MANCHESTER CITY COUNCIL
REPORT FOR INFORMATION

Committee: Health and Well Being Overview and Scrutiny Committee
Date: 16 November 2006
Subject: Stroke: Prevention, treatment, care and support
Report of: Director of Commissioning, Manchester Primary Care Trust
Director of Adult Social Care, Neighbourhood Services

Purpose of Report:
To provide the committee with an overview of services available in Manchester for the prevention of stroke and treatment and care of people who have had a stroke.

Recommendations:
The Committee is asked to:

i) Note the report
ii) Comment on the areas identified for further consideration (see text boxes in main report)
iii) Select specific areas to scrutinise as part of the work programme

Contacts:
Sara Radcliffe
Director of Commissioning
Manchester Primary Care Trust
Tel: 0161 958 4000 Sara.radcliffe@manchester.nhs.uk

Caroline Marsh
Director of Adult Social Care
Tel: 0161 234 3952 c.marsh@manchester.gov.uk

Mary Christie
Associate Director of Unscheduled Care
Manchester Primary Care Trust
Tel: 0161 219 9481 Mary.Christie@manchester.nhs.uk

Helen Hosker
GP with a Special Interest
Older People’s Service Development
Manchester Primary Care Trust
Tel: 0161 948 4000 Helen.hosker@manchester.nhs.uk
1. Introduction

The purpose of this report is to provide an overview of services for Stroke and Transient Ischemic Attack (TIA) in primary, secondary and social care services in Manchester. This will be set in the context of national policy initiatives. Future developments, both nationally and locally will be described and recommendations for areas requiring future consideration will be highlighted.

2. Background

2.1 Definitions and statistics

Stroke is an acute event which results in damage to the brain which can result in a wide variety of disabilities:

- 80% are when the damage is be caused by a clot which causes ischaemia (similar to heart attack)
- 15% are due to bleeding within the brain (haemorrhagic causes)
- 5% are due to miscellaneous causes, for example inflammation of the arteries

The extent of the brain damage can be reduced by good care in the first 72 hours, often referred to as the ‘acute phase’. A TIA is currently defined as a stroke where all the symptoms have resolved within 24 hours. This is a retrospective diagnosis. It is being increasingly recognised that many TIAs are in fact strokes and that an identifiable group of people who have had a TIA may have a risk of a stroke within the first week which is as high as 30%.

Stroke is the third most common cause of death in the UK; one of the most important causes of significant adult disability and most common cause of neurological disability. Each Year in the UK, approximately 120,000 people have a first stroke, 30% of whom die within a month. In addition about 30,000 recurrent strokes occur. The risk of having a stroke before the age of 85 years is one in four for men, and one in five for women.

2.2 The Manchester Picture

In 2005 (the latest year of data), 406 Manchester residents died from a stroke. This accounts for around 10% of all deaths in the city. There is a strong age-gradient to stroke deaths with over three-quarters (76.8%) of deaths occurring in people aged 75 or over. The proportion of stroke deaths occurring prematurely (i.e. before the age of 75) is much higher in Manchester compared with England as a whole. In Manchester, 23.2% of stroke deaths occurred in people aged under 75 compared with 18.8% in England as a whole.

The table below shows trends in premature mortality rates from stroke in persons aged 0-64 and 65-74 years in Manchester compared with the North West Region and England as a whole.
Mortality from stroke (ICD10 I60-I69) in persons aged 0-64 and 65-74 years (1993-04)
Directly age-standardised rates (DSR) per 100,000 European Standard population

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<td>1993-95</td>
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<td>8.5</td>
<td>242.3</td>
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Change (%) | -26.5 | -27.3 | -26.9 | -18.6 | -33.3 | -34.3 |

Source of data: National Statistics (Extracts may only be reproduced by permission)

In persons aged under 65 years, mortality rates in Manchester have fallen by 26.5% - a rate of change which is comparable with that in the North West and England as a whole. However, the degree of change in the 65-74 age group is much lower than other areas – 18.6% compared with 34.3% in England as a whole. Some black and minority ethnic (BME) groups will have higher levels of risk factors for stroke and other circulatory diseases.

