

**ENFIELD
JOINT STROKE STRATEGY
2011 – 2016**

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1. EXECUTIVE SUMMARY

- NHS Enfield and Enfield Council have jointly identified the improvement of adult stroke services as a key local priority.
- This strategy sets out how health and social care commissioners will work together 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.
- The strategy is a local response to the recommendations outlined in the National Stroke Strategy¹ and has been informed by what we know about the needs of our local population and what we know about current service provision, quality and performance. The development of the strategy has been guided by the expert advice of the Stroke Implementation Team which includes representation from people who have experienced a stroke, carers, Public Health, Primary Care, Acute Sector, Adult Social Care, and the Voluntary and Community Sector.
- A stroke happens when the blood supply to your brain is disrupted. This can be by a blood clot blocking an artery in your brain (ischaemic stroke) or a blood vessel bursting in your brain (haemorrhagic stroke). It is sudden and can cause immediate loss of feeling and weakness, usually on one side of your body. A stroke can also affect your speech, vision, memory and emotions. A stroke is a medical emergency; the faster someone reaches expert help, the greater their chances of making a full recovery or reducing the risk of long term disability.
- A Transient Ischaemic Attack (TIA), sometimes called a 'mini-stroke' is also a medical emergency. The symptoms are the same as for a stroke but usually last only for a few minutes, up to a few hours, and disappear completely within 24 hours. A patient who has had a TIA is at increased risk of having a stroke and after assessment may need to start preventative treatment straight away.
- Most people who have a stroke are over 65, but many are younger than this. This strategy is focused on services for adults aged 18 years and over.
- 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. Stroke 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.²
- 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.³

¹ National Stroke Strategy. Department of Health. 2007.

² ASSET2 (Department of Health, 2009)

³ Enfield Joint Strategic Needs Assessment 2009.

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.⁴

- Promoting healthy living is very important in helping to prevent stroke, particularly in disadvantaged areas and groups. Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke. It is estimated that in Enfield, 115 strokes a year could be avoided through preventive work on high blood pressure, irregular heartbeats, smoking cessation, and wider statin use.⁵
- Preventing strokes can not only reduce the associated suffering, morbidity and mortality caused by strokes; it may also lead to NHS savings, as each stroke costs approximately £15,000 to treat over five years.⁶ If Enfield made a reduction of 115 preventable strokes per year (a reduction of approximately 20%) it could potentially save the local health and social care economy some £345,000 each year and £1.725 million over 5 years.
- Unavoidable risk factors for stroke include age (being over 55 years), gender (being male), ethnicity (being of African or Caribbean ethnicity) and family history of stroke or TIA.
- There is a new London stroke system which became fully operational in July 2010. All stroke patients are now taken directly to one of eight hyper acute stroke units (HASU) for emergency treatment, before being transferred to a local acute stroke unit (ASU) to commence their rehabilitation.
- There is an agreed stroke pathway for Enfield and the hyper acute and acute stroke pathway is working well, with significant improvement in stroke outcomes being evident since its establishment. There is however, only limited provision of community rehabilitation services, early supported discharge and community re-integration services. Lack of these services has been identified as a key gap in the agreed stroke pathway.
- Following discharge from an acute stroke unit, some patients will require a further period of inpatient rehabilitation. Enfield has relatively long lengths of stay for inpatient rehabilitation due to the limited provision of community rehabilitation services. Analysis indicates that we may not currently have the optimum mix of inpatient and community rehabilitation to meet the needs of our population.
- In June 2010 the PCT and Council were asked by the Care Quality Commission to complete a review of stroke services. 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. This strategy sets out how we plan to respond to the review findings and

⁴ London Health Observatory Health Inequalities Intervention Tool

⁵ Department of Health, 2006, ASSET 2 – Action on Stroke Services: an Evaluation Toolkit for *commissioners*, London, DH

⁶ National Audit Office, 2005, Reducing Brain Damage: Faster access to better stroke care

highlights the significant progress we have made towards addressing these findings.

- A Stroke Network has been in place in Enfield for some time and has been meeting regularly to progress the development of local services. This network has now become the Enfield Stroke Implementation Team and its membership includes carers, service users, health and social care professionals, public health and the voluntary and community sector. The Stroke Implementation Team has contributed significantly to the development of this strategy and will have a key role in implementation.
- Formal public consultation on this strategy was undertaken over a 3 month period from 1 March to 20 May 2011. A total of 148 responses were received and a summary of submissions précisising the responses has been prepared. The summary of submissions describes the consultation process, summarises the submissions, and sets out the Council and NHS Enfield response to the comments and suggestions that were received.

Our Vision

We will reduce the prevalence of stroke in Enfield by 20% by 2016.

We will reduce inequalities relating to stroke.

By 2016 our stroke services will be assessed as being in the top 10% in the country.

Stroke survivors and their families will receive the services and support they need to achieve the best possible outcomes for them.

Strategic Objectives

This strategy sets out 9 strategic objectives which are aligned with the national stroke strategy and 10 point action plan. 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 and described in more details in Section 9: Gap Analysis and Design of Future Provision:

1. INCREASE PUBLIC AND PROFESSIONAL AWARENESS OF STROKE SYMPTOMS

The sooner somebody who is having a stroke gets urgent medical attention, the better their 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.

Training plans for key frontline NHS and Social Care, Voluntary, private and independent sector staff to include the use of the FAST test to recognise stroke symptoms.

Run local awareness campaigns initially targeting those at highest risk of stroke, including:

- Older people
- Edmonton Green Ward
- People of African and Caribbean ethnicity

Explore innovative methods of awareness raising within the general public in partnership with local organisations.

Increase awareness of Transient Ischaemic Attacks (TIA) or mini-strokes.

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.

Ensure that there are systems in place locally for the following key prevention measures:

- managing hypertension so systolic blood pressure is below 140 mmHg;
- warfarin for individuals with atrial fibrillation;
- statin therapy for all people with more than 20 per cent risk of cardiovascular disease within ten years; and
- referral of all smokers to stop smoking services

Commission active management of hypertension as an extension of primary care Quality and Outcomes Framework.

Continue to invest in healthy lifestyles promotion and support to people to change behaviour initially targeting those at greatest risk of stroke, including:

- Older people
- Edmonton Green ward
- People of African and Caribbean ethnicity

Encourage partnership working across health, social care, and the community and voluntary sector for the provision of healthy lifestyles information and support.

Support initiatives that aim to making physical activity part of everyday life.

Commission a clinical stroke coordinator (or co-ordinators) whose role will include providing training and awareness raising on local stroke pathways to GPs, A&E staff and hospital medical teams, focusing on:

- High and low risk stroke pathways
- Importance of urgent response to suspected stroke and TIA
- Assessment of high-risk patients

- Case management and follow up

Explore role of Clinical Commissioning Group in increasing GP awareness of secondary stroke prevention and agreed local pathways.

Improve Quality and consistency of clinical care.

Development of stroke registers.

3. INCREASE THE 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.

Commission stroke specific survivor training to facilitate full and active participation in service delivery and advocacy for current patients.

Develop brokerage services to enable access to direct payments/individual budgets for stroke survivors and their families.

Ensure people with stroke are informed partners in their care planning.

Continue to include service users and carers in the Enfield Stroke Implementation Team and ensure that those with communication and/or physical disabilities are supported to participate.

Ensure that stroke survivors benefit from the personalisation agenda by working closely with service users, voluntary, private and third sector organisations to develop flexible, accessible, responsive services across sectors including transport, leisure and accommodation services.

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.

Support stroke units to engage patients in service design and delivery through

the development of formal links with patient and carer organisations.

Ensure all patients are given the recently developed North Central London stroke handbook which provides details of all local stroke services and how to access them.

Develop a local performance management and monitoring framework for assessing local stroke units against national clinical guidelines and quality standards.

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.

Review the provision of rehabilitation services to ensure that we have the right mix of inpatient, community rehabilitation and early supported discharge services to meet the needs of our population.

Develop comprehensive community rehabilitation services which include vocational rehabilitation, Occupational therapy, Physiotherapy, Dietetics, Speech and Language Therapy, rehabilitation assistants and access to Psychology, Counselling, Nursing, Sensory impairment, orthotics, spasticity clinics and driving rehabilitation.

Commission services to support self-management, e.g. stroke specific expert patient programmes, from a range of providers including the voluntary sector.

Develop and support a wide range of local community-based and peer-delivered activities for people who have had strokes and their carers, involving the local voluntary and community sector, for example peer-led conversation groups and peer-support or befriending schemes.

Commission information, advice, advocacy and sign-posting through the community and voluntary sector.

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.

Ensure comprehensive, accessible information and advice is given to stroke survivors on discharge from hospital and that systems are in place to provide information in a variety of formats accessible to all those who have experienced a stroke, and their carers.

Commission a stroke navigator to provide a single point of contact for stroke specialist advice, undertake regular reviews and help coordinate complex discharges.

Expand the newly established Improving Access to Psychological Therapies (IAPT) service across the Borough.

Ensure that those working with stroke survivors have the details of the Improving Access to Psychological Therapies (IAPT) and other commissioned psychological therapy services so that those that need it can access the service.

Develop effective community based provision of aphasia support.

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.

Undertake a review of the current local workforce (formal and informal) and develop a plan supporting development and training to create a stroke skilled workforce.

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.

Continue to support the work of the local stroke implementation team in improving local services.

Ensure that the stroke network have a key role in the implementation and monitoring of the stroke strategy.

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.

Fund a Gold Standards facilitator to support care homes and primary care to implement the Gold Standard Framework for End of Life Care and reduce avoidable admissions to hospital.

Revise the locally agreed pathway to include people's preferred place to die following stroke and people's preference re use of DNARs (do not resuscitate orders).

Work with care homes that are identified as high admitters to hospital in order to identify what support and training they require to enable them to support residents to die in the care home.

2. INTRODUCTION

The purpose of this strategy is to outline joint local plans to improve the range and quality of adult health and social care services for people who have suffered a stroke and their carers; address health inequalities related to stroke; improve awareness of stroke symptoms; and reduce the prevalence of stroke in Enfield. It has been developed in partnership with people who have experienced a stroke, carers, Public Health, Primary Care, Acute Sector, Adult Social Care, and the Voluntary and Community Sector.

The strategy describes an agreed integrated stroke pathway and identifies current gaps in the pathway. It then details the proposed actions that are required in order to fully implement the pathway.

The strategy addresses a number of shared priorities that are identified in Enfield's Joint Strategic Needs Assessment (2009), 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 joint commissioning strategies currently being developed for Dementia, End of Life Care, Intermediate Care and Re-ablement, Prevention and Early Intervention, Accommodation, Carers, and Voluntary and Community Sector.

In 2007 the Department of Health published a national stroke strategy for adults that provides a framework for improving stroke services and a guide to high quality health and social care services.

The National Strategy sets out 20 quality markers along with associated actions that will need to be taken to improve the quality of treatment and care over the next ten years. The strategic objectives and commissioning intentions detailed in this strategy are aligned with the national quality markers and designed to ensure that we continue to make progress towards fully achieving them.

3. NATIONAL GUIDANCE AND POLICY CONTEXT

Stroke is caused by a disturbance to the blood supply to the brain causing 'an earthquake in the brain'. The shockwaves of stroke can leave a lasting and profound impact on how people move, see, speak, feel or understand their world. Stroke is a medical emergency in which time is critical; the faster someone reaches expert help, the greater their chances of making a full recovery or reducing the risk of long term disability. Patients who are left with residual disability need timely, high quality services and longer term support in many aspects of their lives.

There are two main types of stroke:

Ischaemic-the most common form of stroke, caused by a clot narrowing or blocking blood vessels so that blood cannot reach the brain. This leads to death of brain cells due to lack of oxygen

Haemorrhagic-caused by bursting blood vessels producing bleeding into the brain and brain damage

A Transient Ischaemic Attack (TIA), sometimes called a 'mini-stroke' is also a medical emergency. During a TIA, blood supply to part of the brain is interrupted for a very short time. The symptoms are the same as for a stroke but usually last only for a few minutes, up to a few hours, and disappear completely within 24 hours. A patient who has had a TIA is at increased risk of having a stroke and after assessment may need to start preventative treatment straight away.

In December 2007, the Department of Health published a national strategy for stroke services in England. The strategy is intended to:

- provide a quality framework against which local services can secure improvements to stroke services and address health inequalities relating to stroke over the next ten years;
- provide advice, guidance and support for commissioners, strategic health authorities, the voluntary sector and social care, in the planning, development and monitoring of services; and
- inform the expectations of those affected by stroke and their families, by providing a guide to high-quality health and social care services.⁷

The national strategy sets out 20 quality markers that describe the features of a good service. The quality markers are designed to help commissioners, stroke networks and service providers judge the quality of their local services and plan for the improvements needed. These markers are distilled into a ten-point plan for action to guide those affected by stroke, their carers and the public in looking at the services available locally.

National Stroke Strategy: 10 point evidence-based action plan

- **Awareness** – improving awareness of the symptoms of stroke among professionals and members of the general public.
- **Prevention** – supporting healthier lifestyles and tackling vascular risk, such as hypertension, atrial fibrillation and high cholesterol.
- **Involvement** - ensuring people who have had a stroke are involved in planning their care and evaluating local services.
- **Warnings** – responding quickly to transient ischaemic attacks (TIAs).

⁷ National Stroke Strategy (Department of Health, 2007)

- **Medical emergency** – ensuring stroke is treated as a medical emergency and that patients are transferred to an acute stroke centre with access to 24-hour scans and specialist care.
- **Stroke Unit** – ensuring stroke units are staffed by multidisciplinary teams with specialist stroke skills.
- **Rehabilitation** – providing intensive rehabilitation immediately after stroke, which should: be available seven days a week; continue after discharge from hospital; and involve health, social and voluntary services.
- **Participation** – helping people to overcome physical, communication and psychological barriers after having a stroke so that they can lead more autonomous lives.
- **Workforce** – undertaking a needs assessment to plan for a skilled and competent workforce to care for people who have had a stroke.
- **Service improvement** – creating care networks looking at all aspects of the care pathway, undertaking regular local and national audits or services and increasing participation in clinical trials.

Every year in England, approximately 110,000 people have a stroke, and some 20-30% of these people die within the first month. Stroke is the third largest cause of death and some 11% of deaths in England are as a result of stroke. It is also the single largest cause of adult disability and approximately 300,000 people in England live with moderate to severe disability as a result of stroke.⁸

The Department of Health estimates that as many as 20,000 strokes every year could be prevented through implementing the changes recommended in the National Stroke Strategy.⁹

Social inequalities in stroke are persistent and premature death rates in the most deprived areas are around three times higher than in the least deprived. The prevalence of stroke among those aged over 75 is increasing in England; for men, the prevalence in this age group has increased from 9% in 1994 to 13% in 2006. Nearly 40% of men and more than 30% of women in England have high blood pressure, a key risk factor for stroke. Half of people with high blood pressure are not receiving any treatment.¹⁰

People from Asian, African and African Caribbean communities are at greater risk of having a stroke.¹¹ Studies have highlighted that the incidence of stroke

⁸ National Audit Office, 2005, Reducing Brain Damage: Faster access to better stroke care, London, NAO

⁹ ASSET 2: Department of Health

¹⁰ British Heart Foundation. Stroke Statistics 2009.

¹¹ What is a Stroke? The Stroke Association

among black populations is more than twice that of white populations and that black populations also tend to have a stroke a younger age than white populations.¹²

Stroke has a devastating and lasting impact on the lives of people and their families. Individuals often live with the effect for the rest of their lives. A third of people who have had a stroke are left with long-term disability.¹³ The effects can include aphasia, physical disability, loss of cognitive and communication skills (e.g. leading to aphasia), depression and other mental health problems.

Stroke costs the NHS and the economy about £7 billion a year.¹⁴ Our services are among the most expensive in the world and yet our outcomes compare poorly, with unnecessarily long lengths of stay and high levels of avoidable disability and mortality.¹⁵

Further detail on the wider national policy context for improving stroke services can be found in Appendix 1.

4. LOCAL GUIDANCE

In April 2008, Enfield published *Getting Personal*¹⁶ a joint social care and health document which set out the commissioning intentions for older people's services (2008 – 2011). This document included a commitment to the continued development of an integrated stroke service.

This strategy builds on the intentions outlined in *Getting Personal* and aims to ensure that our strategic objectives and commissioning intentions are underpinned by robust evidence based approach and informed by the priorities identified in the Joint Strategic Needs Assessment, Health and Wellbeing Strategy and Local Area Agreement. The priorities identified in these documents include:

- Reducing health inequalities;
- Early intervention and prevention for people with long term conditions;
- Improving outcomes for people with stroke;
- Focusing on healthy lifestyles and improved cardiovascular health;
- Improving access to health and wellbeing information;
- Giving people increased choice and control;
- Maximising independence and enabling people to remain in their own homes for as long as possible;
- Strengthening the Voluntary and Community Sector and developing their capacity to deliver services.

¹² Stewart et al Ethnic Differences in the incidence of stroke BMJ 318:967-971 1999

¹³ British Heart Foundation. Stroke Statistics 2009.

¹⁴ Ibid.

¹⁵ Leal J, et al., 'Economic burden of cardiovascular diseases in the enlarged European Union', *European Heart Journal* 27, 1610–1619, 2006

¹⁶ London Borough of Enfield – *Getting Personal - 2008*

Enfield Council and NHS Enfield are also developing a number of other joint health and social care commissioning strategies that will sit alongside the Stroke Strategy and will contribute to achieving the strategic objectives outlined in Section 6 of this document. They include:

- End of Life Care
- Dementia
- Intermediate Care and Re-ablement
- Carers
- Learning Disability
- Mental Health
- Accommodation

All of the strategies are being developed as part of a wider local work programme to develop personalised services and take forward the recommendations outlined in *Putting People First (2007)*¹⁷. This is an ambitious work programme that aims to transform local services and will make a significant contribution to achieving the strategic objectives for Stroke that are set out in this strategy. It includes a commitment to:

- Local Authority leadership accompanied by authentic partnership working with NHS Enfield, other statutory agencies, third and private sector providers, users and carers and the wider local community to create a new, high quality care system which is fair, accessible and responsive to the individual needs of those who use services and their carers.
- Agreed and shared outcomes which should ensure people, irrespective of illness or disability, are supported to:
 - live independently;
 - stay healthy and recover quickly from illness;
 - exercise maximum control over their own life and, where appropriate, the lives of their family members;
 - sustain a family unit which avoids children being required to take on inappropriate caring roles;
 - participate as active and equal citizens, both economically and socially;
 - have the best possible quality of life, irrespective of illness or disability;
 - retain maximum dignity and respect.

Stroke Co-ordinator

In September 2010, NHS Enfield and Enfield Council jointly appointed a Stroke Co-ordinator to facilitate delivery of an agreed local pathway for stroke. The position was funded by the Local Authority Stroke Grant and is based within NHS Enfield.

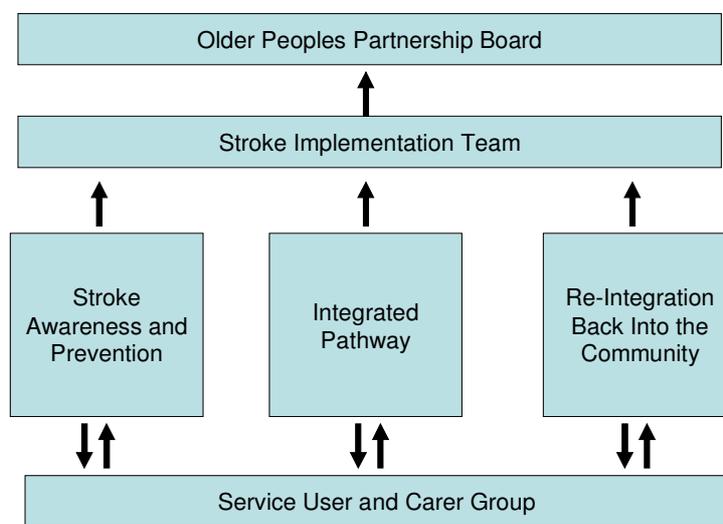
The key objectives of the stroke co-ordinator are to implement an agreed local pathway for stroke in Enfield and ensure that any gaps in the current pathway

¹⁷ Department of Health – *Putting People First - 2007*

are addressed. The co-ordinator will also develop a set of joint performance metrics to enable us to better monitor service performance.

In order to ensure that the implementation of the stroke pathway is owned and is informed by local partners and stakeholders, the Stroke Co-ordinator has established a Stroke Implementation Team which is supported by 3 working groups. The Stroke Implementation Team reports to the Older Peoples Partnership Board of the Enfield Strategic Partnership. Figure 1 below illustrates how these groups are structured and governed:

Figure1: Governance Arrangements



It should be noted that whilst governance of the Stroke Implementation Network is through the Older Peoples Partnership Board, the stroke pathway is for all adults.

North Central London Cardiac and Stroke Network

The North Central London Cardiac Network was established in 2005, and spans the boroughs of Enfield, Haringey, Barnet, Islington and Camden. The objective of NHS Networks is to bring together clinicians, other professionals and managers from all constituent organisations so that they can work together to improve services for patients.

During 2007, a national assessment of centrally funded bodies approved the continuation of Cardiac Networks, to support strong and informed commissioning of cardiac services. In parallel, the Department of Health released the National Stroke Strategy (2007) which set out a clear role for Networks to support local implementation of the stroke agenda. As a result, in late 2007 the North Central London Cardiac Network Board opted for the establishment of a joint Network Board, covering both cardiac and stroke services.

The North Central London Cardiac & Stroke Network Board is one of five Networks in London, which are accountable to the London Commissioning Group, chaired by the Chief Executive of NHS London (the strategic health authority for London). It is well placed to work alongside users, clinicians and managers in primary, secondary and tertiary care to reduce inequity and deliver improvements in cardiac and stroke care.

Key stakeholders within the Network include:

- Barnet PCT
- Camden PCT
- Enfield PCT
- Haringey Teaching PCT
- Islington PCT
- Barnet and Chase Farm Hospitals NHS Trust
- North Middlesex University Hospital NHS Trust
- Royal Free Hampstead NHS Trust
- The Whittington Hospital NHS Trust
- UCLH NHS Foundation Trust, incorporating The Heart Hospital and The National Hospital for Neurology & Neurosurgery

To reflect identified priorities, a number of Network task groups have been established to take forward specific areas of work across North Central London. Each task group is responsible for making recommendations to the Board around relevant areas of work, developing a project plan, and reporting progress regularly to the Network Board.

Most task groups are chaired by local clinical stakeholders. The Network task groups are grouped into three categories, covering Prevention, Cardiac and Stroke activity respectively. The stroke task group is further divided into 3 subgroups:

The Urgent Care Task Group

The Urgent Care task group was convened to make sure that the introduction of hyperacute stroke units and local acute stroke units was organised efficiently. The group's key purpose is to ensure that acute stroke services are developed in line with the requirements specified in the National Stroke Strategy and the Stroke Strategy for London whilst also incorporating local priorities. Membership of the task group includes representatives from the five Acute Trusts, as well as commissioning representation.

The 2010/11 work plan includes:

- Oversee and resolve issues arising out of the introduction of hyperacute and local stroke units
- Develop transfer policies for hyperacute units to local stroke units
- Develop a sector wide TIA pathway and referral process
- Explore IT solutions for developing stroke registers and joined up

patient referral process.

- Joint working between this group and the Life After Stroke Task Group for seamless transfer of care from acute to rehabilitative care
- Develop a sector MRSA Policy & process for transfer of patients

The Life After Stroke Task Group

The Life After Stroke task group was established in 2008, to focus on the longer term care pathway for stroke patients, starting from the end of the acute phase when they leave hospital.

The 2010/11 work plan includes:

- Undertake an exercise to understand the likely number of stroke clients needing community rehabilitation, the number of rehabilitation beds needed and the workforce needed to provide inpatient and community rehabilitation services across North Central London.
- Provide advice to the Stroke Commissioning Group on Early Supported Discharge service and community rehabilitation services needed for stroke
- Provide advice to the Stroke Commissioning Group on the role of stroke navigator, seeking advice from the Stroke Association and other organisations already commissioning this service
- Explore the feasibility of a single point of access for all stroke rehabilitation services in each borough
- Explore the feasibility of a sector rehabilitation bed management service
- Look at how to measure patient feedback rapidly and make recommendations to Commissioning Group
- Facilitate the co-ordination of patient information across all 5 boroughs
- Explore staff rotations and sector-wide training for stroke rehabilitation staff

The Stroke Commissioning Group

The Stroke Commissioning Group was set up in 2008 to represent the 5 North Central London PCTs of Barnet, Enfield, Haringey, Camden and Islington to collaborate for the effective commissioning of stroke service.

