

# **CARDIOVASCULAR DISEASE AND STROKE PATHWAY**

## **HEALTH NEEDS ASSESSMENT**

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# 1 EXECUTIVE SUMMARY

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## 1.1 CVD BURDEN

Stroke prevalence is slightly higher than national average, although lower than statistical neighbours. There is an overall downward trend in premature mortality over the past 15 years. The average age of death from stroke is higher among females. Female stroke mortality is higher than males in Herefordshire.

Although CHD prevalence has steadily increased over the past 10 years, CHD premature mortality has been following a steady downward trend over the past 15 years. There is a higher mortality rate and lower average age of death among males. CHD can be diagnosed at a young age, with approximately 14% of CHD patients diagnosed in both Herefordshire and Worcestershire between the ages of 40-50.

There is a downward trend in heart failure prevalence since 2018, although continues to remain higher than statistical neighbours.

The COVID-19 pandemic has seen a notable drop in mortality rates for most causes of death, notably cerebrovascular disease in Herefordshire. In Worcestershire, there have been increases in ischaemic heart disease and other forms of heart disease.

There is evidence of greater prevalence of CVD burden amongst some of the 30% most deprived areas across the ICS.

## 1.2 PREVENTION

There is evidence of greater prevalence of high-risk conditions and CVD burden amongst some of the 30% most deprived areas across the ICS.

Hypertension prevalence is higher than national average and some statistical neighbours. Overall, there are no areas of concern in terms of hypertension primary prevention across the ICS, although there is variation between PCNs. It is estimated that 30.3% of residents with hypertension remain undiagnosed, and increasing active case-finding and primary prevention measures in primary care remain a priority. Across the ICS there is good recording of blood pressure screening amongst those patients on the mental health register.

AF prevalence is slightly higher than national average and lower than some statistical neighbours. The average age at diagnosis across the ICS is 73-74. There is an indication that a greater proportion of AF patients in Worcestershire PCNs are diagnosed at a younger age than those in Herefordshire.

In terms of primary prevention, assessing stroke risk and appropriate treatment, all PCNs across the ICS perform very well, highest out of statistical neighbours and national average. Across the ICS, it is currently estimated that 17.4% of AF patients are undiagnosed, and 10.9% of high risk AF patients are not adequately anticoagulated.

Whilst there is currently no comprehensive national collection of data on cholesterol, in terms of secondary prevention with lipid-modifying treatment, there is some improvement to be made in treating diabetic patients with a history of CVD with statins.

Additional CVD risk factors also remain an issue across the ICS. Although smoking prevalence remains below national average, there are higher smoking rates amongst the 30% most deprived areas across the ICS. Compared to the general population, smoking rates remain higher amongst residents with Severe Mental Illness, and those in manual and routine occupations. Diabetes and chronic kidney disease prevalence remains higher than national average, with diabetes higher than most statistical neighbours.

NHS Health Check uptake rates are lower across the ICS than the national rate. Non-attendance rates across the ICS are highest in the most deprived population groups, and also higher in BAME groups in Herefordshire. Non-attendance rates are higher among men and younger 40-49 age groups. Local service data shows that there has been successful active case finding of high risk of CVD and with hypertension through NHS Health Checks. Past engagement work suggests that consistent communications by variety of media would be beneficial.

### 1.3 STROKE PATHWAY

Hyper acute and acute care across ICS is provided at Wye Valley NHS Trust and Worcester Acute Hospitals NHS Trust. There is evidence of improving trend in many hyper acute and acute care indicators- particularly specialist and multidisciplinary assessment. Ongoing work is being done to improve admission to HASU within 4 hours.

In-hospital stroke mortality rate has remained stable at both sites over past 3 years. Out-of-hospital (<90 days) crude stroke mortality rates at WA have risen in last 3 years. In 2020/2021. At the end of the second COVID-19 wave there is a rise of in-hospital deaths and a fall in out-of-hospital deaths for days at Worcester Acute.

Early Supported Discharge (ESD) is available at both acute providers, facilitating early transfer of care to a community setting. Rate of stroke survivors discharged with the support of this team is lower at WVT than WA. Both sites have excellent rates of stroke survivors discharged with a health and social care plan.

Applicable patients who have a six month review is above national rate at both sites. There is an opportunity to optimise secondary prevention of stroke at this point as the % of stroke survivors who were in AF but not on anticoagulation was 16.7% at WVT and 14.6% at WA.

Stroke Association provides commissioned life after stroke services to patients in Worcestershire. Some attributed outcomes identified by service users are; having a better understanding of stroke and stroke risk, feeling reassured, reduced anxiety or distress and reduced carer stress. A voluntary sector organisation Headway provides a LAS service in Herefordshire but is not formally commissioned.

An engagement gap analysis and equality impact assessment will be conducted as part of the ICS communication and engagement plan for stroke. Relevant past engagement work has been conducted by Healthwatch. Notably- Healthwatch Herefordshire's 'Men's Health' Report 2020 highlighted views on preventative health and preferred communication methods of improving health and wellbeing- apps, TV and use of role models.

## 2 RECOMMENDATIONS

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- The ICS stroke outcomes dashboard can be used by partners across the stroke pathway to inform, review and optimise stroke care.
- The ICS stroke outcomes dashboard can be used alongside other published CVD resources to support in-depth review at PCN and practice level of CVD high risk conditions, and to support PCN specification requirement 2021-2023 for CVD.
- Support delivery of the NHS LTP ambitions with a focus on the three high-risk CVD conditions; high blood pressure, atrial fibrillation (AF) and raised cholesterol, by increasing detection rates amongst the undiagnosed, and lowering numbers of those who are inadequately treated or untreated.
- Continue to build on CVD prevention work programmes which address health inequalities in the most deprived population groups, and specific groups such as Severe Mental Illness, Learning Disability, homelessness, and ethnic minorities.
- Continue to explore options to optimise CVD case finding with NHS Health Checks by targeting those eligible population groups who are more likely non-attenders or who may not routinely access services. Increase communications from across system about the benefits and importance of NHS Health Checks.
- Build on and develop communications for increasing widespread awareness and understanding of the risk factors and high-risk conditions for CVD amongst the public.
- Review and build on current communications around awareness of signs and symptoms of stroke amongst the public.
- Investigate the significance of the increasing trend in out-of-hospital stroke mortality at Worcester Acute Hospitals NHS Trust.
- Use the six-month post-stroke review as an opportunity to improve secondary prevention of stroke and ensure patients with AF are appropriately anticoagulated.
- Review local LAS service provision against the key components of the ISDN full service specification, with a focus on identified gap in Herefordshire to ensure equitable service provision across the ICS.
- Any engagement conducted as part of by ICS stroke engagement plan should involve the whole stroke pathway and the voluntary sector, and aim to understand level of awareness and knowledge of the stroke pathway. Further work could include a re-evaluation of the Early Supported Discharge teams to note any changes from WVT review in 2015.

### 3 INTRODUCTION

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The NHS Long Term Plan (LTP) [1] has identified stroke and cardiovascular disease as clinical priorities and has set out 10 year ambitions to prevent premature cardiovascular disease (CVD) deaths, and reduce the burden stroke places on families and carers, the health and social care system and on wider society. This will require increased public health and NHS action for lifestyle and preventable factors, while also optimising early detection and treatment of high risk conditions. A major ambition of the LTP is to prevent 150,000 strokes and heart attacks over the next 10 years [1].

The National Stroke Service Model was published in May 2021, and provides a plan for transforming stroke care along the entire pathway, from prevention to rehabilitation to life after stroke, across the integrated care system (ICS) [2]. Integrated Stroke Delivery Networks (ISDNs), led by ICSs, will be required to adopt a full pathway approach in order to implement the National Stroke Service Model pathway.

Whilst this needs assessment will focus on the prevention, detection and management of cross-cutting high risk CVD conditions, it will then look at CVD through the lens of the full stroke pathway. This needs assessment is produced in parallel to a Herefordshire & Worcestershire ICS stroke quality outcomes dashboard which compiles and presents data from the entire pathway; prevention, hyper acute care, acute care, rehabilitation and life after stroke. The stroke outcomes dashboard will be digital, interactive and accessible across the whole system.

## 4 BACKGROUND

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### 4.1 WHAT IS CARDIOVASCULAR DISEASE?

Cardiovascular disease (CVD) is a general term used for diseases of the heart and circulation. It is usually characterised by a build-up of fatty deposits inside the arteries “atherosclerosis” and a subsequent increased risk of blood clots. CVD can also be linked to blood vessel damage in organs such as the brain, heart, kidneys and eyes [3].

CVD can lead to both acute events and chronic disease, and is one of the leading causes of death and disability in England [4]. There are four main types of CVD; coronary heart disease (CHD), strokes and transient ischaemic attacks (TIAs), peripheral arterial disease, and aortic disease [3].

Coronary heart disease occurs when the flow of oxygen-rich blood to the heart muscle is blocked or reduced. This increased strain on the heart can result in severe chest pain (angina), heart attacks (where the blood flow to the heart is suddenly stopped) and heart failure (where the heart is unable to pump blood around the body properly) [3]

A stroke is where the blood supply to part of the brain is cut off, which can cause brain damage and possibly death. Strokes can be caused by bleeding from a blood vessel in the brain or by blood clots. A transient ischaemic attack (TIA) is when the blood flow to the brain is only temporarily disrupted. Atrial fibrillation is one of the most common forms of abnormal heart rhythm and a major cause of stroke [3].

