Stroke: *Factsheet*

Tower Hamlets Joint Strategic Needs Assessment 2010-2011

Executive Summary

There are approximately 2000 people living in Tower Hamlets who have had a stroke and each year there are approximately 350 incidences of stroke admissions to secondary care each year. Stroke, is a largely preventable condition and modifiable risk factors are the same for all other cardio-vascular disease. The condition is caused by a disturbance to the blood supply to the brain and is the single highest cause of adult disabilities in the UK. The condition has long-term health consequences which usually require specialist rehabilitative services.

The 2007 National Stroke Strategy sets out 10 point action plan and 20 Quality Markers for stroke service improvement. NICE provides clear guidance regarding the acute and long-term medical and rehabilitative management for stroke patients.

The CVD secondary prevention care package has been implemented in primary care from April 2011 to ensure optimum support for people after a stroke and to improve transitional arrangements once they have been discharged from community health services.

Community Stroke Services were recently rated above average in the country in a CQC review, excelling in the areas of early supported discharge and end of life care. Key patient reference groups have been established with people with experience of stroke, which provide an invaluable resource for service improvement advice. The Stroke Association has been commissioned to provide key worker support to link individuals into all the support services available to them.

Secondary care services see 100% of patients with TIA within 24 hours, and have a smooth pathway of referral into community care services.

Recommendations

- **Integrated Care;**
  Provision of a joined up stroke care service ensuring a smooth pathway between NHS and social services. In addition to considering timely home adaptations this needs to consider social isolation and facilitation for patients to leave their home. Statutory organizations should consider how they work with Stroke Association key workers to make this process as fluid as possible.
- **Community to primary care pathway;**
  Systems for assessment and review in primary care at 12 months need to be implemented, ensuring continuity of care following the six week and six month reviews that take place in community health services.
- **Care Planning consultations;**
  Care planning consultation processes need to be sensitively adapted to the needs of stroke patients, taking account of communication difficulties, housebound populations, impact on mood, isolation, etc. Pre-care planning advice should be given to the patient to help them prepare for their review and consultations should include carers/family members to devise individually relevant goals that are written up and given to the service user.
- **Carer Support;**
  Stroke specific carer support groups need to be developed along withspecific training and information needs.

- **Information;**
  Information needs to be provided via a directory of services, and consider different types of information that may be required along the length of the patient pathway.
- **Prognosis;**
  The disparity in 30-day mortality and one-year mortality for people with stroke requires further investigation to diagnose the underlying cause.
- **Evaluation;**

The CVD secondary prevention care package was implemented in April 2011, with the intention of improving management of Stroke patients and improving the transition between community and primary care for people who have had a Stroke. An evaluation against these objectives will need to be conducted one year after implementation.

1. What is Stroke?[1]

Stroke is also known as a 'brain attack' that is caused by a disturbance to the blood supply to the brain causing a range of clinical outcomes. Transient ischaemic attacks (TIA), also known as minor strokes, occur when stroke symptoms resolve within 24 hours. Stroke is an extremely important topic as this largely preventable condition is the third biggest cause of death in the UK(11%) and is the single largest cause of disability in the UK.

There are over 900,000 people (~ 1.6% of all registered patients) living in England who has had a stroke. Of these300,000 people in England are living with moderate to severe disability as a result of stroke and 40% of patients (2008/9) are not able to return to their normal place of residence after hospital admission for stroke. Each year more than 110,000 people in England will suffer from a stroke which costs over £2.8 billion in direct costs to the NHS, £2.4 billion of informal care costs (e.g. the costs of home nursing borne by patients' families) and £1.8 billion in income lost to productivity and disability.

The major modifiable risk factors include all those associated with vascular disease which can be altered through lifestyle change. In order of impact, these are smoking, diet, exercise and excessive alcohol consumption. A number of medical conditions carry a fixed risk of stroke as a complication including atrial fibrillation, diabetes, hypertension,and sickle cell anemia.