Objectives for 2010/11

- To collaborate on a short-term basis until July 2010 to develop and implement a Project Plan to deliver the Sector Collaborative Commissioning Intentions for Stroke
- To take a co-ordinated and whole-system approach to commissioning post-acute stroke services across North Central London
- To seek advice and actively engage with Providers and Services Users via the NCL Life After Stroke Task Group, to inform commissioning decisions
- To take collaborative commissioning decisions on behalf of the 5 above-named PCTs for appropriate elements of the care pathway for stroke patients
- To monitor the delivery of stroke services and targets, as required

- To report to the North Central London Cardiac & Stroke Network Board and the NCL Joint Committee of PCTs on progress against agreed milestones on a regular basis.

5. LOCAL NEEDS ASSESSMENT

Enfield is an outer London borough situated in the north of the city. The population is approximately 289,500 which makes it the fifth largest borough in London.

Some 28.8% of the population in Enfield are aged over 50; 13.3% are aged over 65; and 1.8% are aged over 85. The older population is predicted to grow over the coming years, particularly the over 85 population as shown in Table 1 below.

Table 1: Enfield's Population by Age Projected to 2030

	2009	2015	2020	2025	2030
People aged 18 - 64	182,900	186,000	188,500	191,200	192,900
People aged 64 - 84	32,800	35,100	36,500	39,600	45,000
People aged 85 and over	5,200	5,700	6,500	7,600	8,500
Total population – all ages	289,500	299,500	307,900	316,000	323,600

Enfield is an ethnically diverse borough with estimates indicating that just over 50% of Enfield's population is classified as non White British. Table 2 below shows the ethnic make up of Enfield in 2009.¹⁸

It is estimated that 7.9% of Enfield's population is of African or Caribbean ethnicity. This group have a higher risk of stroke than the general population.

Table 2: Enfield's Adult Population by Ethnicity

Ethnic group	Number	%
White British	111944	49.9%
White Irish	7532	3.4%
Greek	2308	1.0%
Greek Cypriot	13942	6.2%
Turkish	7531	3.4%
Turkish Cypriot	7463	3.3%
Kurdish	2041	0.9%
Italian	6383	2.8%
Polish	4415	2.0%
Russian	1783	0.8%

¹⁸ 2009 Round of GLA Demographic Projections (supplied by Enfield Observatory)

Traveller	98	0.0%
Gypsy/Romany	460	0.2%
White Other	2601	1.2%
White & Black Caribbean	1387	0.6%
White and Black African	703	0.3%
White and Asian	1685	0.8%
Other mixed	1541	0.7%
Indian	9280	4.1%
Pakistani	1497	0.7%
Bangladeshi	3003	1.3%
Sri Lankan	1699	0.8%
Other Asian	3402	1.5%
Black Caribbean	11796	5.3%
Other Black African	2015	0.9%
Somali	1870	0.8%
Ghanaian	4217	1.9%
Nigerian	5297	2.4%
Black Other	1173	0.5%
Chinese	1560	0.7%
Other	3643	1.6%
Total	224270	100.0%

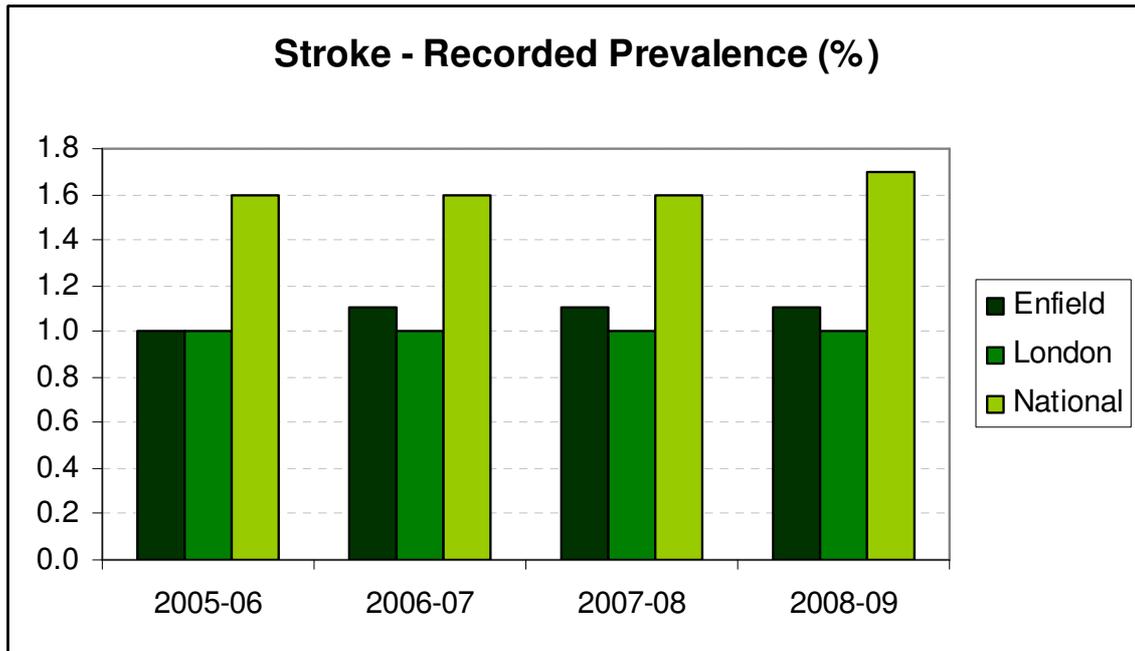
Burden of Disease

It is estimated that there are 550 strokes per year in Enfield. In the total population it is estimated that there are 4,595 stroke and TIA survivors, of which 1,470 have moderate or severe disabilities caused by stroke. These estimates are based on the age/gender/ethnic profile of the population.¹⁹

As illustrated in Figure 2, the recorded prevalence of stroke in 2008 was 1.09% in Enfield; this was higher than the London average (1.03%) but lower than the national average (1.63%).

Figure 2: Recorded prevalence of stroke (Source: NHS Comparators)

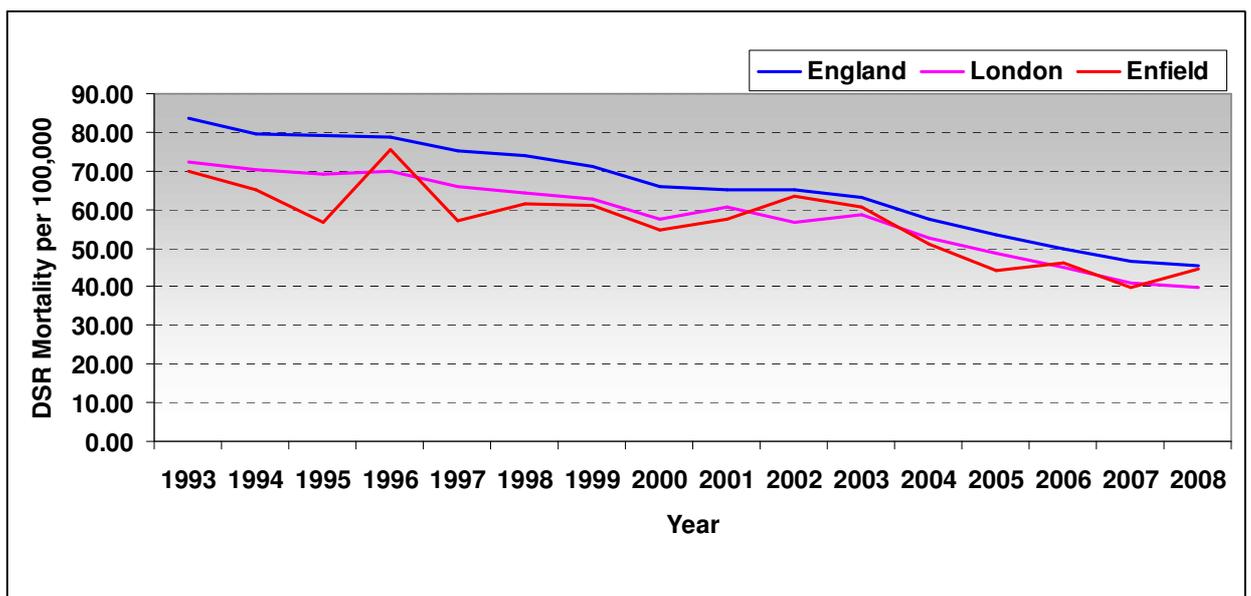
¹⁹ ASSET2 (Department of Health, 2009)



Mortality Rate for Stroke

In 2005-07, 547 people in Enfield died due to stroke. Enfield's mortality rate due to stroke is falling and continues to be significantly below national rates, but is roughly in line with the London average. However the rate of fall in mortality rates is not as sharp as seen nationally – if this trend continues, Enfield may see stroke mortality rates exceeding national rates within the next 5 years.²⁰

Figure 3: Rate of Mortality due to stroke at all ages per 100,000 population, for Enfield and its Comparators 1993-2008



Source: National Centre for Health Outcomes Development (NCHOD)

²⁰ Enfield's Joint Strategic Needs Assessment (2010-11)

Tables 3 and 4 show the number of adults living in Enfield predicted to be affected by stroke.

Table 3: People aged 18-64 living in Enfield and predicted to have had a stroke and require help with daily activities, projected to 2025.²¹

	2009	2015	2020	2025
Males 18-44	0	0	0	0
Males 45-54	12	13	13	12
Males 55-64	42	47	57	63
Total Males	54	61	70	75
Females 18-44	13	12	12	13
Females 45-54	31	34	32	30
Females 55-64	54	57	66	70
Total Females	98	103	110	113
Total population 18-64	162	164	180	188

**Data is not currently available on the number of people aged 65 years and over predicted to have had a stroke and require help with daily activities*

Table 4: People aged 18 and over living in Enfield and predicted to have a longstanding health condition caused by a stroke, projected to 2025.²²

	2009	2015	2020	2025
Males 18-44	0	0	0	0
Males 45-64	274	302	323	328
Males 65 -74	260	269	283	311
Males 75 and over	289	331	361	407
Total Males	823	902	967	1,045
Females 18-44	58	57	58	60
Females 45-64	176	186	192	194
Females 65-74	126	132	137	144
Females 75 and over	213	224	237	262
Total Females	572	599	624	660
Total population 18 and over	1,395	1,501	1,591	1,705

Inequalities

Life expectancy in Enfield is higher than the London and national averages for both males and females. In 2005-07, the life expectancy for males in Enfield was 77.2 years and 81.5 years for females. However, this disguises a significant life expectancy gap seen between the most and least deprived wards in Enfield. There is an 8.8 year life expectancy gap between males in Highlands ward (81.3 years) and Edmonton Green ward (72.3) and this gap is widening.²³

²¹ Projecting Adult Needs Service Information System - PANSI

²² Projecting Older People Population Information System - POPPI

²³ Office for National Statistics

Circulatory diseases (which include stroke) are the biggest causes of the life expectancy gap, accounting for 26.2% of the male life expectancy gap and 29.0% of the female life expectancy gap.²⁴ If Enfield females in the most deprived areas of the borough had the same mortality rates for stroke as those in the least deprived areas, life expectancy would be increased by 0.5 years. This means that successful efforts to reduce stroke mortality rates in the most deprived areas would have the biggest impact on reducing the female life expectancy gap in Enfield.

Data from the 'Active People Survey', the 'Taking Part Survey', Hospital Incidence data and the lifestyle data from Experian have been compiled by Proactive North London from the Sport England Market Segment to produce a map for Enfield showing your likelihood of having a stroke based on where in Enfield you live. The map is included in Appendix 3 and illustrates that people living in the Western part of the borough are far less likely to have a stroke than those living in the Eastern parts of the borough.

6. MARKET ANALYSIS

A market analysis has been undertaken to assist us to build a picture of existing local services and their use, as well as a wider picture of the market and an assessment of current gaps in service availability, quality and performance.

As part of the preparation to inform this strategy a mapping exercise was undertaken to provide a comprehensive understanding of the range of health and social care services that are currently being provided in Enfield for people who have had a stroke or TIA, and their carers. It is an evolving description of services based on our current market intelligence and it is acknowledged that there may be more services that provide support to people with stroke and their carers. As part of the ongoing development of our strategic approach to the commissioning of services we will continue to develop our understanding of the services that people who have had a stroke and their carers are accessing in Enfield.

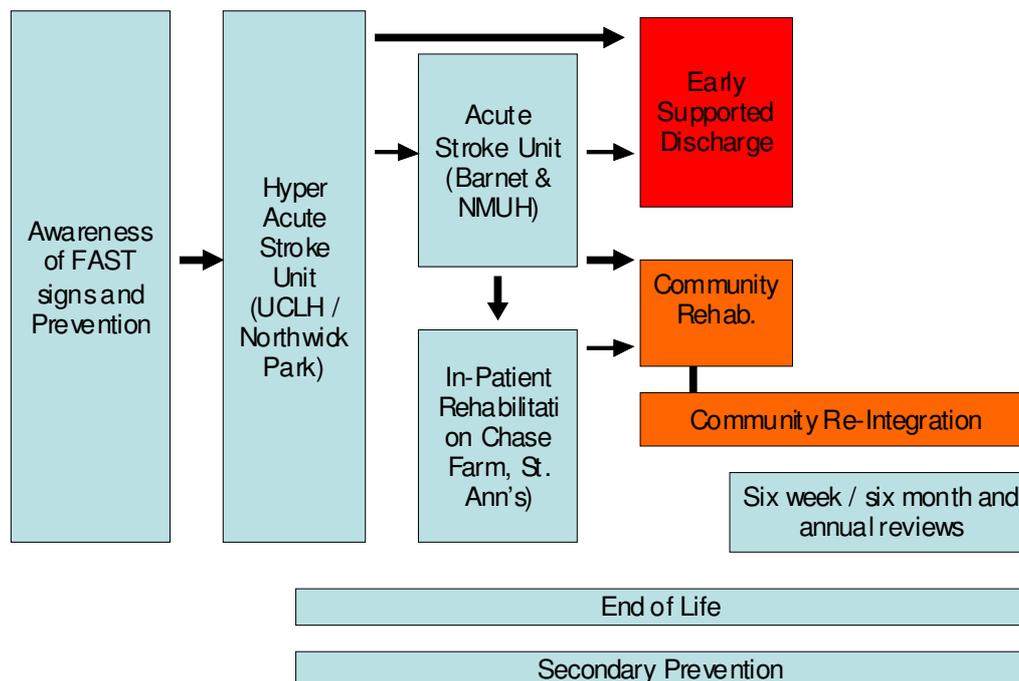
Following is a description of the range of services that are available to Enfield residents and a gap analysis against the agreed local stroke pathway. Information on activity and cost is also included.

6.1 Stroke Pathway

The agreed stroke pathway for Enfield is illustrated in Figure 4 below. Identified service gaps are highlighted in red. Parts of the pathway where there is only a limited service provision are highlighted in orange.

Figure 4: Stroke Pathway

²⁴ LHO Health Inequalities Intervention Tool



The service components that make up the stroke pathway are described in detail below.

6.2 Awareness of Stroke Symptoms and Primary Prevention

Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke. It is estimated that in Enfield, 115 strokes a year could be avoided through preventive work on high blood pressure, irregular heartbeats, smoking cessation, and wider statin use.²⁵

Preventing strokes can not only reduce the associated suffering, morbidity and mortality caused by strokes; it may also lead to NHS savings, as each stroke costs approximately £15,000 to treat over five years.²⁶ If Enfield made a reduction of 115 preventable strokes per year it could potentially save the local health and social care economy some £345,000 each year and £1.725 million over 5 years.

²⁵ Department of Health, 2006, ASSET 2 – Action on Stroke Services: an Evaluation Toolkit for *commissioners*, London, DH

²⁶ National Audit Office, 2005, Reducing Brain Damage: Faster access to better stroke care

The failure to recognise stroke symptoms as a medical emergency – including by NHS Direct and GPs – can mean that urgent medical treatment for stroke is delayed.²⁷ A MORI poll commissioned by the Stroke Association in 2005 suggested that only half of people asked can correctly identify what a stroke is, with only 40 per cent correctly naming three stroke symptoms, and a quarter did not believe that any specialised treatment or care could make a difference.²⁸

In October 2010, Enfield PCT ran a stroke awareness campaign, which included:

- A questionnaire to measure public awareness of the FAST message. This was carried out by Health Champions, who also provided information on stroke at the same time.
- Posters and leaflets were sent out to GPs and pharmacies (pharmacies ran a stroke campaign).
- FAST posters on large council billboards.
- FAST life channel advert in targeted GP practices.
- Some promotion of stroke awareness also took place during the local Healthy Hearts campaign in November 2010, which included a lot of information being distributed on primary prevention.
- Information on stroke on the NHS Enfield web pages (including the life channel advert) -
http://www.enfield.nhs.uk/healthy_enfield/healthy_hearts/stroke.shtm

In addition to this, Enfield commissions a number of generic preventative services, which include:

- Health Trainers
Health Trainers provide one to one advice and support to people who want to make lifestyle changes e.g. lose weight, increase physical activity or stop smoking. In the first 3 Quarters of 2009/10, this services undertook 320 consultations and 223 people either achieved or partly achieved their goals. The annual cost of this service was £120,000.
- Health Checks
NHS health checks are currently being piloted in Edmonton. These are health checks for people aged between the ages of 40 and 74 years old, and include checking blood pressure and cholesterol. These will be evaluated and may be available to other parts of the borough next year.
- Blood pressure and cholesterol screening
A blood pressure and cholesterol screening service is provided in local pharmacies.
- Smoking cessation
This service offers free support to people who want to give up smoking.
- CHIEF: Changing habits in exercise and food
Weight management programme for families

²⁷ National Audit Office, 2005, Reducing Brain Damage: Faster access to better stroke care

²⁸ MORI poll, 2005; commissioned by the Stroke Association

6.3 Hyper Acute and Acute Stroke Units

The new London stroke system began operating in February 2010 for FAST positive stroke patients and went fully live in July 2010. All stroke patients are now taken directly to one of eight hyper acute stroke units (HASU) for emergency treatment, before being transferred to a local acute stroke unit (ASU) to commence their rehabilitation.

Hyper-acute stroke units (HASU) are 24 hour centres providing high-quality expertise in diagnosing, treating and managing stroke patients. Patients with a suspected stroke are taken by the London Ambulance Service to the HASU that involves the shortest journey time and this will be located no more than 30 minutes travel time away. On arrival a patient will be assessed by a specialist, have access to a brain (CT) scan and receive clot-busting drugs (thrombolysis) if appropriate, all within 30 minutes. Patients will then be admitted to a HASU bed where they will receive hyper-acute care for up to 72 hours following admission.

People in Enfield who have a stroke will usually be taken to a HASU at either University College London Hospital in Euston or Northwick Park Hospital in Harrow. London Ambulance Service will transport all stroke patients to the nearest appropriate HASU and pan-London operating protocols have been agreed.

Healthcare for London has estimated that the establishment of hyper acute units will reduce the number of people who die as a result of suffering a stroke by 20%. Based on current mortality rates, this would mean saving the lives of approximately 36 people in Enfield every year.

Following a patient's hyper-acute stabilisation, patients will be transferred to a stroke unit. Acute stroke units for Enfield residents are provided by Barnet Hospital (24 beds) and North Middlesex Hospital in Edmonton (24 beds).

Some patients may also be discharged directly home or to residential or nursing care.

Stroke units provide multi-therapy rehabilitation and ongoing medical input. Length of stay will vary and will last until the patient is well enough to be discharged from the stroke unit setting. The stroke unit a patient should be taken to is determined by a catchment table available on the NHS Commissioning Support for London website (<http://www.londonsulookup.nhs.uk/>) which assigns all London postcodes to a stroke unit. The intention of the catchment table is to ensure patients are transferred to a stroke unit close to their home. Following their stay in the stroke unit, patients will either be discharged home, where they should have access to appropriate community rehabilitation services, or discharged to a specialist inpatient rehabilitation facility.

Figure 3: Map of London Stroke Units and their Catchments Areas

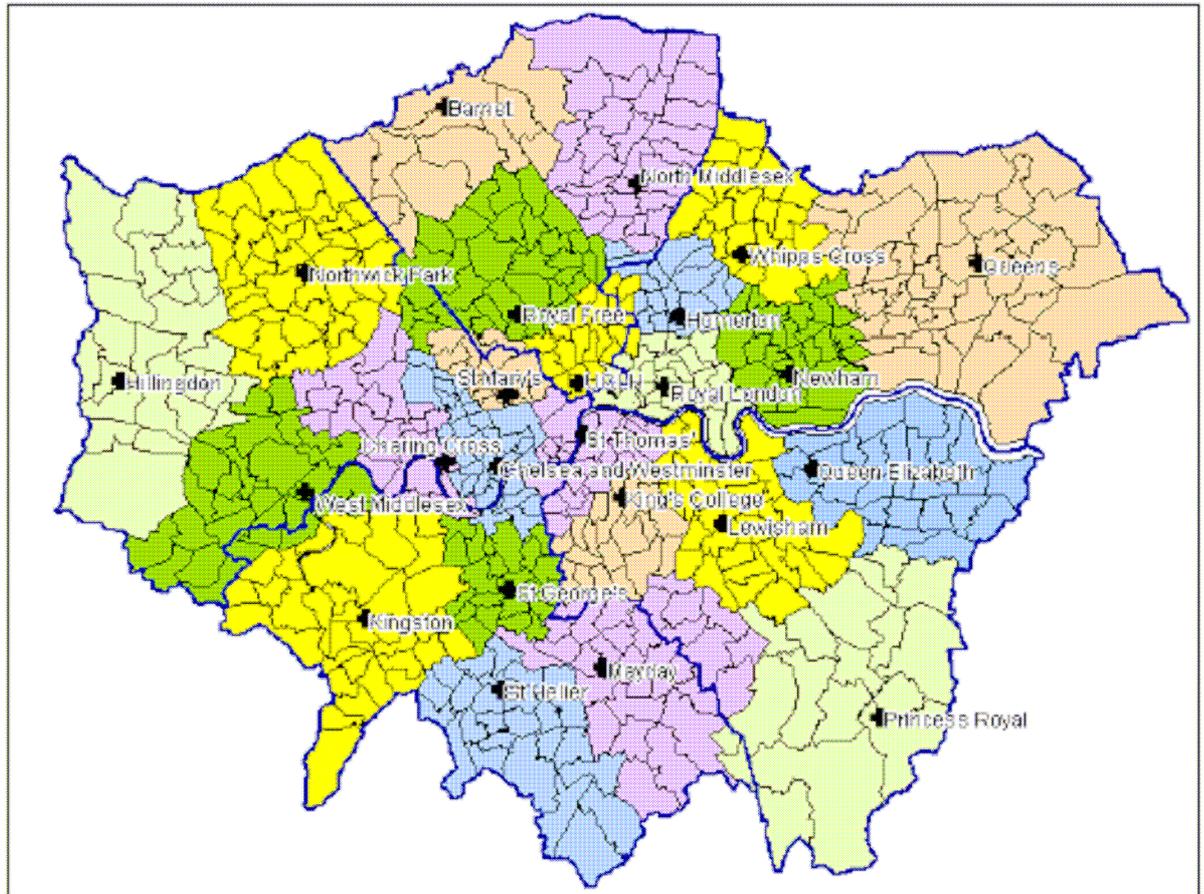


Table 5 below sets out current cost and volume information for the HASUs and ASUs commissioned by Enfield PCT.