Peripheral arterial disease occurs when there is a blockage in the arteries to the limbs, usually the legs. Aortic disease are a group of conditions affecting the aorta which is the largest blood vessel in the body- the most common being aortic aneurysm [3].

### 4.2 CAUSES OF CARDIOVASCULAR DISEASE

The exact cause of CVD isn't clear, but the majority of CVD types share common risk factors which increase the chance of getting CVD. These can be split into modifiable risk factors associated with lifestyle behaviours, and a number of underlying determinants of CVD [5].

#### 4.2.1 Modifiable or lifestyle risk factors:

Understanding the modifiable risk factors are important for calculating individual risk of CVD, and for prevention and mitigation of CVD outcomes on a population level.

Hypertension; high blood pressure is one of the most important risk factors for CVD. It can damage blood vessels, particularly if it is very high or left untreated.

Smoking and other tobacco use; this is a significant risk factor for CVD. The harmful substances in tobacco can damage and narrow the blood vessels.

Diabetes; this is a lifelong condition that causes blood sugar level to become too high

Hypercholesterolemia; Cholesterol is a fatty substance found in the blood. High cholesterol can cause blood vessels to narrow and increase the risk of developing a blood clot.

Being overweight or obese; this increases risk of high blood pressure and type 2 diabetes

Unhealthy diet and excessive or harmful alcohol consumption; this can lead to increased cholesterol, blood pressure levels and weight gain.

Inactivity; this is linked to CVD as a lack of regular exercise is associated with a greater chance of high blood pressure, high cholesterol and obesity.

#### 4.2.2 Underlying determinants:

Age; CVD is most common over the age of 50, and all CVD risk increases with age.

Gender; men are more likely to get CVD than women at a younger age.

Family history; the risk of developing CVD increases with a family history of early CVD (<55 for men and <65 for women)

Ethnicity; In the UK, CVD is more common in people of South Asian and African Caribbean backgrounds because of an increased risk of associated risk factors such as hypertension or type 2 diabetes.

Poverty and deprivation; CVD is a condition strongly associated with health inequalities. People living in one of England's most deprived areas will have almost four times the risk of dying as a result of CVD than those in the least deprived 10% of the population [1].

### 4.3 NATIONAL CARDIOVASCULAR DISEASE BURDEN

There are around 7.6 million people estimated to be living with CVD in the UK as of 2020, with heart and circulatory diseases causing a quarter of all deaths in the UK [4]. CVD rates are generally on the decline, and have almost halved in recent decades [6], however rates of decline are seen at a slower rate in the more deprived areas of the country [1].

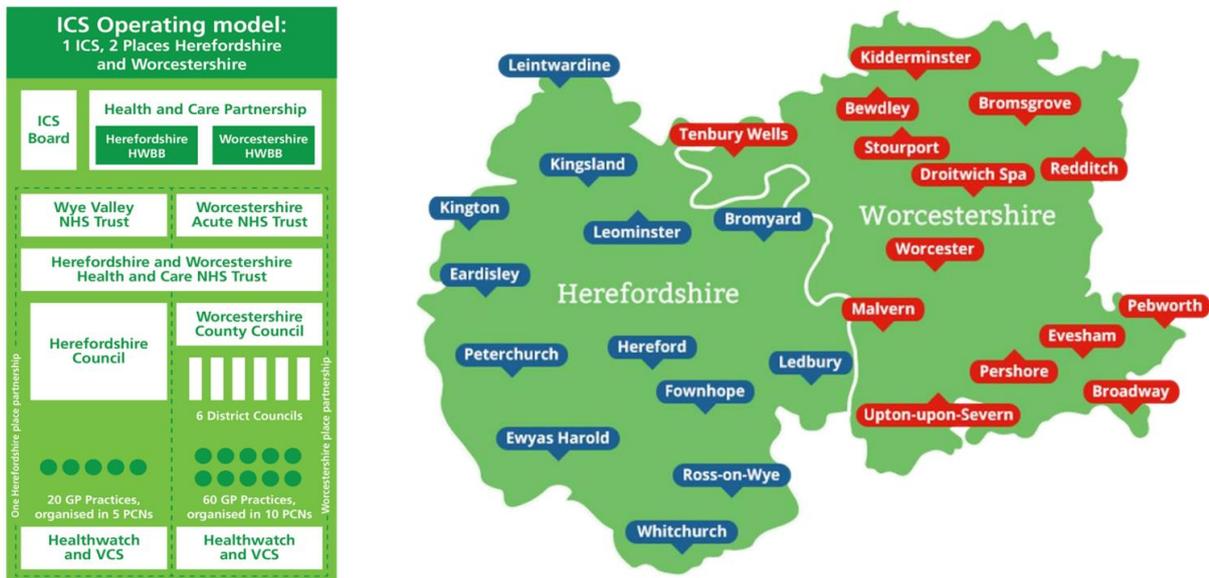
Coronary heart disease is the most common type of CVD and was the 3<sup>rd</sup> leading cause of death in 2020 in England [7]. Cerebrovascular disease/ strokes is the 4<sup>th</sup> leading cause of death in England and the single biggest cause of severe disability in the UK [7]. People with CHD or who have a heart attack are twice as likely to have a stroke [3]

# 5 HEREFORDSHIRE & WORCESTERSHIRE ICS

## 5.1 LOCAL POPULATION DEMOGRAPHICS

The Herefordshire & Worcestershire ICS comprises a variety of NHS bodies, Local Authorities, Primary Care Providers and other organisations. Data used in this document will be taken from sources which either use the H&W CCG/ STP footprint or Herefordshire and Worcestershire upper tier local authorities depending on measure used.

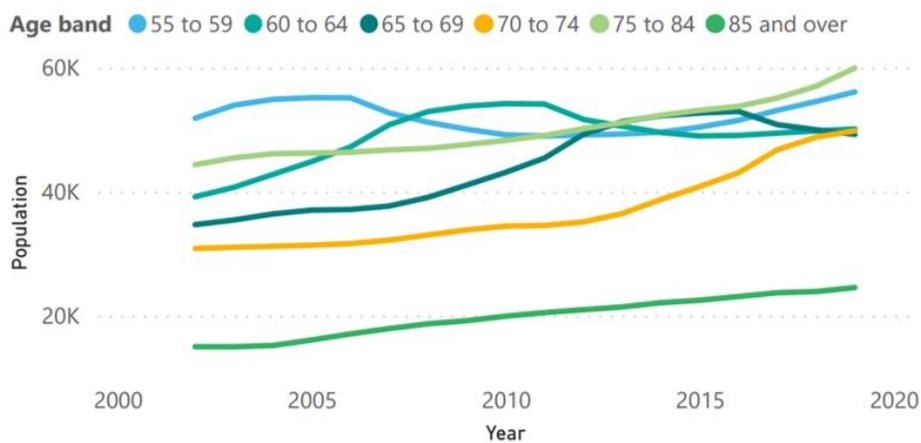
Figure 1: ICS Operating model [8]



### 5.1.1 Age and gender

Population projections estimate that in the next 10 years populations will increase by 6% in Herefordshire [9] & by 4.5% in Worcestershire [10]. Rural localities will experience greater relative change in population. Characterising these population growths is an ageing profile. In 2019, the population distribution shows an older than national average population in men and women across Herefordshire & Worcestershire. Older adults (65+) populations have steadily increased over the past 20 years, and this is expected to continue (Figure 2). Approximately 10.7% of H&W population is aged over 75.

Figure 2: H&W ICS population 2000-2020, by age groups (> 55 years)