2.3 National Policy Drivers

Stroke is referred to in three National Service Frameworks (NSFs):
- Coronary Heart Disease (2000)
- Older People (2001)
- Managing Long Term Conditions (2005)
- A New Ambition for Old Age (2006) the next steps for the NSF for Older People

Following a report by the NAO (National Audit Office) Reducing Brain Damage: faster access to better stroke care’ (2005) which identified ‘major problems with the consistency delivery of high – quality stroke to all patients in England. Evidence clearly demonstrating that stroke is both preventable and treatable has accumulated over recent years, and health services have developed to reflect this albeit not as rapidly as we would like’. Following a hearing at the Parliamentary Accounts Committee in February 2006 the Department of Health has started work on a National Stroke Strategy which is due for completion in late 2007. A commissioning strategy will be published in December 2006. Prof Roger Boyle, National Director for Heart Disease has been appointed to lead this work.
The Greater Manchester Stroke Network Board held a conference in September 2006 entitled ‘Improving Stroke Services in Greater Manchester – how can we do better?’. Prof Roger Boyle was the key note speaker. Other speakers included internationally recognised experts and local experts. This was well attended and there was high level of interest.

Also in the development stage are NICE (National Institute for Health and Clinical Excellence) guidelines for ‘Stroke: diagnosis and initial management of acute stroke and TIA’. These are due for publication summer 2008.

3. Provision of health services for Stroke

3.1 Introduction

Prevention and long term care has been delivered through primary and community care services. The new GP contract has indicators for Stroke which give a measure of certain standards of care for people who have had a stroke. (See Appendix 1 for further details.)

The three acute hospitals in Manchester: Wythenshawe, Manchester Royal Infirmary and North Manchester General Hospital, all provide acute stroke services.

3.2 Prevention and Primary Care Services

Primary prevention for stroke (preventing a first stroke) includes lifestyle measures and treatment of other medical conditions, particularly hypertension (raised blood pressure), atrial fibrillation (an irregularity of heart rhythm), diabetes and blood disorders such as sickle cell disease.

The important changes in lifestyle behaviours which can reduce the risk of a stroke are:

- Stopping smoking
- Regular exercise
- Healthy diet: reduce salt intake, ‘Five a day’
- Sensible alcohol intake
- Obesity

The Health Trainer scheme will focus on diet and exercise with BME groups which will impact positively on stroke prevention.

Programmes are now in place to address all of these public health priorities but more targeted investment is required in order to reduce health inequalities.

General Practitioners are now able to identify those who have had a stroke or TIA. Comparison of the Quality and Outcome Framework for stroke show an improvement across all the indicators between 2005 and 2006. PCTs have followed up areas of concern on the inspection visits. Hypertension is also measured by this method, and again there has been an overall improvement in treating this condition. Atrial fibrillation is a new indicator for 2006-07.
Overall there has been good progress made across the domains within the QOF for stroke services, but there are further areas for improvement for the PCT to continue to address with individual practices.

3.3 The Management of TIA

The national Royal College of Practitioners (RCP) guidelines are that all TIAs are seen within seven days. Previously referrals could be faxed through to consultants but GPs are now being encouraged to use the ‘Choose and Book’ system for referring to secondary care. The National Directory of Services does not include provision for Rapid Access TIA clinics and this problem has been raised at a national level.

Across Manchester the waiting time for an appointment at a TIA clinic is variable:
- Manchester Royal Infirmary – 1-2 weeks
- Withington Hospital – 4 weeks
- Wythenshawe Hospital – 4 weeks
- North Manchester General Hospital – 1-2 weeks

Following assessment in the clinic, investigations need to be arranged promptly followed by referral to a vascular surgeon with the results for definitive treatment.

Whilst waiting for national direction from the National Stroke Strategy and NICE guidelines the Manchester PCT should undertake work to improve management of TIA.

3.4 Ambulance Service

A new stroke is a medical emergency. The NAO report uses the phrase ‘Time is Brain’.

At present the national standards for ambulance responses only categorise stroke as requiring a 30 minute response time. Local attempts to raise stroke to a higher priority has not proved possible. The national guidelines will be changed in late 2006 so that the response time for stroke is eight minutes. A nationally recognised assessment tool for stroke is included in the North West Ambulance Service protocols and paramedics have been trained in its use.

3.5 Hospital Services

All three acute hospitals all have Accident and Emergency Departments have a dedicated ASU (Acute Stroke Unit) and at least one Consultant in Stroke Medicine. The ASU at North Manchester General Hospital was the most recent and became fully operational in October 2005. It is essential that the ASUs have the correct capacity to treat all new within the first 72 hours and carry out appropriate monitoring by experienced nursing staff. A key element of managing a new acute stroke is access to CT (or MR) scanning within 48 hours, preferably 24 hours, and availability over seven days to correctly diagnose a stroke and the type of stroke. This information is crucial for the immediate management of a stroke. The National
Sentinel Audit, Organisation Indicators 2006, measurements include size of an ASU and access to scanning (see appendix 2).

