Healthier Lancashire & South Cumbria

Lancashire and South Cumbria Stroke Prevention Strategy

2018-2023

Lancashire County Council
Blackpool Council
Blackburn with Darwen
Cumbria County Council
NHS

Contents

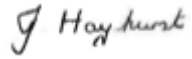
Forward

Over the last 20 years there has been steady improvement in adult stroke care which accelerated with the advent of the National Stroke Strategy. Stroke mortality has almost halved in the UK over the last 20 years but we know there is much still be done in regard of preventing strokes in the first place.

More than 1,100 people in Lancashire and South Cumbria lose their lives as a result of stroke each year yet many of these deaths are preventable[i]. Stroke Prevention has been identified as one of our key priorities within our integrated care system (ICS) and this strategy outlines the strength of ambition for the people of Lancashire and South Cumbria over the next five years and the potential to reduce this avoidable loss of life each year.

This strategy has been written by the Lancashire and South Cumbria Stroke Prevention Alliance and has been extensively consulted upon with key partners. As with any strategy, implementation is never easy but we are confident that with the right blend of leadership, vision, collaborative working and appropriate allocation of resources that our opportunity to achieve this vision has never been greater.

Dr Mammen Ninan, GP Clinical Lead for the Healthier Lancashire and South Cumbria Stroke Prevention Workstream



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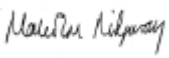

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1. Local Context in Lancashire and South Cumbria

Though our local stroke admission rate is lower than the England average, more than 2,700 hospital admissions were still attributed to stroke in 2016/17 alone[i]. In the three year period of 2014 to 2016, there were 2,739 deaths amongst the over 75s and 676 deaths amongst the under 75s[i]. In both age groups, rates of death due to stroke were higher than England average (10% and 9% respectively). Indeed, three of our eight Clinical Commissioning Group (CCG) areas have stroke mortality rates which are significantly higher than the England average for the over 75s though only one CCG area exceeds the England average rate for the under 75s. It is of course important to remember the significant morbidity that is also associated with stroke and the ongoing work that is being undertaken through the Lancashire and South Cumbria Stroke Programme Board that is strategically improving the quality of local Stroke Services right across the entire pathway.

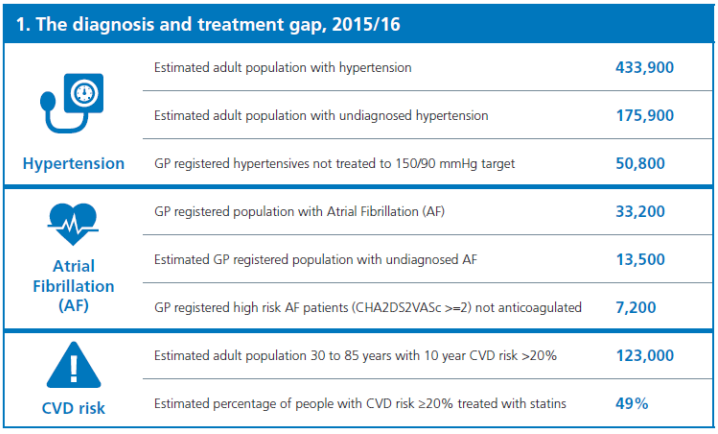
2. Stroke Prevention

There are many factors that can place a person at increased risk of stroke. These include some factors that can't be changed (age, ethnicity and family history). Similarly, there are some factors that can be changed and these are the focus of our strategy. These include:

- Lifestyle factors e.g. smoking, obesity, alcohol, lack of exercise and stress
- Clinical risk factors e.g. hypertension (high blood pressure), atrial fibrillation (a heart conditions which causes an irregular and abnormally fast heart rate) and high cholesterol

Reducing the impact of these factors on our population is absolutely key to achieving a reduction in strokes and stroke mortality locally. Public Health England has highlighted the considerable diagnosis and treatment gap that currently exists for these key risk factors:

Figure 1: The diagnosis and treatment gap across Lancashire and South Cumbria[ii]



