7.5.6 Stroke

Why is this issue important?

Stroke is the second most common cause of death in England and Wales, accounting for one in fourteen deaths in men and one in 10 deaths in women. It is also the single largest cause of disability.

Key outcomes

- ***Under 75 mortality rate from all cardiovascular diseases including stroke (Public Health Outcomes Framework)***
- ***Preventing people from dying prematurely (NHS Outcomes Framework)***
- ***Improving recovery from stroke (NHS Outcomes Framework)***
- ***Proportion of people feeling supported to manage their condition (NHS Outcomes Framework)***
- ***Improving functional ability in people with long-term conditions (NHS Outcomes Framework)***

Impact in Brighton & Hove

In 2011/12 there were 3,898 patients on GP registers in Brighton & Hove recorded with stroke, equivalent to an all age (crude) prevalence of 1.3%.[1] This observed prevalence is 56% of the estimated prevalence of 2.3%. In the South East Coast area 1.8% of people on GP registers have had a stroke which is 69% of the estimated prevalence of 2.6% and in England as a whole 1.7% of all people on GP registers have had a stroke which is 68% of the estimated 2.5%.[2], This suggests there may be under-reporting or under-diagnosis of stroke on GP registers although it should be noted that differences between modelled and recorded prevalence could also be due to local variations not captured by the model.

Stroke was the main cause of death for 146 people in Brighton & Hove in 2010.[3] This was approximately 7% of all deaths in that year.

There is a downward trend in deaths from stroke. In 2014, the mortality rate for stroke in Brighton & Hove is predicted to be 31.9 per 100,000 for males and 25.5 for females, which is a 10 year decrease of 43.3% for males and 39.9% for females. The rates in South East Coast are predicted to decrease by 46.3% for males to 28.2 per 100,000 and by 44.5% to 27.6 for females. In England as a whole, the mortality rate is predicted to decrease by 44.4% to 33.1 per 100,000 for males over the same 10 years and by 41.7% to 31.9 for females.[2]

Figure 1: GP registered prevalence in 2011/12 and estimated prevalence

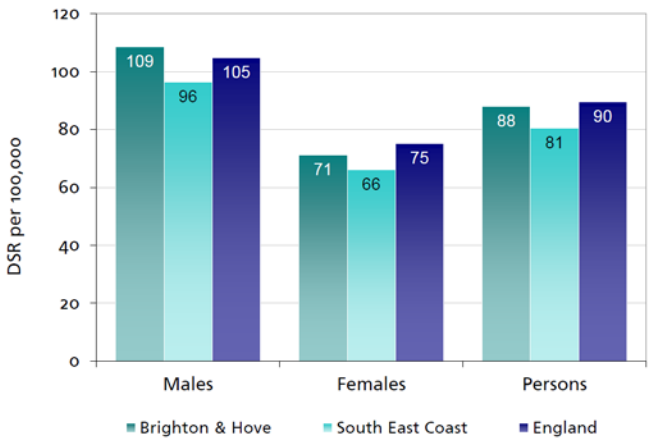
Source: South East Public Health Observatory. Cardio Vascular Disease Health Profile

In 2011/12 the emergency admission rate for stroke, all persons, in Brighton and Hove was 87.9 per 100,000 (330 admissions). This is lower than England (89.5 per 100,000) but higher than South East Coast (80.5 per 100,000). Despite the decrease in mortality from stroke, the emergency admission rate for stroke in Brighton & Hove has increased by 13.3% between 2004/05 and 2011/12 while in England it has increased by 3% and in South East Coast it has increased by 3.5%.[4]

GP performance for 2011/12 showed that for most indicators (including recording and control of cholesterol, % hypertension patients given a cardiovascular risk assessment and the % non-haemorrhagic stroke patients taking anti-coagulants) local performance was significantly lower than the England average.[5] However, the differences were generally small, such as for % non-haemorrhagic stroke patients taking anti-coagulants which was 92.6% in Brighton & Hove compared to 93.6% in England as a whole.

[1] http://www.sepho.org.uk/NationalCVD/docs/00ML_CVD%20Profile.pdf
[2] http://www.sepho.org.uk/NationalCVD/docs/00ML_CVD%20Profile.pdf.
[3] Office for National Statistics Vital Statistics tables (VS3) and Public Health Mortality Files
[4] HES, Health and Social Care Information Centre, ONS, DCLG
[5] Quality and Outcomes Framework 2011/12

Figure 2: Stroke emergency admission rates (DSRs), for all ages, 2011/12



Source: Hospital Episode Statistics (HES): Information Centre for Health and Social Care

Key priorities for primary prevention of stroke include:

- Identifying and controlling high blood pressure
- Stopping smoking
- Improving diet and physical activity
- Managing risk in those with greater than 20% 10-year cardiovascular disease (CVD) risk. The NHS Health Check programme aims to identify and manage CVD risk in people aged 40-74.

