

**Overview & Scrutiny Committee** **On 28<sup>th</sup> April 2008**

Report Title: <b>Feasibility study for a scrutiny review of stroke services in Haringey.</b>	
Forward Plan reference number (if applicable): <b>N/A</b>	
Report of: <b>Chair of Overview &amp; Scrutiny</b>	
Wards(s) affected: <b>ALL</b>	Report for: <b>Non Key</b>
<p><b>1. Purpose (That is, the decision required)</b></p> <p>1.1 To consider the feasibility of the Overview and Scrutiny Committee commissioning a full scrutiny review on the performance of stroke services in Haringey.</p>	
<p><b>2. Recommendations</b></p> <p>2.1 That a scrutiny review be undertaken to consider the measures that are taken by local health and social care services to prevent strokes.</p>	
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<p><b>3. Legal:</b> The Overview and Scrutiny Committee is empowered to undertake the review of stroke prevention services by regulation 2 of the Local Authority (Overview and Scrutiny Committees Health and Scrutiny Functions) Regulations 2002, which allows the Overview and Scrutiny Committee to ‘review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority’. These regulations are made under section 21 of the Local Government Act 2000 as amended by section 7 of the Health and Social Care Act 2001.</p>	
<p><b>4. Finance:</b> There are no immediate financial implications raised in this report. There are likely to be resource implications to implement any recommended actions contained in the proposed full scrutiny review of stroke services, and these will need to be identified when the review is complete.</p>	
<p><b>5. Local Government (Access to Information) Act 1985</b></p> <p>Key background papers relating to this report:</p> <ul style="list-style-type: none"> <li>• National Sentinel Stroke Audit, RCGP, 2007</li> <li>• National Stroke Strategy, DoH, 2007</li> <li>• Improving Stroke Service: a Guide for Commissioners, DoH, 2007</li> <li>• Reducing Brain Damage: Faster Access to better stroke care NAO, 2007</li> <li>• Economic Burden of Stroke in England, Kings College London, 2006</li> </ul>	

- Quality of Stroke Care and TIA in General Practice Using the New GMS Contract Indicators, QResearch, 2006

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## 6. Background

Approximately 130,000 people will have a stroke each year and whilst one-third of people may fully recover with no long term ill-effects, one-third may experience long term disability and further one-third will die.<sup>1</sup> With 45,000 deaths in England each year, stroke is the second most common cause of death and is attributed to 13% of deaths among women and 8% among men<sup>2</sup>. Stroke is also the single largest cause of disability in England, where over 300,000 people live with a physical or cognitive impairment which has resulted from a stroke. The estimated cost of providing both formal and informal care for those having experienced stroke is £7 billion annually.<sup>3</sup>

7. 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 (no hospitals in London met the target of 90% within 24 hours)
  - 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.
8. In response to these and other concerns, a National Stroke Strategy was published in December 2007. This strategy set out the key objectives to improve stroke services in England & Wales. The strategy highlighted the importance of developing managed stroke networks to ensure that appropriate treatment, care and support is available within the different patient pathways of stroke care: prevention, acute hospital care and community rehabilitation.
9. The NHS Stroke Improvement Programme was launched to support the implementation of the National Stroke Strategy. The programme aims to establish stroke care networks and to lead on work to improve stroke services. The North Central London Cardiac Network (NCLCN) has been delegated to take a lead role in developing stroke care networks across the North Central London NHS sector (Barnet, Camden, Enfield, Haringey & Islington). Initial discussions with local stakeholders have indicated that a review of stroke prevention services in Haringey by the Overview & Scrutiny Committee would greatly assist and compliment the work of the NCLCN and would be supported by local health commissioners (Haringey Teaching Primary Care Trust).

## Epidemiology of stroke

<sup>1</sup> National Stroke Strategy, Department of Health, 2007

<sup>2</sup> Office of National Statistics, 2007

<sup>3</sup> Economic burden of stroke in England, Kings College London, 2005

### What is a stroke?

10. A stroke is the brain equivalent of a heart attack. A stroke occurs where the blood supply to the brain has been blocked. The restricted or blocked supply of blood may affect how the brain functions, which has wider repercussions throughout the body depending on the severity of the stroke. There are two main types of stroke:

- *Ischaemic* is the most common form of stroke (accounting for 80% of all strokes) and is caused by the narrowing or blocking of arteries so that blood cannot reach the brain. *Transient Ischaemic Attack* (TIA) is a minor stroke which has usually rectified itself within 24 hours, but is a strong risk indicator of a possible further stroke
- *Haemorrhagic*, is less common (accounting for 20% of all strokes) and results when blood vessels burst and impairs blood flow in the brain.