Table 5: HASU and ASU Activity and Cost Data (April 2010 - October 2010)

Service	Provider	Inpatient Hospital Admissions Activity Apr – Oct 10/11	Total Cost for Period Apr-Oct 10/11
Hyper Acute Stroke Unit	University College London Hospital	71	£43,352
	Northwick Park (North West London Hospitals NHS Trust)	unavailable	unavailable
Acute Stroke Unit	North Middlesex University Hospital	66	£327,700
	Barnet Hospital	90	£335,959
	Barts and the London NSH Ttrust	10	£41,843
	University College London Hospital	34	£69,764

Service	Provider	Inpatient Hospital Admissions Activity Apr – Oct 10/11	Total Cost for Period Apr-Oct 10/11
	Royal Free Hampstead Hospital	10	£30,985

Data Source: Commissioning Support for London

Since the new stroke system began operating in London, a number of significant improvements have been reported:

- 77% of patients of FAST positive stroke patients were taken directly to a HASU in July 2010, up from 45% the previous year
- Mean average journey time in July 2010 from site of stroke to HASU across London was 18 minutes (target 30 minutes)
- Length of stay has decreased from approximately 17 days to 11 days
- Thrombolysis rates are up from 3.5% to 12.1%, a rate higher than that reported for any other large city in the world
- In quarter one 2010/11, 84% of patients spent 90% of their time in hospital on a specialist stroke unit in London, up from 60% in quarter one 2009/10
- 400 extra nurses have been recruited and nearly 90 extra therapists to work in stroke care across London

Since the new system became operational, the following activity data has been collected for Enfield:

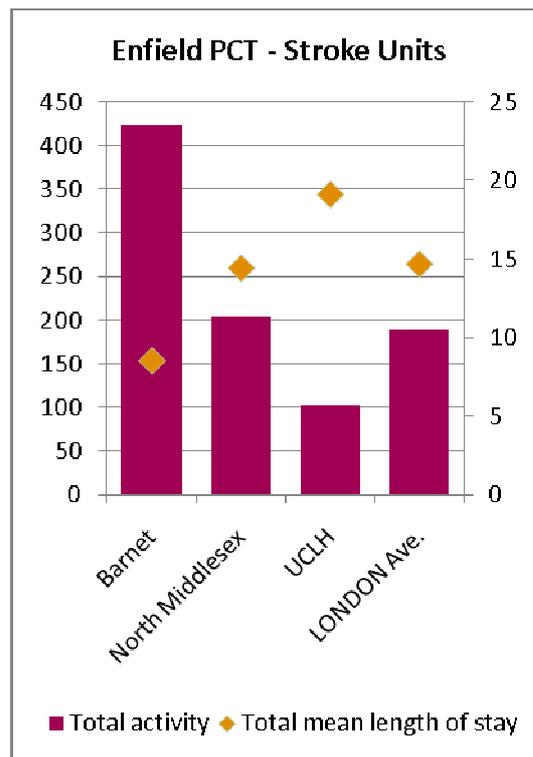
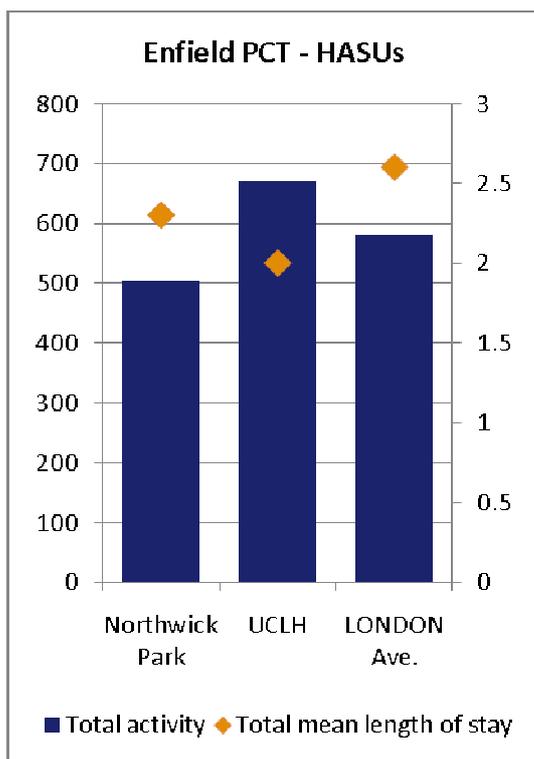
Travel time

Travel time data from London ambulance service for all patients in May and June 2010 conveyed to a HASU from within the borough:

Month	No. patients conveyed	Journey to hospital (in minutes)		From 999 call to hospital (in minutes)	
		Average	Range	Average	Range
May 2010	21	22	5-35	62	38-81
June 2010	13	22	4-36	57	41-72

Length of stay & activity

The total activity levels and average lengths of stay for the providers of stroke care most frequently used by residents of Enfield PCT are shown below. Data in the graphs below is for the period February to September 2010 inclusive unless otherwise stated.



Destination following discharge from HASU

HASU data for all stroke patients admitted to the relevant units. Data below shows the destination upon discharge for all patients (regardless of PCT) that have been through the HASU. Data is for the period February 2010 to September 2010.

Northwick Park Hospital HASU		
	Activity	%
Home	135	26.7
Other	17	3.4
Other SU	99	19.6
Own SU	227	45.0
Deceased	27	5.3
TOTAL	505	

UCLH HASU		
	Activity	%
ESD	3	0.4
Home	278	41.5
Other	89	13.3
Other SU	183	27.3
Own SU	96	14.3
Deceased	21	3.1
TOTAL	670	

Destination following discharge from ASU

The data in the tables below shows the discharge destination for all patients (regardless of PCT) that have been through the ASU. Data is for the period February 2010 to September 2010.

UCLH ASU		
	Activity	%
ESD	0	0
Home	40	38.8
Inpatient Rehab	34	33.0
Intermediate Care	0	0
Other	22	21.4
Residential Care	0	0
Deceased	7	6.8
TOTAL	103	

Barnet Hospital ASU		
	Activity	%
ESD	1	0.2
Home	249	58.9
Inpatient Rehab	40	9.5
Intermediate Care	7	1.7
Other	63	14.9
Residential Care	14	3.3
Deceased	29	11.6
TOTAL	423	

North Middlesex Hospital ASU		
	Activity	%
ESD	0	0
Home	115	56.9
Inpatient Rehab	40	19.8
Intermediate Care	2	1.0
Other	23	11.4
Residential Care	7	3.5
Deceased	15	7.4
TOTAL	202	

6.4 TIA Clinics

The NICE²⁹ clinical guidelines on stroke define a transient ischaemic attack (TIA) as stroke symptoms and signs that resolve within 24 hours. A non-disabling stroke is defined as a stroke with symptoms that last for more than 24 hours but later resolve, leaving no permanent disability. Some people who have had a stroke or TIA, have narrowing of the carotid artery that may require surgical intervention (carotid endarterectomy). Carotid imaging is required to define the extent of carotid artery narrowing. A TIA or non-disabling stroke is a medical emergency and an urgent response can save lives and reduce the risk of someone having a full stroke.

The National Stroke Strategy recommends that there should be care pathways in place to ensure that patients with suspected TIA and non-disabling stroke are immediately referred for appropriately urgent specialist assessment and investigation so that a secondary prevention management plan can be put in place. Nearly half of the stroke risk following a TIA is incurred within the first two days, so immediate action may be necessary to prevent the impending stroke.

It has been estimated that in England the annual incidence of TIA is around 0.5 per 1000 people, equivalent to about 25,777 cases per year³⁰. Providing carotid surgery within 2 weeks to patients who need it could prevent around 250 strokes, and result in a net saving to the health service of around £4 million each year. Therefore it is reasonable to assume that investing in services for people with TIA would save money in the future by avoiding future strokes.

The North Central London (NCL) Network has taken the lead on developing and monitoring TIA services across the sector. Services for stroke and transient ischaemic attack TIA have been re-organised across London, including the designation of new centres for TIA management. As part of this process, new TIA referral forms have been created for the North Central sector. These forms incorporate the key information needed for GPs to assess and refer patients with suspected TIA to their chosen TIA clinic.

NCL London TIA clinics are situated in:

- Barnet and Chase Farm Hospital
- North Middlesex Hospital
- Royal Free Hospital
- University College Hospital

The new TIA referral pathways for NC London:

The pathways have been designed attain the following performance standards as defined by the London Stroke Strategy:

²⁹ National Institute of Clinical Excellence - guideline CG68

³⁰ Department of Health (2007) [Impact Assessment: a new ambition for stroke](#). London: Department of Health.

- 90% of high risk TIA patients to receive specialist assessment and treatment within 24 hours of first presentation to a medical professional
- 90% of low risk TIA patients to receive specialist assessment and treatment within 7 days of first presentation to a medical professional
- 90% of appropriate TIA patients with symptomatic carotid stenosis to undergo Carotid Endarterectomy within 14 days of first presentation to a healthcare professional.
- To view the pathway please click on the link <http://www.nclcn.org.uk/clinical-guidelines-a-protocols/tia-referral.html>

Progress to date (January 2011)

- There is an agreed TIA pathway for low and high risk patients
- The new referral forms are being used extensively by GPs.
- A & E departments are receiving ongoing training in diagnosis and referral of TIA

Continuing education of GPs and ongoing education of A & E teams is crucial to maintaining an effective TIA pathway

The following table describes what we know about TIA Clinic activity from April – October 2010.

Provider	TIA Inpatient Admissions Activity Apr – Oct 2010	TIA Total Cost For Period Apr-Oct 2010	Carotid Artery Syndrome Inpatient Admissions Activity Apr – Oct 2010	Carotid Artery Syndrome Total Cost For Apr –Oct 2010
BARNET AND CHASE FARM HOSPITALS NHS TRUST	31	£44,668	-	
BARTS AND THE LONDON NHS TRUST	3	£3,175	-	
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	14	£22,116	-	
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	13	£16,180	2	£2,564

Data Source: Commissioning Support for London

6.5 Inpatient Rehabilitation

Following discharge from an acute stroke unit, some patients will require a further period of inpatient rehabilitation. Inpatient rehabilitation is currently provided at Chase Farm Hospital in Enfield, St Ann's Hospital in Haringey and Potters Bar Community Hospital.

Inpatient Rehabilitation is currently funded through community contracts with individual providers, whereas the acute stroke unit activity is now funded

through the London Stroke Tariff. That London Stroke Tariff provides for a daily rate in a stay in the Hyper Acute Stroke Unit and then a set price for a stay in an Acute Stroke Unit, based on an average length of stay of 21 days.

Whilst this has advantages for financial planning, it means that if a borough is able to provide good rehabilitation services and support people to be discharged from hospital earlier than 21 days, there is no financial benefit to that borough. Work is currently being done at both London and local levels to 'unbundle' the London Stroke Tariff in order to free up stroke resources to spend on community rehabilitation where that is appropriate.

The following table details current Inpatient Rehabilitation commissioned by Enfield PCT:

Provider	Service Description	Inpatient Rehab *OBD Utilised in 2009/10	Total Cost For Inpatient Rehab 09/10	Inpatient Rehab *OBD Utilised in Apr - Aug 2010/11	Total Cost For Apr-Aug 10/11
Chase Farm Hospital	Capetown unit is a 28 bedded rehabilitation unit of which 21 are designated stroke beds	5178	Block - £517,304	1,085	£518,207
Green Trees rehabilitation Unit – St Ann's (Haringey)	Green Trees is a 24 bedded rehabilitation unit with 12 designated stroke beds which NHS Enfield patients utilise 33% of annually	1623	£489,968	563	£182,159
Potters Bar Community Hospital	General Rehab – unable to unpick stroke rehab data	239	£37,080	29	£4,495

**OBD means Occupied Bed Days*

6.6 Early Supported Discharge

The National Stroke Strategy states that: "Early Supported Discharge (ESD) to a comprehensive stroke specialist and multidisciplinary team (which includes social care) in the community, but with a similar level of intensity to stroke unit care, can reduce long-term mortality and institutionalisation rates for up to 50 per cent of patients and lower overall costs."

No ESD service is currently commissioned in Enfield. The primary reason for this is that the funding for this service is part of the stroke unit tariff and therefore if Enfield PCT was to commission it, then they would effectively be paying twice for these patients. The North Central Sector has made a commitment to unbundle some of the stroke unit tariff to support the development of this service in Enfield.

6.7 Community Rehabilitation

Following discharge from hospital, many patients will need ongoing rehabilitation to enable them to maximise their independence. Enfield does not currently have a dedicated stroke rehabilitation team and minimal access to generic rehabilitation. Should patients require rehabilitation within the community, two services are available:

- Generic community rehabilitation service provided by Enfield Community Services.
- Out-patient rehabilitation provided by Barnet and Chase farm Outreach team

Both services are very small and they are only able to offer short term intervention for a specific problem after which the patient is discharged. They are not able to provide intensive rehabilitation, early supported discharge or extensive long term support.

Key interventions include:

- Assessments, education, and clinical management
- Home visiting service for housebound patients
- Limited neuro-physiotherapy service, providing one-to-one support (as an outpatient) and group sessions
- Limited adult Speech and Language Therapy sessions providing one-to-one support (as an outpatient) and group sessions
- Assessment and provision of walking aids and simple communication aids
- Telephone reviews and support

The limited provision of community rehabilitation services has been identified as a key gap by stakeholders during development of this strategy.

The stroke outreach provides limited therapy service to patients who have suffered a stroke post discharge. The table below shows that 101 referrals were made to the service and 67 were accepted. 34 referrals were declined this is because the referrals didn't meet the stroke outreach criteria and this most often relates to a lack of clearly defined goals from the referring team or goals that cannot be met with the input of Stroke Outreach.

Provider	Service Description	Total Activity For 2009/10	Total Cost For 09/10	
Chase Farm	Stroke outreach is a	101 referrals	NOT	

Outreach Team	community based service staffed by inpatient ward staff (approximately 0.1 WTE each of PT, OT, SLT) that provides limited therapy input to patients post discharge who have recently suffered a stroke.	67 referrals accepted 298 follow-up	AVAILABLE	
Community Rehab	Data not available			

6.8 Community Re-integration

The National Stroke Strategy suggests that the range of support someone may need after a stroke includes:

- Re-ablement (including lifestyle advice)
- Care and support (including regular reviews)
- Mental health and emotional well-being (including access to work and leisure activities, counselling and psychological support)
- Communication (including aphasia-friendly information and speech and language therapy)
- Short break provision (including family and carer support groups and carer training)
- Practical help (including accessible transport and leisure facilities, advice on benefits and returning to work and occupational therapy)

Enfield currently commission a range of services to support people who have had a stroke, their relatives and carers, to achieve a good quality of life, and maximise independence, well-being and choice. There are some excellent services being provided, however, it is acknowledged that there is limited provision of services to support re-integration into the community. This component of the stroke pathway has been identified as a key area of concern by stakeholders during development of this strategy and in a recent Care Quality Commission Review(attached as Appendix 4).

Current services include:

Social Care

Social care is available to enable people to look after themselves and live as safely and independently as possible. Stroke survivors access a range of social care services including homecare, residential care, and day care.

Support available includes:

- equipment to enable people to get about in their homes
- individual re-ablement programmes to enable people to develop or maintain skills to live as dependently as possible
- support to enable a parent or person responsible for a child to undertake their parenting responsibilities

- practical support with personal care needs, preparing food, eating and drinking
- support to access community facilities, work, education and learning
- support for informal carers

As detailed below, the number of stroke survivors accessing social care services is growing and has increase from 351 in 2006/07 to 514 in 2009/10. The annual cost of social care provision has increased from £1.5 million to £2.2 million.

Year	Number of service users	Annual cost
2006/2007	351	£1,526,807
2008/2009	408	£1,656,907
2009/2010	514	£2,211,040

We can predict further increases based on the projected growth of our population, and particularly in the growth of our population of older people, as described in Section 5. It is anticipated that the the growing cost may be partially mitigated by the development of re-ablement services and the increasing focus on prevention.

Psychological Therapies

Psychological therapies can be categorised into those for people who have mild to moderate needs and those who have severe and enduring mental health problems. In respect of the former, NHS Enfield received funding in the 2010/11 baseline resource allocation for Improving Access to Psychological Therapies (IAPT). An IAPT service has recently been commissioned from Barnet, Enfield and Haringey Mental Health NHS Trust working in partnership with Haringey Community Health Services.

The newly established IAPT service covers Edmonton and Ponders End and plans are in place to expand it further across the Borough in 2011/12

In addition to IAPT services, NHS Enfield commissions the following psychological therapies and counselling services:

- Primary Care Psychological Therapy Services provided by Barnet, Enfield and Haringey Mental Health NHS Trust
- Counselling Services provided by Mind in Enfield
- Lets Talk Counselling Services provided by the Greek and Greek Cypriot Community of Enfield (GGCCE)
- Psychotherapy Services provided by Nafsiyat
- Range of Counselling Services provided at GP Practices

Enfield Council also contributes funding towards the Counselling Services provided by Mind in Enfield.

For people who have severe and enduring mental health problems, psychological therapies are provided mainly by Barnet, Enfield and Haringey Mental Health NHS Trust, and occasionally by other providers with whom NHS Enfield has contracts, for example, South London and Maudsley NHS Foundation Trust and Tavistock and Portman NHS Foundation Trust.

The Department of Health Operating Framework for the NHS in England for 2011/12 states the following in relation to IAPT:

The NHS is expected to continue expanding access to psychological therapy services in 2011/12 as part of the overall commitment to full roll-out of this programme by 2014/15. This will comprise continuing training programmes to develop the workforce and a choice of NICE-approved therapies and delivering the measurable outcomes of patient recovery and improvements in employment.

In partnership with the NHS, the Department of Health will extend access to talking therapies for children and young people, older people, for people with severe and enduring mental health problems and for people with co-morbid mental and physical health long term conditions.

Voluntary and Community Sector services

The Voluntary and Community sector in Enfield provide a wide range of services that support people to maintain their independence and wellbeing. Services provide information and advice, social support, home care, respite, day opportunities and support for carers.

The Council currently invests a total of approximately £3.3 million per annum in these services. Over the past 2 years, the Council has undertaken a comprehensive review of these services in order to explore how we can refocus, reconfigure and reshape existing services to better achieve our strategic objectives. The findings, recommendations and commissioning intentions from the review will form the basis of Enfield's Voluntary and Community Sector Strategy which will set out how services will be reconfigured and investment increased over the next 3 years in order to support the personalisation agenda and the priorities outlined in Enfields Market Statement and associated joint commissioning strategies.

Stroke specific services are provided by Total Healthcare and Stroke Action who receive grant funding of £21,225 from the Council to provide the following services:

- Social Stroke Support Club providing practical support and advice to 35 stroke survivors and their carers to reduce and prevent social exclusion and isolation through shared experiences and activities; and access to

lifestyle advice is provided to prevent further strokes and to promote independence and functional abilities of the stroke survivors. The

- Time Out service for carers of stroke survivors provides a respite service for 10 carers of stroke survivors for 3 hours once a month provided by a formal carer in the service users own home. The formal carer assists the stroke survivor with personal care, exercise and play/leisure activities and also helps the carer of the stroke survivor with minor domestic tasks like ironing, cleaning, cooking. Access to health and active life service (health risk assessment, health check, massage) is also made available to the 10 carers.

6.9 Residential and Nursing Care

Some people who have suffered a stroke will require a level of support that can not be provided at home and will be referred to residential or nursing care. Placements may be short term, where a person is expected to regain their independence and be able to return home, or long term where it is not anticipated that a person will return home.

In 2009/10, Enfield Council funded 106 stroke survivors long term residential care at a total cost of approximately £1.88 million. This is an increase of 147% in the number service users since 2005/06 when there were 43 Council funded stroke survivors living in long term residential care at a total cost of £1.0 million.

The table below sets out the available registered care home provision in Enfield and the Care Quality Commission quality star rating attached to each at the last inspection:

CQC Registration Category	Total Number of Homes	3-Star (Excellent)	2-Star (Good)	1-Star (Adequate)
Old Age	37	7	29	1
Dementia	34	3	29	2
Physical Disability	11	1	10	0
Learning Disability	38	9	29	0
Nursing	11	2	9	0
Mental Health	26	8	16	2
Alcohol Dependency	1	0	1	0

End of Life Care in care homes is described in section 6.11 End of Life Care.

6.10 Secondary Prevention

Prevention of stroke may be classified as primary prevention if there is no previous history of stroke or transient ischaemic attack (TIA) and secondary prevention if there has been such an event.

Well-documented and modifiable risk factors for stroke include hypertension, smoking, diabetes, atrial fibrillation (AF), poor diet, physical inactivity, and obesity.

After a stroke, people should be offered a review of their health, social care and secondary prevention needs from primary care services, typically within six weeks of leaving hospital, before six months have passed and then annually.

Primary Care: Stroke Management and Quality and Outcomes Framework Indicators

The Quality and Outcomes Framework (QOF) is a contractual mechanism that was devised with the aim of paying GPs for the quality of care given rather than just the size of their patient list. The QOF contains groups of indicators, against which practices score points according to their level of achievement. The QOF provides us with a useful dataset for assessing how well local GP practices are managing stroke.

A detailed analysis of the QOF data for Enfield is attached as Appendix 2. In summary, the analysis tells us the following things about how well our primary care services are managing secondary prevention of stroke:

- 96.6% of patients with TIA or stroke have had their blood pressure recorded in their notes. This is the same as the London average but slightly lower than the national average. There is a significant variation between the different parts of Enfield, with the South East cluster performing well below the London average.
- 87.1% of patients with a history of TIA or stroke have a blood pressure reading of 150/90 mg or less. Enfield is performing worse than the London and national average for management of blood pressure. There is also significant variation across the Borough, with the North West performing well above the London and national average.
- 88.9% of patients with TIA or stroke have had their cholesterol level recorded in their notes. This is below both the London and national average. There is significant variance across the borough, with the South East performing significantly worse than the Enfield average.
- 74.4% of patients with a history of TIA or stroke have a total cholesterol measurement of 5mmol/l or less. Enfield is performing slightly worse than the London average and significantly worse than the national average. There is also significant variation across the Borough, with the South East performing significantly worse than the Enfield average and the North West cluster performing better than the national average.
- Enfield is performing better than the London and national averages for GP prescribing of anti-platelet therapy, or anti-coagulants for patients shown to

be non-haemorrhagic, or have a history of TIA. However, there is significant variation across the borough, with the South West performing significantly worse than the Enfield average.

6.11 End of Life Care

Many people who die as a result of stroke, do so with impaired communication and/or cognitive skills. Providing high-quality end-of-life care in such circumstances can be challenging and requires an appropriately skilled and experienced workforce. Judging when it might be more appropriate for someone who has had a stroke to receive end-of-life care rather than active rehabilitation and providing such care when communication is difficult is a considerable challenge and requires skilled decision-making and interaction from an experienced workforce. The needs and wishes of both the individual and their carer or family, if appropriate, should be sought as part of this process and should be reviewed regularly to ensure that their needs continue to be met throughout the last phase of life and into bereavement. This includes the management of pain and other symptoms, and the provision of psychological, social, spiritual and practical support. People in need of this care will often already be in hospital, but they may also be at home, in care homes or other care settings.

End-of-life care should be provided in line with best practice guidance. A number of approaches to support best practice in End of Life Care are available. These include:

- Preferred Priorities for Care (PPC), which is an example of advance care planning. This is a patient-held document designed to support patient choice, ensuring that the information is shared with all health and social care staff involved in their care. Recording people's preferences for care helps to direct the planning and continuity of care.
- The Gold Standards Framework (GSF), enables identification of people approaching the end of their lives, and ensures comprehensive assessment of their needs and appropriate care planning.
- The Liverpool Care Pathway (LCP) for the dying is used to care for people in the last days or hours of life. It enables clinical staff to deliver high-quality care as death approaches, providing guidance on comfort measures, anticipatory prescribing, psychological and spiritual care and family support. It is mainly used in hospitals and hospices but is increasingly being adopted for use in other care settings.

The national End of Life Care Strategy³¹ sets out a detailed pathway to improve the quality of care for all adults approaching the end of life, and the families and carers. The QIPP³² work stream for End of Life Care has selected the first steps of this pathway; identifying people as they approach the end of life, and planning effectively for their care. The national strategy

³¹ End of Life Care Strategy (department of Health 2009)

³² Quality, Innovation, Productivity and Prevention

and the QIPP work stream are clear that the system still needs significant development, including training, to improve these first steps³³.

NHS Enfield and Enfield Council have identified End of Life Care as a high priority for service development and to this end are developing a joint strategy setting out how they plan to improve End of Life Care over the next 5 years (2011-2016).

A number of local care homes have been identified as having high emergency admission rates to hospital and whilst quality payments have been offered for implementation of the Gold Standard Framework, implementation has been inconsistent.

Of the total number of people who died in Enfield over the period 2007 – 2009, 68% died in hospital. This is significantly higher than the desired level (Commissioning Support for London proposed that PCTs should aim for less than 50% of deaths taking place in hospital), and there is a significant cost associated with emergency admissions in the last year of life.

Current level of identification of patients on primary care palliative care registers is limited when compared to the expected level of identification.

Some PCTs in the sector have (or have previously had) local enhanced services in place to incentivise the use of palliative care registers and Gold Standards Framework tools and approaches in Primary Care but evidence of achievement is patchy.

Joint working with community service providers in order to improve the identification of patients nearing end of life, for example on the district nursing caseload, needs to be developed so that appropriate care planning can take place.

A growing amount of evidence shows that the majority of people suffering from a terminal illness would prefer to die at home. A survey conducted by YouGov on behalf of Marie Curie Cancer Care revealed that only four per cent of Britons would prefer to die in hospital, compared to 64 per cent who would rather die at home and 23 per cent who would choose a hospice.

Evidence suggests that once a patient is identified as end of life and asked their preference for care and place of death, their preferred choice is more likely to be put in place.

The priority is to deliver better quality of care and greater choice in End of Life Care. The specific focus is on increasing deaths occurring outside the hospital setting (home, care home, and hospice) in order to support patient choice and avoid unnecessary admissions and treatments. Focussed efforts need to be

³³ (Tessa Ing (2010), Locality Registers and QIPP).

made to improve identification of patients, advanced care planning and co-ordination of care.

7. QUALITY & PERFORMANCE

This section summarises what we know about how well our services are currently performing.

