aspect could be further developed through developing self care and peer support skills (see 5.3 below).

Recommendation:

Develop stroke clubs to support and empower users to access mainstream services and explore fit with Age Concern Haringey Resource Centre development.

5.3. Facilitating self-care and peer support

As can be seen from the long-term conditions pyramid, self –care is by far the greatest resource in dealing with any health condition. The NHS has recognised this and supporting self-care is now a major priority.[15]

The aim of self-care is to empower people to be active participants in improving symptoms, avoiding ‘flare-ups’, slowing deterioration and preventing development of complications and other conditions. Research shows that self-care results in a better quality of life while living with a long term condition and greater patient satisfaction. Most importantly for the NHS though, self-care has a ‘significant impact on the use of services, with fewer primary care consultations, reduction in visits to outpatients and A&E, and decrease in the use of hospital resources.’[16]

The Department of Health recommends NHS and Social Care agencies and practitioners:

- ‘to provide condition specific personalised care plans for people with long-term conditions’
- ‘to develop partnership between agencies in the community to provide user led social support’
- ‘to encourage community peers to provide help to others on how to use health information’

[15] DH: Self Care – A real choice
[16] DH: Self Care – A real choice

- 'to encourage people with similar problems to keep in touch and support each other in the community'[17]

The Stroke clubs are a ready-made platform for self-care support for people living with stroke in Haringey. Some of the building blocks of self-care like appropriate and accessible advice and information are already in place while others, such as utilising networks of peers with experience of the illness, could quite quickly be developed by the group. (e.g. members of the club could be encouraged to stay in touch between meetings by phone or e-mail to enable them to share experiences and concerns.) Links to the expert patient programme should be developed, expertise shared and learning from this incorporated into the Stroke Clubs.

The Stroke Clubs could also play an important role in developing the necessary skills and techniques for self-care. The following self-care skills and techniques have been identified to enable patients to be 'health literate':

- problem solving
- planning decision making and taking actions to fulfil plans
- controlling and taking care of symptoms
- utilising supportive resources
- developing effective partnerships with practitioners[18]

Developing and practising these skills could be incorporated into the programme of the Stroke Clubs without great resource implications.

Recommendation:

Develop links to the Expert Patient Programme and incorporate techniques and training into stroke clubs.

[17] Department of Health: Self Care – A real choice, 2005

[18] DH: Self Care – A real choice

5.4 Developing volunteer support

The Audit Office Report on Stroke Care published in 2005 highlighted the value of voluntary groups and volunteers in the support of stroke services.[19] The report also praised the example of an aphasia group in Barnet run by the Stroke Association with the support of volunteers. The group meets 45 times a year to practise communication skills but volunteers also support users on a one-to-one basis. This model, with continuity of additional resources, could also be implemented at the Stroke Clubs to work with each user on clearly specified goals and tasks.

In the sample of user views a significant minority of members expressed the wish to do more exercise and practise activities of daily living like walking and cooking. The members identified very clear goals that they wanted to achieve like 'I want to be able to walk to the other side of this room without my stick' or 'I want to be able to cook a simple meal for myself'. While it might be very difficult to incorporate very specific activities in the programme of the group some of this work could be very effectively done by volunteers specifically recruited for these tasks and supported by the Stroke Clubs Co-ordinator. A model for this has already been developed by Age Concern England and was piloted in 5 Age Concerns across the country with great success.[20] Volunteers could support members with motivation, exercises, practise cooking with them or support them in accessing public transport for the first time after coming out of hospital. This approach would complement the therapeutic interventions offered by professionals and help individuals facing the new challenge of living with a long term health conditions 'bridge that gap' to real life settings in the community.

Involving more volunteers in supporting Stroke Club members has resource implications in terms of the co-ordinator's time to give to recruiting, placing, training and supporting volunteers as well as additional costs such as volunteer's out of pocket expenses.

Recommendation:

Identify volunteer roles in stroke clubs and in working with members outside the club meetings and ways to support and resource these new volunteer roles.

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[19] National Audit Office: Reducing Brain Damage: Faster access to better stroke care, 2005, p31

[20] Age Concern England: Social Rehabilitation, 2002

6. The Way forward

The Stroke Clubs run by Age Concern Haringey are clearly highly valued by users and professionals alike. However, while they offer a great service to their members, there role in the care pyramid of managing long-term conditions in Haringey is poorly defined and their potential not fully realised.

