Stroke Club Review

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Stroke Clubs Review

Contents

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.

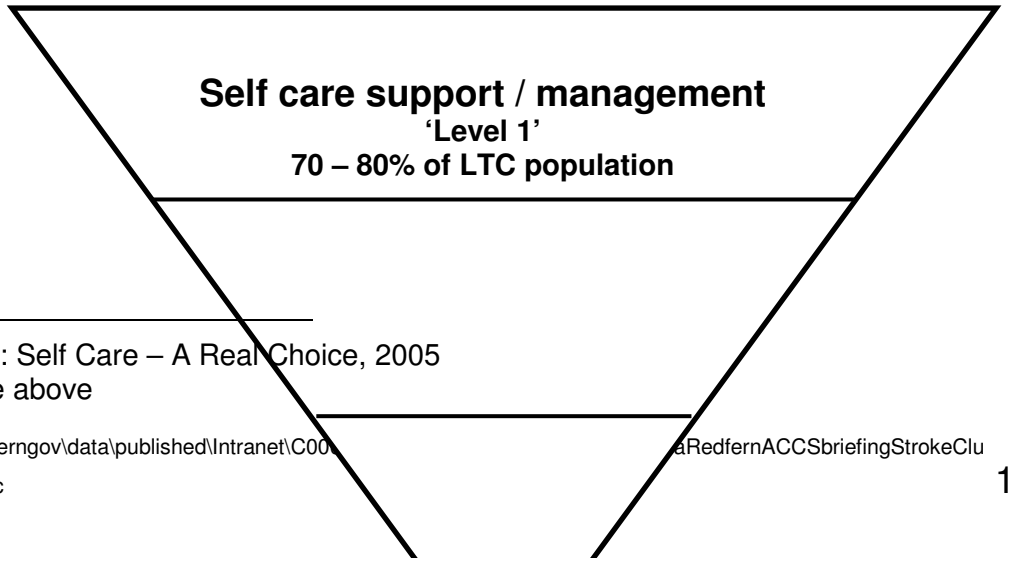
When asked what else they would like to include in the programme relaxation, massage and aromatherapy were mentioned as well as return to work support for younger people and cooking simple meals. More involvement of family and carers and their support as well as counselling and psychological support 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

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

[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.

[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.

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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:

Stroke Information Leaflets / Magazines

Chair Based Exercises

Nutrition & Diabetes Advice

Health Promotion

Age Concern Info and Services

Social Groups Out & About Activities

Lifelong Learning

Board Games, Quizzes

Dominoes

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						