In terms of health inequalities, people who are economically disadvantaged have a higher rate of stroke and the incidence of stroke amongst the African or Caribbean population is twice as high as for the white population.Stroke is more common in men compared with women by the age of 75 but the latter have a higher mortality rate.

[1] www.apho.org.uk

2. What is the local picture?

Incidence & Prevalence

In March 2010, there were 2044 residents on GP stroke registers which means that over 2000 people living in Tower Hamlets have previously suffered one or more strokes.The 2008/9 incidence of Stroke emergencies was 153.5 which is an increase from 2006/7 (151.8)[1].

Prognosis

The absolute number of deaths from stroke is low compared to London due to the relatively young population within the borough but stroke deaths in <75 year olds is the third highest in London and Stroke death rates in >65 year olds is the fourth highest. In contrast however, one-year survival is higher than national average. In Tower Hamlets in 2007/08 the age-sex standardised incidence rate for death within 30 days of emergency admission to hospital was 21993 per 100,000 population compared to 20537 per 100,000 population in London and 22746 per 100,000 population nationally[2]. A recent CQC report found that the standardised mortality ratioat one year post-stroke was approximately 1.15(dates and indirectly standardised rates not given)[2]. This indicates that while stroke survival in Tower Hamlets is better than average after 30 days, it is above average one year later.

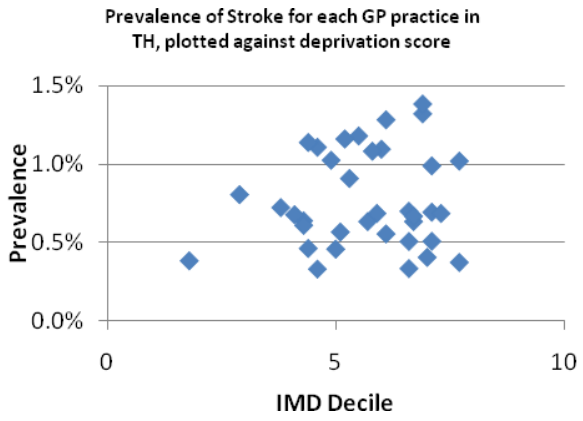
Patient experience

The percentage of patients returning to their normal place of residence after a stroke is 57% (2008-2009) which is better than the national average of 40%. It is very common for patients who have had a stroke to have two or more co-morbidities (~20% in TH) and depression is also frequently associated. (Data; CEG, 2010)

Health Inequalities

Health inequalities regarding stroke exist throughout London. These include a higher incidence in men, black ethnic groups, those in lower socio-economic groups and those with higher levels of deprivation. In Tower Hamlets there is no strong correlation between the GP practice deprivation score and the prevalence of stroke (Figure 1).

Figure 1. Crude prevalence of stroke in each GP practice within Tower Hamlets plotted against the corresponding deprivation score. (Data source; CEG)



Secondary care

The admission ratefor stroke in 2010/11 was 207 per 100,000 population,which is lower than for neighbouring

boroughs Newham (379) and Hackney and lower than 2009/2010 (299) but has increased from the Tower Hamlets' rate in 2007/8 (187). This can be in part attributed to the success of the national FAST campaign, which saw symptoms increasingly being acted on across the country.Admissions follow a bimodal distribution with regard to age, the highest being for 45-49 and 75-79 year olds.87.5% of those admitted with stroke spend 90% of time on a stroke unit and 100% of TIA cases with a higher risk were treated within 24 hrs[3].The standard readmission ratio for TH is below 1, meaning there are less emergency re-admissions than expected.The relative risk of re-admission is 9.2 (2010/11) which follows a downward trend since 2006 when the relative risk was 20.5.

