LONDON BOROUGH OF BROMLEY

HEALTH SUB-COMMITTEE

DATE:	**16th February 2012**
SUBJECT:	**Stroke Services in Bromley**
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Summary

This report provides an outline of stroke services in Bromley and the issues that currently impact on the delivery of best care. The report also highlights steps taken to map stroke services in Bromley and how we may deliver against the recommendations made by the 2010 CQC Review of Stroke Services in South East London. Various stakeholder groups have been involved with this project and we would like to thank the South London Cardiac and Stroke Network in their support of this piece of work.

Recommendations to the Committee

1. **To acknowledge the report**
2. **To support the recommendations that have been made**

Outline of Stroke Report

1. Stroke in Bromley –Stroke data, stroke in context
2. Stroke services and issues in Bromley including risk factor management
3. Stroke pathway mapping event –Steering groups, support from Stroke and Cardiac Network
4. Pre-hospital care and going forward
5. Post-hospital care and going forward

1. Stroke in Bromley

Circulatory disease comprising heart disease and stroke form a significant cause of death in Bromley (33.9%, 2006-2010). Though stroke mortality has been falling since 1993, health inequalities do exist between different areas in Bromley.

The crude incidence for stroke is approximately 2.4/1000 of the population per year. The prevalence of stroke in Bromley has been stable over the last 2-years and sits at 1.61%. This is lower than the England average at 1.7% but higher than the London average at 1.1%. There are approximately 5362 stroke patients on the 2010/2011 disease register (reflecting the higher proportion of older people in Bromley) with an estimated 200 deaths/year.

1.1 In context

The 2010 CQC Review of Stroke Services in South East London focused on the post-hospital discharge part of the pathway through to long-term care and support in the community. A number of recommendations were made to Bromley:

- Improve secondary prevention measures
- Improve access to TIA services

- Develop an early supported discharge service
- Develop patient information and support services in the community
- Integrate social care to provide information and opportunities for patients returning to the community
- Improve sign-posting around life after stroke
- Provide appropriate performance indicators to address outcomes at 6-weeks, 6-months and 1-year post event

Establishing a stroke review group to conduct a detailed analysis of the stroke pathway, its gaps and agreeing how to move forward was in direct response to this review.

2. Stroke services in Bromley

The Princess Royal Hospital on the 18th of May 2011 launched a 6-bedded hyper-acute stroke unit (HASU) to care for patients post-thrombolysis and acute stroke. The aim was to increase bed capacity in phased response to a maximum of 18 beds. For the HASU and Acute Stroke Unit (ASU) to work efficiently, an early supported discharge (ESD) service would be required to enable a reduction in patient bed days. Bromley PCT at the same time delivered, through procurement, a specialist neuro-rehabilitation service providing therapy, nursing and sign-posting to patients with long-term chronic neurological conditions including stroke. The service was not commissioned exclusively for the benefit of stroke patients nor was there (at the time) capacity built in for an ESD service.

There are currently 2-transient ischaemic attack (TIA) clinics operating between 2-sites across SLHT. Though operational during working hours, 5-days a week, the service is not thought to be utilised to its full capacity. Most high risk patients continue to put pressure on accident and emergency services. There are thus opportunities for pathway re-development and better streamlining of patients to this service.

2.2 Stroke prevention

With respect to risk factor management, the most significant findings were the variation in care provided between practices, mainly around secondary prevention measures. With a variable stroke mortality rate between the most and least deprived areas, Bromley has scored significantly worse than the England average in the following areas:

- Hypertension prevalence (patients registered with hypertension 2007/2008)
- Blood pressure recordings in the last 15-months (patients registered with stroke or TIA 2008/09)
- Blood pressure readings of 150/90mmHg or less (patients registered with stroke or TIA 2008/09)
- Cholesterol recorded in last 15-months (patients registered with stroke or TIA 2008/09)
- Cholesterol readings 5nmol/L or less (patients registered with stroke or TIA 2008/09)
- New patients referred for further investigation (patients registered with stroke or TIA 2008/09)

There has also been a continuous rise in the prevalence of diabetes mellitus (DM) over the last 8-years from 1.6 to 5%. This represents a massive increase from 4846 in 2002 to 13, 307 in 2010. Additionally there is concern about the rise in the prevalence of hypertension in Bromley, which is currently higher than the national average (47.8% versus 43.9 for England and 41.1% for London) and has risen over the last 6-years.