Although the members of the club most valued the socialising, there was overwhelming support for a time-limited more rehabilitation focused service. The professionals surveyed also unanimously supported this idea, but their priorities for the rehabilitation focused service differed considerably from those of the users. Balancing the views and wishes of the existing members of the clubs with those of the professionals and any future club members will be a considerable challenge. Continuing two of the three clubs might best achieve this as more social contact based whilst developing a third as a time limited club for 6 to 12 weeks with a rehabilitation focus.

The more rehab-focused club could then incorporate activities such as

- rebuilding confidence
- working towards identified goals
- improving mobility and developing new interests and activities.

The model for the new service could be a combination of more targeted support for people with long-term conditions and rehabilitation activities. If the clubs are to be time limited work to integrate members into mainstream services and to support self-care and peer support after members leave the clubs would be vital. Given the limited resources of staff time additional volunteer input should have to be facilitated to harness the competencies of Age Concern and to offer greater user and carer involvement.

The resource implications at least in the short run are considerable. Given the limited hours of the co-ordinator it is difficult to see how she could develop a new service model while continuing to support the existing clubs. The fact that she and her colleague who provides part-time care assistance only have 'term-time' contracts makes this particularly difficult.

There is however great enthusiasm to support the development of the new service with a number of users and health and social care

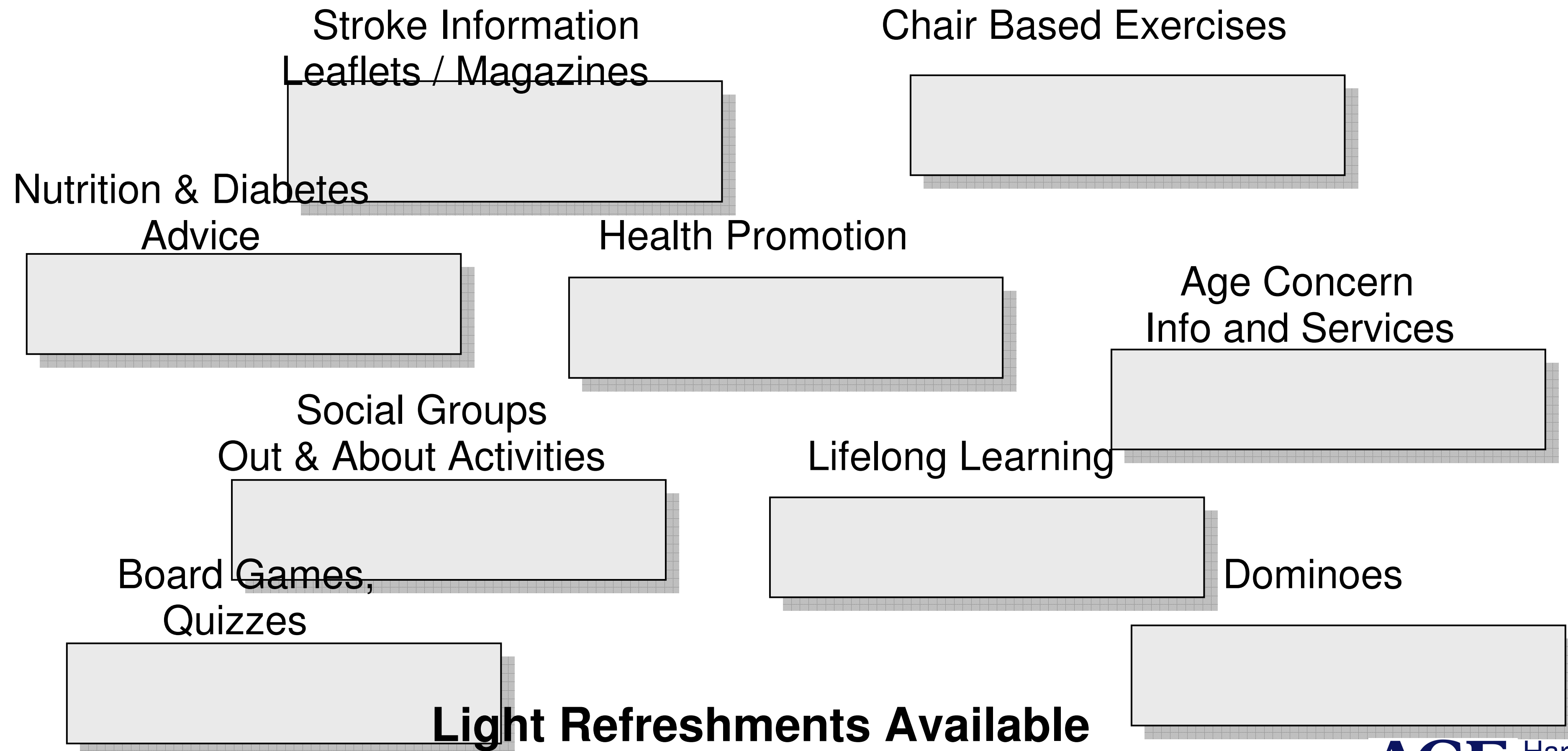
professionals indicating their willingness to be part of a Steering group.