1. The diagnosis and treatment gap, 2015/16		
Hypertension	Estimated adult population with hypertension	433,900
	Estimated adult population with undiagnosed hypertension	175,900
	GP registered hypertensives not treated to 150/90 mmHg target	50,800
Atrial Fibrillation (AF)	GP registered population with Atrial Fibrillation (AF)	33,200
	Estimated GP registered population with undiagnosed AF	13,500
	GP registered high risk AF patients (CHA2DS2VASc >=2) not anticoagulated	7,200
CVD risk	Estimated adult population 30 to 85 years with 10 year CVD risk >20%	123,000
	Estimated percentage of people with CVD risk ≥20% treated with statins	49%

Achieving optimal treatment of hypertension and high risk atrial fibrillation alone in Lancashire and South Cumbria could result in the prevention of more than 1000 strokes and 300 heart attacks as well as £18.2 million saved in treatment costs over a three year period. Furthermore, tackling these risks will lead to wider benefits such as a reduction in poor health outcomes, levels of disability and associated deaths.

3. Our overarching ambition for stroke prevention

By working closely with clinicians and local system leaders, whilst also ensuring our alignment with the emerging thinking of the national CVD Prevention Board, we are have developed a clear ambition to significantly reduce the number of avoidable strokes in Lancashire and South Cumbria by the end of 2023. In order to achieve this we aim to have:

1. Diagnosed 90% of all people estimated to have atrial fibrillation
2. Treated (with anticoagulation) 90% of those with atrial fibrillation who are at high risk of stroke
3. Diagnosed 80% of all people estimated to have high blood pressure
4. Treated (to NICE recommended blood pressure thresholds) 80% of those diagnosed with high blood pressure
5. Ensured that 75% of people aged 40-74 have had their cardiovascular disease risk assessed
6. Treated 60% of those at high risk (>20%) of developing cardiovascular disease over the next 10 years

Achieving these ambitions will ensure that Lancashire and South Cumbria effectively delivers locally upon national ambitions being developed by the National Cardiovascular Disease Prevention System Leadership Forum. It should be acknowledged that our timeframe for implementation is more challenging than those advocated nationally. However given the population need across our ICS, the degree of prioritisation within our ICS system and the commitment and enthusiasm being displayed by partners we are confident that these are still achievable by the end of 2023.

4. Delivery Framework

In order to effectively deliver our strategy, we have developed a delivery framework to help develop and align both ICS and ICP implementation plans. Our delivery framework is built around three core dimensions:

- Prevent – reduction of lifestyle risk factors
- Detect – closing the diagnosis gap
- Correct and Perfect – initiation and optimisation of treatment

As part of our planning we have clearly outlined what needs to happen in order to deliver across these three dimensions:

Dimension 1: Prevent - Supporting a reduction in lifestyle risk factors leading to stroke

Many lifestyle factors are more common in Lancashire and South Cumbria than in England as a whole as demonstrated in Figure Two:

Figure 2: Variation in key lifestyle factors across Lancashire and South Cumbria[iii]

	Average number of portions of fruit consumed daily (2016/17)	Average number of portions of vegetables consumed daily (2016/17)	Excess weight in adults - classified as overweight or obese (%) (2016/17)	Adult (18+) smoking prevalence (%) (2017)	Smoking attributable hospital admissions[A] - rate per 100,000 (2016/17)	Inactive[B] adults (%) (2016/17)	Admission episodes for alcohol-related conditions (narrow definition)[C] - rate per 100,000 (2016/17)
BwD	2.68	2.55	66.4	16.7	2113	23.4	800
Blackpool	2.47	2.51	63.5	22.3	3116	26.2	1151
Cumbria	2.76	2.77	62.4	14.5	1903	20.8	676
Lancashire	2.55	2.57	63.9	14.8	1888	22.9	645
ENGLAND	2.65	2.70	61.3	14.9	1685	22.2	636

Key: Red = Significantly above England average, Green = significantly below England Average and Yellow = Not statistically different

A: Concerns total number of hospital admissions for diseases that are wholly or partially attributed to smoking in persons aged 35 and over

B: <30 moderate intensity equivalent minutes per week

C: Concerns admissions to hospital where the primary diagnosis is an alcohol-related condition or a secondary diagnosis is an alcohol-related external cause