7.1 Stroke Indicators

The spine chart below shows how stroke data for this PCT compares with London and the rest of England. This PCT's results for each indicator are displayed as a circle. The average rate for England is shown by the red line in the centre of the chart. The range of results for all PCTs in England is shown as a grey bar. A red circle means that data for this PCT is significantly worse than the England average. A green circle shows that data for this PCT is significantly better than the England average; however, this may still indicate an important public health problem.

The chart below shows how Enfield stroke data compares to London and the rest of England.

STROKE PATHWAY SUMMARY

The spine chart below shows how stroke data for this PCT compares with London and the rest of England. This PCT's results for each indicator are displayed as a circle. The average rate for England is shown by the red line in the centre of the chart. The range of results for all PCTs in England is shown as a grey bar. A red circle means that data for this PCT is significantly worse than the England average. A green circle shows that data for this PCT is significantly better than the England average; however, this may still indicate an important public health problem.

Key:

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

England Key:



Domain	Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Risk Factors	1 Hypertension prevalence, modelled	67,755	29.6	30.5	37.4		21.7
	2 Hypertension prevalence, recorded	39,006	13.6	13.4	16.7		8.0
	3 Atrial Fibrillation prevalence, recorded	2,744	1.0	1.4	2.3		0.4
	4 Adults who smoke	n/a	20.5	22.2	35.2		10.2
	5 Binge drinking adults	n/a	11.4	20.1	33.2		4.6
	6 Obese adults	n/a	23.2	24.2	32.8		13.2
Primary Care	7 Stroke/TIA prevalence, modelled	5,162	2.3	2.5	3.7		1.4
	8 Stroke/TIA prevalence, recorded	1,741	0.9	1.7	2.4		0.7
	9 Blood pressure recorded in last 15months	3,373	96.3	96.8	94.8		96.2
	10 Blood pressure reading 150/90 mmHg or less	3,002	87.6	88.1	83.4		93.9
	11 Cholesterol recorded in last 15 months	3,098	90.1	91.4	85.9		94.2
	12 Cholesterol reading 5 mmol/L or less	2,444	75.5	77.3	70.4		83.9
	13 Immunisation for influenza	2,685	87.9	89.0	83.0		92.5
	14 Anti-platelet / anti-coagulant therapy	2,006	93.9	94.1	92.2		96.2
	15 New patients referred for further investigation	612	86.3	90.2	82.8		97.0
Secondary Care	16 Emergency hospital admissions for stroke all ages	204	55.3	76.7	127.3		25.9
	17 Emergency hospital admissions for stroke age <75yrs	84	31.9	43.7	80.3		13.3
	18 Emergency hospital readmissions within 28 days of stroke	15	8.5	10.8	23.7		5.1
	19 Length of inpatient stay	359	20.6	17.1	26.6		8.8
	20 Stroke admissions who spent 90% of time on stroke unit	154	71.3	60.2	23.3		97.1
	21 Patients admitted for TIA who spent 90% of time on stroke unit	70	95.9	51.2	1.1		100.0
Mortality	22 Mortality from stroke all ages	555	43.5	47.3	63.1		23.7
	23 Mortality from stroke age <75yrs	117	14.4	13.7	25.6		8.4
	24 Years of life lost due to mortality from stroke	117	16.8	16.5	35.8		8.6
	25 Death in 30 days of emergency stroke admission	40	19,670	22,746	31,378		11,664
Spend	26 Overall spend on cerebrovascular disease	5,783,000	20.7	19.3	41.9		2.4
	27 Primary care spend on cerebrovascular disease	414,000	1.5	2.7	0.2		33.3
	28 Secondary care spend on cerebrovascular disease	5,369,000	19.2	16.9	40.4		1.1

1% aged 16yrs+ 2010 (ERPHO). 2 % registered GP patients on hypertension register 2009/10 (QOF). 3 % registered GP patients on arterial fibrillation register 2009/10 (QOF). 4-6 % adults, modelled estimate using Health Survey for England 2006-2008 (APHO Health Profiles). 7 % aged 16yrs+ 2010 (ERPHO). 8-15 % of registered GP patients on stroke register 2009/10 (QOF). 16-17 Directly age standardised rate per 100,000 European Standard population for hospital admission 2007/08 (HES). 18 Indirectly age standardised % of hospital discharges 2007/08 (NCHOD). 19 Total number and average number of days spent in hospital after stroke 2008/09 (HES). 20 % of patients admitted for stroke Q2-Q4 2009/10 (DH). 21 % of patients admitted for transient ischaemic attack Q2-Q4 2009/10 (DH). 22 Directly age-standardised rate per 100,000 European Standard population 2006-2008 (NCHOD). 23-24 Directly age-standardised rate per 100,000 population <75yrs 2006-2008 (NCHOD). 25 Indirectly age and sex standardised rate per 100,000 population 2007/08 (NCHOD). 26-28 £ per weighted head of population 2008/09 (DH).



Spine chart preparation based on West Midlands Public Health Observatory Spine Chart Tool Version 4
Analysis undertaken by PCT Intelligence Team, Commissioning Support for London

In summary, Enfield scores better than the English average for:

- Prevalence of hypertension (modelled)

- Prevalence of atrial fibrillation
- Binge drinking
- Prevalence of stroke/TIA
- Emergency hospital admissions
- Number of stroke/TIA patients who spent 90% of their time in hospital on a stroke ward
- Stroke mortality (all ages)

and worse for:

- Prevalence of hypertension (recorded)
- Primary care recording of stroke patients cholesterol levels
- Stroke patients cholesterol levels recorded as 5 nmol/L or less
- Influenza immunisation
- Number of new primary care patients referred for further investigations
- Inpatient length of stay
- Secondary care spend on cerebrovascular disease

7.2 Care Quality Commission Review of Stroke Services

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
- 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 have had a stroke and carers what they thought about the information given to people when they leave hospital. Overall the review scored 15 aspects of care. This data was then used to compare services in different local areas. 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 full report is available in Appendix 4.

Many of the issues that were highlighted in the Care Quality Review were also identified during the development of this strategy through stroke pathway mapping and conversations with local stakeholders, service users and carers.

This strategy provides an overarching medium term strategic framework to improve stroke services, including addressing the findings of the CQC review. Since 2010 significant progress has been made towards addressing the review findings and improving the delivery of stroke services.

8. STAKEHOLDER, PATIENT AND CARER FEEDBACK

The expertise and experience of local stakeholders has been integral to the development of this strategy. We have held numerous workshops and discussions with a wide range of stakeholders in order to inform our understanding of key issues and service gaps, as well as ideas on how best to improve local services.

In July 2010 a stakeholder workshop was held to assist us in identifying the key gaps in local services and identify priorities for development. The workshop was well attended by a range of stakeholders including hospital and community health services, social care, public health, the voluntary sector, carers and service users, Enfield over 50's Forum and members of Enfield's Health Scrutiny Panel.

The following priorities were identified by workshop participants:

- Identification and primary prevention
 - Risk registers
 - Health promotion events (dietary advice, cholesterol testing, BP testing)
 - GP health checks (people over 40 years)
 - Home Care Providers awareness of cultural factors e.g diet
 - F.A.S.T education
- Secondary prevention (primary care quality)
- Coordination – information, navigation, sign-posting, key workers, champion
- Awareness
- Post inpatient rehabilitation
 - community based
 - multi-disciplinary & enhanced e.g psychology
 - Integrated
- Early Supported Discharge
- Training and education to meet Quality Standards
- Clear pathways - mapping of available resources
- End of Life Care

A Stroke Network has been in place in Enfield for some time and has been meeting regularly to progress the development of local services. The recently appointed stroke co-ordinator has revised the terms of reference and membership of this group and it is now operating as the Enfield Stroke Implementation Team. The Stroke Implementation Team has contributed significantly to the development of this strategy. Membership is included in Appendix 5.

The Stroke Implementation Team has 3 working groups who have been meeting regularly to address specific parts of the local stroke pathway. Their recommendations are summarised below.

Stroke Service User and Carer Working Group

In October 2010, a stroke service user and carer meeting was held to enable us to further identify the gaps in local services and identify priorities for development. The meeting was well attended by members of several voluntary organisations in Enfield.

A further meeting was held in November 2010 where stroke survivors nominated three members to represent the group at the local implementation team meetings. This has enabled the group to have a voice in the development of the stroke pathway and to ensure that services are designed and developed with users at the centre.

The working group has recommended that the key priorities Enfield should be working towards are:

- Communication/Information
 - Proper and adequate information given to people when they leave hospital.
 - Information across the pathway to be made into an information booklet that is easy to understand and is developed with input from stroke survivors and carers.
- Public Education
 - It was agreed that the FAST advert on television was very good and was well communicated but more needs to be done on stroke awareness.
- Secondary Prevention
 - There should be more information and awareness on secondary prevention.
- Training
 - Stroke survivors and their carers should be involved in the training of health and social care professionals.
 - There should be a basic training for carers on what they should expect when they take their loved ones home to care for.
- Awareness
 - There should be greater awareness of depression after suffering a stroke. Greater recognition of this condition amongst the health and social care professionals could help thousands of stroke sufferers.

Re-integration into the Community Working Group

The aim of the re-integration into the community working group is to ensure that the stroke pathway has a clear re-integration back into the community within the Enfield stroke pathway. The group have outlined the key areas that need to be addressed and are currently mapping third sector provision for stroke survivors, families and carers.

The group had their first meeting in November 2010 where gaps within service provision were identified and it was noted that there was a need to develop the role of the voluntary and community sector. The group felt that the key areas that need addressing are:

- Stroke Navigator Service
- Regaining life roles
- Social support

The group had a further meeting in January 2011 and they are currently developing service specifications for a stroke navigator, social support for stroke survivors and their families and helping stroke saviour regain life roles.

9. GAP ANALYSIS AND DESIGN OF FUTURE PROVISION

The following table sets out our key strategic objectives for the development of local stroke services and our associated commissioning intentions. This is the nub of the strategy and describes what we intend to do to improve services over the next 5 years for people who have experienced stroke or TIA, and their carers.

The strategic objectives and associated commissioning intentions were developed in consultation with key stakeholders. They are aligned with the aims and objectives of the National Stroke Strategy and are underpinned by a robust evidence base which includes the research, needs assessment and market analysis described in the preceding sections.

* Add rows

Strategic Objective	Link to National Quality Markers	Rationale	Commissioning Intentions	Funding Source
1. Increase public and professional awareness of stroke symptoms	QM 1	<p>Stroke is a medical emergency however too few people understand what a stroke is or know to call 999 when symptoms occur. This can result in urgent medical treatment being delayed and increasing the risk of death or disability.</p> <p>People who are economically disadvantaged have a higher rate of stroke, as well as heart disease and other related diseases.</p> <p>People of African or Caribbean ethnicity are at higher risk of having a stroke. Incidence rates, adjusted for age and sex, are twice as high in black people as for white people.</p>	<p>Ensure that training plans for key frontline NHS and Social Care, Voluntary, private and independent sector staff includes the use of the FAST test to recognise stroke symptoms.</p> <p>Run local awareness campaigns initially targeting those at highest risk of stroke, including:</p> <ul style="list-style-type: none"> • Older People • Edmonton Green Ward • People of African and Caribbean ethnicity <p>Explore innovative methods of awareness raising within the general public in</p>	<p>Cost neutral</p> <p>Public Health</p> <p>Explore the potential to tap in to corporate</p>

Strategic Objective	Link to National Quality Markers	Rationale	Commissioning Intentions	Funding Source
			<p>partnership with local organisations such as amongst children who are potential 'stroke savers' and who's parents, grand parents and other loved ones might be at risk of having a stroke.</p> <p>Increase awareness of Transient Ischaemic Attacks (TIA) or mini-strokes.</p>	social responsibility programmes.
2. Reduce the prevalence of stroke and the prevalence of major stroke in people who have had a TIA or minor stroke.	QM 2, 5 & 6	<p>Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke. It is estimated that in Enfield, 115 strokes a year could be avoided through preventive work on high blood pressure, irregular heartbeats, smoking cessation, and wider statin use.³⁴</p> <p>Preventing strokes can not only reduce the associated suffering, morbidity and mortality caused by strokes; it may also lead to NHS savings, as each stroke costs approximately</p>	<p>Ensure that there are systems in place locally for the following key prevention measures:</p> <ul style="list-style-type: none"> • managing hypertension so systolic blood pressure is below 140 mmHg; • warfarin for individuals with atrial fibrillation; • statin therapy for all people with more than 20 per cent risk of cardiovascular disease within ten years; and 	Primary Care

³⁴ Department of Health, 2006, ASSET 2 – Action on Stroke Services: an Evaluation Toolkit for *commissioners*, London, DH

Strategic Objective	Link to National Quality Markers	Rationale	Commissioning Intentions	Funding Source
		<p>savings, as each stroke costs approximately £15,000 to treat over five years.³⁵ If Enfield made a reduction of 115 preventable strokes per year it could potentially save the local health and social care economy some £345,000 each year and £1.725 million over 5 years.</p> <p>A more urgent response to both stroke and TIA will save lives and reduce long-term disability. Stroke is a treatable condition. Intensive physiological and neurological monitoring in the early phase of a stroke supports early treatment that halts stroke progression and prevents more brain cells being damaged. Investigating and treating high-risk patients with TIA within 24 hours could produce an 80 per cent reduction in the number of people who go on to have a full stroke.³⁶</p> <p>There are agreed high and low risk pathways in Enfield however they are not being used consistently.</p>	<ul style="list-style-type: none"> referral of all smokers to stop smoking services <p>Commission active management of hypertension as an extension of QOF, for example, through funding continuous blood pressure monitoring devices.</p> <p>Continue to invest in healthy lifestyles promotion and support to people to change behaviour initially targeting:</p> <ul style="list-style-type: none"> Older people Edmonton Green ward People of African and Caribbean ethnicity <p>Encourage partnership working across health, social care, and the community and voluntary sector for the provision of healthy lifestyles information and support.</p> <p>Support initiatives that aim to make physical activity part of everyday life.</p>	<p>Public health</p> <p>Cost neutral</p> <p>Everybody Active Strategy.</p>

³⁵ National Audit Office, 2005, Reducing Brain Damage: Faster access to better stroke care

³⁶ Rothwell PM, et al., 2007, 'Effect of urgent treatment of transient ischaemic attack and minor stroke on early recurrent stroke (EXPRESS study): a prospective population-based sequential comparison', *Lancet* 370, 1432–42

Strategic Objective	Link to National Quality Markers	Rationale	Commissioning Intentions	Funding Source
			<p>Commission a clinical stroke coordinator (or co-ordinators) whose role will include providing training and awareness raising on local stroke pathways to GPs, A&E staff and hospital medical teams, focusing on:</p> <ul style="list-style-type: none"> • High and low risk stroke pathways • Importance of urgent response to suspected stroke and TIA • Assessment of high-risk patients • Case management and follow up <p>Explore role of Clinical Commissioning Group in increasing GP awareness of secondary stroke prevention and agreed local pathways.</p> <p>Improve Quality and consistency of clinical care.</p> <p>Development of stroke registers</p>	Stroke Grant/re-ablement funding
3. Increase involvement of service users and carers in the planning, development and delivery of	QM 4	Involvement of service users and carers in the planning, development and delivery of services will lead to improved quality and better outcomes.	<p>Commission stroke specific survivor training to facilitate full and active participation in service delivery and advocacy for current patients.</p> <p>Develop brokerage services to enable access to direct payments/individual</p>	<p>Re-ablement funding</p> <p>Through reconfiguration of</p>

Strategic Objective	Link to National Quality Markers	Rationale	Commissioning Intentions	Funding Source
services.			<p>budgets for stroke survivors and their families.</p> <p>Ensure people with stroke are informed partners in their care planning.</p> <p>Continue to include service users and carers in the Enfield Stroke Implementation Team and ensure that those with communication and/or physical disabilities are supported to participate.</p> <p>Ensure that stroke survivors benefit from the personalisation agenda by working closely with service users, voluntary, private and third sector organisations to develop flexible, accessible, responsive services across sectors including transport, leisure and accommodation services.</p>	existing voluntary and community sector services (3 rd sector review).
4. Improve stroke unit quality	QM 9	<p>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.</p> <p>Successful stroke units are built around a</p>	<p>Support stroke units to engage patients in service design and delivery through the development of formal links with patient and carer organisations.</p> <p>Ensure all patients are given the recently developed North Central London stroke handbook which provides details of all local</p>	Cost neutral

Strategic Objective	Link to National Quality Markers	Rationale	Commissioning Intentions	Funding Source
		stroke-skilled multidisciplinary team that is able to meet the needs of the individuals.	stroke services and how to access them. Develop a local performance management and monitoring framework for assessing local stroke units against national clinical guidelines and quality standards.	
5. Improve access to comprehensive rehabilitation and community services	QM 3 & 10	Specialist co-ordinated rehabilitation, started early after stroke and provided with sufficient intensity, reduces mortality and long-term disability. Early rehabilitation is effective when provided in specialist stroke units, or as part of properly organised early supported discharge and longer-term support in the community, according to need. ³⁷ Early supported discharge (ESD) to a comprehensive stroke specialist and multidisciplinary team (which includes social care) in the community, but with a similar level of intensity to stroke unit care, can reduce long-term mortality and institutionalisation rates for up to 50 per cent of patients and lower overall costs. ³⁸	Review the provision of rehabilitation services to ensure that we have the right mix of inpatient, community rehabilitation and early supported discharge services to meet the needs of our population. Develop comprehensive community rehabilitation services which include vocational rehabilitation, Occupational therapy, Physiotherapy, Dietetics, Speech and Language Therapy, rehabilitation assistants and access to Psychology, Counselling, Nursing, Sensory impairment, orthotics, spasticity clinics and driving rehabilitation. Commission services to support self-management, e.g. stroke specific expert	Within existing resources. Unbundle rehabilitation component of acute stroke unit tariff.

³⁷ Langhorne P, et al., 2005, 'Early supported discharge services for stroke patients: a meta-analysis of individual patients' data', *Lancet* 365, 501–6
³⁸ Department of Health, 2005, The National Service Framework for Long-term Conditions, London, DH

Strategic Objective	Link to National Quality Markers	Rationale	Commissioning Intentions	Funding Source
		<p>The limited provision of community rehabilitation services has been identified as a key gap by stakeholders during development of this strategy. In addition, a recent Care Quality Commission review highlighted the following key areas of concern:</p> <ul style="list-style-type: none"> Occupational therapy, psychological therapy, counselling 1-1 with stroke counsellors, neuropsychological support with cognitive difficulties, specialist support re vision and vision perceptual difficulties is not available following assessment to people after transfer from home. Spasticity clinics, specific vocational rehabilitation, specific rehabilitation focussed on driving and stroke nurses are not available. <p>Modelling of demand for inpatient rehabilitation by the North Central London Sector recommends that 16 beds are required. –</p>	<p>patient programmes, from a range of providers including the voluntary sector.</p> <p>Develop and support a wide range of local community-based and peer-delivered activities for people who have had strokes and their carers, involving the local voluntary and community sector, for example peer-led conversation groups and peer-support or befriending schemes.</p> <p>Commission information, advice, advocacy and sign-posting through the community and voluntary sector.</p>	<p>Re-ablement funding</p> <p>Re-ablement funding</p> <p>Through reconfiguration of community & voluntary sector services (through 3rd sector review)</p>
6. Enable stroke survivors to fully	QM 4	<p>People who have had a stroke, and their carers, should be enabled to live a full life in</p>	<p>Ensure comprehensive, accessible information and advice is given to stroke</p>	<p>Reablement grant</p>

Strategic Objective	Link to National Quality Markers	Rationale	Commissioning Intentions	Funding Source
participate in the community.		<p>the community</p> <p>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. This will be across the range of community services – housing, education, leisure, transport, employment – that can help people to participate in community life again.</p> <p>In a large review of 500 stroke survivors, almost 40% of respondents said that their largest area for concern was the social and emotional consequences of stroke.³⁹</p> <p>Large scale literature reviews show that depression is present in at least a third of stroke survivors and that complications such as emotional ability and anger proneness are also commonplace.⁴⁰</p> <p>People with aphasia have been shown to be at</p>	<p>survivors on discharge from hospital and that systems are in place to provide information in a variety of formats accessible to all those who have experienced a stroke, and their carers.</p> <p>Commission a stroke navigator to provide a single point of contact for stroke specialist advice, undertake regular reviews and help coordinate complex discharges.</p> <p>Expand the newly established Improving Access to Psychological Therapies (IAPT) service across the Borough.</p> <p>Ensure that those working with stroke survivors have the details of the Improving Access to Psychological Therapies (IAPT) and other commissioned psychological therapy services so that those that need it can access the service.</p> <p>Develop effective community based provision of aphasia support.</p>	<p>Re-ablement funding</p> <p>PCT IAPT Funding</p> <p>Re-ablement funding</p>

³⁹ Murray, J., Ashworth, R., Forster, A., Young, J. (2003). Developing a primary care based stroke service: a review of the qualitative literature. British Journal of General Practice, 53(487): 137-142

⁴⁰ Life After Stroke: Commissioning Guide: Commissioning Support for London. 2010.

Strategic Objective	Link to National Quality Markers	Rationale	Commissioning Intentions	Funding Source
		increased risk of depression, loneliness, ability to engage with rehabilitation and diminished social networks. ⁴¹		
7. Stroke survivors receive care from staff with the skills, competence and experience appropriate to their needs	QM 18 & 19	People with stroke need to be treated by a skilled and competent workforce. Resources need to be provided to assist services in planning their workforce requirements. Sufficient staff with the appropriate levels of knowledge, skill and experience is essential to the success of the Strategy	Undertake a review of the current local workforce (formal and informal) and develop a plan supporting development and training to create a stroke skilled workforce.	
8. Ensure Continuous Service improvement	QM 17	The new vision for stroke care demands services working together in networks, looking across all aspects of the care pathway.	Continue to support the work of the local stroke implementation team in improving local services. Ensure that the stroke implementation team have a key role in the implementation and monitoring of the stroke strategy.	
9. Improve End of Life Care	QM 11	Many people who die as a direct result of stroke will do so with impaired communication and/or cognitive skills. Providing high-quality end-of-life care in such circumstances can be	Fund a Gold Standards facilitator to support care homes and primary care to implement the Gold Standard Framework and reduce avoidable admissions to hospital.	2010/2011 Additional Funding for Re-ablement linked to Hospital

⁴¹ Ibid.

Strategic Objective	Link to National Quality Markers	Rationale	Commissioning Intentions	Funding Source
		<p>challenging and requires an appropriately skilled and experienced workforce.</p> <p>A number of local care homes have been identified as having high emergency admission rates to hospital and implementation of the Gold Standard Framework (GSF) has been inconsistent.</p> <p>Of the total number of people who died in Enfield over the period 2007 – 2009, 68% died in hospital. This is significantly higher than the desired level (Commissioning Support for London proposed that PCTs should aim for less than 50% of deaths taking place in hospital), and there is a significant cost associated with emergency admissions in the last year of life.</p>	<p>Revise the locally agreed pathway to include people's preferred place to die following stroke and people's preference re use of DNARs (do not resuscitate orders).</p> <p>Work with care homes that are identified as high admitters to hospital in order to identify what support and training they require to enable them to support residents to die in the care home.</p>	Discharge

10. IMPLEMENTATION AND MONITORING ARRANGEMENTS

The implementation and monitoring of the strategy will be overseen by the Enfield Stroke Implementation Team, a local network of stroke stakeholders whose membership includes representation from people who have experienced a stroke, carers, Public Health, Primary Care, Acute Sector, Adult Social Care, and the Voluntary and Community Sector. The Stroke Implementation Team will report to the Older Peoples Partnership Board, a Thematic Action Group of the Enfield Strategic Partnership⁴², who will be ultimately accountable for delivery of the strategy.

The Stroke Implementation Team will have a key role in contributing to the development of a detailed 5 year implementation plan that will be developed jointly by NHS Enfield and the Local Borough of Enfield. This will be agreed by the Older Peoples Partnership Board who will monitor implementation to ensure that the strategy is shaping services in the way intended. A lead commissioner from NHS Enfield and the Local Borough of Enfield will be identified and they will be tasked with delivering the implementation and reporting progress and issues to the Older Peoples Partnership Board.

The Older Peoples Partnership Board and Stroke Implementation Team will also have a lead role in the development of a communication and engagement plan that will set out:

- how implementation of the strategy will be communicated to key stakeholders and members of the public; and
- how stakeholders will be engaged throughout the implementation.

An annual progress report on implementation of the strategy will be published and will report on progress towards implementing agreed commissioning intentions as well as key performance metrics including Quality and Outcomes Framework (QOF), national stroke strategy (2007) quality markers, and NICE Quality Standard and associated measures.

⁴² The Enfield Strategic Partnership is a mature partnership and brings together organisations, businesses and the third sector.