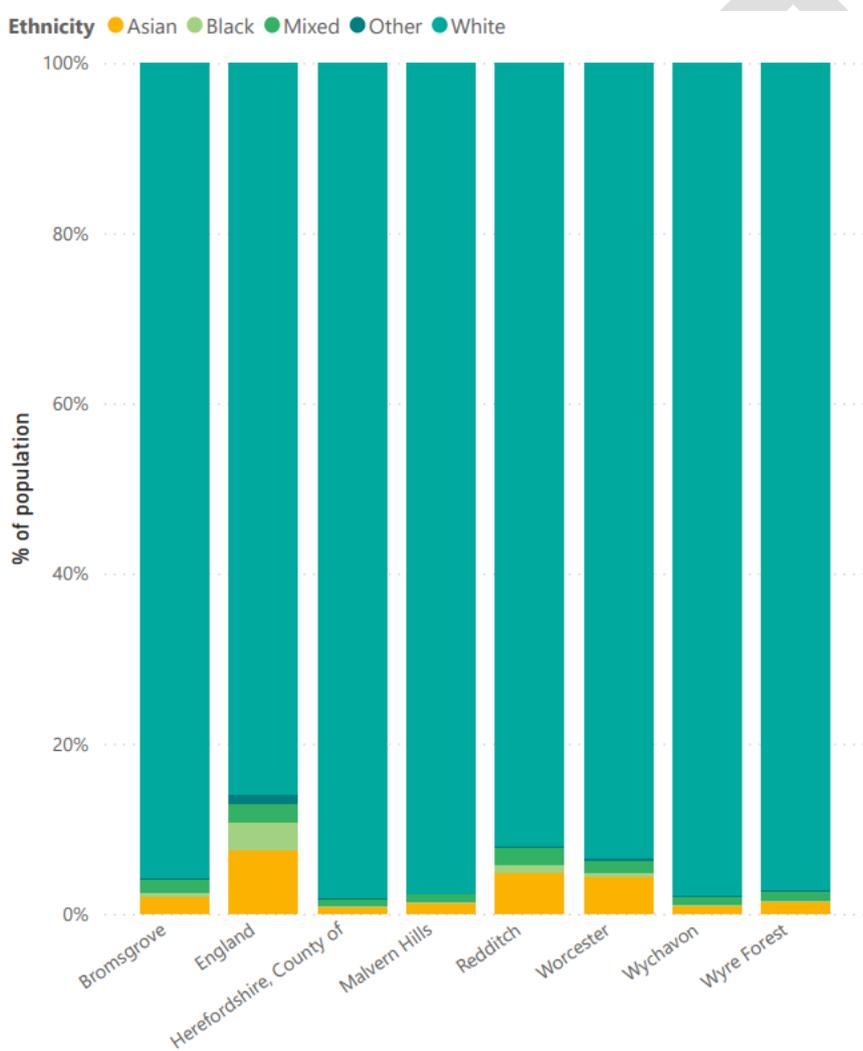


Source: PHE Fingertips- Quality Outcomes Framework 2019/20 data- upper tier local authorities

### 5.1.2 Ethnicity

For data visualisation purposes, high level ethnic groups have been used in figure 3 to highlight the proportion of local authority (LA) population which are of black and minority ethnic (BAME) groups, but there will be further granularity within this. Using ethnicity data from the Office for National Statistics 2011, the average BAME population for England is approximately 14.6%. Worcester and Redditch have higher BAME groups compared to other areas in ICS.

Figure 3: H&W ICS population by ethnicity



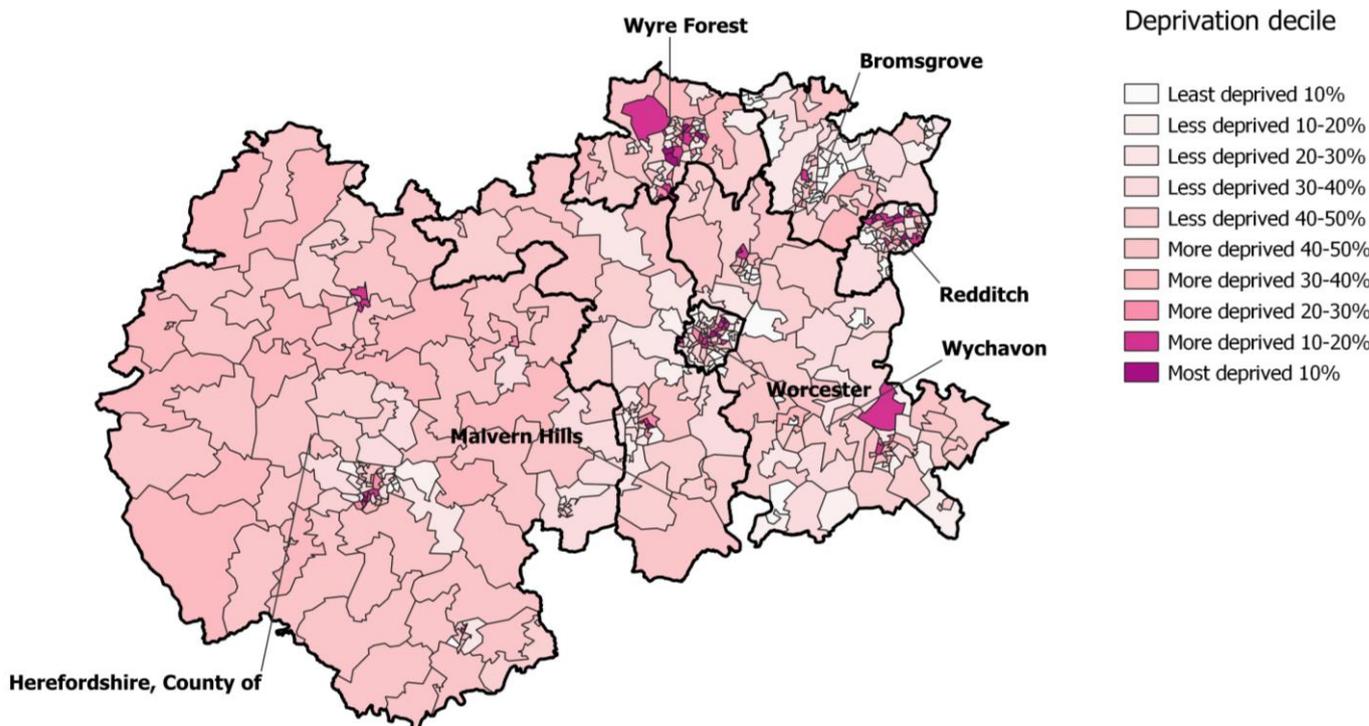
Source: Office for National Statistics 2011 Census

## 5.2 INEQUALITIES

### 5.2.1 Deprivation

Herefordshire & Worcestershire are more rural than average, and relatively affluent with growing economies. Compared to England, H&W performs well on measures of health, wellbeing and deprivation. Life expectancy, for e.g., is higher than national average for both females and males, however, there are areas across the ICS in the more deprived 10-20%, and efforts should be made to address underlying inequalities leading to poorer health outcomes between residents.

Figure 4: Deprivation by Lower Super Output Area and Local Authority District boundaries in Herefordshire and Worcestershire (2019-2020)



*Source: PHE Fingertips- Quality Outcomes Framework 2019/20 data- upper tier local authorities*

## 5.2.2 Homelessness

Although not easily defined, homelessness is an important concern across the ICS. Homeless people are at increased risk of a wide range of health problems related to physical health, including circulatory health, mental health and substance misuse [11]. Homeless people are much more likely to smoke, and much more likely to live with multiple long term conditions. Worcestershire Homeless Health Audit 2017 [12] found that the majority, 87%, of the sample were smokers. Homeless people are more likely to contribute to the unmet CVD health need in the ICS.

By LA, Worcester has a recorded 0.78% of households owed a duty to secure accommodation, which is higher than the national average of 0.52%. Of these households, the main support needs were mental health problems (23.2%) and physical health needs (18.0%). The remaining six local authorities across the ICS have below the national average.

## 5.2.3 Learning Disabilities

The proportion of adults (18+ years) with a learning disability (LD) receiving long-term support from local authorities (per 1000 population) in Herefordshire LA is 3.89% and Worcestershire LA is 3.12% compared to national average of 3.46% [13]. There is ongoing work across the ICS to appropriately record number of people on the LD register to better reflect the local population, and deliver interventions, such as NHS Health Checks, in a more personalised way. In 2018/19, the proportion of the eligible adults with a LD who had a GP health check was 58.5% in Herefordshire and 56.6% in Worcestershire, both proportions were better than the national and regional averages [13].

## 6 PREVENTION

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The importance of CVD prevention has been highlighted in the NHS Long Term Plan and the national CVD Prevention programme [14] has been set up to develop targeted interventions to optimise care by maximising diagnosis and treatment to minimise both individual risk factors, and population risk.

Public Health England (PHE) CVD prevention packs can be used to support the delivery of the NHS LTP ambitions by providing and displaying data at CCG/ STP level focusing on the three high-risk CVD conditions; high blood pressure, atrial fibrillation (AF) and raised cholesterol. However, the focus remains on the first two conditions because there is currently no comprehensive national collection of data on cholesterol.

The NHS RightCare Pathway for CVD prevention [15] also highlights opportunities for better risk detection and management in primary care, and can be used as a framework for system level action at the STP/ ICS level (Appendix 1). This pathway covers six cross-cutting high risk conditions: high blood pressure, atrial fibrillation, familial high cholesterol, non-diabetic hyperglycaemia, diabetes and chronic kidney disease.

To support the LTP ambition, NHS England and NHS Improvement (NHSEI) have commissioned a national primary care audit –‘CVDPREVENT’ which will support continuous clinical improvement and addressing the large numbers of people undiagnosed or under treated [16]. CVDPREVENT will automatically extract routinely collected GP data on the six high risk conditions stated in NHS RightCare CVD pathway.

Figure 5: Overview of CVD risk factor prevalence in H&W (2019/20)

	<b>Smoking</b>	<b>Obesity</b>	<b>Hypertension</b>	<b>Diabetes</b>	<b>Chronic Kidney Disease</b>	<b>AF</b>
<b>H&amp;W CCG</b>	13%	12.3%	16.5%	7.4%	5.5%	2.61%
<b>National</b>	14.3%	10.5%	14.1%	7.1%	4%	2.1%

Source: PHE Fingertips- Quality Outcomes Framework 2019/20 data

## 6.1 SMOKING:

Smoking rates across the ICS are 13% which is currently below the national average of 14.3%. However, smoking prevalence continues to be much higher in adults with severe mental illness (40% in Herefordshire and 37% Worcestershire), and amongst those in routine or manual occupations (28.6% in Herefordshire and 18.6% in Worcestershire) when compared to the general population [17].