3. What are the effective interventions?

NHS in England: operational plans 2008/9-2010/11 requires all PCTs to implement the recommendations in the **National Stroke Strategy** which sets out 20 Quality Markers (QMs) by which service provision should be measured. A summary, 10 point action plan is available and includes the following points;

- ✓ Raising awareness of stroke symptoms.
- ✓ Improving stroke prevention by managing modifiable risk factors.
- ✓ Involvement of stroke patients and their carers in care planning.
- ✓ Improvement of TIA management to prevent the high incidence of stroke following a TIA.
- ✓ Provision of acute stroke centres and successful admission to these services for all stroke patients.
- ✓ Provision of a multi-disciplinary team stroke unit after emergency admission.
- ✓ Provision of intensive rehabilitation and community support.
- ✓ Stroke patients to participate in community life as soon as possible following a stroke.
- ✓ Stroke patients to be treated by a skilled and competent work force.
- ✓ Constant drive to improve services with participation in regular local and national audit as well as clinical trials.

NICE Guidance (CG68 – published 2008)

- Brain imaging should be performed immediately or as soon as possible according to guidance.
- Thrombolysis should be administered according to guidelines if symptoms have occurred under 3 hours previously and there are no contraindications.
- A swallowing and nutrition screen should occur as soon as possible.
- Condition permitting, the patient should be sat up and mobilised as soon as possible.
- Patients should be treated with anti-thrombotic and anti-coagulant therapy according to guidelines.
- Patients should not be commenced on statin therapy immediately after an acute stroke episode.
- For TIA, those patients with an ABCD2 score of >4 should be referred for specialist assessment within 24hrs. For those with a score of 3 or less, assessment should be within a week.
- Imaging for TIA should be diffusion-weighted MRI unless contraindicated and then substitute with CT.
- If a patient is eligible and suitable for carotid endarterectomy, this should be performed within one week of symptoms.

4. What is being done locally to address this issue?

Prevention

Tower Hamlets is involved in a NHS Health Check programme for 40 – 74 year olds to identify those at risk of developing cardiovascular disease, including stroke and encourage lifestyle change to reduce risk. Complementary factsheets are available on NHS Health Checks, Smoking, Obesity, Physical Activity and Alcohol.

Primary Care

The borough has a secondary prevention care package in place for cardiovascular disease, including stroke. The package includes; care planning sessions to promote self management, patient education, regular health checks (including cholesterol and blood pressure measurements) and medication reviews. Patients are managed in primary care following their 6 month review within community health services.

Community Services

A post discharge, fully multi-disciplinary Community Stroke Team, which covers all of the PCT, provides specialist rehabilitation includingspecific vocational rehabilitation, orthotics and stroke nurses. There is also access toorthoptics, spasticity clinics, and support for home enteral feeding. Systems are in place for assessment and review after transfer home at 6 weeks and 6 months are under development. Patients have access to a single point of care through a commissioned Stroke Association Family & Carer Support Worker who acts as an independent advocate and can coordinateacross services in order to help with care after return home. Community peer support includes a befriending service for people with aphasia and information is provided which is clear and accessible.

Secondary Care

The secondary care services at The Royal London include a fully implemented TIA pathway in collaboration with community services for follow up, a Hyper-Acute and an Acute Stroke Unit (all HASU beds fully operational by July 2010)and a substantial end-of-life care package.

Social Care

Regarding social care services, in Tower Hamlets (2009/10) 215 adults per 10,000 population used services for physical disability (compared to 225 per 10,000 population in London)[3]. This lower rate is likely to reflect the relatively small older population in Tower Hamlets.

5. What evidence is there that we are making a difference?

Prevention

Complementary factsheets are available on Atrial Fibrillation, NHS Health Checks, Smoking, Obesity, Physical Activity and Alcohol.

Primary Care

Implementation of the CVD secondary prevention care package began in April 2011 so it is too early to evaluate its impact. Performance against QOF metrics indicate that control of cholesterol in people who have had a stroke has been very successful but further work is required to achieve the same standards in blood pressure control (table 1).