### What are the risk factors associated with stroke?

11. 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 Factor	Relative Risk
Age (per decade)	2.2
Male gender	1.4
BP (per 10mmHg diastolic)	2.3
BP ( $\geq$ 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)

12. Age is the most significant of the demographic risk factors. Almost half of all strokes occur in people aged 75 years or over and the incidence (new cases) of stroke doubles with each successive decade after the age of 55. Older people are also significantly more likely to die after having a stroke where fatality is twice as high among people aged 85 and over compared to those aged 65 and over. Stroke however is not exclusively a disease of old age however, as 10,000 people under the age of 55 suffer a stroke every year of which 1,000 of these will be under the age of 30.<sup>4</sup> Men are more likely to experience a stroke than women, though the relative risk of gender is smaller than other demographic factors (see 11).

<sup>4</sup> Different Strokes, Younger People Stroke Survivor Charity, <http://www.differentstrokes.co.uk/>

13. Ethnicity would appear to be a significant risk factor for stroke. A number of studies have highlighted the disproportionate burden of stroke among black and other minority ethnic groups. These studies have highlighted that the incidence of stroke among black populations is more than twice that of white populations and that black populations also tend to have a stroke at a younger age than white populations.<sup>5</sup> It should also be noted that there is a greater prevalence of hypertension among black and other ethnic minority populations which may place these communities at greater risk of stroke.<sup>6</sup> Given the ethnic diversity of Haringey's population this is of significance for local preventative strategies.
14. There are also other health conditions which may increase the incidence of stroke in individuals, most notably a previous stroke or TIA where there may be a tenfold increase in the relative risk of having a stroke (see 11). Other health conditions such as hypertension (increase blood pressure), arterial fibrillation (clogged arteries) or health treatments such as warfarin (blood thinning agent) also significantly increase the relative risk of stroke (see 11). The relative stroke risk of these conditions suggests that the identification and management of existing health conditions should be central to stroke prevention strategies.

#### **What is the incidence of stroke?**

15. The incidence of stroke refers to the number of new cases of stroke within a defined population over a given time frame. The national incidence of stroke is estimated to be 1.7 - 2.1 per 1,000 of the general population.<sup>7</sup> In Haringey, with a population of approximately 250,000 this would equate to between 425 and 525 strokes occurring each year in the borough. 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.<sup>8</sup> There is some evidence to suggest that the geographical incidence of stroke in Haringey is not proportionate across the borough, where rates for emergency admissions for circulatory disease (including stroke) are three times higher in the east of the borough (Appendix C).

#### **What is the prevalence of stroke?**

16. The prevalence of stroke is the total number of existing cases of stroke in a defined population (all those people who have had a stroke and survived). The prevalence of stroke is an important indicator given the level of associated disability with this condition and the requirements that this places on health and social care support systems. It is difficult to obtain reliable prevalence data, though nationally, this is estimated to be 9% among men and 8% among women.<sup>9</sup>
17. There is widespread recognition of the underreporting of stroke. This is reflected in local GP stroke registers, which indicate that there are just 2,259 stroke survivors in Haringey, which equates to less than 1% of the population.<sup>10</sup> Further work by London Health Observatory would appear to suggest that underdiagnosis / recording of stroke

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<sup>5</sup> Stewart et al Ethnic Differences in the incidence of stroke BMJ 318:967-971 1999

<sup>6</sup> London Health Observatory, Healthcare for London Presentation

<sup>7</sup> Mant J, et al (2004) 'Health care needs assessment: stroke'. in *Health care needs assessment: the epidemiologically based needs assessment reviews*. 2<sup>nd</sup> Ed.