Further discussions with other partners, particularly HTPCT's community therapy team and the health advisors with their realigned remit as Community Matrons, are clearly needed to develop this new service model further. The Stroke Clubs development suggested in this review and specifically that of a re-hab focussed service would usefully inform and be informed by the other local developments, especially HTPCT's Community Rehabilitation Strategy (forthcoming) and local commissioning strategies to support the management and self-care of long-term conditions.

Haringey Stroke Clubs

What Do We Offer …

A warm and friendly environment for people who have had a stroke to interact and participate in their chosen activities which include:



Light Refreshments Available

AGE Concern Haringey

AGE CONCERN HARINGEY
STROKE CLUB ATTENDANCE
APRIL 2005 – MARCH 2006

CLUB	TOTAL ATTENDANCE	NO OF SESSIONS
SOUTH TOTTENHAM	220	33
NORTH TOTTENHAM	568	40
WOOD GREEN	420	37
HORNSEY	488	40
GRAND TOTAL	**1696**	**150**

ETHNICITY		AGE		SEX		Referral source	
AFRO/CARIB	24	50 - 59	6	MALE	24	PCT / GPs	19
UK/EURO	19	60 – 69	19	FEMALE	33	Intermediate Care	16
IRISH	3	70 – 79	19			Hospital	22
ASIAN	5	80 - 90	12				
BLACK AFRICAN	5	90 +	1				
TURK/CYPRIOT	1						

Haringey Council

Agenda item No:

Briefing for:	Councillor Bob Harris Lead Member for Adult Social Care an d Wellbeing
Title:	Funding for Stroke Care for Adults
Purpose of briefing:	To inform the lead Cabinet Member of possible options for investment of Stroke-Care Grant
Date:	30th May 2008

1. Background:

Ring Fenced funding has just been allocated to councils to support stroke care for residents in the community. The allocation made to Haringey is £92,000 a year for three years. The funding is to support the implementation of the National Stroke Strategy launched in December 2007.

Over the three years of the funding it is expected that local authorities and partners can demonstrate improvements against outcomes in relation to some of the 20 Quality Markers identified in the National Strategy.

The guidance makes clear that Local Authorities are pivotal in providing a range of services to people who remain in the community and helping ensure that people live as independently as possible.

2. Local Priorities:

The delivery of the National Stroke Strategy achieves many of the priority outcomes for Adult Services. Specifically:

- D41 – Reducing levels of delayed discharge in hospitals by having appropriate preventative services in place and community services that are able to facilitate timely discharge and optimise levels of independence.
- N125 / N141 / PAFC32 & C29 - Supporting adults and older people to live independently in the community.

We are also required to deliver an improvement in supporting younger disabled people back into work.

Haringey Council

Agenda item No:

All of these priorities are elements of the forthcoming Rehabilitation and Intermediate Care Strategy – any work undertaken now will be in line with the outcomes anticipated from full implementation of this strategy.

3. Suggested options for use of the Grant Funding:
Given the above priorities and the clear steer of the DH that the money is used to work across partnerships to improve outcomes, it is proposed that this resource is used as follows:

- Appointment of a Stroke Coordinator for 3 years to work across health and social care. Elements of this role will involve improving care pathways from Acute Services into rehabilitation – including social care within the community and in care homes. Anticipated costs of this post are around £52k. Initial discussions with HTPCT suggest that this may be jointly funded (thus the costs to the council would only be £26k).
- Support for existing initiatives – specifically the Age Concern Stroke Clubs (£10k) and the Different Strokes (£5k to each of the 2 centres).
- Support the council Welfare to Work strategy by allocating £22k to Winkfield Resource Centre to support outreach work to help working age adults return to work.
- Enhance the establishment of Haven Day Centre by 1 wte to enable more intensive work with older people who have returned to the community & could benefit from further intermediate care. (£24k)

Expenditure and measurement of outcomes against each of these investments would be undertaken quarterly. Where evidence of progress is lacking ongoing funding to be withdrawn (given agreed notice). The monitoring of outcomes will be undertaken by a joint panel including representation of LBH, HTPCT and the Haringey Forum for Older People.