Table 1: Control of clinical indicators in CHD patients (QOF, 2008/09, 2009/10)

	Blood pressure <150/90		**Cholesterol < 5mmol/l**	
	2008/09	**2009/10**	**2008/09**	**2009/10**

	%	Rank	%	Rank	%	Rank	%	Rank
Tower Hamlets	**86.0**	-	**87.7**	-	**80.7**	-	**78.9**	-
London	**87.5**	**26th**	**87.9**	**18th**	**74.5**	**1st**	**75.3**	**3rd**
England	**87.9**	**140th**	**88.1**	**90th**	**77.0**	**6th**	**77.3**	**26th**

Community Health Services

- A recent report by the Care Quality Commission, found Tower Hamlets to be classed as "Better Performing"among trusts across England.
- Tower Hamlets has the highest percentage in the country of patients supported by an Early Supported Discharge team (40%)
- 80% of all discharged patients have goal focused care plans and are contacted by the community team within 72 hours.
- On discharge the majority of patients (98%) are given a named support worker
- 100% of patients are given a helpline telephone number
- There is a low wait-time for community SALT and physiotherapy services
- 79% of patients did not experience any problems with equipment or home adaptations
- Of those who have had home adaptations 56% said their quality of life has been made "much better"
- A "conversation partner" scheme has been implemented and a local carer centre is available but does not yet provide stroke specific support.

Secondary Care

- 100% of high risk TIA patients are assessed and treated within 24 hours.
- 87% of stroke patients spend 90% of their time on a dedicated stroke unit.

6. What is the perspective of the public on support available to them?

A recent national survey of individuals with stroke revealed that while 89% are satisfied with the care they received, almost half are dissatisfied with the information they received and 52% wished they had been more involved in their care. Carers, too, are often dissatisfied with the amount of information they are given.

A recent report by the Care Quality Commission detailed the following findings for Tower Hamlets' stroke patients;

- Satisfaction levels with the level of care received by social services as "quite" (31%), "very" (38%) and "extremely" (29%).
- With regard to how care workers treat patients in Tower Hamlets, responses were; "always happy" (77%) and "usually happy" (22%).

In March 2011 the Community Health Services team held a Stroke Service User and Carer Planning Launch Day, attended by approximately 60 people, the majority of whom were people with stroke or carers. Suggestions for service improvement arising from this event included:

- Some of the Bengali female service users suggested some light exercises would help prevent stroke. Day care is good but they require services that will help them to go out i.e. walking in the summer.
- 'Buddy' with stroke once you've been discharged from all services. Having a buddy that you can talk to and will help point you in the right direction for dealing with some of the problems that come after a stroke. Time for a buddy could be six months down the line or so.

- Shadwell ward is a shared ward with people who will not be going home – "It's depressing to be in day room with patients who will be going to a care home, it does not motivate the stroke patients".
- Incontinence problems – there is no one to talk to. There are delicate issues that you would like to discuss but not able to do so.
- No one to take you out – isolation.
- "No one explained what a stroke is".
- "Preferred Victoria ward as it was only a stroke unit".
- Patients could teach other people how to set goals.

7. What more do we need to know?

- There is currently little known about the equitability of service delivery for stroke patients. The service would benefit from conducting an equality impact assessment to determine any areas for improvement.
- The disparity in 30-day mortality and one-year mortality for people with stroke requires further investigation to diagnose the underlying cause.
- The CVD secondary prevention care package was implemented in April 2011, with the intention of improving management of Stroke patients and improving the transition between community and primary care for patients who have had a Stroke. An evaluation against these objectives will need to be conducted one year after implementation.

8. What are the priorities for improvement over the next 5 years?

- **Integrated Care;**
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- **Information;**
  Information needs to be provided via directory of services,and consider different types of information that may be required along the length of the patient pathway.

9. Key Contacts

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