APPENDIX 1: NATIONAL POLICY CONTEXT⁴³

The *National Service Framework for Older People* (2001) has a standard covering stroke services, which stresses the importance of specialist multi-disciplinary teams. In 2005, the National Audit Office (NAO) reported on stroke services and identified the need for further improvements. These conclusions were reinforced in a further report from the Public Accounts Committee (2006). The Royal College of Physicians' sentinel stroke audit, completed every two years, shows that services are improving, but still face many challenges in delivering high quality stroke care.

The National Service Framework for Older People (2001)

Standard Five: Stroke

The standard states: 'The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate. People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation.' The milestones focus on the development of specialised stroke services, clinical audit systems, and primary care protocols for risk management, TIA referrals and treatment.

Reducing Brain Damage: Faster access to better stroke care (National Audit Office, 2005)

This sets out ten recommendations covering public awareness, TIA services, thrombolysis, scanning access, acute stroke units, health and social care coordination, the role of the voluntary sector, and the benchmarks and priority attributed to stroke. It notes that current services are often inefficient, with scans and surgery often taking place too late to be of benefit to patients.

National Stroke Strategy (Department of Health, 2007)

In December 2007, the Department of Health published a national strategy for stroke services in England. The strategy is intended to:

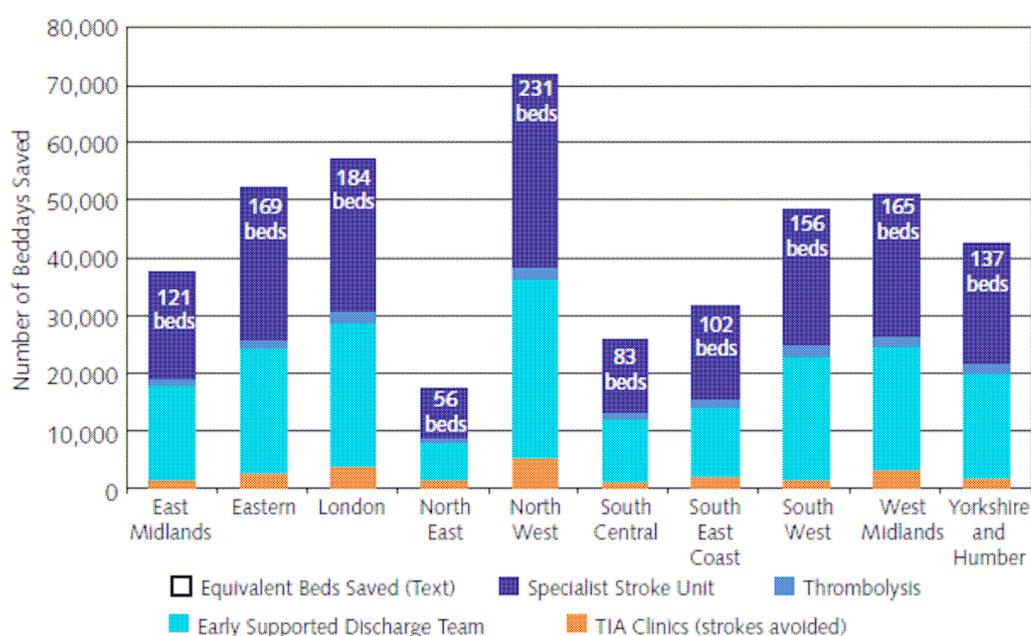
- provide a quality framework against which local services can secure improvements to stroke services and address health inequalities relating to stroke over the next ten years;
- provide advice, guidance and support for commissioners, strategic health authorities, the voluntary sector and social care, in the planning, development and monitoring of services; and
- inform the expectations of those affected by stroke and their families, by providing a guide to high-quality health and social care services

The Strategy will build on the progress made under the *National Service Framework for Coronary Heart Disease* as part of an integrated approach to vascular disease – the two diseases share similar risk factors and important

⁴³ Improving Stroke Services: A Guide for Commissioners (Department of Health, 2006)

elements of the emergency response. Further information is at www.dh.gov.uk/stroke.

In Spring 2006, the Department produced *Action on Stroke Services: An Evaluation Toolkit for Providers* (ASSET1) to help hospital trusts – and commissioners – appraise current performance on stroke and consider the merits of making four specific improvements: increasing their acute stroke unit capacity, rapid access TIA services, rapid scanning to enable thrombolysis, and early supported discharge arrangements. If all services made these changes, then each year in England 840 strokes would be prevented and 3,900 stroke victims would regain their independence (who would otherwise have died or experienced long-term dependency). The chart below shows the predicted cumulative bed-day impact of shorter lengths of stay and fewer strokes across each Strategic Health Authority.



Improving Stroke Services: a Guide for Commissioners

The wider policy context is the health reform programme to deliver more choice and say for patients, a broader range of good quality care options and an NHS in good financial health. Transforming stroke services to be faster, more responsive and more personalised resonates particularly strongly with two key policy agendas: the development of urgent care and the *Our Health, Our Care, Our Say* white paper. Modern interventionist stroke care is highly specialised and unlikely to be appropriate for every hospital. In redesigning urgent care services, local areas will need to consider how to ensure that those patients who may benefit can access thrombolysis and other specialised treatments, either through paramedic triage to specialist centres on a ‘treat and return’ basis or (for more remote localities) telemedicine solutions. After the immediate period of intensive medical care, many people will want to receive rehabilitation closer to or within their home. To this end, the 2007/08 Payment by Results tariff offers indicative figures for ‘unbundling’ acute stroke care to make it easier to respond flexibly and appropriately to the varying needs of people who experience a stroke.

APPENDIX 2: STROKE MANAGEMENT AND QOF INDICATORS

Figure 5 shows how good GPs are at recording blood pressure in patients with a TIA or stroke (**Stroke 5**). The graph shows that Enfield is performing as well as the London average but worse than the national average. Enfield was in the bottom 30% nationally for this indicator in 2008/09. There is also significant variation between the clusters with the South East cluster performing well below the London average.

Figure 5: Performance in QOF indicator Stroke 5 (Source: QMAS and NHS Information Centre)

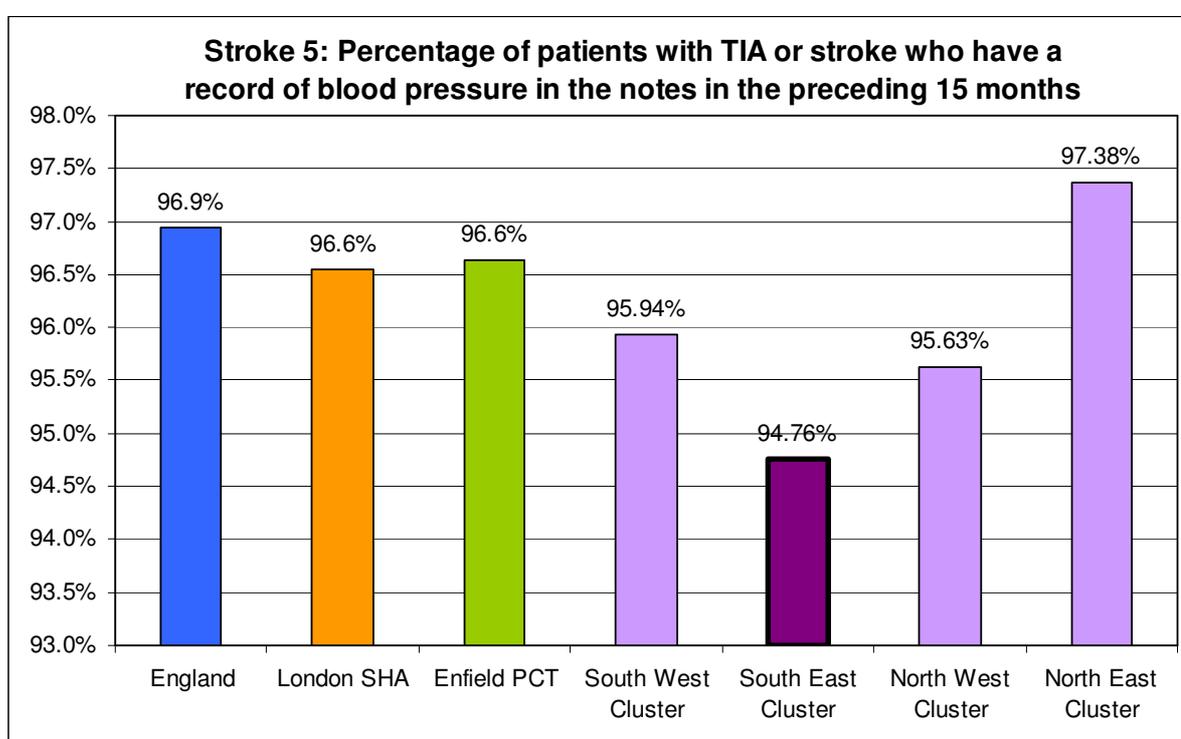


Figure 5.10 shows how well GPs are at managing blood pressure in patients with a history of TIA or stroke (**Stroke 6**). The graph shows that Enfield is performing worse than the London and national average. Enfield was in the bottom 25% nationally for this indicator in 2008/09. There is also significant variation between the clusters, with the North West cluster performing well above the London and national average.

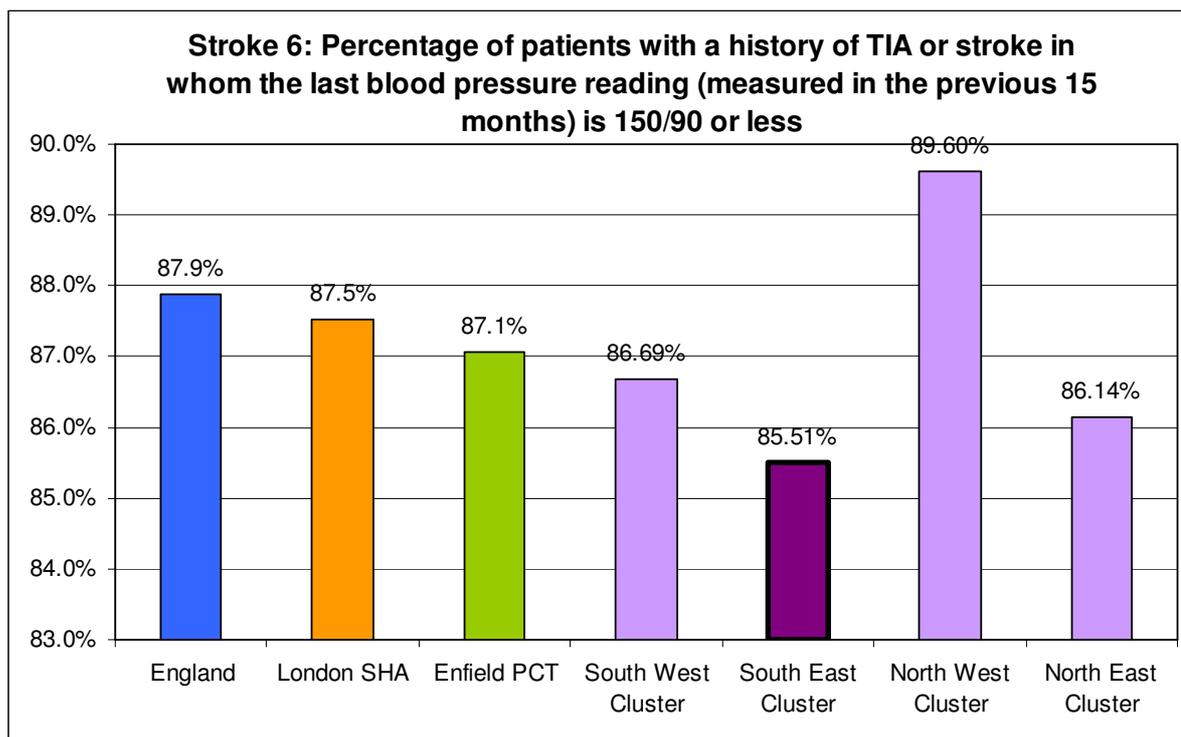


Figure 5.10: Performance in QOF indicator Stroke 6 (Source: QMAS and NHS Information Centre)

Figure 5.11 shows how well GPs are at recording cholesterol levels in patients with TIA or stroke (**Stroke 7**). The graph shows that Enfield is performing worse than the London and national average. In fact, Enfield was in the bottom 10% nationally for this indicator in 2008/09. There is also significant variation in performance across the clusters, with the South East cluster performing significantly worse than the Enfield average.

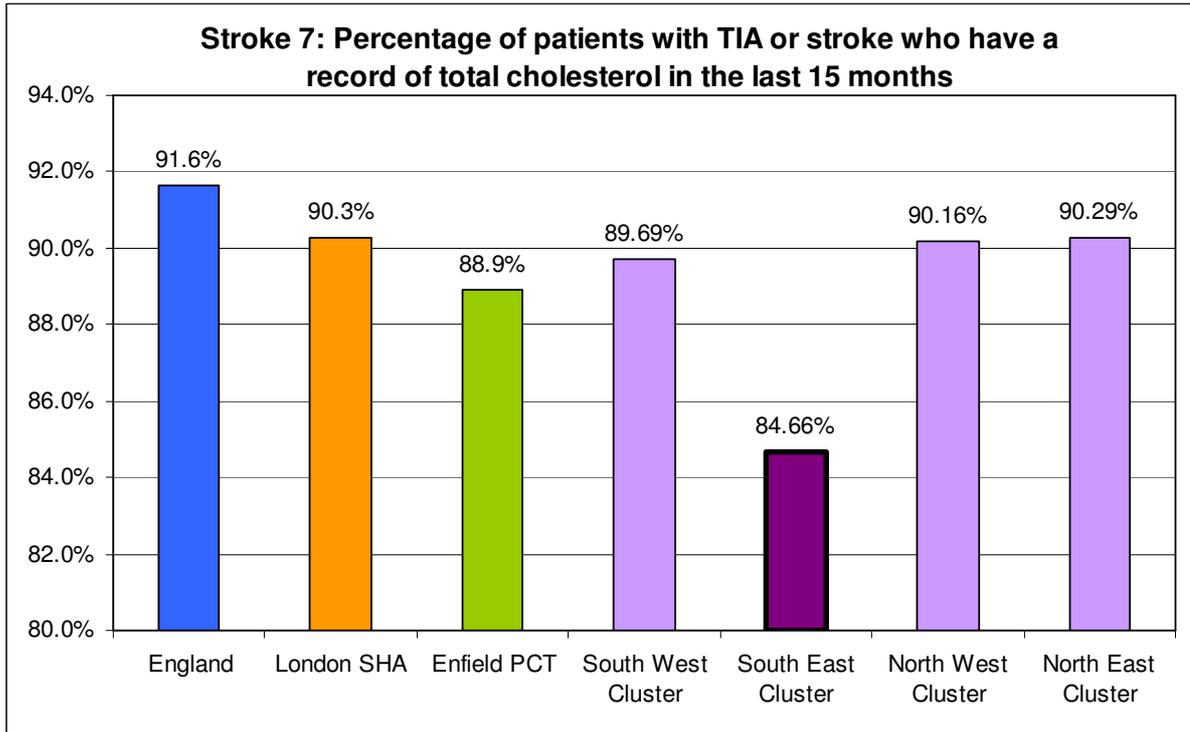


Figure 5.11: Performance in QOF indicator Stroke 7 (Source: QMAS and NHS Information Centre)

Figure 5.12 shows how well GPs are at managing cholesterol in patients with TIA or stroke (**Stroke 8**). The graph shows that Enfield is performing slightly worse than the London average and significantly worse than the national average. Enfield was in the bottom 20% nationally for this indicator in 2008/09. There is also significant variation between the clusters, with the South East cluster performing significantly worse than the Enfield average and the North West cluster performing better than the national average.

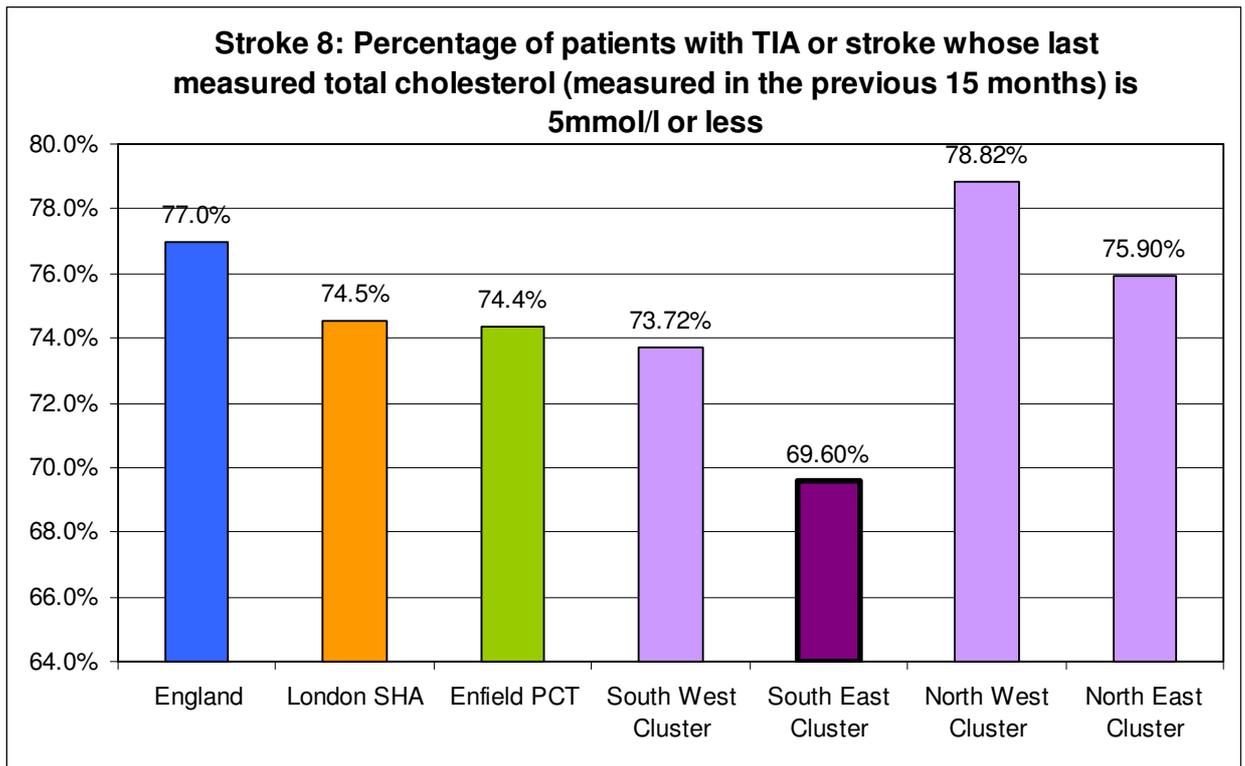


Figure 5.12: Performance in QOF indicator Stroke 8 (Source: QMAS and NHS Information Centre)

Figure 5.13 shows how well GPs are at prescribing anti-platelet therapy or anti-coagulants for patients shown to be non-haemorrhagic or a history of TIA (**Stroke 12**). The graph shows that Enfield is performing better than the London and national averages. Enfield was in the top 20% nationally for this indicator in 2008/09. However, there is significant variation between the clusters, with the South West cluster performing significantly worse than the Enfield average.

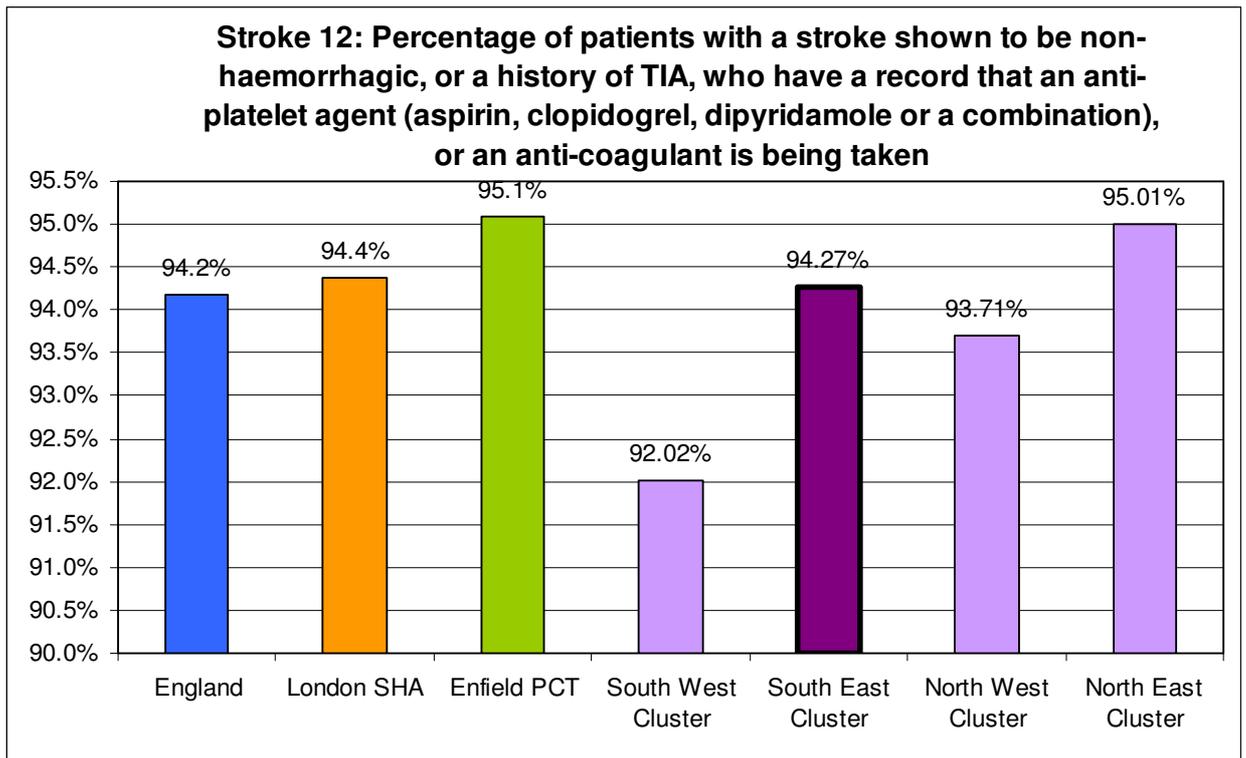
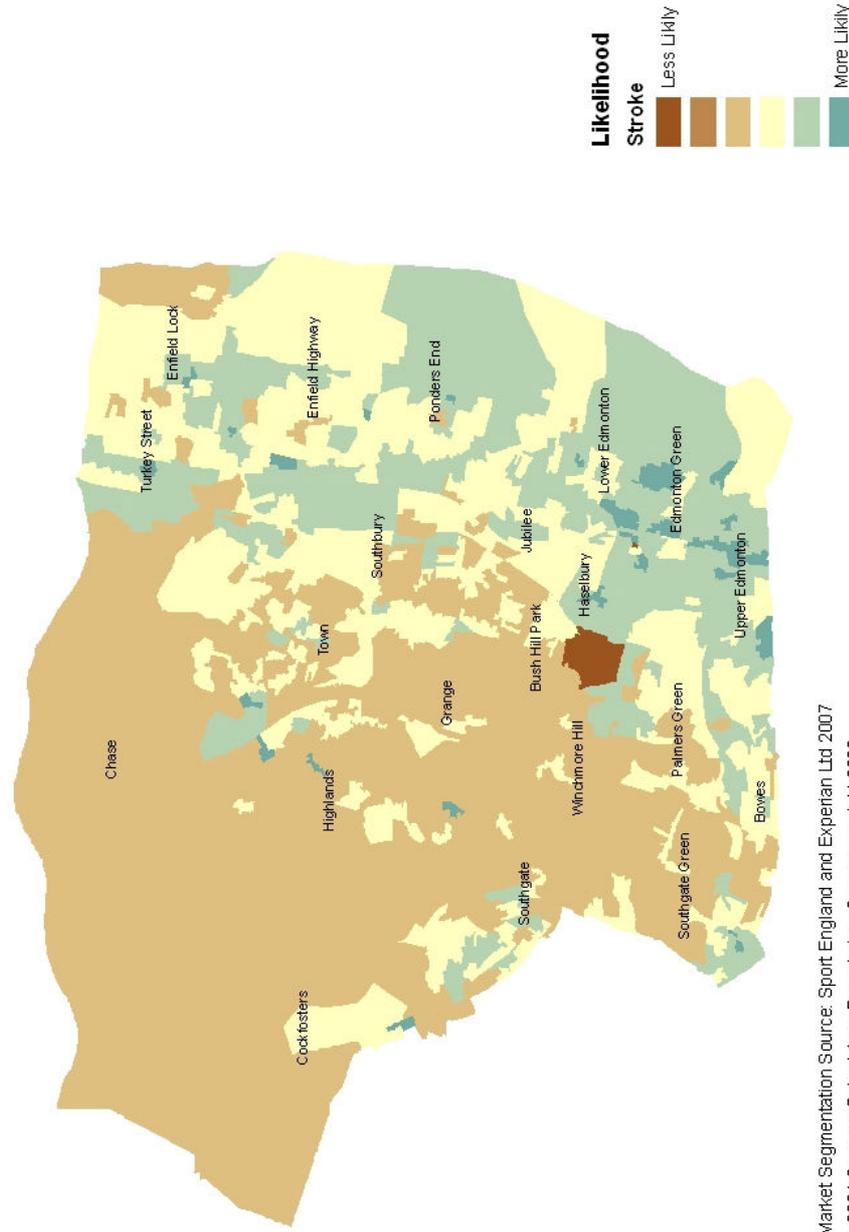


Figure 5.13: Performance in QOF indicator Stroke 12 (Source: QMAS and NHS Information Centre)

APPENDIX 3: LIKELIHOOD OF HAVING A STROKE



Likelihood to Have a Stroke



Sport Market Segmentation Source: Sport England and Experian Ltd 2007
 Source: 2001 Census, Output Area Boundaries, Crown copyright 2003.