Further work is required to ensure that there is adequate number of beds on acute stroke units, the monitoring equipment is available and the staffing levels are sufficient for the needs of the patients.

Thrombolysis is a ‘clot busting’ treatment for ischaemic stroke which has to be given within three hours of the onset of a stroke. It can dramatically reduce the level of disability, but can prove fatal if given to the wrong stroke victim. Delivery of this is called ‘hyperacute stroke service’. At present Manchester Royal Infirmary is providing a 9-5pm, Monday to Friday thrombolysis service.

The Greater Manchester Stroke Network Board is proposing to commission a project to look at the need and requirements for the provision of hyperacute stroke services across Greater Manchester. Manchester PCT will be approached to engage with this piece of work.

3.6 NHS role in rehabilitation

All three hospitals have dedicated SRUs (Stroke Rehabilitation Units) for inpatient rehabilitation. Therapists include physiotherapy, occupational therapy, speech and language therapy, dietetics and psychology. Multi disciplinary working is a key element of good practice.

The RCP guidelines recommend assessment and treatment by stroke specialist therapists in the first instance. Referral to generic therapy services may be considered appropriate for some patients depending on their assessed functional needs.

Community rehabilitation may be delivered as part of an early supported discharge programme and/or as out patient therapy treatment following on from in patient treatment. Provision of therapy is variable across the three Manchester PCT hubs. Services have developed in a fragmented way. Intermediate Care services in North Manchester provide a service for stroke. There is good evidence for early supported discharge services and models of service. Stroke patients frequently have complex discharge needs and require input from both health and social care to ensure a sustainable return home and maximum independence.

There is further work required to develop equitable early supported discharge provision for stroke across Manchester. Commissioning these services will need to take account of Payment by Results and ‘unbundling the tariff’ to release monies from secondary care.
3.7 Social Care Services for people who have suffered a stroke and their families/carers

The consequences of stroke are commonly:

- Reduced mobility – temporary or permanent.
- Problems with speech.
- Difficulty in swallowing food and drink.
- Loss of upper arm mobility – arm and hand use.
- Possible mental health problems, notably depression.
- Impact on relationships, including sudden enforced changes in roles and sudden increases on demand on relatives/friends to undertake a carer role.

Often stroke survivors will regain some lost functions with support from Health and Social Care professionals. Services required to achieve this are:

1. Intensive physiotherapy, occupational therapy, re-enablement and counselling to assist recovery.
2. Support for the individual and families/carers to ensure that the full potential of rehabilitation is realised before decisions on the long-term future are made.
3. Provision of equipment or in some cases adaptations to the home.
4. Possibly a need for re-housing to single level accommodation.

Re-enablement Services form part of the overall rehabilitation package mentioned above and staff work intensively with an individual either in a residential establishment or in his/her own home to regain mobility and the practical skills necessary to carry out basic tasks (getting dressed, preparing a drink etc.). This can be extremely important in terms of self-confidence, personal dignity and the potential development of depression due to anxieties about loss of control and independence.

Social Care Services need to focus on promoting recovery and confidence to relearn basic skills to ensure a return to independence and not the development of dependence. The proposed citywide re-enablement service, supported by Scrutiny Committee and recently by the Executive, will significantly improve access to this important facility.

Following rehabilitation and re-enablement, Social Care Services will carry out an assessment of needs. This will be undertaken by either the Physical Disability Service for people under 65 or Older People's Service for those over 65. The aim of both these services is to support people to return home and achieve their maximum level of independence. This may be through commissioning short or long-term home support services, arranging respite care and support for carers, requesting equipment and/or adaptations, supporting applications for re-housing or facilitating Direct Payments or Individual Budgets so that people can purchase their own services. There is also a small but increasing range of supported and extra care housing available to which Social Care staff can make referrals.
Manchester Equipment and Adaptations Partnership (MEAP) also play a pivotal role in helping people who have experienced a stroke achieve some level of re-ablement or independence. All new customers are initially visited by an Assessment Officer whose primary role is to carry out a baseline assessment and meet basic needs with equipment and minor adaptations provision. The following equipment and minor adaptations are mostly used in stroke cases:

- Kitchen equipment such as jar grippers, kettle tippers, gas knob turners, vegetable baskets – these ‘gadgets’ help the customer carry out a simple task independently and, more importantly, safely. It is essential that people affected by stroke are encouraged to achieve their own personal level of independence and MEAP staff help customers with these everyday tasks using equipment to restore confidence and ability in doing things independently (thus not being over-reliant on carers).