On average, across the ICS, 90% of smokers are offered support and treatment (QOF SMOK004), which is above the national average of 89.7%. There is some variation below this seen at PCN level (figure 6), with The Rurals (73%), Nightingales 96%, WCB 83% and HMG 87%.

In terms of deprivation, there is a clear link with increased areas of deprivation by LSOA, and smoking prevalence levels by GP practice, as seen in figure 7, where the highlighted 30% most deprived areas are mapped against higher levels of smoking prevalence (17.44-19.35).

### Performance by PCN compared to H&W and England

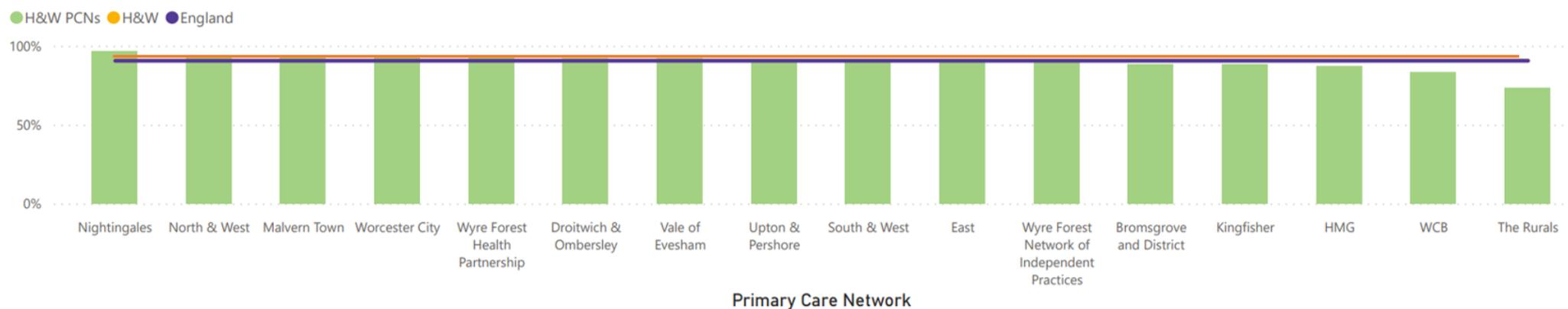
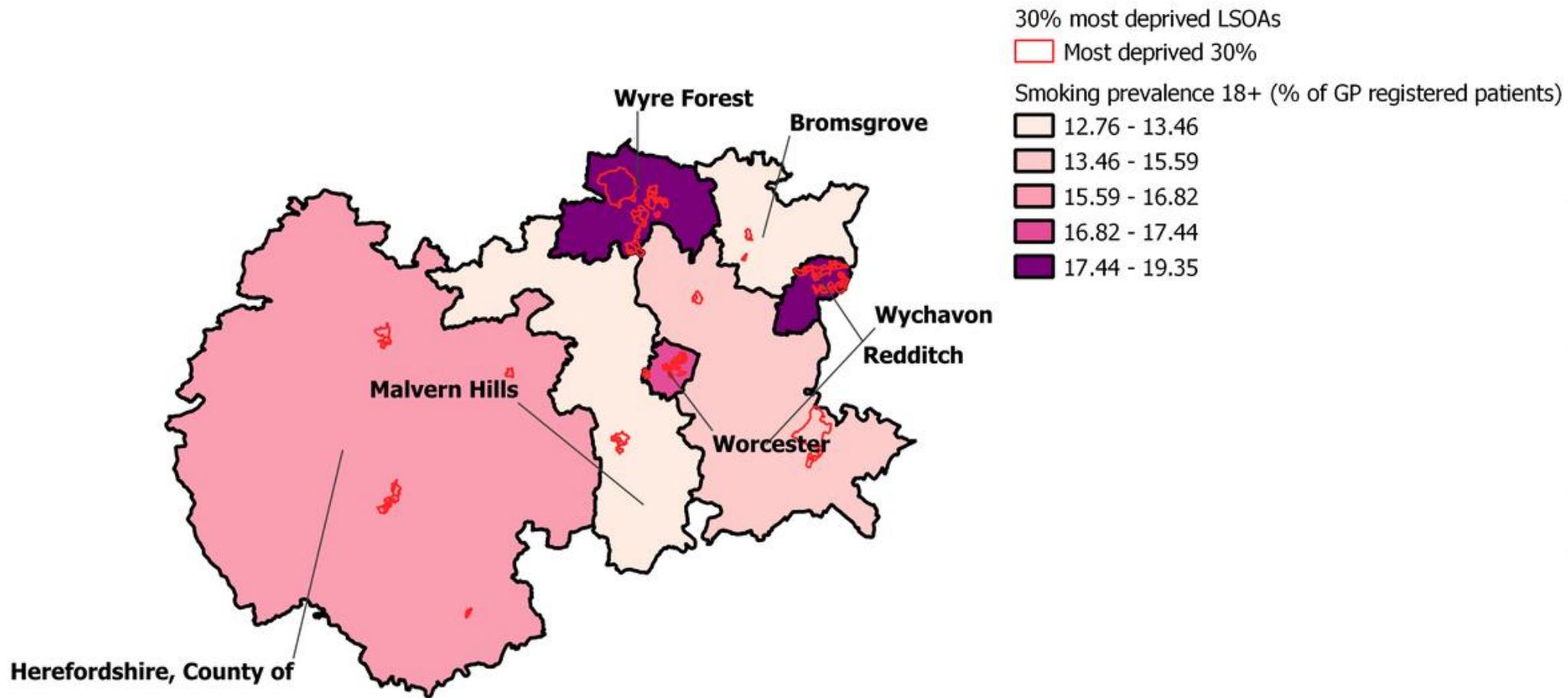


Figure 6: QOF SMOK004- The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months (2019/20)

Source: PHE Fingertips- Quality Outcomes Framework 2019/20 data

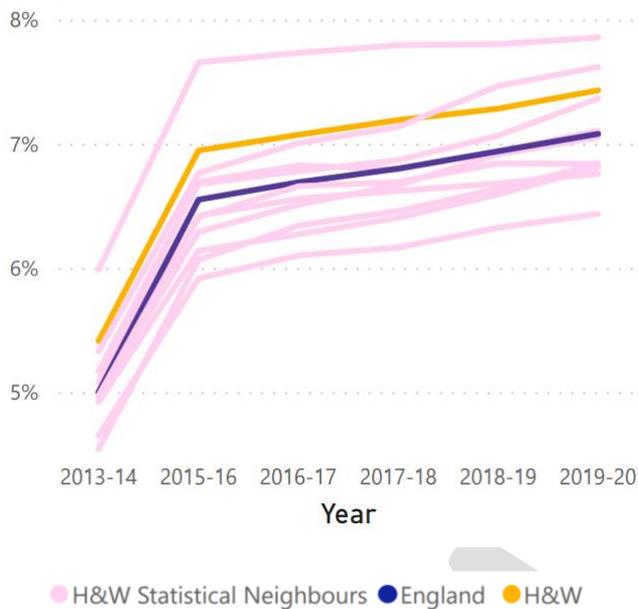
Figure 7: Smoking prevalence as a percentage of registered GP patients (18+) and the 30% most deprived LSOAs in England (2019-2020)





## 6.2 DIABETES

Figure 8: Prevalence of Diabetes in H&W over time compared to statistical neighbours (2013-



Diabetes prevalence in 2019/20 in H&W CCG is 7.43% which is slightly higher than the national rate of 7.1%.

Since 2013, diabetes prevalence has been comparatively higher than statistical neighbours (figure 8).

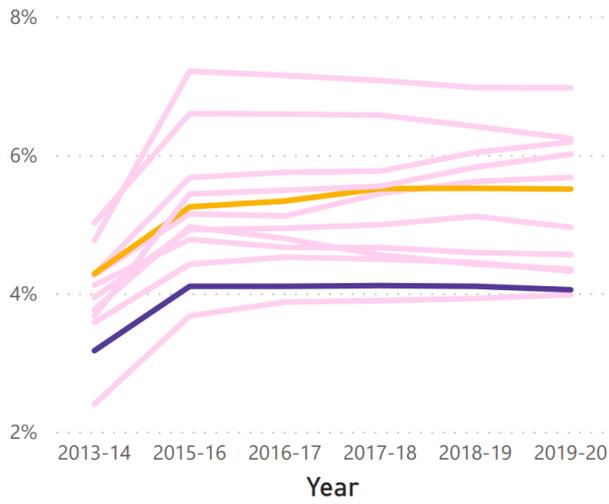
In terms of primary prevention in patients with diabetes, the percentage of diabetes patients with a blood pressure reading in last 12 months of 140/80 mmHg or less (QOF DM019) is 78% - this is similar to statistical neighbours and above national average of 76%.

