MUNICIPAL YEAR 2011/2012 REPORT NO. 77

MEETING TITLE AND DATE:
Cabinet
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Council
21 September 2011

REPORT OF:
Ray James - Director of Health, Housing and Adult Social Care

Agenda – Part 1	**Item: 8**
Subject: Enfield Joint Stroke Strategy 2011 - 2016 **Wards: ALL**	
Cabinet Member consulted: **Councillor Don McGowan**	

Contact officer and telephone number:

Bindi Nagra – Joint Chief Commissioning Officer

E mail: Bindi.nagra@enfield.gov.uk
Tel: 0208 379 4512

1. EXECUTIVE SUMMARY

1.1 This report proposes the agreement of a 5 year Enfield Stroke Strategy jointly with NHS Enfield. The full strategy and supporting documents are available online and in the Members' library and Group Offices.

1.2 Every year in Enfield, it is estimated that approximately 550 people have a stroke, and some 20-30% of these people die within the first month. Stoke is the third largest cause of death in England and the single largest cause of adult disability. Approximately 1,470 people in Enfield live with moderate to severe disability as a result of stroke.

1.3 There is a significant life expectancy gap between the deprived and more affluent areas in Enfield and there is evidence that this gap is widening. Circulatory diseases (which include stroke) are the biggest causes of the life expectancy gap, accounting for 26% of the male life expectancy gap and 29% of the female life expectancy gap.

1.4 The Enfield Joint Stroke Strategy sets out how health and social care commissioners will work together over the next 5 years (2011 -16) to improve the range and quality of local stroke services; address health inequalities related to stroke; improve awareness of stroke and Transient Ischaemic Attack (TIA) symptoms; and reduce the prevalence of stroke.

1.5 The Strategy has been prepared and been subject to a 3 month period of consultation with key stakeholders and the general public. The

strategy has been endorsed by the Stroke Implementation Team which includes representation from people who have experienced a stroke, carers, Public Health, Primary Care, Acute Sector, NHS Commissioning, Adult Social Care, and the Voluntary and Community Sector.

1.6 In June 2010 the PCT and Council were asked by the Care Quality Commission to complete a review of stroke services. The review, published in January 2011, found Enfield to be one of the PCT areas that is 'least well' performing' in the country and highlighted a number of key areas for improvement. The strategy sets out how we plan to respond to the review findings.

1.7 Implementation of the strategy will require an investment of £536,500 in year 1 and £591,500 in year 2 which will be funded from social care grant, reablement monies and NHS social care grant. From year 3 funding for ongoing service provision will be met from health efficiency savings.

2. RECOMMENDATIONS

2.1 Cabinet is asked to:

i) note the contents of this report; and

ii) approve the Enfield Joint Stroke Strategy 2011-16 and associated implementation plan.

3. BACKGROUND

The Joint Stroke Strategy has been developed as a local response to the National Stroke Strategy (2007). The strategy addresses a number of shared priorities that are identified in Enfield's Joint Strategic Needs Assessment, including inequalities, long term conditions, healthy lifestyles, and access to health and wellbeing information. It also links to a number of other strategies including the Health and Wellbeing Strategy, Local Area Agreement, and other joint commissioning strategies for Dementia, End of Life Care, Intermediate Care and Re-ablement, Carers, and the Voluntary and Community Sector framework.

The strategy aims to ensure resources are used efficiently and effectively, to improve the quality and range of service provision, reduce inequalities and

reduce the prevalence of stroke. It provides a robust framework for a more integrated approach to the delivery of health and social care services.

3.1 Care Quality Commission Review

In June 2010 the PCT and Council were asked by the Care Quality Commission (CQC) to complete a review of stroke services. The review covered all health and social care services that provide care and support to people who have had a stroke and their carers and looked specifically at:

- Acute care in hospital, after the initial 'hyper-acute' stage;
- how people who have had a stroke are discharged from hospital;
- whether they have access to rehabilitation in hospital and in the community; and
- what ongoing care and support they receive.