<sup>8</sup> Action on Stroke Services (ASSET) <http://www.dh.gov.uk/>

<sup>9</sup> Epidemiology of Stroke (J Kwain) Journal of Geriatric Medicine, 3 (3) 94-98 2001

<sup>10</sup> Quality & Outcome Framework <http://www.gpcontract.co.uk/>

is particularly problematic in Haringey where just 61% of expected cases are diagnosed and managed in the community (the lowest rate in London).<sup>6</sup>

### What are the social and economic costs of stroke?

18. The social and economic costs of stroke are considerable. The impact of a stroke is not limited to the person who suffers it but also impacts on their partner and among their wider support network of family and friends. Caring for a patient following a stroke may precipitate many social and economic pressures, particularly as there may be a legacy of disability after the stroke has occurred. Psychological support is also often required for both the patient and the carer to help them adapt to a life that is often very different after stroke, (e.g. disability, exclusion from workforce, new caring role).
19. From a more global perspective, there has been considerable research to identify the economic impact of stroke. It is estimated that the total cost (direct and indirect) of stroke in England & Wales to be in excess of £7 billion each year, the most significant cost areas being the provision of informal care (£2.4 billion) and community care/rehabilitation (£1.7 billion).<sup>3</sup> A summary of the estimated stroke care costs are provided below:

Direct Costs	£ million	Indirect Costs	£ million
Diagnostics	9.6	Informal care	2,406.4
Inpatient	530	Income lost mortality	483.7
Outpatient	46.2	Income lost to morbidity	604.1
Drugs	507.2	Benefits	686.6
Community Care	1,741.1		
	<b>2,834.1</b>		<b>4,180.8</b>

### What can be done to prevent stroke?

20. Whilst there are a number of significant predisposing factors which may increase an individual's risk (see 11), 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.<sup>11</sup> 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.
21. 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<sup>6</sup>:
- Reducing salt intake as effective as medication for reducing blood pressure
  - 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
22. 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

<sup>11</sup> Epidemiology of Stroke (J Kwain) Journal of Geriatric Medicine, 3 (3) 94-98 2001

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 (see 38).

23. 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.<sup>12</sup> Local health commissioners will be expected to develop strategies to ensure that vascular checks are available through primary care and a broader range of providers within the community.
24. 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.

<b>Cost of preventing 1 stroke per year<sup>6</sup></b>	
<b>Measures</b>	<b>£</b>
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
Carotid surgery (removal of plaque from arteries)	£162,000-£232,000

25. 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. Local health commissioners will 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

#### **National Policy Framework**

26. Prior to 2007, national policy and guidance for the prevention, treatment and rehabilitation of stroke was provided primarily through the National Service Framework for Older People. This has been superseded to a large extent by the launch of the National Stroke Strategy<sup>13</sup>, which has provided detailed guidance and a national improvement plan for stroke services. Other strategic guidance is obtained through the Department of Health (for stroke service commissioning)<sup>14</sup>, National Audit Office

<sup>12</sup> Putting Prevention First Vascular Checks, risk assessment and management DoH 2008

<sup>13</sup> National Stroke Strategy, DoH, gateway reference 9025

<sup>14</sup> Improving Stroke Services: a guide for commissioners DoH gateway reference 7418

(independent review of services)<sup>15</sup>, National Institute of Clinical Excellence (clinical guidelines)<sup>16</sup> and the Royal College of Physicians (benchmarking of organisational and clinical services for stroke).<sup>17</sup>

### **National Stroke Strategy**

27. The National Stroke Strategy provides a template for service redesign and improvement and spans all aspects of stroke care provision. Critically, the strategy seeks to ensure that those who have a stroke can access the most skilled practitioners and specialised services through the development of specialist treatment centres supported by managed networks of care in each locality. The strategy also emphasises the importance of promoting greater awareness of stroke, enhancing detection and management of those at risk of a stroke, improving the quality of service provision and reducing social exclusion of those who have experienced a stroke. The strategy provides a 10 point action plan for service improvement:

- **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 are appropriately stroke skilled
- **Service improvement** – research & evaluation to support service development

### **National Audit Office – reducing brain damage**

28. The National Audit Office report provides a comprehensive independent assessment of stroke services in England & Wales. Whilst the report identifies the significant improvements that have been made in many aspects of stroke services in recent years, it underlines the considerable work that needs to be done to improve health outcomes of those people who have a stroke. In particular, the report highlighted four key areas where improvements are necessary:

- More emphasis needed on primary and secondary prevention measures
- Stroke is still not sufficiently seen as a high priority in policy making
- Emergency response to stroke and effective acute care is lacking
- Patients need further support and access to rehabilitation services on discharge

### **National Institute for Clinical Excellence**

29. The National Institute Clinical Excellence (NICE) has recently published draft guidance for the care and management of stroke which is currently being consulted on with professional bodies. Final guidance from NICE is expected to be published in July 2008 along with Royal College of Physicians National Clinical Guidelines for Stroke. Together, these two sets of guidance will be highly influential in developing new standards in the treatment and care of those having a stroke and provide further impetus for the improvement of stroke services both nationally and locally.

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<sup>15</sup> National Audit Office Reducing Brain Damage: Faster access to better stroke care

<sup>16</sup> NICE <http://www.nice.org.uk/guidance/>

<sup>17</sup> National Sentinel Audit Organisational and clinical audit of stroke services, Royal College of Physicians

### **National Sentinel Audit (Royal College of Physicians)**

30. The National Sentinel Audit is a benchmarking review of the provision of stroke services which is undertaken every two years in all acute care settings in England & Wales. The audit therefore provides key performance data from local acute hospitals against agreed service targets / standards. The latest audit was conducted in 2006.
31. The Sentinel Audit made a number of significant observations regarding the organisation and clinical make up of services in the acute sector. Nationally, the main findings from the 2006 audit were:
- Patients managed on stroke units have much better results than patients looked after in other settings in terms of diagnostics, assessments and rehabilitation and discharge planning
  - Whilst there are more specialised stroke units, more patients are directly admitted to stroke units and patients spend more of their time on these specialist units, there is an overall lack of capacity to meet stroke needs
  - Minor strokes and TIA are not given sufficient priority or access to specialist support to prevent a full stroke from occurring
  - Brain imaging is important for the diagnosis and treatment of stroke, yet only 42% of patients had brain imaging to confirm their diagnosis within 24 hours of a stroke
  - Access to stroke investigation / diagnostics is improving though access beyond normal working hours remains problematic (i.e. outside weekdays 9-5)
  - Thrombolysis (clot busting drugs) needs to be administered within 3 hours yet few patients actually benefit (just 218 nationally) due to poor access to diagnostic services and lack of urgency in which stroke patients are seen
32. The Sentinel Audit also assesses services that support stroke patients in their transition from acute to community settings. National findings from this audit are thus:
- Stroke patients are increasing being discharged earlier in to the community though there has not been an accompanying increase in the number of specialist community rehabilitation teams
  - Although early discharge programme is beneficial to the patient, only 22% of hospitals have such a programme
  - Problems remain with stroke patients getting access to multidisciplinary support in both the acute and community setting with there being particular problems in accessing physiotherapy, occupational therapy and social workers
  - Psychological input in to multidisciplinary teams is negligible

### **Stroke Services in Haringey – commissioning**

33. Acute stroke services are generally commissioned through Haringey Primary Care Trust, it is planned that hyper acute services (e.g. scanning, imaging services and thrombolysis) will be commissioned collaboratively with other PCTs within the North Central London sector. Rehabilitation services, primary and secondary prevention, including the management of stroke and TIA in the community is commissioned by Haringey PCT.
34. The North Central London Cardiac Network, although not commissioners of services, will take the lead in the planning and delivery of stroke services across Barnet, Camden, Enfield, Haringey & Islington. The NCLCN will take the strategic lead in scoping local stroke services to assess the level of service provision and to identify any service gaps across the sector. Whilst the initial focus of the work will be on acute



stroke care provision, work will also be undertaken in respect of stroke prevention and stroke rehabilitation.