Of those diabetes patients with a history of CVD (excluding haemorrhagic stroke) treated with a statin 76.3% are treated with a statin (QOF DM023). This is lower than the national average of 82.3%.

Source: PHE Fingertips- Quality Outcomes Framework 2019/20 data

## 6.3 CHRONIC KIDNEY DISEASE (CKD)

Figure 9: Prevalence of CKD in H&W over time compared to statistical neighbours (2013-2020)

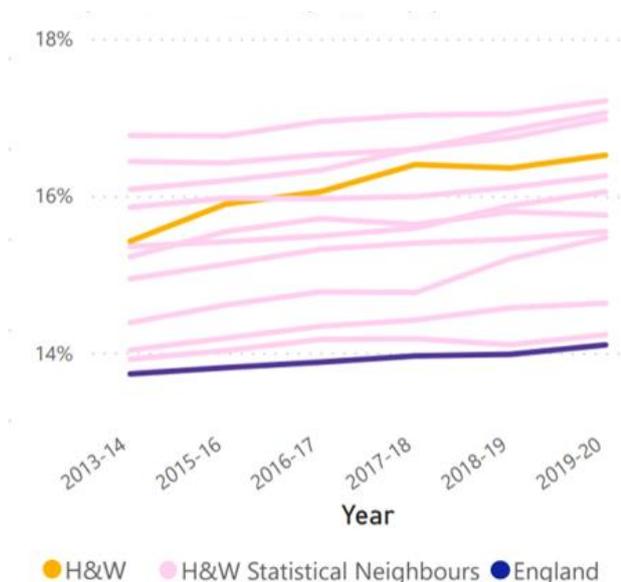


● H&W Statistical Neighbours ● England ● H&W

CKD prevalence in H&W CCG in 2019/20 was 5.5% compared to 4.05% nationally. This is similar to statistical neighbours

## 6.4 HYPERTENSION

Figure 10: Prevalence of HTN in H&W over time compared to statistical neighbours



Hypertension (HTN) prevalence in H&W CCG in 2019/20 was 16.5% which is higher than national average 14.1%

Over the past 5 years there is an increasing trend in hypertension prevalence, with H&W being consistently higher than statistical neighbours (figure 10).

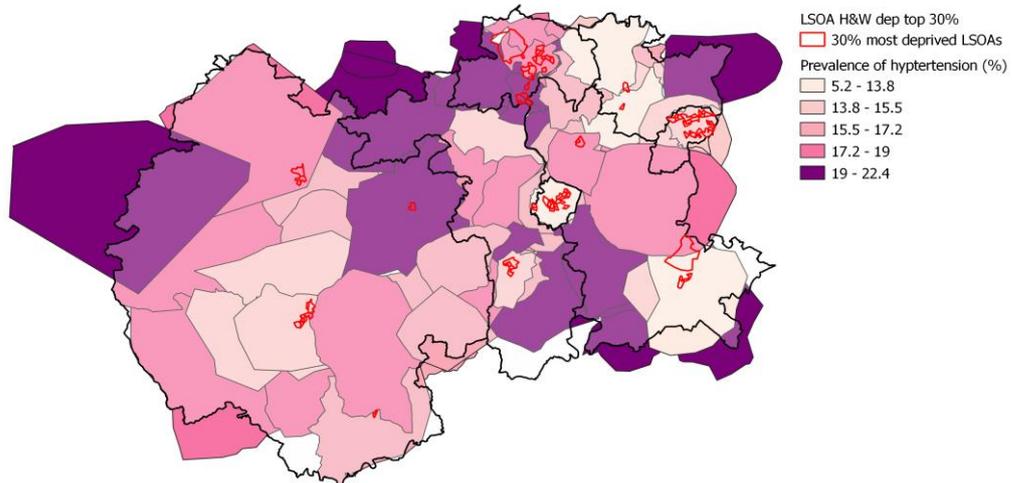
There is some variation in prevalence amongst PCNs- Worcester City has the lowest at 14% and the highest prevalence recorded is in Upton & Pershore with 20% (figure 12).

When looking at hypertension prevalence by GP boundary against deprivation by LSOA (figure 11), there isn't a strong gradient seen. However, this could be due to regression to the mean in the larger GP boundaries, as are some pockets of higher prevalence of hypertension amongst the 30% most deprived areas across the ICS.

Source: PHE Fingertips- Quality Outcomes Framework 2019/20 data

Of those patients on the Mental Health register, 81.6% had a record of blood pressure in the preceding 12 months. This is better than the national average of 80.3%.

Figure 11: Hypertension prevalence by GP boundary against 30% most deprived LSOAs (2019/20)



### Prevalence by PCN compared to H&W and England

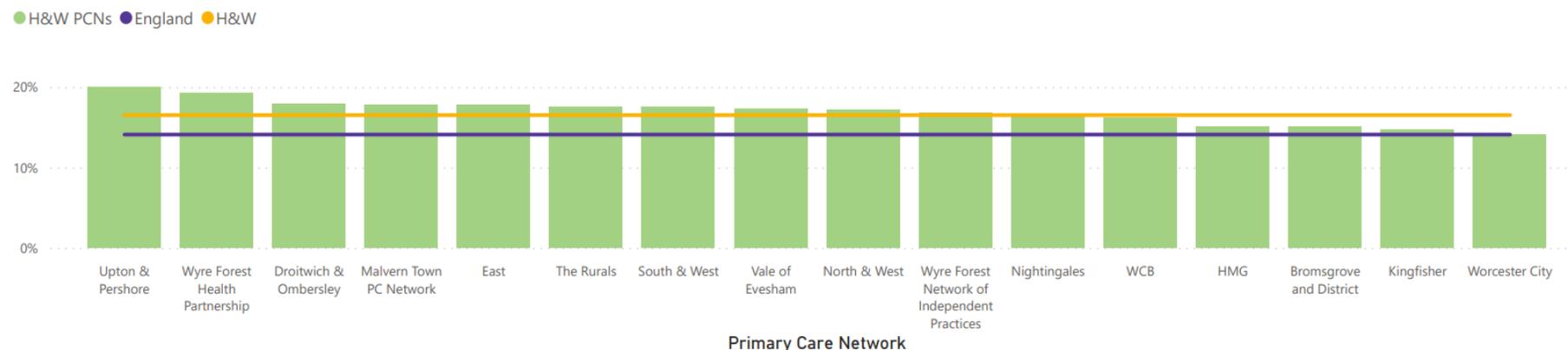


Figure 12: Prevalence of HTN by PCN 2019-2020

Source: PHE Fingertips- Quality Outcomes Framework 2019/20 data

In terms of primary prevention, 68.8% of hypertension patients aged 79 and under, had a blood pressure reading in the last 12 months of 140/90 mmHg or less (QOF HYP003). This is slightly better than the national average of 67.3%.

79.5% of patients aged 79 or under with a history of CHD and a blood pressure reading in the last 12 months of 140/90 or under (CHD008). This is better than the national average of 77.8%.

The CVD Prevention programme hypertension ambition is that 80% of the expected number of people with hypertension are diagnosed by 2029, and 80% of people diagnosed are treated to target by 2029.

Across the ICS, it is currently estimated that 67.7% of people with hypertension are diagnosed [18], which leaves an estimated additional 24,160 people required to be diagnosed to meet the ambition. This estimated number of additional people required to be diagnosed can be broken down by PCN (Appendix 2). It is currently estimated that 72.2% of patients with recorded hypertension has blood pressure treated to target. This leaves an estimated additional 10,380 patients required to be treated to reach the 80% PHE ambition. This estimated number of additional people required to be treated can be broken down by PCN (Appendix 2).

## 6.5 ATRIAL FIBRILLATION

AF prevalence across H&W CCG in 2019/2020 was 2.61%. This is higher than the national average of 2.1%, however is lower than some statistical neighbours. Over the past 5 years, there is a very slight increasing trend in prevalence seen across all statistical neighbours (figure 13). There is some variation in prevalence between PCNs in 2019/20, with Kingfisher, Worcester City and HMG at lowest prevalence of 2%, and Upton & Pershore with the highest prevalence of 4%.