The review collected data from local health services and councils and also used some data already collected by government. The CQC also asked people who had had a stroke and carers what they thought about the information given to people when they leave hospital. The review found Enfield to be one of the PCT areas that is 'least well' performing' in the country and highlighted a number of key areas for improvement. The Joint Stroke Strategy summarises the findings of this review and sets out how we will address the review findings.

Significant progress has been made over the past year in addressing the findings of the CQC stroke review. The majority of issues that were raised in the CQC review had already been identified during the process of developing the strategy and it was considered important to begin to address these immediately. Where appropriate, the actions taken to respond to the CQC review have been incorporated in the strategy and its associated implementation plan.

3.2 Consultation

Formal public consultation on the draft stroke strategy was undertaken over a 3 month period from 1 March to 20 May 2011. A total of 148 responses were received. In addition, verbal feedback was received at several live consultation events.

A summary of submissions received in response to the consultation is available online and in the member's library. This document describes the consultation process, summarises the submissions, and sets out the Council and NHS Enfield response to the comments and suggestions that were received.

3.3 Funding

It is difficult to accurately quantify the annual cost stroke to the NHS and Council however estimates have been made at a national level. King's College, London and the London School of Economics and Political Science undertook a 'burden of illness' analysis to calculate the direct and indirect costs of stroke to the health services and the economy more widely. They calculated that stroke results in total costs of £7 billion a year nationally. Total annual direct care (diagnosis, inpatient care, outpatient care, drugs and community care) accounts for approximately 40% of this total; informal care for 35%; and the indirect costs for approximately 25%.

The following table summarises what we know about 2011/12 direct stroke costs in Enfield.

Service	Provider	Approximate Cost 2010/11
NHS Funded		
Hyper Acute Stroke Units	University College London Hospital & Northwick Park Hospital	£43,352 (April-October 10/11)
Acute Stroke Units	• North Middlesex University Hospital • Barnet Hospital • Barts and the London NSH Trust • University College London Hospital • Royal Free Hampstead Hospital	£806,251 (April-October 10/11)
TIA Clinics	• Barnet and Chase Farm Hospital • North Middlesex Hospital • Royal Free Hospital • University College Hospital	£172,300
Inpatient rehabilitation	• Chase Farm Hospital • St Ann's Hospital (Haringey) • Potters Bar Community Hospital	£1.7 million
[1]Community rehabilitation	Enfield Community Services	£400,000
Council Funded		
Social care	Enfield Council	£2.2 million[2]
Social Stroke Support Club & respite service	Total Healthcare and Stroke Action	£21,000

[1] This health service is being funded by reablement monies in 2011/12 and 2012/13. From 2013/14 it will be funded by health and the costs will be met through planned efficiency savings.
[2] Total cost of social care services accessed by stroke survivors

Stroke Navigator	Stroke Association	£40,000 (From July 2011)
Stroke Social Support Co-ordinator	Stroke Action	£25,000 (From August 2011)
Life Roles Facilitator	Attend	£25,000 (From August 2011)
Train the trainer – aphasia communication skills	Connect	£15,000 (From September 2011)
Strategy implementation project management support	Enfield PCT	£30,000

An implementation plan with indicative resource implications for implementing this strategy over the next 3 years has been developed and is available online and in the member's library. The total cost of implementation in year 1 (2011/12) is £559,568 to fund the following services which are included in the table above:

- Community Rehabilitation
- Stroke Navigator
- Stroke Social Support Co-ordinator
- Life Roles Facilitator
- Train the trainer – aphasia communication skills
- Strategy implementation project management support

Funding has been sourced from re-ablement budgets, NHS Social Care funding and stroke grant which allow service improvements to be delivered without additional costs to the Council.

Many of the commissioning intentions set out in the strategy are cost neutral and will be delivered through reprioritised activity and more efficient use of existing resources. Some of the costs of implementation will be met through a developing partnership with primary care services.