3.0 Stroke pathway mapping event

On the 7th of November 2011, various stakeholder groups were invited to a workshop supported and facilitated by the South East-London Stroke and Cardiac Network. The aim was to map the Stroke pathway in Bromley and assess

where and how improvements in stroke care may be made. Two areas in particular were looked at in detail, stroke prevention and post-stroke care/rehabilitation. A group comprising acute clinician, specialist nurse, CHD-nurses and rehabilitation service manager were asked to assess prevention management while a second group comprising acute trust therapists, GPs, local authority and commissioning leads were asked to assess access to rehabilitation and community services as well as the delivery of 6-monthly post stroke reviews.

The workshop helped showcase a number of community service providers supporting stroke patients and how they may integrate within existing services.

Following discussion, steering groups were identified to develop strategies and techniques to implement change with a view to feeding back to the wider group after 6-months.

4.0 Stroke prevention and going forward

This group addressed stroke prevention and agreed that the following areas required further development and how that may be achieved:

- TIA services
    - Communication of service to wider healthcare community
    - Education and training in TIA management and onward referral
    - Practice based care of patients with TIA
    - Atrial fibrillation (AF) and stroke helpline

- Risk factor management including atrial fibrillation (AF)
    - Collaboration of health professionals working with stroke patients
    - Increase use of CHD nurses and practice leads
    - Incentivisation of care around AF and admission avoidance

The following actions were agreed:

1. TIA
    a. Highlight the TIA service to GPs in a useable format
    b. Delivery of educational events around management of TIA
    c. Dr Piechowski (Consultant Neurologist, PRUH) volunteered as Clinical Champion in taking ideas forward
2. Atrial fibrillation (AF)
    a. Dr Piechowski to join AF working group (led by Dr A. Parsons)
3. Hypertension and lipid management
    a. Public health CHD/vascular nurses to develop a model for better engagement with primary care leads
    b. Gillian Fiumicelli and Mary O'Sullivan to lead on this
4. DM
    a. Public health diabetes group to continue audit of patients with metabolic syndrome

5.0 Post-stroke care and going forward

This group identified how to improve access to community based services and agreed that the following areas needed further development:

- Business proposal for an early supported discharge service
- Single point access referral system for GPs referring patients into community services
- Increased use of voluntary organisations e.g. Stroke Association to deliver sign-posting and case management reviews
- Delivery of 6-month post-stroke reviews offering the opportunity to re-engage with rehabilitation services

The following actions were agreed:

1. ESD
    a. Yee Cho (Head of Non Acute Commissioning), Dr Shivali Talsania (GP Clinical Associate) to work on a business proposal for development of an ESD service with support from the Stroke and Cardiac Network.
2. Single point access referral system
    a. Yee Cho currently engaged with developing the service
    b. To be evaluated at 3-months with steering group
3. 6-month post stroke review
    a. Clinical sub-group to develop a framework for 6-month reviews
    b. Dr Jon Doyle (GP lead nominated by Dr A. Parsons) and Dr Piechowski to provide clinical leadership

Recommendations

The priority areas that have been identified through this work are essentially around prevention and post-stroke rehabilitation. The following will need to be achieved to improve stroke care in Bromley:

1. **Improve access to TIA services and education around its management in primary care**
2. **Improve education and management of risk factors in stroke**
3. **Deliver an Early Supported Discharge Service (ESD) that can integrate within existing services**
4. **Better manage referrals to community services through a single point access referral service**
5. **Develop an effective model for delivering 6-monthly post-stroke reviews**