### Stroke Services in Haringey – hospital services

35. The North Middlesex University Hospital (NMUH) and the Whittington Hospital both provide acute stroke services for people living in Haringey. Under the current configuration of stroke services, residents from 12 of the 19 local authority wards are taken to NMH for stroke care and residents from the remaining 7 taken to the Whittington Hospital. A summary of key stroke services provided through these hospitals is provided in the table below:

<b>Stroke service at the Whittington and NMUH 2005/6</b>		
	<b>Whittington Hospital</b>	<b>NMUH</b>
<b>Stroke Unit</b>	Combined acute (6 beds) / rehabilitation (12 beds)	Dedicated Acute unit 8 beds
<b>Multidisciplinary Stroke Team</b>	Yes	Yes
<b>Mobile stroke team</b>	No	Yes
<b>Early supported discharge team</b>	Yes	No
<b>Specialist stroke Nurse/ Consultant</b>	No	No

36. In total, there were approximately 600 emergency admissions for stroke to the Whittington and NMUH in 2005/6. It is difficult to identify how many of these are Haringey residents, as the catchment area of these hospitals span other local authority districts. In the period 03/04 to 05/06, the Whittington saw a decline in the number of admissions for stroke (47 cases /16%). Conversely, the NMUH saw a significant increase (180 cases / 104%) in emergency stroke admissions over the same period.

<b>Emergency stroke admissions 2003-2006</b>		
	<b>Whittington Hospital</b>	<b>NMUH</b>
<b>03/04</b>	292	173
<b>04/05</b>	254	298
<b>05/06</b>	245	353

37. The National Sentinel Audit provides performance data on both the Whittington and NMUH against 12 stroke indicators. Full data on the performance of all hospitals in the North Central London sector is provided in Appendix A. From this data the following may be surmised:
- There would appear to capacity issues for stroke care at the NMUH where just 53% patients were treated in the dedicated stroke unit and just 47% spent more than half of their stay in this unit. This is below sector, London and national averages.
  - Only 50% of stroke patients at the Whittington received a brain scan within 24 hours which was below the sector and London wide average.
  - The NMUH scored consistently lower than other hospitals in the sector in respect of assessments provide for stroke patients (physiotherapist, occupational therapy, weight and mood assessment). This would infer that there may be scope to improve the multidisciplinary nature of stroke services at the NMH.
  - The NMUH also scored poorly on those services that concern the transition of the patient from the acute to the community setting: only 81% of stroke patients had their

rehabilitation goals agreed by a multidisciplinary team and in only 42% of cases was a home visit undertaken prior to discharge.

- The performance of both hospitals against agreed stroke standards (as measure in 12 key indicator scores) has improved from 2004 to 2006, though the performance of the NMUH is still someway off other hospitals in the sector.

### Stroke Services in Haringey – Primary Care

38. 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 in Haringey.
39. 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. The performance across individual practices however would appear to be more variable; in some practices 100% of stroke patients had had their cholesterol regularly checked, though in other practices this figure was just 64%. Similar variations are seen for blood pressure monitoring.

<b>Management of stroke &amp; TIA in Haringey 2006/7 <sup>19</sup></b>		
	<b>Haringey % / No.</b>	<b>General Practice variance across Haringey No/%</b>
<b>Patients on stroke register</b>	0.8% (2,259)	0.1%-2.0%
<b>New stroke patients referred investigation</b>	90.8% (168)	0-100%
<b>Stroke Patients BP Check in past 15 months</b>	96.8% (2,118)	82.4% - 100%
<b>Stroke Patients BP 150/190 or less</b>	88.0% (1,834)	35.7-100%
<b>Stroke Patients cholesterol checked in past 15 months</b>	88.9% (1,870)	64.3-100%
<b>Stroke Patients with cholesterol &lt;5.0</b>	72.2% (1,399)	25-100%
<b>Stroke Patient with anti platelet /anti coagulant</b>	93.2% (1,091)	50-100%
<b>Stroke Patients given flu immunisation</b>	87.1% (1,631)	35.7-100%

40. Given the relative stroke risk of other underlying health conditions such as hypertension, arterial fibrillation, smoking and obesity, the identification and management of these conditions is clearly important to stroke prevention strategies. The identification and management of other underlying stroke risk factors in primary is also would also seem to vary across general practices in Haringey (see Appendix B).