APPENDIX 4: CQC REVIEW OF STROKE SERVICES



Review of services for people who have had a stroke and their carers

SUPPORTING LIFE AFTER STROKE LOCAL ASSESSMENT REPORT

Enfield PCT area

Introduction

This review looks at the care experienced by people who have had a stroke (or TIA— which is similar to a stroke, but the symptoms disappear within 24 hours) and their carers. It starts from the point people prepare to leave hospital, to the long-term care and support that people may need to cope with stroke-related disabilities. It looks at both health and adult social care, as well as links to other relevant services, such as local support groups and services to help people participate in community life.

As the Quality Markers (QMs) set out in the National Stroke Strategy are now well established, they form the basis of the 'assessment framework' for this review. We used the QMs to create a set of 15 scored indicators, which we combined to give an overall assessment for each local area, with four categories:

- 'Best performing' – on average these areas scored the top two marks across 8 or 9 of the 15 scored indicators and only scored low marks in 1 or 2.
- 'Better performing' – with more areas of strength than weakness.
- 'Fair performing' – with more areas of weakness than strength.
- 'Least well performing' – typically scored low marks in 8 or 9 of the 15 scored indicators and only scored high marks in 1 or 2.

For this review, the areas we used for our assessments were based on the boundaries of primary care trusts (PCTs). PCTs are the main organisations responsible for commissioning care for people who have had a stroke and their carers, although local councils, in particular adult social services departments, also have an important role in assessing people's needs and commissioning a range of community-based support, care and advice services.

This detailed report is intended primarily for professionals involved in stroke care. We have also produced a summary report designed for people who have had a stroke and their carers. Both versions show how well the area performs in each of the scored indicators, and are available (from mid January 2011) on the review webpage cqc.org.uk/stroke. The webpage includes a link to the assessment framework, which includes the definitions of the review's scored indicators and explains how they are combined to produce the scored assessment for each area.

Understanding the results for an area

The table on page three sets out the list of scored indicators, along with the scores for this area. The following pages consider each scored indicator in turn, with charts showing the distribution of values or scores for the constituent parts for each indicator. In order to keep this report to a reasonable length only a selection of the available data is shown. The remaining data will be released as benchmarking data for the services that took part.

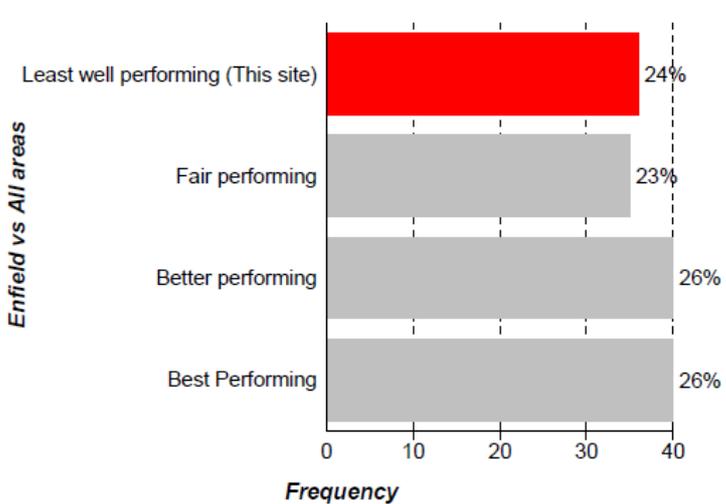
The position of this area within most charts (graphs) is shown by the asterisk below the horizontal axis and the vertical line. In charts showing the results of multiple-choice questions, the value for this area is shown as "(This site)" against the response that applies. Many of the question descriptors shown on charts are abbreviated versions of the full question wording. For the majority of charts higher values indicate better performance (any exceptions are noted in the text next to the relevant chart).

Ref	Scored indicator	Score	Page
12	Management of transfer home	1	5-6
10	Early Supported Discharge	1	7
13a	Community-based services	1	8-9
13b	Services for carers	2	10-11
13c	Secondary prevention	3	12
13d	Meeting individuals' needs	3	13-14
13e	Outcomes at 1 year	3	15
15	Support for participation in community life	3	16-17
6	TIA care and support	2	18
14	Reviews and assessments after transfer home	1	19-20
3a	Range of info provided	3	21
3b	Signposting, coordination and personalisation	1	22-24
11	End of life care	1	25
4	Involvement in planning and monitoring	2	26-27
17	Working together	2	28
	Average score	1.93	
Overall assessment		Least well performing	

Further details about this review can be found at <http://www.cqc.org.uk/stroke>

Overall Result

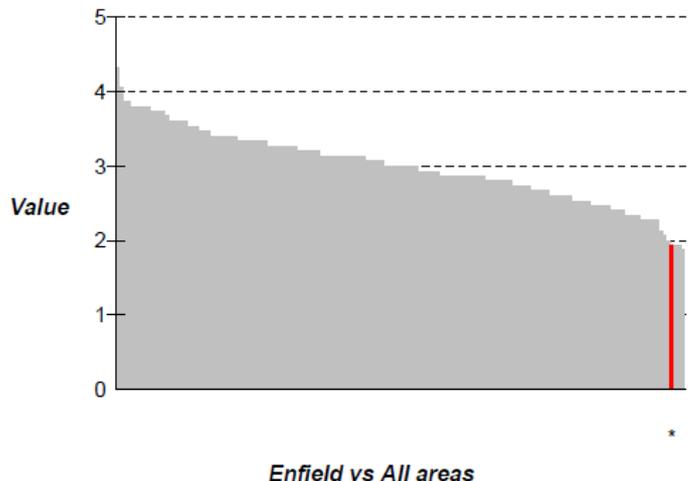
Overall assessment



This chart shows the percentage of areas given each scored assessment, with the score for this area highlighted and identified as "(This site)".

Based on all Scored indicators

Average score



Average of all Scored Indicators

Management of transfer home 1 (of 2)

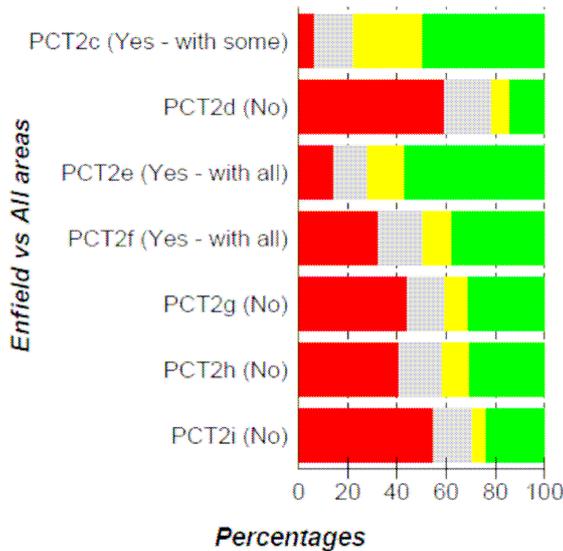
Total points for Transfer Home



All inputs to Scored Indicator 12

Enfield vs All areas

Transfer home (PCT Questions)



Answers for this area shown in brackets. Includes answers to Qs:

2c: Are there policies in place re transfer home of stroke patients?

2d: Are these policies stroke-specific?

Do they state that:

2e: Patients and carers should be involved in discharge planning?

2f: Patients should agree/write the goals in the discharge plan?

2g: Community stroke team should be involved?

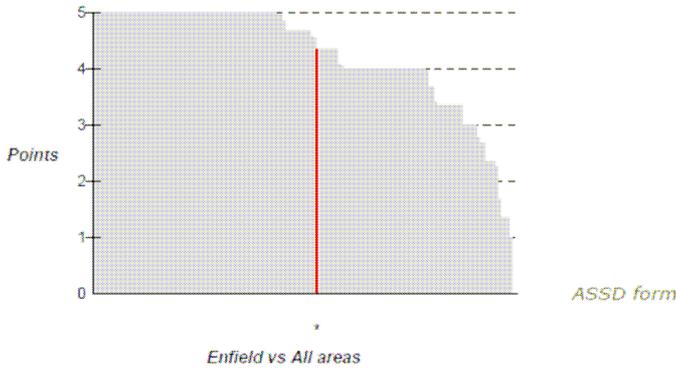
2h: Patients should be given a copy of the discharge summary?

2i: Patients should be followed up in 72 hrs by stroke rehab services?

PCT2c - PCT2i

Management of transfer home 2 (of 2)

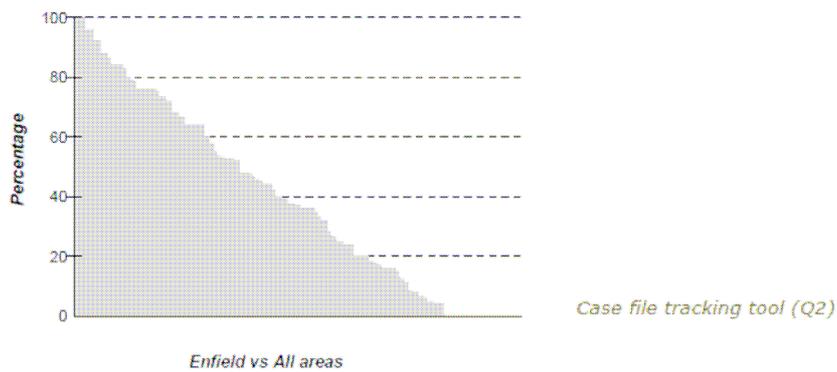
Transfer Home - points from Adult Social Services Department (ASSD) form



HES 30 day emergency readmissions

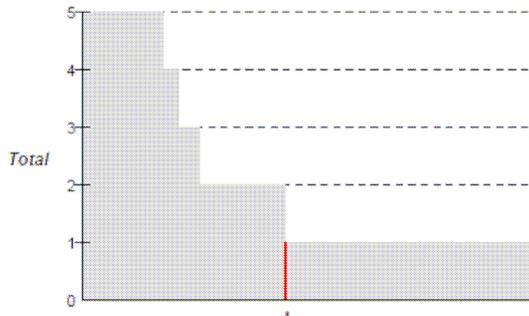


Percentage of people contacted within 2 days of transferring home (CFT)



Early Supported Discharge (ESD)

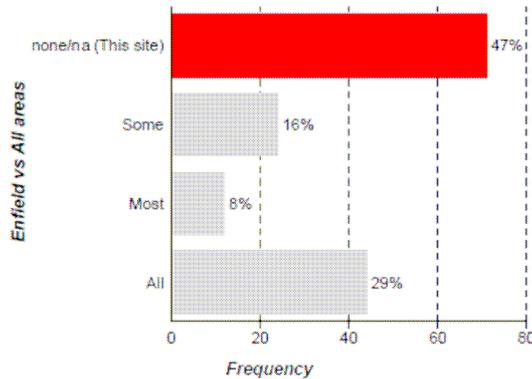
Total points for ESD



Enfield vs All areas

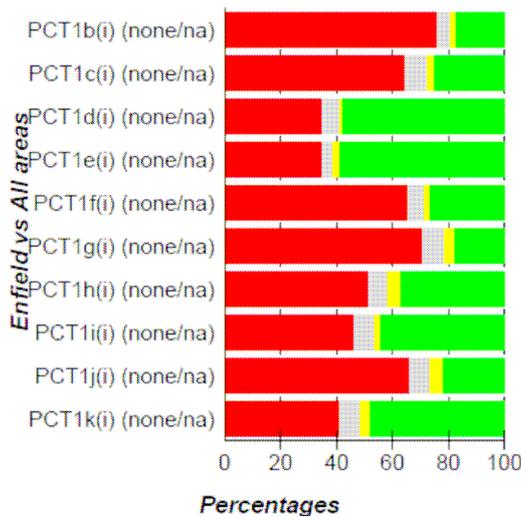
All inputs to Scored Indicator 10

Proportion PCT area with specialist ESD



PCT 1a(column i)

ESD - available roles

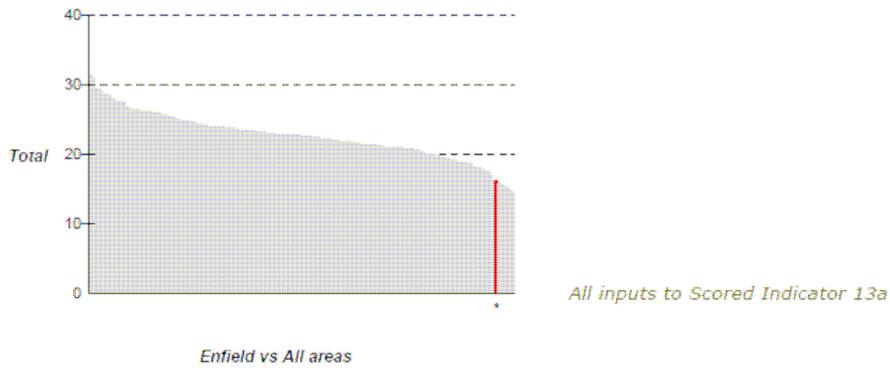


- 1b: a clinical psych./neuropsychologist
- 1c: a dietician
- 1d: an occupational therapist
- 1e: physiotherapists
- 1f: a social worker
- 1g: a doctor
- 1h: a nurse
- 1i: a SALT
- 1j: staff trained re counselling/psych supt
- 1k: a rehab assistant

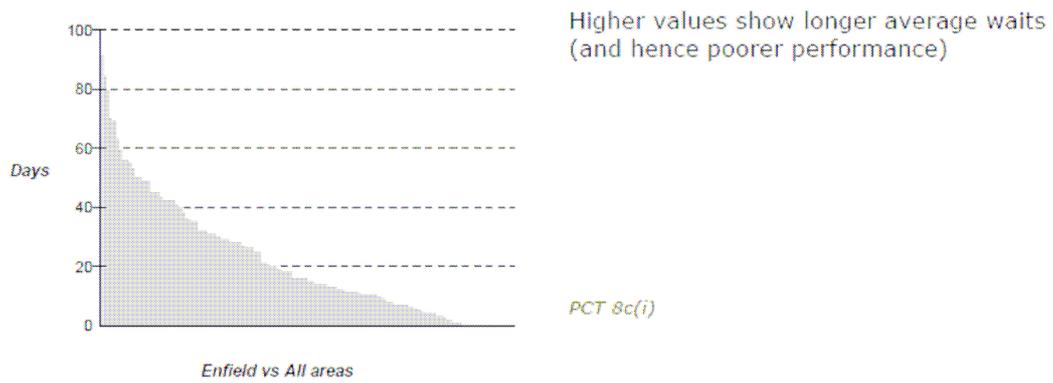
PCT1b(i) - PCT1k(i)

Community-based services 1 (of 2)

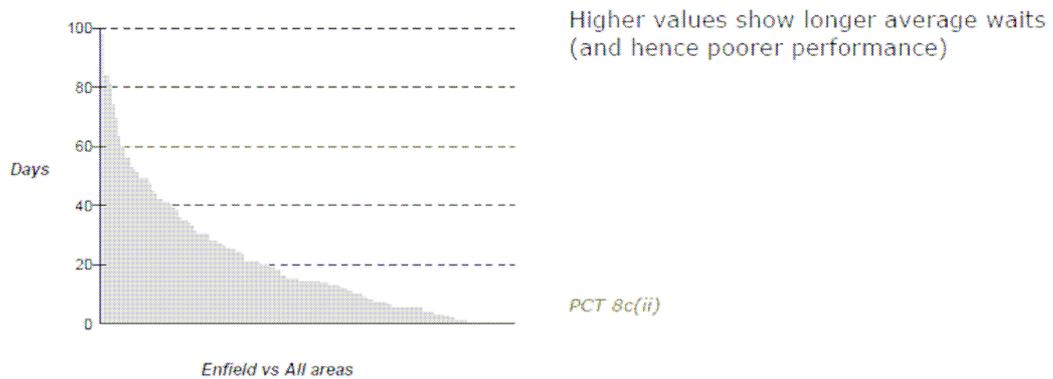
Total points for Community services



Community Speech and Language Therapy - average wait (8c(i))

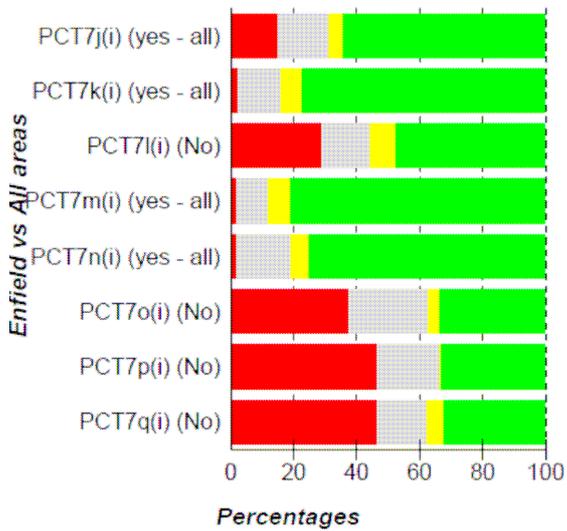


Community Physiotherapy - average wait (8c(ii))



Community-based services 2 (of 2)

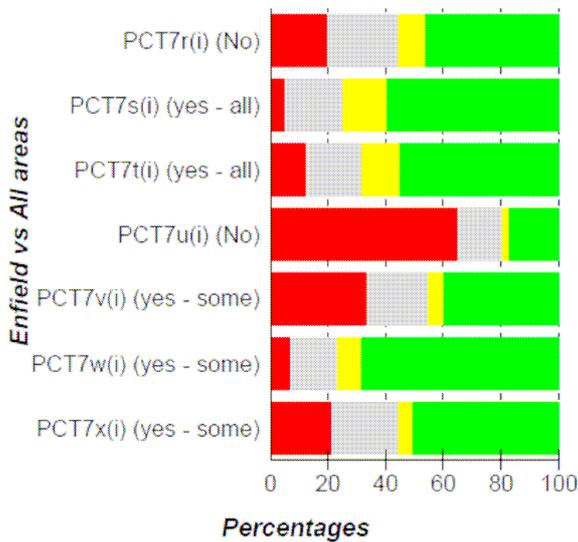
Specialist rehab services available



- 7j: Orthoptics
- 7k: Orthotics
- 7l: Spasticity clinics
- 7m: Support for home enteral feeding/PEG
- 7n: Dietetics
- 7o: Specific vocational rehabilitation
- 7p: Specific rehabilitation re driving
- 7q: Stroke nurses

PCT7j(i) - PCT7q(i)

Peer support etc available

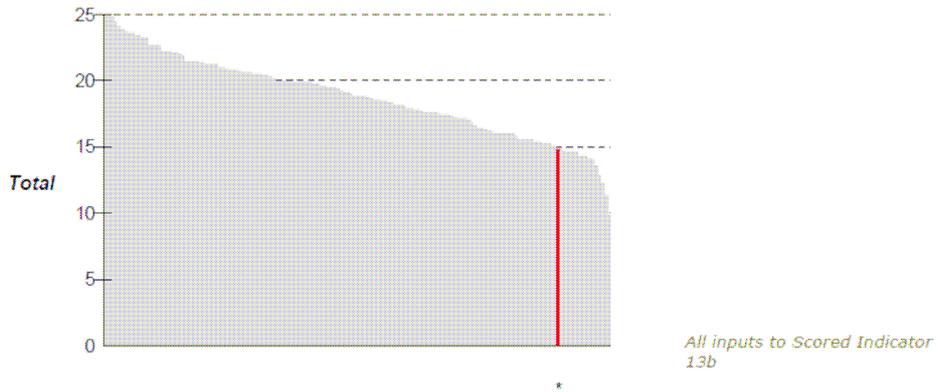


- 7r: 1-1 befriending service
- 7s: Peer support groups
- 7t: Dysphasia/aphasia support groups
- 7u: Conversation partners in care homes
- 7v: Stroke support groups for adults of working age
- 7w: Help with ad hoc information needs
- 7x: Other peer support

PCT7r(i) - PCT7x(i)

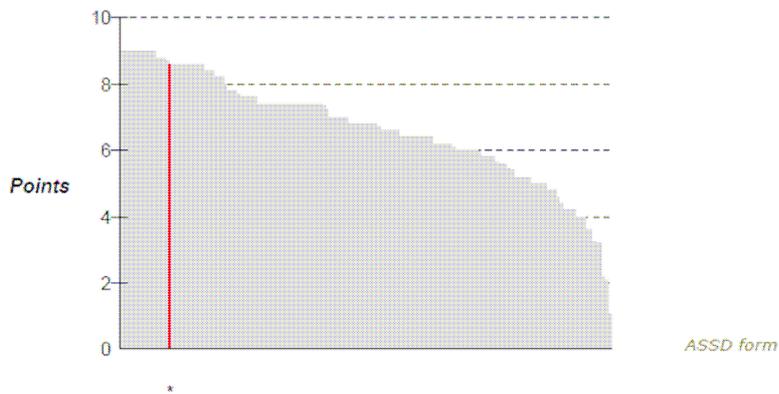
Services for carers 1 (of 2)

Total points for Services for carers



Enfield vs All areas

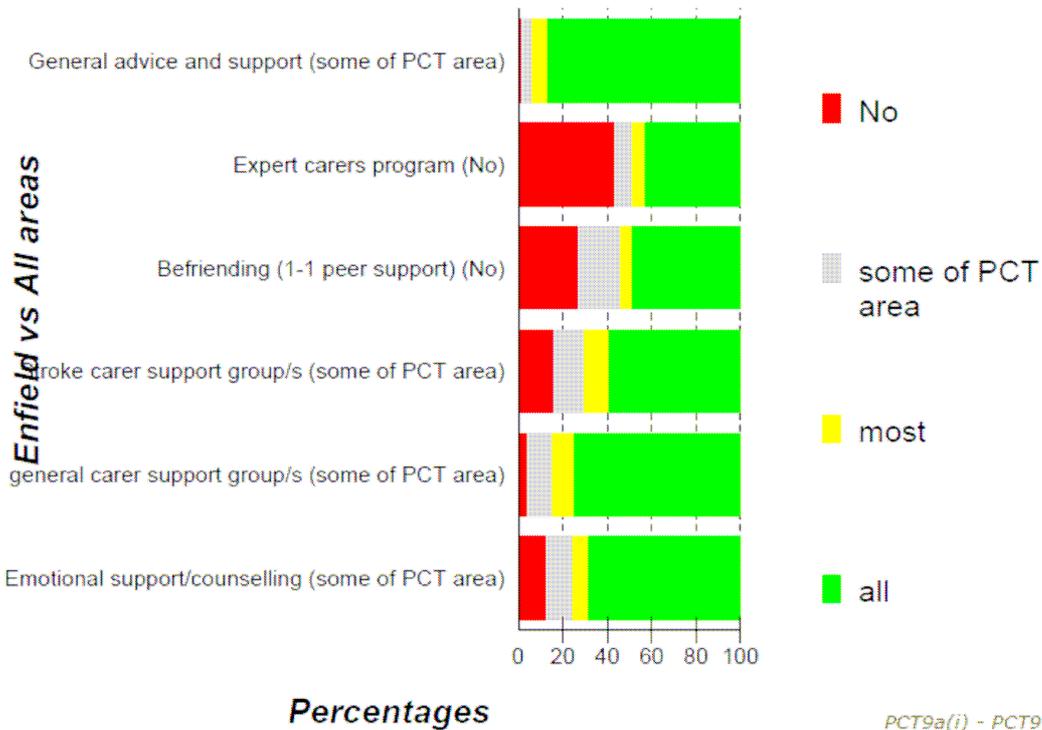
Services for carers - points from ASSD form



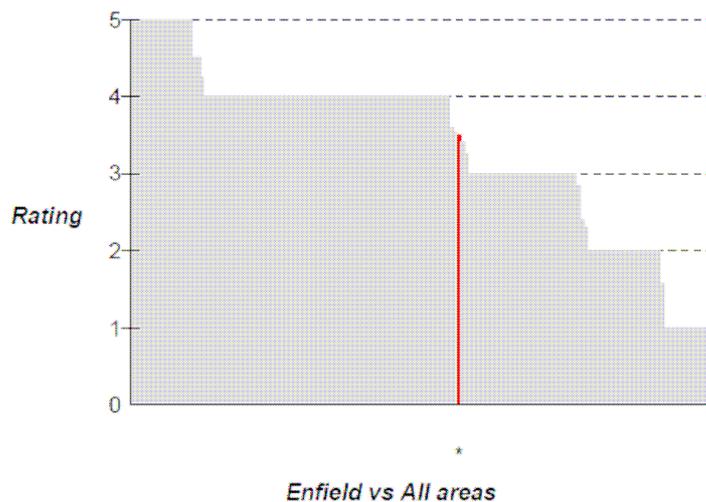
Enfield vs All areas

Services for carers 2 (of 2)

Services for carers



THIA(L) Q3 Was info clear and helpful for carers?