The contribution of existing Public Health programmes in support of this strategy cannot be underestimated. Alongside these existing primary prevention strategies and initiatives aimed at tackling the wider determinants of health across Lancashire and South Cumbria, the NHS Five Year Forward View additionally advocates for a radical upgrade in prevention going forward. It is also important to recognise the contribution of the at-scale delivery of Making Every Contact Count (MECC) across all organisations in Healthier Lancashire and South Cumbria. MECC is:

'an approach to behaviour change that uses the millions of day-to-day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and well-being'

Wherever someone accesses care in Lancashire and South Cumbria they should receive the same evidence-based advice on lifestyle with effective signposting to other services that can support and empower people to make healthier choices.

What needs to happen?

We will continue to develop our strategic relationship with broader PH population based preventative programmes of work

We will influence and support roll out of MECC amongst all health and social care organisations and beyond by:

- developing a framework for delivery
- Establishing a community of practice and facilitate sharing and implementing best practice
- ensure that MECC supports effective referral processes where appropriate

We will establish strong partnerships with community organisations to also ensure their awareness and involvement with MECC

Dimension 2: Detect – Closing the diagnosis gap on conditions known to increase the risk of stroke

We know that having hypertension, atrial fibrillation and high cholesterol puts people at vastly increased risk of having a stroke but that these conditions can be managed so that their risk is reduced. However, people must first be diagnosed and evidence suggests that these conditions are underdiagnosed.

Case Study 1

Emily has a family member who recently suffered from a stroke and wanted to know what she could do protect herself in the future. She remembered reading a newspaper article about high blood pressure as a risk factor for stroke and a friend had mentioned that she could have her BP checked for free at her local community pharmacy. Following this visit she was referred to her own family doctor and was found to have high blood pressure or "hypertension". Emily then took up the offer of a local exercise programme and was additionally offered appropriate medication.

In Lancashire and South Cumbria:

- There are 46,700 people estimated to have atrial fibrillation but around 13,500 remain undiagnosed
- There are 433,900 people estimated to have high blood pressure but around 176,000 remain undiagnosed

What Needs to Happen?

We need to close this diagnosis gap by increasing detection through:

- Public awareness campaigns e.g. Know Your Pulse, Know Your Numbers and promotion of relevant digital apps

- Increasing testing and detection (including by using newer technology) in:
  - community health settings such as local pharmacies
  - less traditional settings where people can receive testing opportunistically e.g. sports settings, during Fire and Rescue Service Safe and Well Checks

- Increasing diagnosis in general practice by:
  - increased systematic and opportunistic testing including through long term condition reviews, flu vaccination clinics etc
  - systematic audit and review to ensure that those who are at high risk are placed on appropriate disease registers etc

- Maximising the uptake of NHS Health checks as well as ensuring that those at the highest risk are also taking up the offer

- Implementation of best practice guidance concerning familial hypercholesterolaemia (FH). It is estimated that 1 in 270 people nationally have FH and thus addressing risks in those at high risk will ensure substantial population impact.

- Engage our community in the conversation about keeping well and understanding their own health condition(s)

Dimension 3: Correct and Perfect – Effectively treating those with conditions known to increase the risk of stroke

Diagnosing people with conditions known to put them at higher stroke risk is the first step in reducing this risk. These conditions must also be effectively managed.

Case Study 2

Charlie was having a routine review of his diabetes when his Health Care Professional found his pulse to be irregular. Although Charlie had no associated symptoms with this, after appropriate investigations Charlie was found to have atrial fibrillation, a heart condition that places a person at risk for stroke due to the potential to form blood clots that may then travel to the brain. Charlie is now prescribed anticoagulant medication which has significantly reduced the risk of him having a stroke in the future.

Evidence suggests that these conditions are also under-treated. In Lancashire and South Cumbria:

- There are 50, 800 people known to have high blood pressure who are not treated to measured blood pressure thresholds
- There are 7, 200 people with atrial fibrillation who are at high of stroke who are not on treatment to reduce this risk
- There are 62, 700 people at high cardiovascular disease risk who are not on effective cholesterol treatment to reduce this risk

What Needs to Happen?