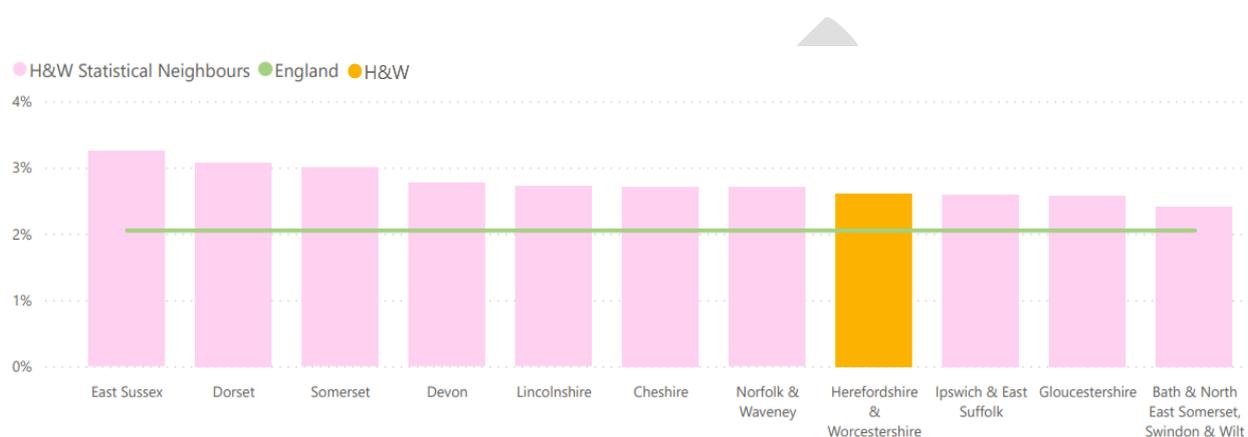
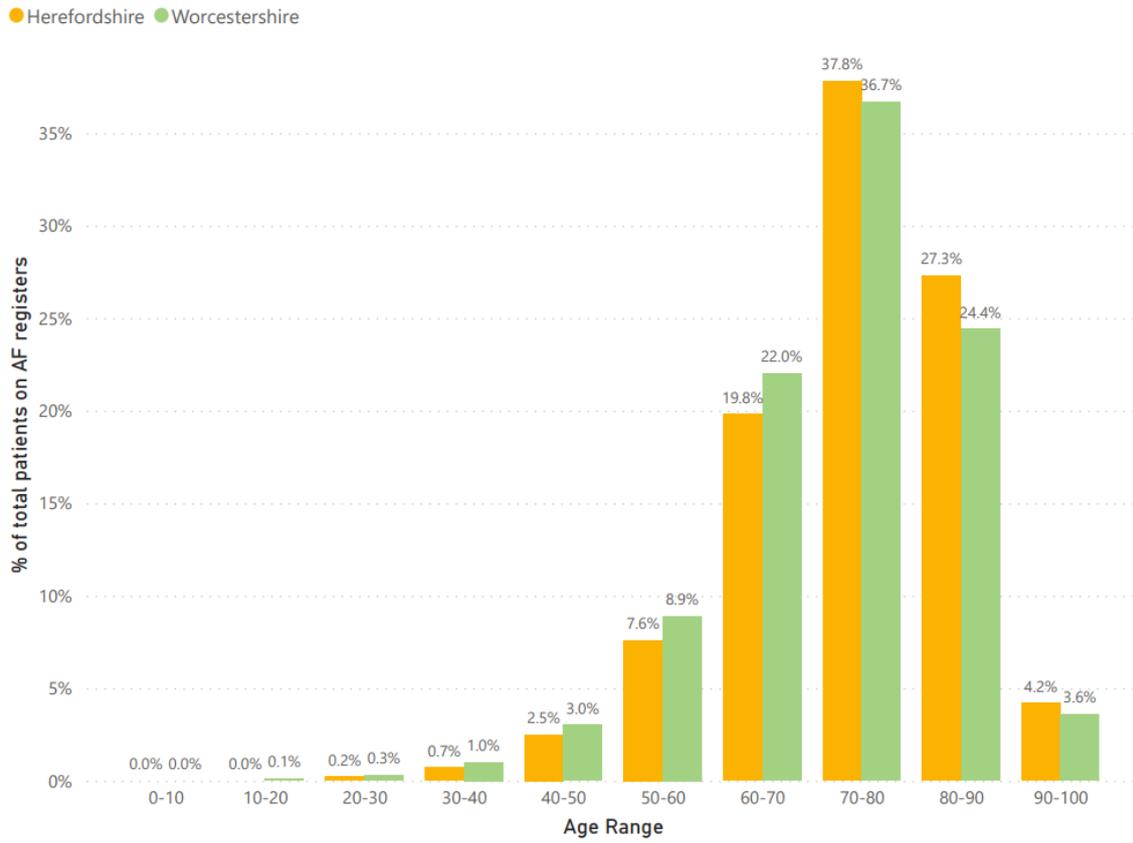


Figure 13: Atrial fibrillation prevalence in H&W

Source: PHE Fingertips- Quality Outcomes Framework 2019/20 data

The average age at which patients are diagnosed with AF is similar across Herefordshire and Worcestershire. The majority of patients are first diagnosed between the ages of 60-90, however, there is a higher proportion of total Worcestershire AF patients being diagnosed at younger ages 40-50, 50-60 and 60-70, whereas age at diagnosis tends to be older in Herefordshire (Figure 14).



Total patients on AF register as of 29/09/2021:

Herefordshire- 5789

Worcestershire- 16117

Average age at which registered:

Herefordshire- 74

Worcestershire- 73

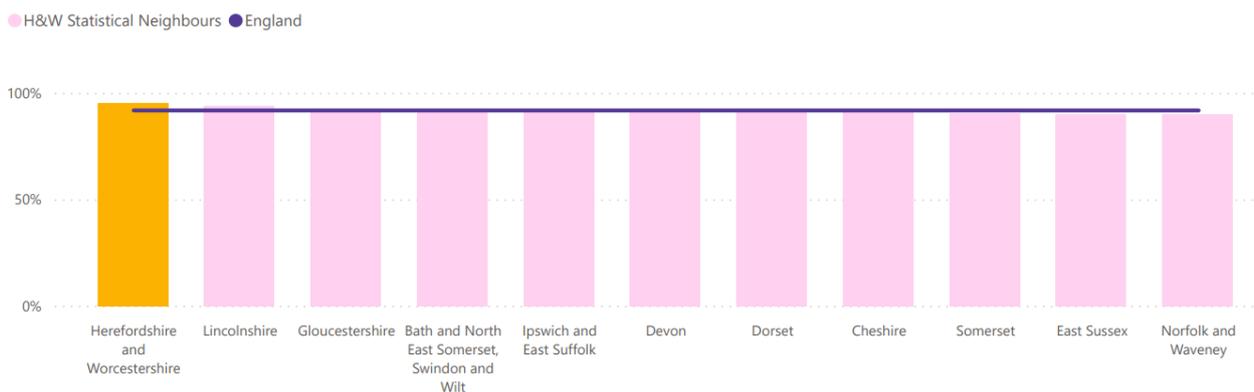
Figure 14: Age at AF diagnosis (Age at registration for all patients on GP AF registers as of 29/09/21)

Data: Taurus GP Federation and H&W CCG

In terms of primary prevention, In 2019/20, 96.2% of patients with AF had their stroke risk assessed using the CHA2DS2-VASc score in the last 12 months (QOF AF006). This is better than the national average of 93.3, and best out of statistical neighbours.

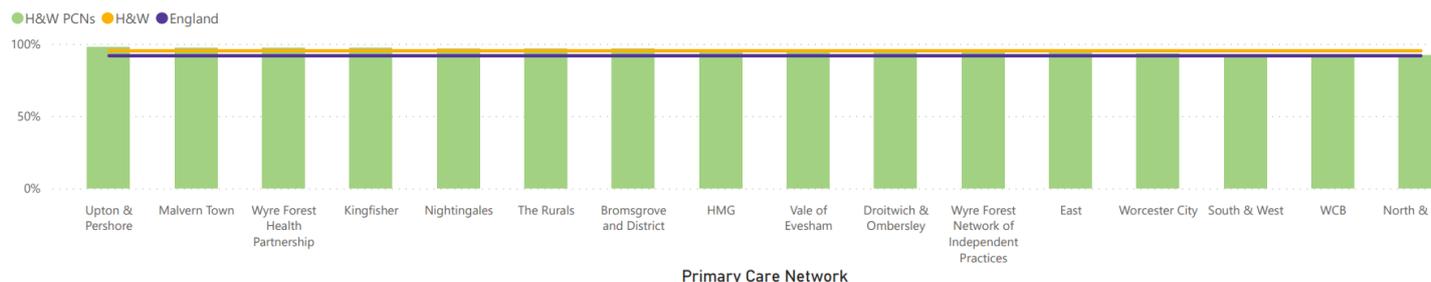
In 2019/20, 88.1% of those patients with AF and a record of a CHA2DS2-VASc score of 2 or more are currently treated with anti-coagulation drug therapy (QOF AF007). H&W CCG performed better than the national average 87.3% and best out of statistical neighbours (figure 15). All PCNs are also performing at or above the national average (figure 16).

Figure 15: QOF AF007 performance in H&W 2019-20 compared to statistical neighbours



Source: PHE Fingertips- Quality Outcomes Framework 2019/20 data

Figure 16: QOF AF007 performance by H&W PCN



Source: PHE Fingertips- Quality Outcomes Framework 2019/20 data

The CVD Prevention programme AF ambition is that 85% of the expected number of people with AF are diagnosed by 2029, and 90% of patients with AF who are known to be at high risk of a stroke to be adequately anticoagulated by 2029.

Across the ICS, it is currently estimated that 82.6% of AF patients are diagnosed, which leaves an additional estimated 600 patients who would need to be diagnosed to reach the PHE ambition. This estimated number of additional people required to be diagnosed can be broken down by PCN (Appendix 3). It is currently estimated that across the ICS, 88.1% of high risk AF patients are adequately anticoagulated. This leaves an additional 350 patients who require treatment with an anticoagulant to reach the ambition. This estimated number of additional people required to be treated can be broken down by PCN (Appendix 3).