Based on results of local discussion group for Transfer Home Information Analysis (THIA (L)) – scored 5 (very good) to 1 (very poor)

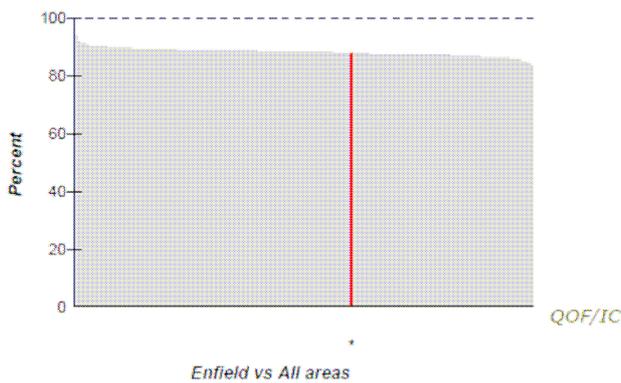
THIA_L Q3

Secondary prevention

13c) Total points for Secondary Prevention

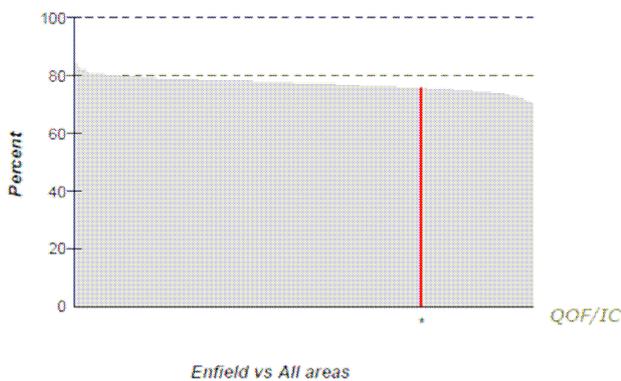


QOF STROKE 06 Percentage stroke or TIA patients with blood pressure in range



The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less.

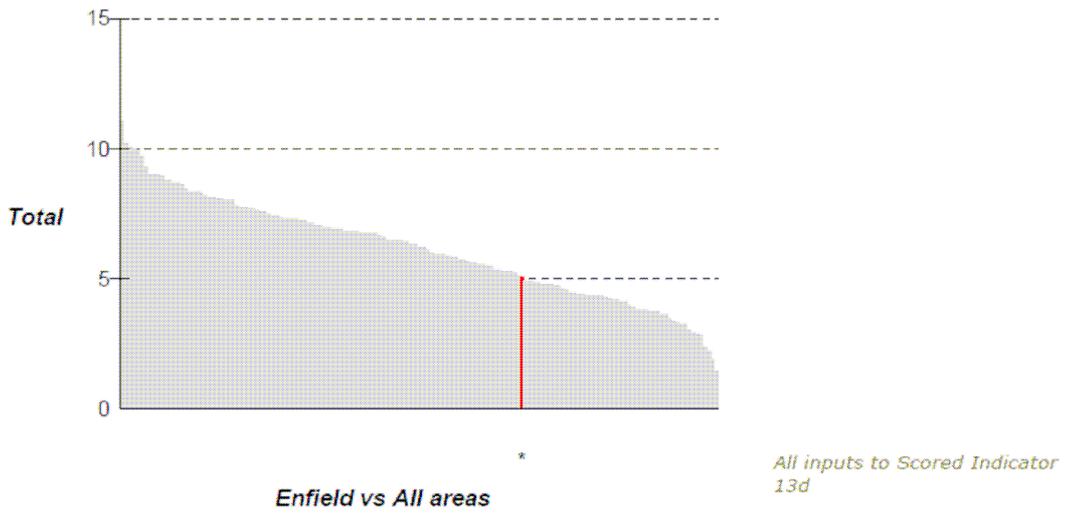
QOF STROKE 08 stroke or TIA patients with Cholesterol in range



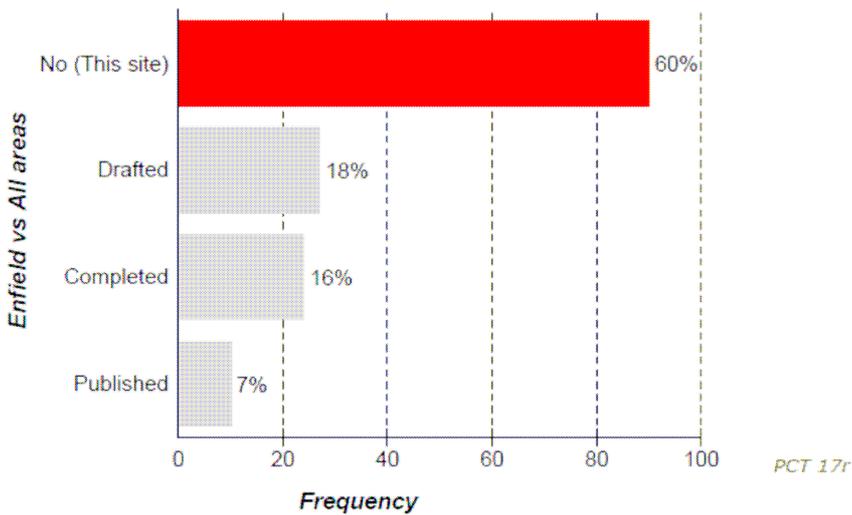
The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less.

Meeting individuals' needs 1 (of 2)

Total points for Individual needs

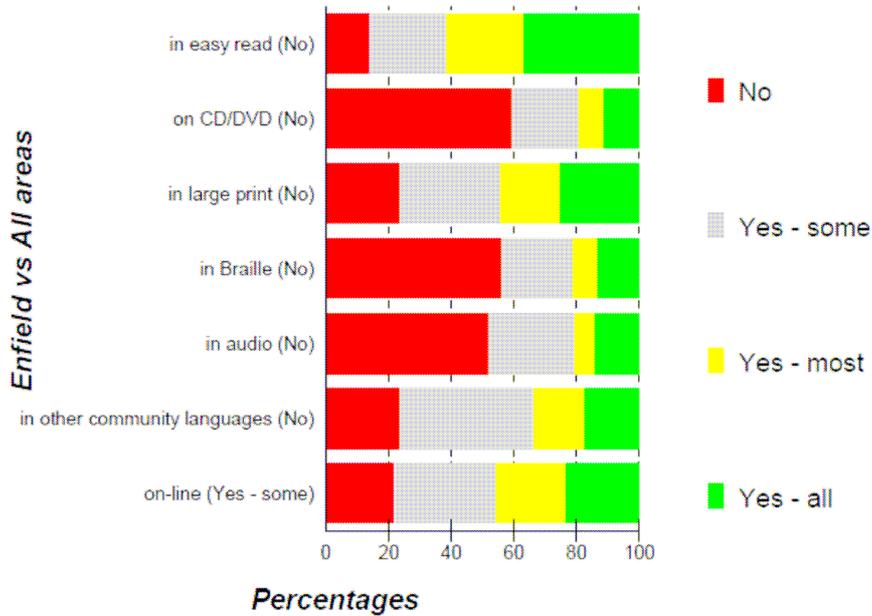


Equality Impact Assessment for implementation National Stroke Strategy

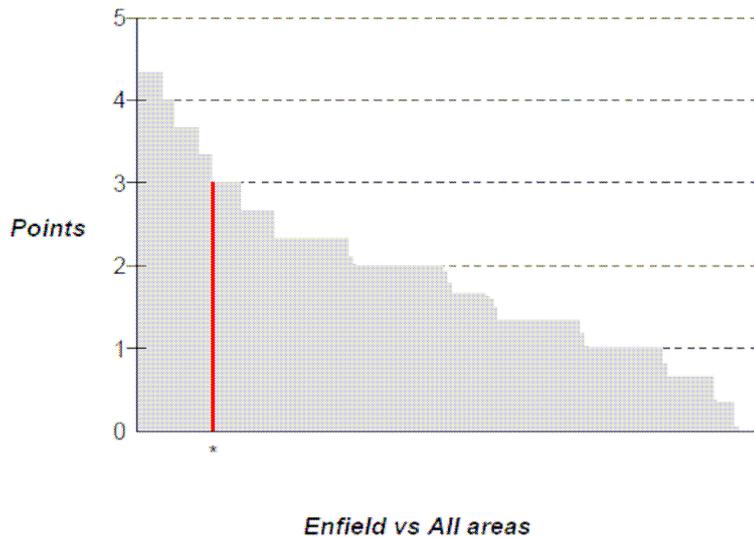


Meeting individuals' needs 2 (of 2)

Information on transfer home - formats

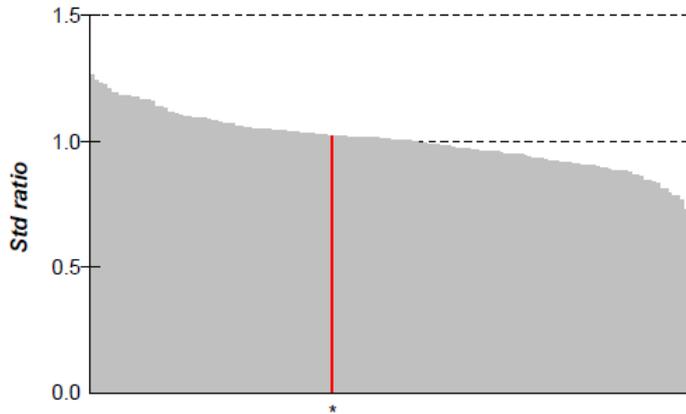


Individual needs points from ASSD form



Outcomes at 1 year

HES 1 year mortality

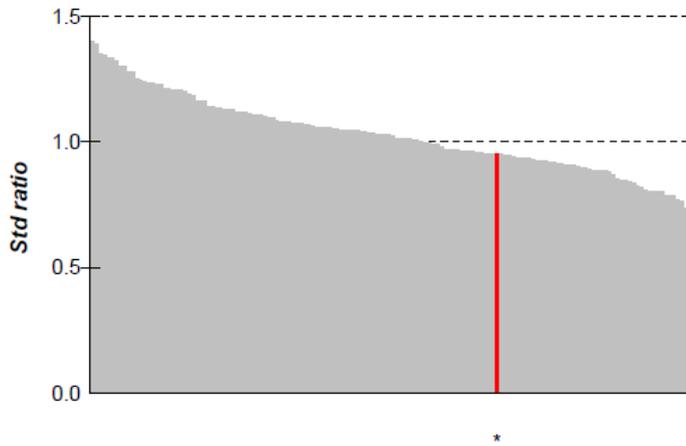


Standardised mortality ratio (values above 1 shows higher mortality than expected, values below 1 show lower mortality than expected)

Enfield vs All areas

HES/ONS

HES 1 year emergency readmissions



Standardised readmission ratio (values above 1 shows more emergency readmissions than expected, values below 1 show fewer emergency readmissions than expected)

Enfield vs All areas

HES

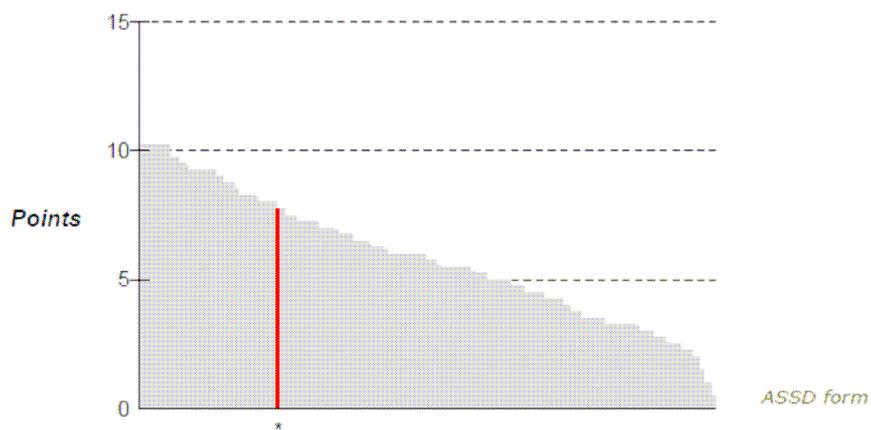
Support for participation in community life 1 (of 2)

Total points for Community life



Enfield vs All areas

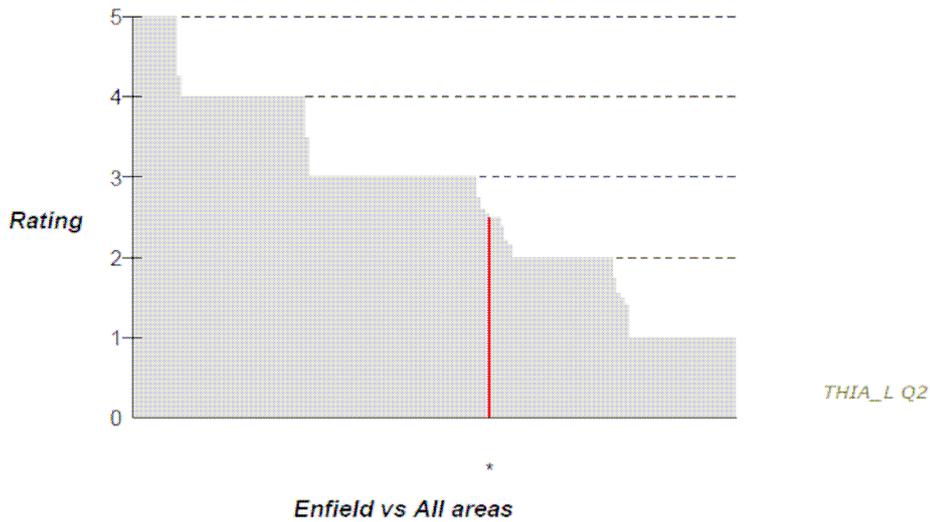
Community life - points from ASSD form



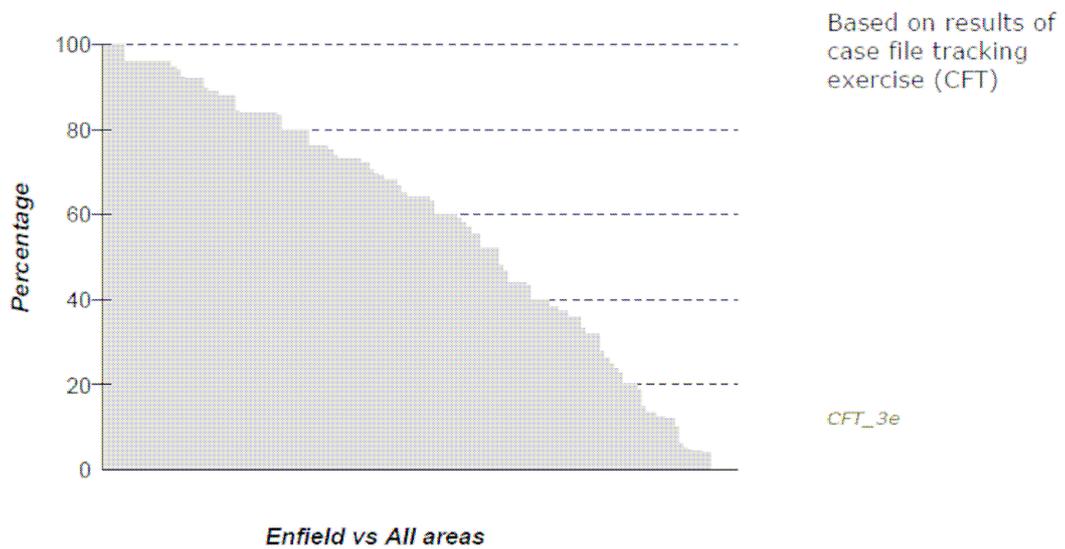
Enfield vs All areas

Support for participation in community life 2 (of 2)

THIA(L) Q2 Was info clear and helpful re money and benefits

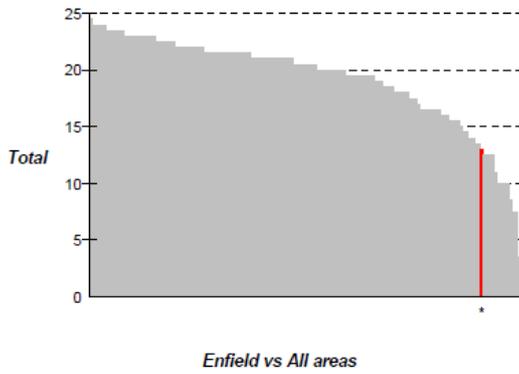


Percentage of people with care plans with outcome-focussed goals (CFT)

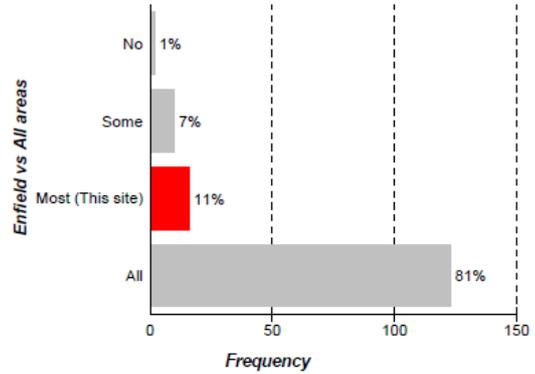


TIA care and support

Total points for TIA



TIA pathway been agreed/implemented

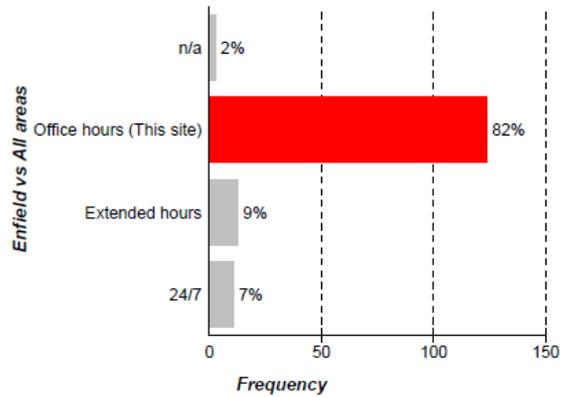
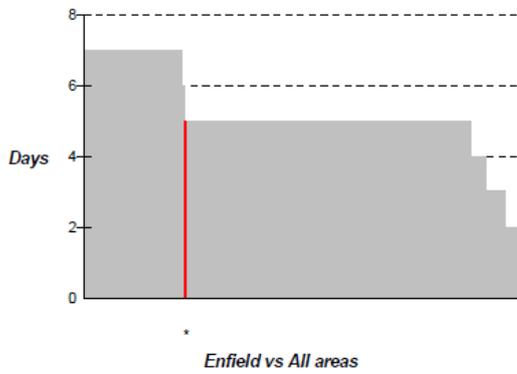


All inputs to Scored Indicator 6

PCT 15a

TIA assessment clinics on how many days

What are their opening hours?

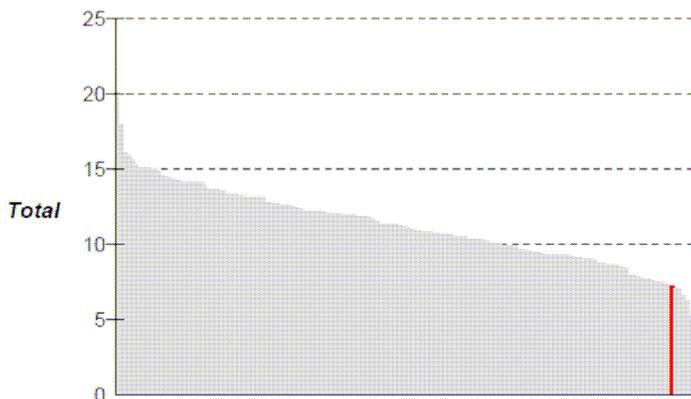


PCT 15l

PCT 15m

Reviews and assessments after transfer home 1 (of 2)

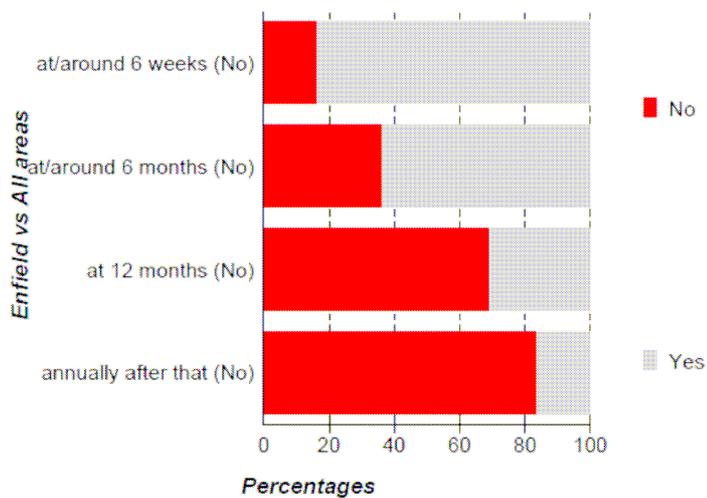
Total points for Reviews



* All inputs to Scored Indicator 14

Enfield vs All areas

Systems in place for reviews after transfer home



PCT5a(i) - PCT5a(iv)

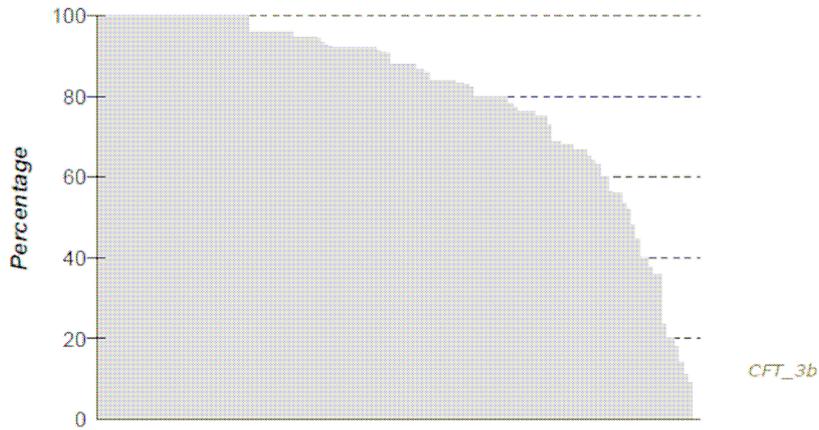
Reviews and assessments after transfer home 2 (of 2)

Percentage for whom a review is carried out at 6 weeks (from local systems)



Enfield vs All areas

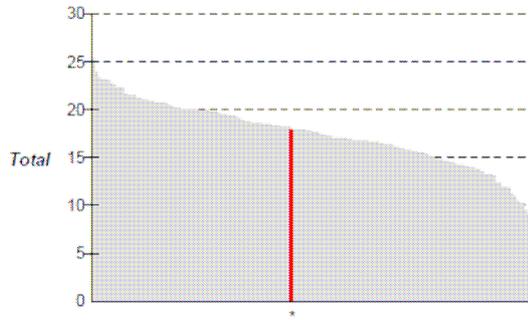
Percentage of people with care plan now in place (CFT)



Enfield vs All areas

Range of information provided

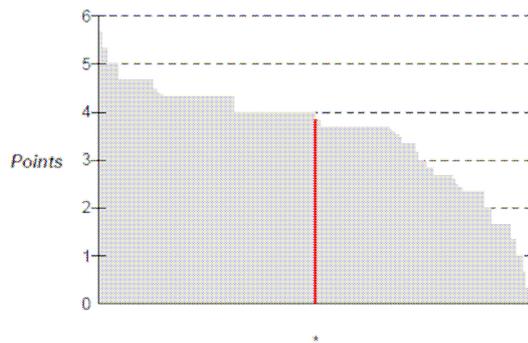
Total points for Range of Info



All inputs to Scored indicator 3a

Enfield vs All areas

Range of Information points from THIA central analysis

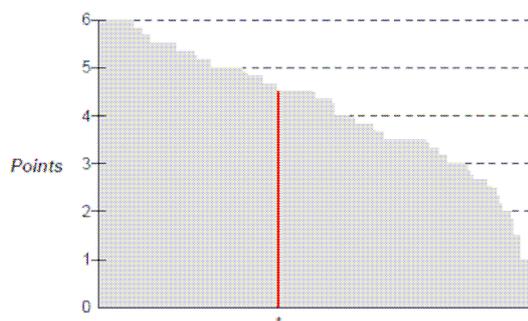


Total points for range of information, based on analysis of Transfer Home Information Analysis tool undertaken centrally by CQC (THIA (C))

THIA(C)

Enfield vs All areas

Range of Information - points from ASSD form

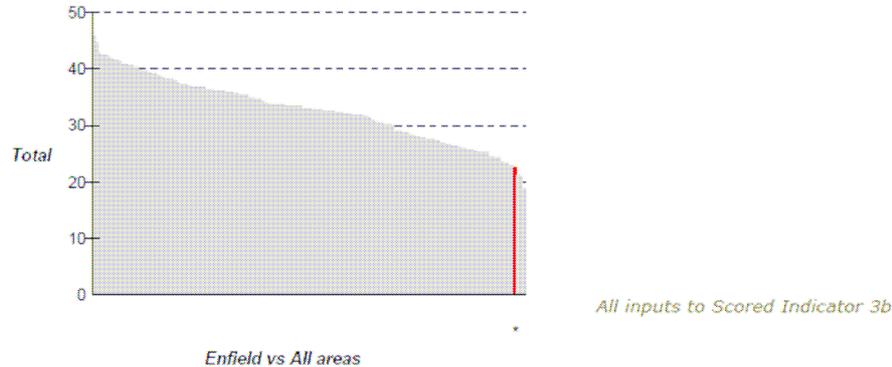


ASSD form

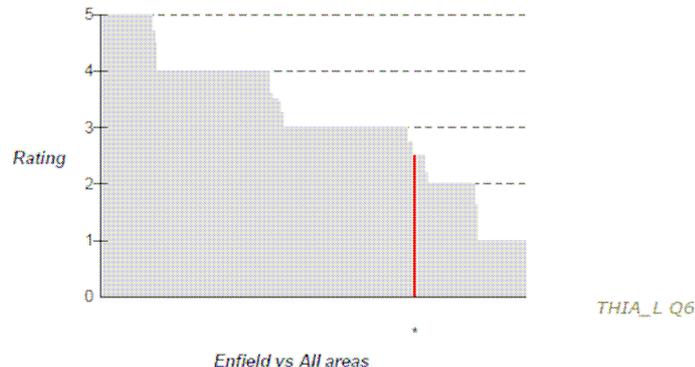
Enfield vs All areas

Signposting, coordination and personalisation 1 (of 3)

Total points for Signposting



THIA(L) Q6 Was it easy to find things in the THIA pack of information?