We need to improve patient treatment and ensure patients are managed according to NICE guidance and associated quality standards by:

- Ensuring that all high-risk patients are correctly identified on GP systems
- Ensuring that patients are on the correct treatment (potentially incentivising primary care to do so) by commencing :
  - Anticoagulation therapy for high risk AF patients and ensuring that specifically that adequate Time in Therapeutic Range (TTR) is achieved for those on Warfarin
  - Antihypertensive drug treatment and ensuring that best practice blood pressure thresholds are reached
  - Statin drug treatment for those at high risk of developing cardiovascular disease and on-going monitoring where clinically appropriate
- Running STP/ICP wide audits to identify areas and practices requiring additional support and improvement in a supportive quality improvement led culture
- Developing appropriate management pathways both to, within and from secondary care

- Promoting self-care support, Lifestyle advice, signposting and referral including through Making Every Contact Count (MECC) interventions and well as empowering appropriate groups of patients to become more involved in self-management approaches

5. Integrating with Secondary Care

Although there is a strong focus on how we implement the three dimensions of the delivery framework in both community and primary care settings, the reality is that all three dimensions all have strong connectivity with secondary care services in a number of key areas including:

- Referral pathways in and out of secondary care
- Quality of care within secondary care
- How results are appropriately communicated back into Primary Care
- How we develop further integration between our providers

Examples of work programmes that are currently being considered, but which need to be still further developed include:

- Referral pathways for patients with secondary hypertension
- Current configuration and provision of anticoagulation services
- Provision of familial hypercholesterolaemia (FH) services

and it is recognised that further engagement with secondary care will be a further key part of the strategy to be developed going forward.

6. Support for local implementation

Leadership

Leadership is needed from partners across the health and care economy to drive forward improvements in stroke prevention. This includes organisations and individuals operating at regional, national and local level. Effective clinical leadership is essential at ICS, CCG and practice/trust level to help drive improvements.

Strategic Support

In 2017, a new Stroke Prevention Alliance was formed to bring together partners across the Lancashire and South Cumbria system on efforts to reduce stroke locally.

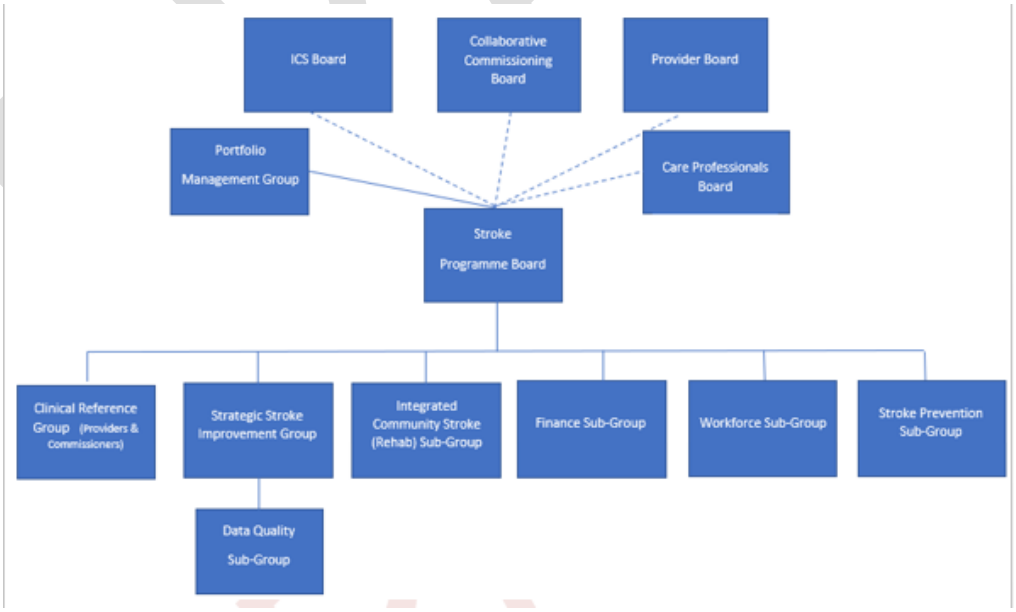
This Alliance currently meet on a six-eight weekly basis and incorporates key stakeholders including Advancing Quality Alliance (AQuA), Right Care, Innovation Agency, North West Coast Strategic Clinical Network (NWCSCN), University of Central Lancashire (UCLAN, Public Health England (PHE), British Heart Foundation (BHF), National Institute for Health and Care Excellence (NICE), Stroke Association and the Commissioning Support Unit (CSU) Medicines Management Team who support Lancashire CCGs.