Atrial fibrillation (AF, a type of irregular heartbeat) is a risk factor for stroke. NICE have identified that better identification and effective treatment of patients with this condition could prevent 6,000 strokes and save 4,000 lives.

The Stroke Association have also highlighted the importance of the emotional impact of stroke in a report *Feeling Overwhelmed* and urged the consideration of the psychological needs of survivors. However, the 2012 Sentinel Stroke National Audit showed that patients do not have access to a clinical psychologist at the Royal Sussex County Hospital.

Where we are doing well

Deaths from stroke have fallen significantly over the last 15 years, in line with the national trend.

During 2010 the Care Quality Commission reviewed how services across the country help people who have had a stroke (and their carers and family members) after they leave hospital. Services in Brighton & Hove were ranked 2nd out of 151 PCTs.[6]

The 2012 Sentinel Stroke National Audit[7] showed that over 8 audit domains including communication with patients and carers and organisation of care, the Royal Sussex County Hospital scored 71 compared to a national average of 73.3. This scored them in the middle half of all Trusts compared to the 2010 audit when they ranked in the upper quartile.

The Brighton & Hove CCG Operating Plan for 2013/14 reported that the proportion of patients spending 90% of their hospital stay on a stroke unit in 2012/13 was 87.77% which is higher than the planned proportion of 80%. The Proportion of people at high risk of Stroke who experience a TIA and were assessed and treated within 24 hours was also higher than the planned figure of 60% at 75.86%.

Local inequalities

The emergency admission rate for stroke in 2011/12 for persons who live in the most deprived areas of Brighton and Hove was 107.1. This is 1.1 times greater than the emergency admission rates for persons who live in the least deprived areas of Brighton and Hove (96.4). This was less of a difference than in England as a whole, where the emergency admission rates for persons who live in the most deprived areas are 1.8 times greater than people who live in the least deprived areas and in the South East Coast where the difference was 1.7 times greater.

Emergency admission rates for stroke were significantly higher than for men than women in Brighton & Hove, at 108.5 per 100,000 for men and 71.2 for women. Deaths from stroke are also higher for men than women.

Nationally there is known to be higher prevalence of stroke in some Black and Minority Ethnic groups, notably Black Caribbean men.[8]

[6] CQC review of stroke services http://www.cqc.org.uk/organisations-we-regulate/special-reviews-and-inspection-programmes/thematic-reviews/stroke-services [Accessed on 26/08/2012].
[7] http://www.rcplondon.ac.uk/stroke/transparency/ssnap
8 Primatesta and Brookes (1999) Health Survey for England: the health of minority ethnic groups: Cardiovascular disease

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Predicted future need

Whilst rates of death from stroke continue to decrease, the population in the UK is ageing. Age is an important risk factor for stroke and prevalence increases with age. Both male and female populations of people over 55 years are expected to have increased by 2030, bringing a possible increased prevalence of stroke and national projections suggest that the number of people living with a long-term health condition caused by stroke will increase by 20% between 2011 and 2030 (1,259 to 1,507).[9] This may increase the need for services supporting people to maintain independence following a stroke.

What we don't know

There is no data for some equality groups (e.g. sexual orientation and the trans population).

Key evidence and policy

NICE Clinical Guideline 68 (2008)

http://www.nice.org.uk/CG68

The Accelerating Stroke Improvement Programme includes the following key areas of work:

- AF detection, risk stratification and optimal treatment
- Direct admission to a stroke unit and time spent on a stroke unit
- Timely brain scan
- Timely and effective management of Transient Ischaemic Attack
- Psychological support
- Joint care planning
- Review at six months
- Early supported discharge (ESD)

http://www.improvement.nhs.uk/stroke/AcceleratingStrokeImprovement/tabid/134/Default.aspx

Recommended future local priorities

1. Continue targeted lifestyle interventions to reduce stroke risk including NHS Health Checks.
2. Ensure equitable uptake by men and people from BME groups of stroke prevention initiatives.
3. Continue to implement Accelerating Stroke Improvement programme locally.

Key links to other sections

- Carers
- Physical disability and sensory impairment
- Smoking
- Healthy weight
- Physical activity
- Ageing well
- Older people – social care

Further information

South East Public Health Observatory CVD Profiles
http://www.sepho.org.uk/NationalCVD/NationalCVDProfiles.aspx

Last updated

July 2013

[9] Projecting Older People Population Information System; Projecting Adult Needs and Service Information www.poppi.org.uk; www.pansi.org.uk based on reported stroke in the General Household Survey. [Accessed on 26/08/2012].