3.4 Enfield Joint Stroke Strategy 2011-16.

The strategy sets out 9 strategic objectives which are aligned with the national stroke strategy (2007) and respond to the findings of the CQC review. Each of the strategic objectives has a number of associated commissioning intentions designed to improve stroke services, reduce the prevalence of stroke and address inequalities. These are summarised below:

STRATEGIC OBJECTIVES:

Priority	**Rational**
1. Increase public and professional awareness of	The sooner somebody who is having a stroke gets urgent medical attention, the better their

stroke symptoms	chances of a good recovery. Rapid diagnosis of TIA (mini-stroke) allows urgent steps to be taken to reduce the risk of having a stroke.
2. Reduce the prevalence of stroke and the prevalence of major stroke in people who have had a TIA or minor stroke.	Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke.
3. Increase involvement of service users and carers in the planning, development and delivery of services.	Involving service users and carers in the planning and delivery of services will improve the quality of current services and lead to better outcomes.
4. Improve stroke unit quality	Stroke unit care is the single biggest factor that can improve a person's outcomes following a stroke. The evidence is overwhelming that stroke units reduce death and increase the number of independent and non-institutionalised individuals.
5. Improve access to comprehensive rehabilitation and community services	Specialist co-ordinated rehabilitation, started early after stroke and provided with sufficient intensity, reduces mortality and long-term disability. The limited provision of community rehabilitation services has been identified as a key gap by stakeholders during development of this strategy.
6. Enable stroke survivors to fully participate in the community.	Assistance to overcome physical, communication and psychological barriers to engage and participate in community activities helps people to lead more autonomous lives and move on after stroke.
7. Stroke survivors receive care from staff with the skills, competence and experience appropriate to their needs	Sufficient staff with the appropriate levels of knowledge, skill and experience is essential to the success of the Strategy.

8. Ensure Continuous Service improvement	The new vision for stroke care demands services working together in networks, looking across all aspects of the care pathway.
9. Improve End of Life Care	Many people who die as a direct result of stroke will do so with impaired communication and/or cognitive skills. A number of local care homes have been identified as having high emergency admission rates to hospital. Of the total number of people who died in Enfield over the period 2007 – 2009, 68% died in hospital.

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 The Strategy sets out the case for change and the rational for the priorities chosen and supported by local stakeholders. It proposes an approach to commissioning Stroke Services that is consistent with national policy drivers and is in line with existing Council and NHS Enfield strategies.

5. REASONS FOR RECOMMENDATIONS

5.1 The strategy is intended to meet the government's key objectives for the delivery of services to meet the needs of people with stroke and ensure that the best possible services are provided for our residents in Enfield for the next five years.

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

6.1 Financial Implications

Based on the projected costs included in the implementation plan (available online and in the member's library):

- The expenditure against LBE resources in Year 1 will be £536,500, Year 2 £591,500 and Year 3 £0k.
- Funding in Year 1 for the service will be meet from the existing base budget for Stroke care (£96k), one off stroke grant project carry forwards from 2010/11 (£129k) and re-ablement monies received and carried forward from 2010/11 (£312k)
- Funding in year 2 of the project will be met from Stroke care base budget (£96k), re-ablement monies, which will need to be carried forward from 2011/12, and NHS Social Care funding (£267k).

- There is no LBE funding requirement in year 3.
- Please note that expenditure in Year 3 relating to 2.2) Management of hypertension (£40k), 2.6) GP Stroke lead and 5.4) Community based activity (£50k) have been identified as being funded through health service efficiencies. They have therefore been excluded from the financial implication to the council, based on lead officer advice.