### Stroke Services in Haringey – Rehabilitation

41. 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:

- Beech Ward at St Ann's Hospital (stroke care can be provided to patients 50+ general rehabilitation 65+)
- Integrated community therapy team (rehabilitation in the clients home)
- Step down beds (to support community discharge)

There would however appear to be a number of omissions in the makeup of local rehabilitation services:

- Stroke care Coordinator (as specified in NSF for older people)
- Specialist community rehabilitation team for stroke in Haringey (National Sentinel Audit)

42. Data collection at the interface between acute and community health care sectors is inherently problematic and there is little reliable data which can be used to assess or compare the performance of local services. Haringey TPCT and the Haringey Council are currently preparing a rehabilitation and intermediate care strategy, which will provide further information about the nature and level of rehabilitation services in Haringey. This is due to be published in the summer of 2008 and which local stakeholders will be consulted upon.
43. The community and voluntary sector (Age Concern) is funded by Haringey TPCT to provide a number of stroke clubs across the borough. These provide lower level support to longer term survivors of stroke. These stroke clubs are well attended and undertake a range of activities including dedicated stroke exercise classes, ongoing stroke prevention, education, peer support and community engagement. Age Concern has recently undertaken a review of this service and is in discussions with commissioners in developing more tailored courses for those having experienced a stroke.

#### **Feasibility Study Conclusions**

44. **The needs of people who have had a stroke are often multiple and complex. These needs also span the breadth of the health and social care economy from prevention, through to emergency medical care through to long term rehabilitation in the community. It is apparent that considerable planning and partnership work is needed among health and social care agencies so that appropriate services are developed in all the care pathways of stroke.**
45. **It is apparent from the evidence presented in this report that a scrutiny review could be beneficial to any of the three key areas of stroke services in Haringey: primary prevention, acute hospital care or community rehabilitation. However given the pan London work in examining acute sector provision for stroke care and the imminent publication of the local rehabilitation strategy, a scrutiny review of stroke prevention services would be of more value.**
46. **The NCLCN will take a lead role in developing stroke care networks across the North Central London NHS sector. The NCLCN has indicated that a scrutiny review of stroke prevention services in Haringey would compliment this work, and inform the development of stroke care networks across the sector. Local health commissioners (Haringey PCT) have indicated that they would support such a scrutiny review as such work may assist them in the development of health promotion work-streams in primary care.**

- 47. It is also suggested that a scrutiny review of stroke prevention services in Haringey may assist local health commissioners in developing arrangements for the introduction of the national vascular risk assessment and management programme. This will help in the identification and management of those people at risk of stroke (and other vascular diseases) in Haringey.**
  
- 48. Given the geographical incidence of stroke and other circulatory diseases across the borough a scrutiny review of stroke prevention services provided through community and primary care may also inform local strategies to reduce health inequalities. A review of prevention services would provide an opportunity to examine the nature, level and quality of service provision across the borough.**

**Appendix A – Performance of north central London sector hospitals against key stroke standards.**

<b>Performance of North Central London Hospitals against 12 key stroke indicators (Hospitals which Haringey residents attend are highlighted)<sup>18</sup></b>								
<b>12 Key Indicators</b>	<b>All Region</b>	<b>London SHA</b>	<b>Barnet</b>	<b>Chase Farm</b>	<b>NMUH</b>	<b>RFH</b>	<b>UCH</b>	<b>Whittington</b>
<b>(number of cases in sample)</b>			59	62	<b>47</b>	45	30	<b>38</b>
<b>Patients treated in a Stroke Unit</b>	62%	67%	81%	73%	<b>53%</b>	87%	87%	<b>79%</b>
<b>Patients treated for &gt;50% of stay in Stroke Unit</b>	54%	60%	71%	68%	<b>47%</b>	80%	87%	<b>71%</b>
<b>Screening for swallowing disorders &lt;24 hours after admission</b>	66%	72%	68%	74%	<b>69%</b>	92%	59%	<b>86%</b>
<b>Brains scan within 24 hours</b>	42%	58%	51%	81%	<b>70%</b>	58%	83%	<b>50%</b>
<b>Aspirin by 48 hours after stroke</b>	71%	89%	94%	91%	<b>94%</b>	100%	100%	<b>81%</b>
<b>Physiotherapist assessment within 72 hours of admission</b>	71%	74%	96%	88%	<b>67%</b>	91%	85%	<b>88%</b>
<b>OT assessment within 7 days of admission</b>	68%	75%	98%	87%	<b>84%</b>	100%	100%	<b>88%</b>
<b>Patient weighted during admission</b>	57%	68%	90%	68%	<b>76%</b>	83%	69%	<b>76%</b>
<b>Patient's mood assessed by discharge</b>	55%	55%	78%	54%	<b>31%</b>	80%	80%	<b>57%</b>
<b>Patient on antithrombotic therapy by discharge</b>	100%	100%	100%	100%	<b>100%</b>	100%	100%	<b>100%</b>
<b>Rehabilitation goals agreed by the multi-disciplinary team</b>	76%	77%	91%	96%	<b>81%</b>	100%	96%	<b>94%</b>
<b>Home visit performed before discharge</b>	63%	73%	93%	79%	<b>42%</b>	100%	50%	<b>92%</b>
<b>2006 key 12 indicator score</b>	65	72	84	80	<b>68</b>	89	83	<b>80</b>
<b>2004 key 12 indicator score</b>	61	66	72	59	<b>47</b>	93	83	<b>61</b>