- Throughout the rest of the home, MEAP provides a range of other equipment that helps maintain independence such as additional grab rails and stairs rails, seating and mobility equipment (e.g. high seat chair and walking sticks/frames etc.), together with a vast range of bathing equipment.

- Following an initial assessment, a case can be referred on to an Occupational Therapist for a more detailed assessment if major adaptations are involved.

- MEAP gathers information on the customer’s medical status or disability and records show that, since April 2006, 305 customers who presented with a stroke received full assessment from MEAP resulting in a range of equipment, minor and major adaptations being provided.

There is potential for Assistive Technology to improve the quality of life of people who have experienced stroke. Adult Social Care, together with Health colleagues, has recently appointed a project manager to investigate and commission appropriate and effective technology.

3.8 Long Term Support

It is well recognised that stroke victims and their carers have long-term needs following a stroke. These include support for long-term physical, psychological and social needs. There are hospital based stroke user groups. The stroke service at Wythenshawe Hospital holds a weekly follow up clinic at Withington Community Hospital which can also be accessed by carers. Central Manchester has jointly commissioned, with the Local Authority, a Family Support Organiser Service and dysphasia service (also for South Manchester stroke victims) from the Stroke Association.

Different Strokes, a charity for younger stroke sufferers, holds a monthly group at the Y Club in Castlefield which includes an exercise class.
Further work needs to be undertaken to develop long-term services to support people who have had a stroke and their families. This should be done collaboratively with the voluntary sector. The needs of specific groups, for example younger people and BME groups, need to be taken in to account.

3.9 Education and Training

It is nationally recognised that there is a major need for education and raising awareness about stroke for clinicians and professionals (at all levels), public, stroke survivors and carers (formal and informal). The GP with Special Interest for Older People’s Services has arranged a number of different educational events for professionals for strokes over the last few years. Central Manchester purchased training from the Stroke Association for carers, but this was poorly attended. Events for the public have been organised to coincide with National Stroke Awareness Week. Generally, stroke has not been a priority for education.

An ongoing educational programme for stroke is required for clinicians and professionals (at all levels), public, stroke survivors and carers (formal and informal). This should be multi agency and involve the voluntary sector.

4 Summary recommendations

Further developments in stroke care and services need to be coordinated across Manchester, led by commissioners involving all stakeholders.

5 Conclusion

With the formation of the Manchester PCT there is an opportunity to drive forward service developments across the Manchester health economy to provide safe, equitable and comprehensive services to improve care for stroke survivors in Manchester. The higher profile that stroke is being given nationally should help accelerate local responses.
Appendix 1
Standards used to measure effective stroke services in Primary Care

GP Contract Quality Outcome Framework for Stroke and TIA

1. The practice can produce a stroke register of patients with Stroke and TIA

2. The percentage of patients with presumptive stroke who have been referred for confirmation of diagnosis by CT or MRI scan

3. The percentage of patients with TIA or stroke who have a record of smoking status in the last 15 months, except those who have never smoked where smoking status need to be recorded only once since diagnosis

4. The percentage of patient with a history of TIA or stroke who smoke and whose notes contain a record that smoking cessation advice or referral to a specialist service, if available, has been offered in the last 3 months

5. The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months

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

7. The percentage of patients with stroke or TIA who have a record of total cholesterol in the last 15 months

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

9. The percentage of patients with a stroke shown to be non haemorrhagic, or a history of TIA, who have a record of aspirin, an alternative anti-platelet therapy, or an anti coagulant is being taken (unless a contraindication or side effects are recorded)

10. The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March
Appendix 2


Top twelve organisational indicators which are markers of good stroke services in Acute Trusts.

1. Treated in Stroke Unit during their stay
2. More than 50% of stay on a stroke unit
3. Screened for swallowing disorders within first 24 hours of Admission
4. Brain scan within 24 hours of stroke
5. Commenced aspirin by 48 hours after stroke
6. Physiotherapy within first 72 hours of admission
7. Assessment by an occupational therapist within 7 days of admission
8. Weighed at least once during admission
9. Mood assessed by discharge
10. On antithrombolytic therapy by discharge
11. Rehabilitation goals agreed by the multi disciplinary team
12. Home visit performed by discharge

Average for 12 indicators