## 6.6 NHS HEALTH CHECKS

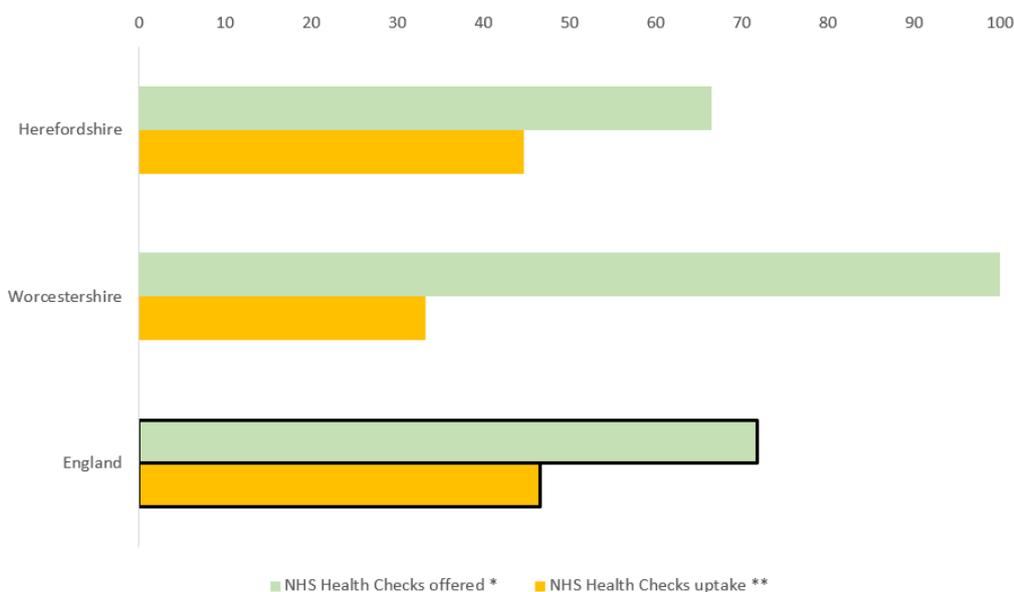
The NHS Health Check is a health check-up for adults in England aged 40 to 74. It is designed to support CVD case finding by spotting early signs of stroke, kidney disease, heart disease and type 2 diabetes. Eligible adults are invited for a health check every 5 years. The check includes assessment and management of key behavioural risk factors such as obesity, physical inactivity, smoking and alcohol, and physiological risk factors such as high blood pressure, blood glucose and cholesterol.

The NHS Long Term Plan has promoted NHS Health Checks as an approach to rapidly identify those identified with high-risk CVD conditions. NHS Health Checks have also been highlighted in the National Stroke Service model that it should be an objective of the ISDN to support uptake of the NHS Health Check in primary care.

There is no national uptake target; however PHE has set an aspirational 66% uptake rate in the eligible population. Local authorities must aim to achieve a 100% offer rate in their eligible resident population over five years; ideally by offering the Health Check to 20% of the eligible population annually. This was achieved by Worcestershire in 2017/18-2020/21. Uptake rates across the ICS are lower than the national rate for this time period (figure 17).

In 2017-2018, the most deprived quintile had the highest non-attendance rate in Herefordshire (63%) and Worcestershire (72.2%), and slightly higher amongst men and in 40-49 age groups across the ICS. Non-attendance was higher in BAME groups in Herefordshire.

Figure 17: NHS Health Checks offered and uptake 2017/18-2020/21



Source: PHE Fingertips \*Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check, by upper tier local authority, 2016/17-2020/21 \*\*Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check, by upper tier local authority, 2016-17-2020/21

A 'snapshot' review of Herefordshire NHS Health Check 2019/20 data provided by Herefordshire local authority, shows that 69.3% of eligible people were offered an NHS Health Check in 2019/20, with 31.7% of eligible people receiving a health check. Of those who received the health check in 2019/20, 57% were female, 98% were of a White ethnic group and the most common age group was the 55 - 64 years old (33%). Of those assessed, 10% had a high risk QRISK2 score of  $\geq 20\%$ , (261 males and 53 females), and 27% had a moderate risk QRISK2 score of 10-20% (451 males and 387 females). 19% of those assessed had an elevated blood pressure (sys $\geq 140$ /and of diastolic $\geq 90$ ).

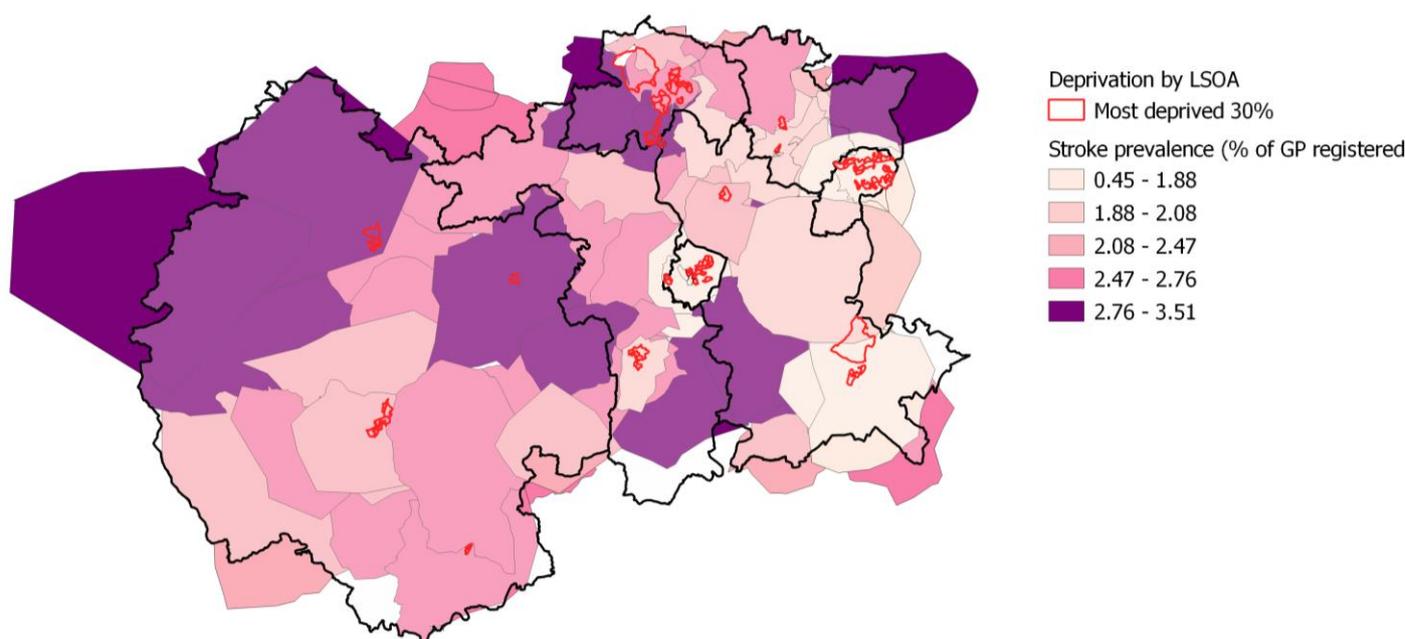
## 7 H&W ICS CVD DISEASE BURDEN

### 7.1 STROKE

Across the ICS, in 2019/20 stroke & TIA prevalence was 2.3%, compared to national rate of 1.8%. There is variation seen among PCNs, with Wyre Forest HP highest (2.83%) and Worcester City lowest (1.77%). Over the last 5 years, stroke prevalence has been consistently lower than statistical neighbours.

Although there is no strong gradient seen when mapping stroke prevalence and deprivation by GP boundary and LSOA, this could be due to regression to the mean in the larger GP boundaries, as there are some pockets of higher prevalence of stroke amongst the 30% most deprived areas across the ICS (figure 18).

Figure 18: Stroke prevalence by GP boundary against 30% most deprived LSOAs 2019/20



The premature mortality rate (under 75 years of age) due to stroke in Worcestershire has shown some variability, although a generally downward trend is evident since 2011-13. In 2018-20 the figure was 11.6 per 100,000, which is considerably lower than that seen in 2004-06. Throughout the period shown in figure 19 the Worcestershire figure has not been significantly different from that for England.

The premature mortality rate (under 75 years of age) due to stroke in Herefordshire has also shown some variability, although a generally downward trend is evident since 2009-11. In 2018-19 the figure was 10.2 per 100,000, which is half that seen in 2004-06. Similarly, throughout much of the period shown in the graph the Herefordshire figure has not been significantly different from that for England.