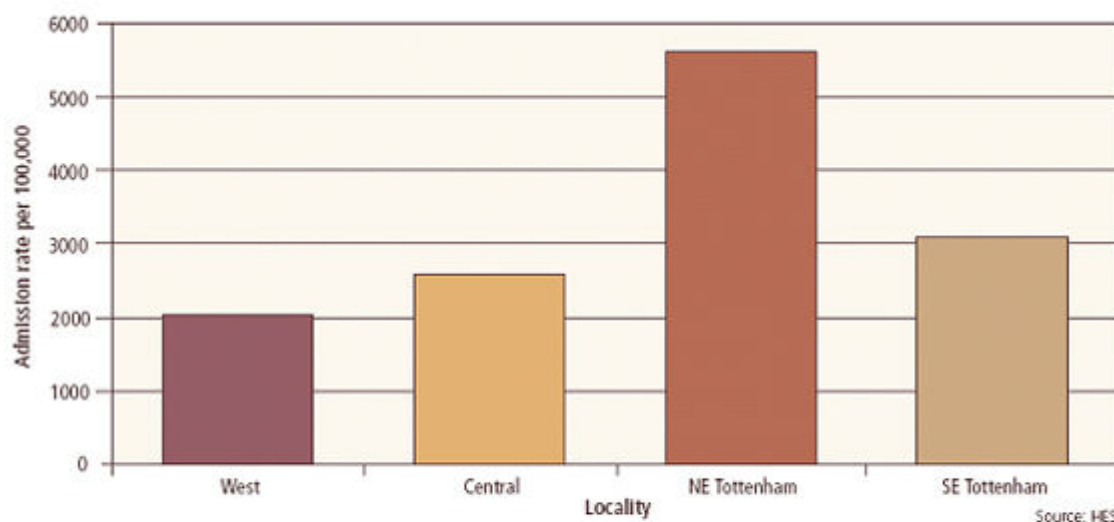
<sup>18</sup> Data taken from the Royal College Physicians National Sentinel Stroke Audit 2006 (April 2007)

**Appendix B – Management of stroke risk factors in primary care in Haringey in 2006/7.**

<b>Performance of GP practices in Haringey in identification and management of stroke related risk factors.<sup>19</sup></b>		
	<b>Haringey</b>	<b>General Practice Variance</b>
<b>Patients on Hypertensive Register</b>	26,706 (9.5%)	2.5%-17.0%
<b>Hypertensive patients blood pressure checked &lt; 9 months</b>	24,074 (91.5%)	76.4%-100%
<b>Patients that are obese (BMI 30+)</b>	19,583 (7%)	2.2%-18.0%
<b>Patients that smoke with chronic condition (i.e. stroke, CHD)</b>	6,398 (16.8%)	8.6%-27.5%
<b>Patient on Arterial Fibrillation Register</b>	1,512 (0.5%)	0%-2.0%
<b>Arterial Fibrillation treated with anticoagulant / platelets</b>	1,330 (93%)	0%-100%

**Appendix C – Admission rates for circulatory disease (including stroke) in Haringey 2003-6)**

*Figure 63 All age admission rate for circulatory disease by locality (2003/04-2005/06)*



<sup>19</sup> Quality and Outcomes Framework <http://www.gpcontract.co.uk/>