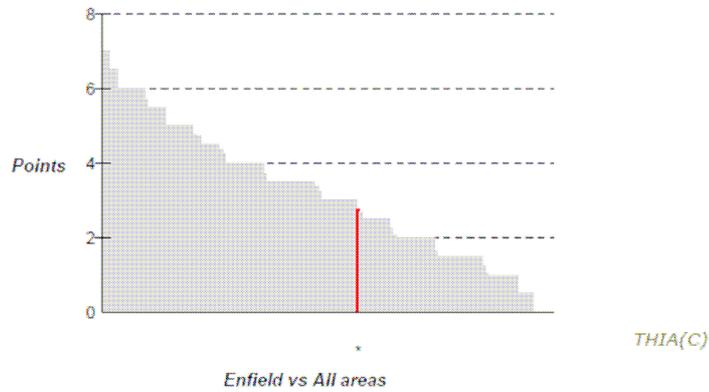


THIA(L) Q7 Was the information in the THIA pack easy to understand?

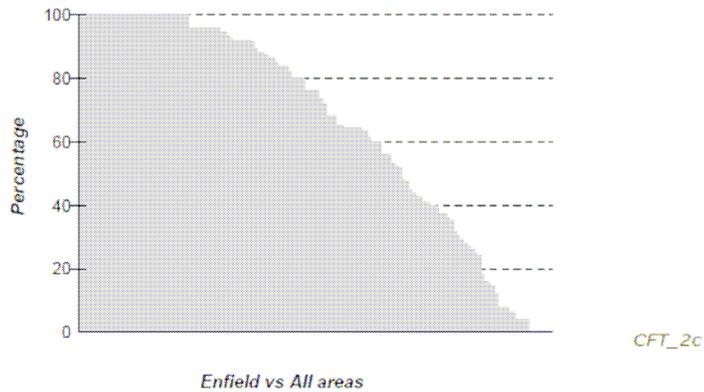


Signposting, coordination and personalisation 2 (of 3)

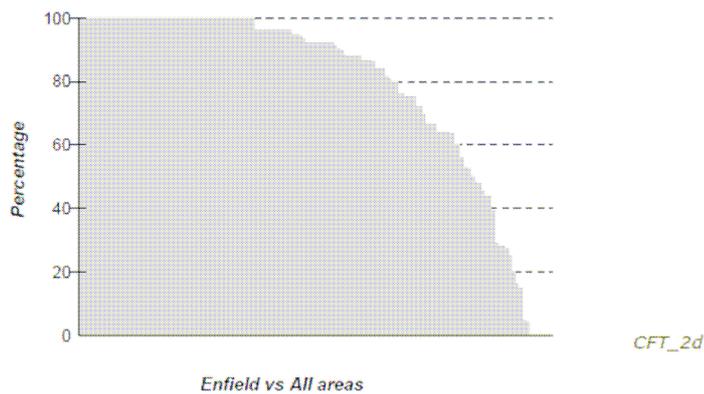
Signposting points from THIA(C)



Percentage of people with named support worker (CFT)

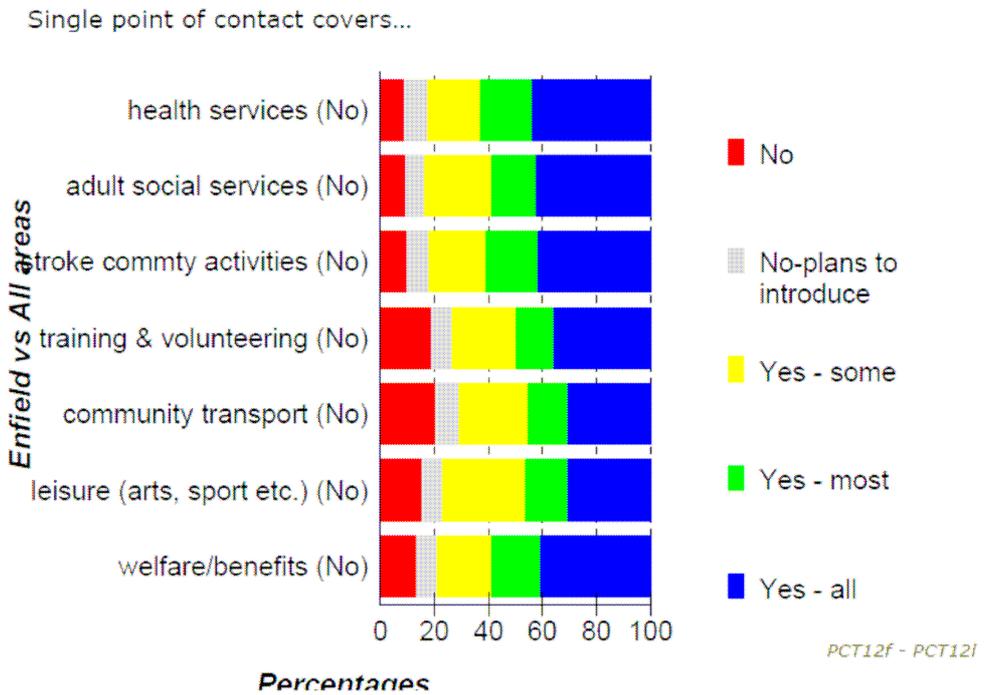
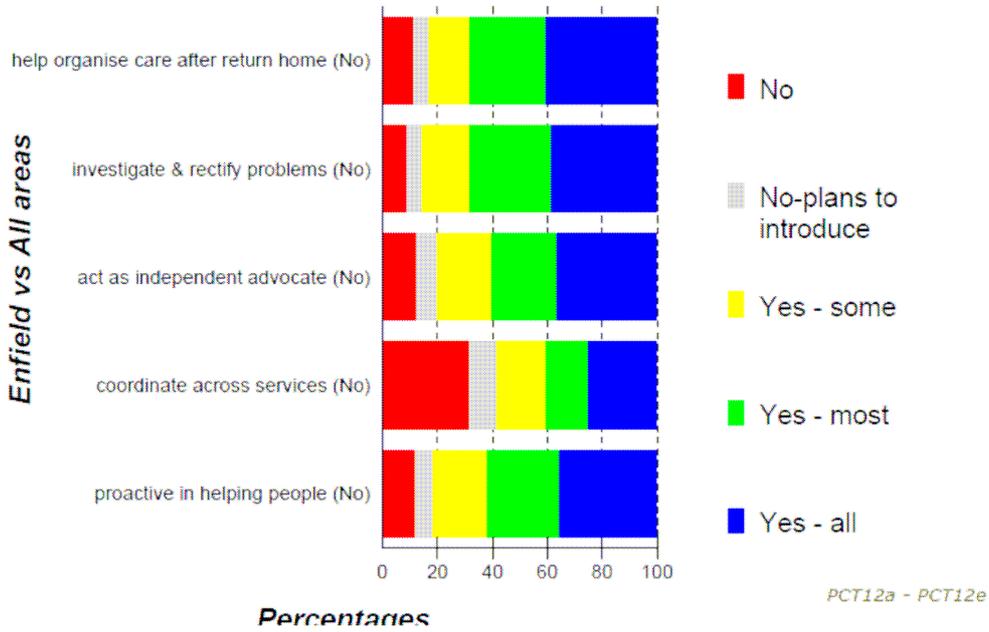


Percentage of people given helpline number (CFT)



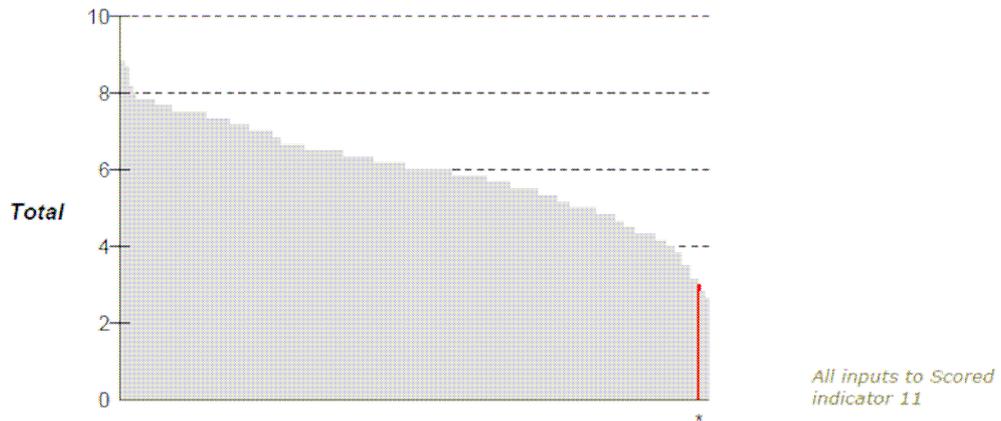
Standard 3: coordination and personalisation 3 (of 3)

Single point of contact (SPOC) role



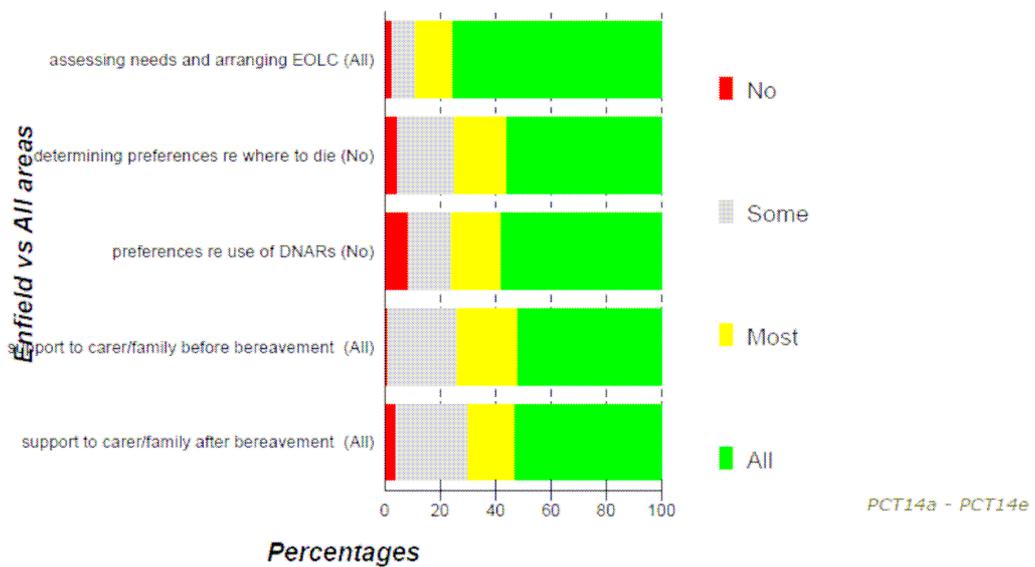
End of life care

Total points for End of life care



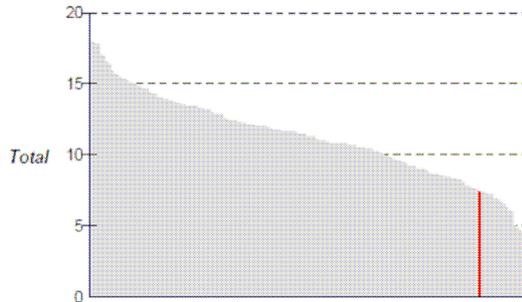
Enfield vs All areas

EOLC pathway (PCT questions)



Involvement in planning and monitoring 1 (of 2)

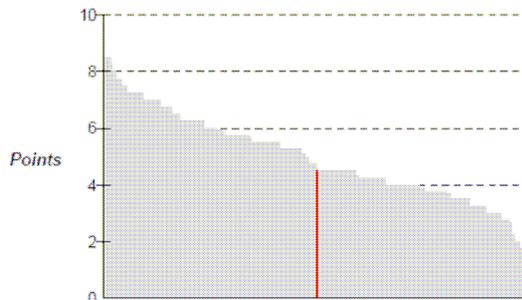
Total points for Involvement



Enfield vs All areas

All inputs to Scored Indicator 4

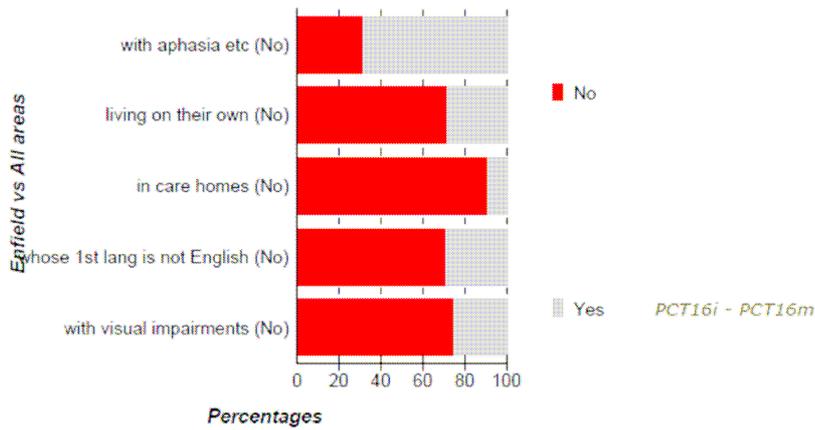
Involvement points - from ASD form



Enfield vs All areas

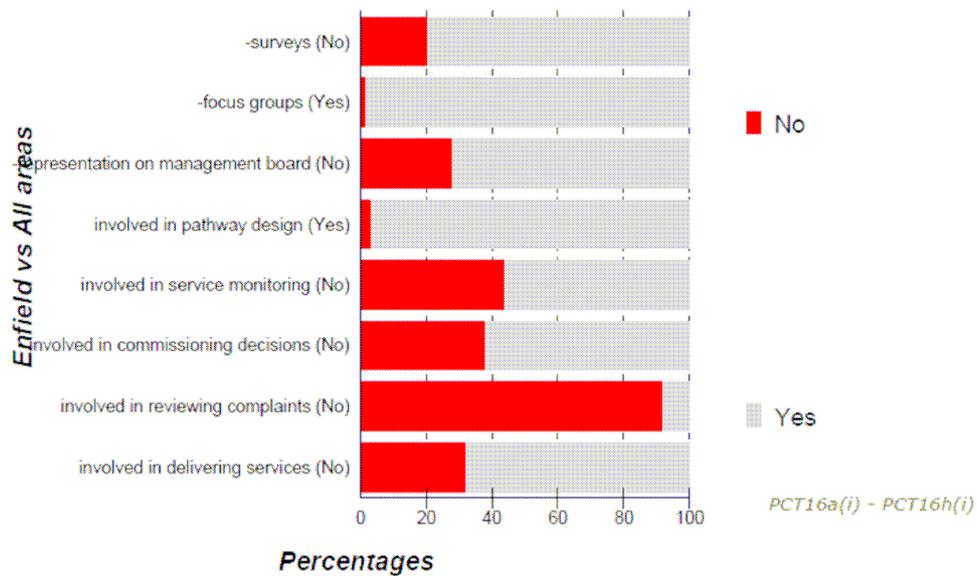
ASD form

Targeted involvement work

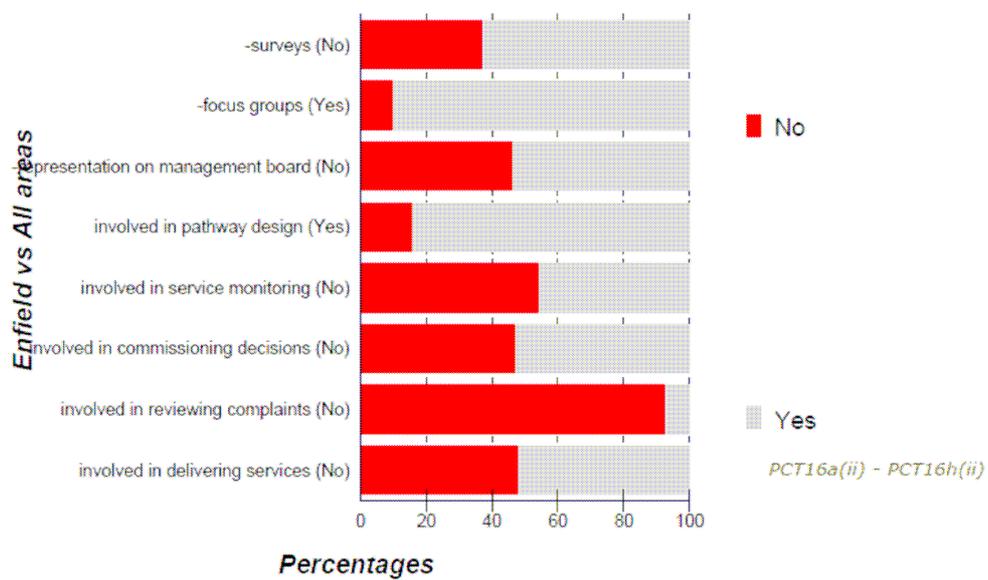


Involvement in planning and monitoring 2 (of 2)

Involvement - stroke survivors



Involvement - carers



Working together

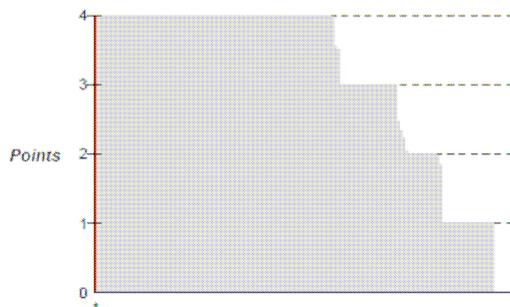
Total points for Working together



Enfield vs All areas

All inputs to Scored Indicator 17

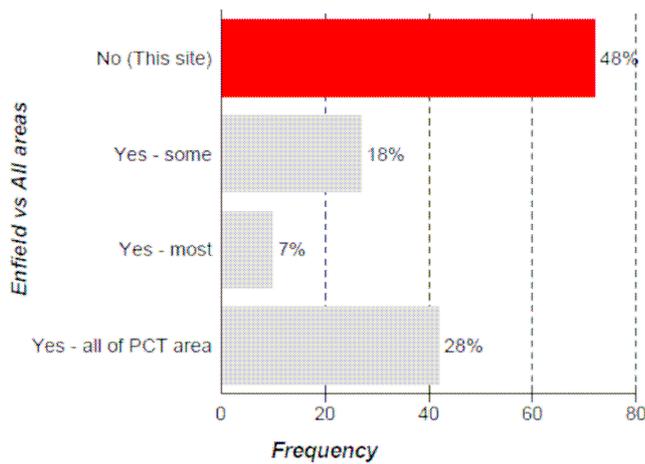
Working together - points from ASSD form



Enfield vs All areas

ASSD form

Integrated reviews of health and social needs



PCT 5u

APPENDIX 5: STROKE IMPLEMENTATION TEAM MEMBERSHIP

Name	Title	Organisation
Amrus Ali	Business Manager	Barnet & Chase Farm Hospital
Aisling Bowman	General Manager Care Group 4	North Middlesex University Hospital
Brigitte Shallow	Acting Assistant Director for Older People and Carers	Intermediate Care Team
Margaret Brand	Manager	Intermediate Care Team
Carol Macgregor	Rehabilitation Co-ordinator	NHS Haringey
Caylie Field	Head of Therapies	North Middlesex University Hospital
Chetna Shah	CEO	Enfield Asian Welfare Association
David Githinji	Charge Nurse	Barnet & Chase Farm Hospital
David Sollis	Head of Income Generation	ATTEND
Dr Bal Athwal	Neurology	Barnet & Chase Farm Hospital
Elmarie Scheepers	Assistant Team Manager	Occupational Therapy Department
Gail Mansfield	Manager - Enablement	London Borough of Enfield
Jackie Gardner	Stroke Survivor	
Glen Stewart	Assistant Director Public Health	NHS Enfield
Helen Nicholau	Assistant Manager - Enablement	London Borough of Enfield
Jan Kennedy	Specialist Stroke Coordinator	North Middlesex University Hospital
Jane Jones	Community Physiotherapy and Dietetics Manager	Barnet & Chase Farm Hospital
Jennie Bostock	Head of Care Closer to Home	NHS Enfield
Jill Jordan	Housing, Health and Adult Social Care	London Borough of Enfield
Jim Whyte	Stroke Survivor	Enfield Stroke Survivor and Family group
Joseph Buttell	Clinical Lead	North Middlesex University Hospital (Acute Stroke Unit)
Kate Charles	Commissioning Manager	London Borough of Enfield
Litsa Worrell	CEO	Greek & Greek Cypriot Community of Enfield
Lee McPhail	Director of Operations	North Middlesex University Hospital
Liberty Rowley	Marketing Assistant	ATTEND
Lynda Rogers	Stroke Survivor	Enfield Stroke Survivor and Family group
Mark McGlinchey	Clinical Lead Physiotherapist	Barnet & Chase Farm Hospital
Melanie Richmond	Assistant Team Manager	AT Home Service
Mrs E.A Henthorn	Stroke Survivor	Enfield Stroke Survivor and Family group
Nathan Theva	Stroke Consultant	Barnet & Chase Farm Hospital
Pinky Millward	Adult Therapy Manager	Enfield Community Service

Rita Melifonwu	CEO	Total Healthcare and Stroke Association
Robert Luder	Stroke Consultant	North Middlesex University Hospital
Sandra Arinze	Stroke Co-ordinator	NHS Enfield
Sarah Baron	Assistant Director for Stroke	NCL Cardiac and Stroke Network
Shaheen Mughal	Commissioning Manager	London Borough of Enfield
Singh Veena	GP	Grovelands Medical Centre
Sue Cripps	Health Scrutiny Officer	Enfield Scrutiny
Tom Greenwood	Head of Operations	Stroke Association
Tracy Goodman	Matron	Barnet & Chase Farm Hospital
Tristan Brice	Stroke Project Manager	NHS Enfield
Veronica Daire	Stroke Survivor	Stroke Working Group
Veronica Wareham	Occupational Therapy	NHS Haringey
Vikki Butler	Deputy Head of Therapy	Barnet & Chase Farm Hospital