Later this year the Stroke Prevention Alliance will merge with the Stroke Prevention Steering Group thus forming a key group of system leaders to support delivery of our stroke prevention ambitions over the next five years at ICP level. The Alliance will host annual ICS wide engagement events and proactively support the development and delivery of local ICP collaborative/protected learning time events in order to support local implementation plans.

Programme Governance

The Stroke Prevention Programme is a formal sub group of the Stroke Programme Board which in turn reports up to both the ICS Board and other associated Boards as outlined below:

Governance Structure for the Stroke Programme Board and associated Sub Groups



The Stoke Prevention Alliance will additionally report directly into the Prevention and Population Health Board of the Integrated Care System

Data and intelligence

Our actions must be needs-led and evidence based to ensure that stroke outcomes are improved, resources are used in the best way and health inequalities reduced. There is already a plethora of data and examples of best practice from local areas and more widely that we can use to target our work. We will also monitor our progress against our ambitions through use of an ICS-wide dashboard. Integrated care partnerships and GP practices will have access to this dashboard and associated clinical search queries to both monitor local progress and identify patients who might benefit from further care. In doing so we will ensure that we are regularly using data and intelligence to influence behaviour and ultimately improve outcomes.

Innovation: adoption and spread

Digital technologies aimed at improving blood pressure and AF detection and management (including self-monitoring for patients at home using Apps and other devices) are revolutionising the way we diagnose and manage high risk conditions. The effect is that we can move some detection away from traditional health care settings, reducing the potential burden on GP practices and help improve access to populations that may be less likely to see their GP. Such approaches will also encourage patients to take a more active monitoring role.

It is important that where we identify programmes and interventions that improve stroke prevention outcomes that we robustly evaluate these and roll these out at scale across Lancashire and South Cumbria to ensure that everyone is able to benefit.

Training and education

Reducing stroke incidence is largely dependent on effective implementation of best practice guidance regarding the diagnosis and management of conditions known to increase the risk of stroke. However, we need to ensure that frontline staff are supported and confident to deliver these interventions through training and education packages aimed at achieving significant quality improvement and opening up traditional health interventions to be delivered in non-traditional settings.

Population engagement and empowerment

Effective and meaningful engagement with the population of Lancashire and South Cumbria is essential to the delivery of this strategy along with the involvement of health and care staff, partner organisations and local voluntary and community sector organisations.

The strategy needs to be supported by communications and engagement campaigns which follow best practice guidance towards engaging with the correct people at the correct times to ensure that our population is informed and empowered to lead healthy lives and access stroke prevention care when appropriate.

7. Monitoring Our Progress

As referenced above, we are developing an ICS-wide dashboard which will enable progress to be monitored both at an ICS and ICP level. In contrast to previous reporting mechanisms this will have the potential to allow neighbourhood teams real time monitoring on progress as well as formalised aggregated quarterly reporting of progress in order to facilitate ongoing development of delivery plans where needed.

8. Acknowledgements

This strategy is written on behalf of the Lancashire and South Cumbria Stroke Prevention Alliance without whose support this strategy would never have come into existence.

We additionally acknowledge the particular support from key system leaders including Dr Malcom Ridgway (Senior Responsible Officer for Primary Care), Dr Sakthi Karunanithi (Senior Responsible Officer for Prevention and Population Health) and our clinical leads Dr Mammen Ninan and Jeannie Hayhurst

9. References

[i] PHE Fingertips (2018). Cardiovascular disease. https://fingertips.phe.org.uk/ (accessed 7th September 2018)
[ii] Size of the Prize Data, Public Health England, 2017
[iii] Public Health Outcomes Framework, Department of Health, 2016/17