Financial Implications - Stroke Strategy

	CC	Year 1 2011/12	Year 2 2012/13	Year 3 2013/14	Comments
Funding Streams available:					
Stroke Grant - Base Budget	SS0559	96,000	96,000	0	
Stroke Grant - Project carry forward 10/11	SS0559	129,000			One-off funds
Reablement - Project carry forward 10/11	SS0122	311,500	228,500		Need to agree PCF in 11/12
NHS Social Care Funding	SS0123		267,000		
PCT Direct funding				*90,000*	
Total Funds		**536,500**	**591,500**	**90,000**	
Projected Expenditure:					
2.2 Mgt of hypertension		0	20,000	*40,000*	Year 3 PCT cost
4.2 NCL Stroke handbook		1,500	1,500	0	
5.2 Develop Comm Rehab service		400,000	400,000	*0*	
5.4 Community based activity		50,000	50,000	*50,000*	Year 3 PCT cost
6.2 Stroke Navigator		40,000	40,000	0	
6.4 Aphasia Support		15,000	0	0	
7.1 Workforce review		0	20,000	0	
Project mgt		30,000	60,000	0	
Total Expenditure		**536,500**	**591,500**	**90,000**	
Surplus/ Deficit		**0**	**0**	**0**	

6.2 Legal Implications

The National Stroke Strategy is non statutory guidance issued by the Department of Health to a range of Public Authorities including Strategic Health Authorities and Directors of Adult Social Services. Its intention is to provide a quality framework to secure improvements to stroke services and provide associated support and guidance to those Public Authorities. The Council has a number of statutory powers and duties to provide social care such as National Assistance Act 1948, Chronically Sick and Disabled Act 1970 and National Health Service and Community Care Act 1990. A Law Commission Report issued 12/5/2011 is recommending changes to the current framework of statutes on Adult Social Care. If the Government accept the

recommendations then the old complex statutory framework will be replaced by one unified Adult Social Care statute with the overarching duty to promoting and contributing to the well-being of the individual and this statute will also recognise and promote the current Government initiatives for joint working in the area of Health and Social Care.

7. KEY RISKS

7.1 There are no significant risks identified as a result of this strategy.

7.2 Implementation of service changes will be managed and considered in the context of proper risk management arrangements.

8. IMPACT ON COUNCIL PRIORITIES

8.1 Fairness for All

- A key priority of the strategy is to reduce inequalities.
- Awareness raising will target Black and Minority Groups and the more deprived wards of the Borough.

8.2 Growth and Sustainability

- The voluntary and community sector will be key partners in implementation of the strategy.

8.3 Strong Communities

- The strategy is intended to enhance access to services by the whole community.
- The strategy has been informed by the views of local residents who responded to the consultation.
- We will engage local communities to gain advice on the best way to raise awareness and spread the prevention message within their communities.

9. PERFORMANCE MANAGEMENT IMPLICATIONS

9.1 We will continue to monitor progress towards full achievement of the Quality Markers set out in the national Stroke Strategy. These quality markers formed the basis for the 2010 Care Quality Commission review and we have already made significant progress towards achieving these standards.

9.2 Stroke services are assessed against the NICE Quality Standard for Stroke which are accompanied by quality measures that are intended to improve the structure, process and outcomes of health and social care.

9.3 The Quality Outcomes Framework (QOF) provides a framework for measuring performance in secondary prevention of stroke.

9.4 There are a number of indicators within the New Local Area Agreement relevant to Health and Adult Social Care. In particular the following are most significant:

- Number of Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets)
- Carers receiving needs assessment or review and a specific carer's service, or advice and information.
- People supported to live independently through social services
- Number of Delayed Discharges from Acute Hospitals.

9.5 NHS Stroke Indicators

9.6 NHS Integrated Performance Measures

9.7 We will review the implementation of the strategy in January 2011 and thereafter produce and publish an annual report on implementation which will include performance on the measures listed above.

10. HEALTH AND SAFETY IMPLICATIONS

No Health and Safety Implications arising directly from this report.

Background Papers

The following background papers are available online and in the Members' library and Group Offices:

- Enfield Joint Stroke Strategy (2011 -2016)
- Enfield Joint Stroke Strategy (2011 -2016): Summary of Submissions to Consultation
- Enfield Joint Stroke Strategy (2011 -2016): Predictive Equalities Impact Assessment
- Enfield Joint Stroke Strategy (2011 -2016): Implementation Plan
- National Stroke Strategy (2007)