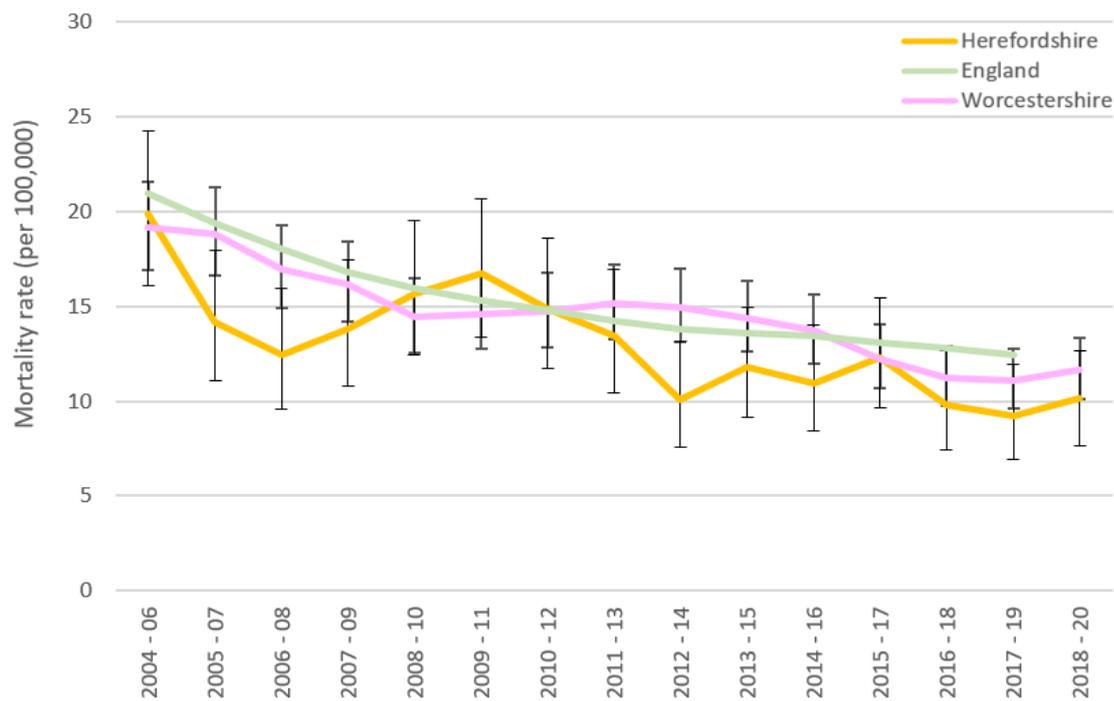


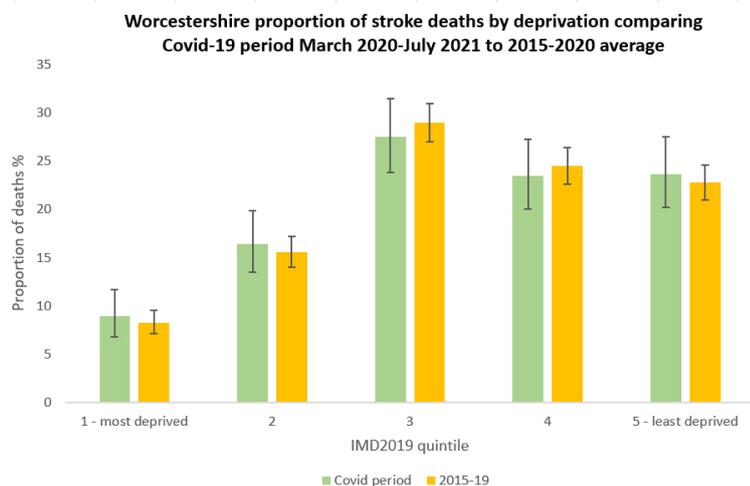
Figure 19: Standardised stroke premature rate (age <75) 2004-2021

Data source: under 75 mortality DSR 2004/06 to 2017/19 from Fingertips 2018/20 calculated from PCMD

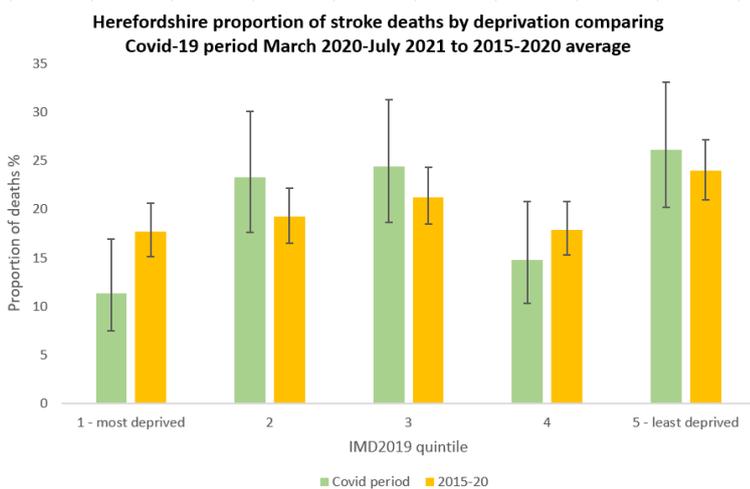
Between the years 2015 to 2020, the average age of death from stroke for females is higher than for males both in Worcestershire and Herefordshire, graphs for which can be found in Appendix 5. In Herefordshire, although directly standardised mortality rates show a decreasing trend for both males and

females since 2015, the mortality rate for females remains consistently higher than for males during this time period. This pattern is not seen amongst Worcestershire residents, where male mortality rate has been higher between 2015 and 2019.

Figures 20 & 21: Stroke mortality by deprivation quintile comparing 2015-2020 to Covid-19 period March 2020-July 2021



During the time period 2015-2020, there was no clear trend between increased deprivation and stroke mortality. However, there was an increase in stroke mortality in the two most deprived groups (1) and (2) during the Covid period. This does not appear to be a statistically significant difference, however may require further investigation, as there was also a slight increase in stroke mortality during the Covid period in the least deprived group (5).



During the time period 2015-2020, there was no clear trend between increased deprivation and stroke mortality. There is the greatest decrease in stroke mortality during the Covid period in the most deprived group (1), although an increase in stroke mortality during this period in groups (2), (3), and the least deprived (5).

*Data source: mortality DSR 2004/06 to 2017/19 from Fingertips 2018/20 calculated from PCMD*

From looking at this data, it is difficult to determine a trend between increased deprivation and stroke mortality both before and during Covid, however there is some indication of an increased burden of mortality amongst the more deprived groups during the Covid period.

## 7.2 CORONARY HEART DISEASE

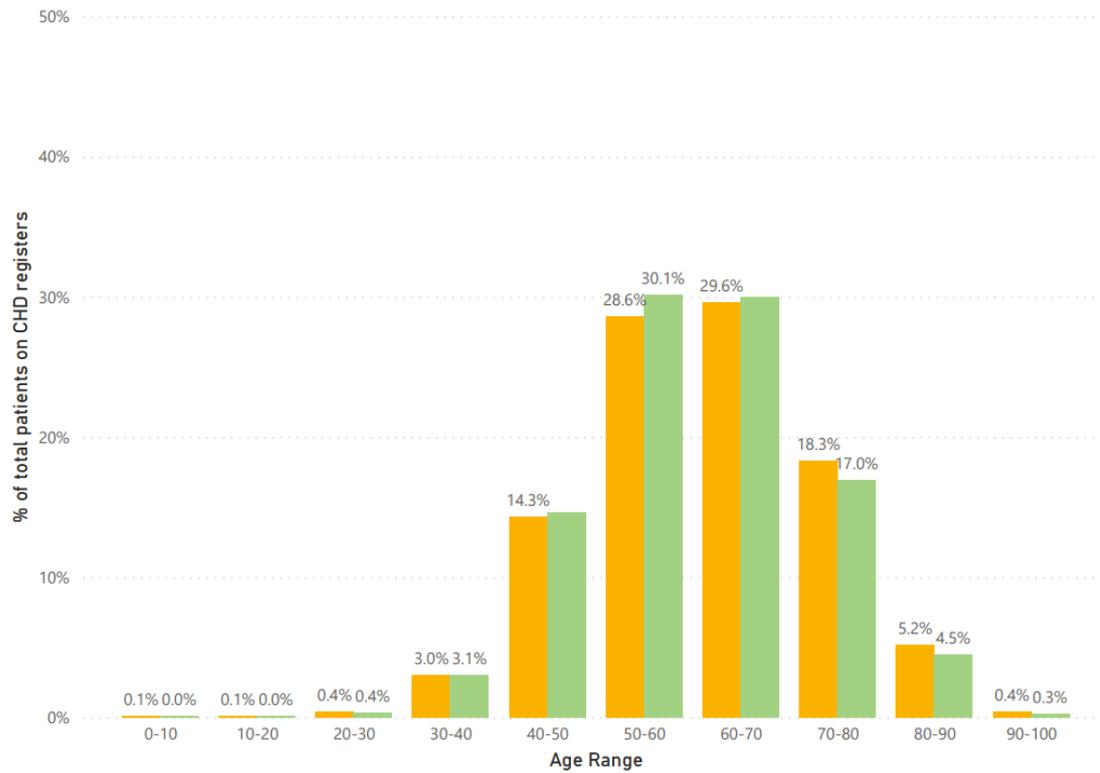
Across the ICS, in 2019/20 CHD prevalence was 3.4%, which was slightly higher than the national rate of 3.1%. There is variation seen among PCNs, with North & West highest (4.03%) and Worcester City lowest (3.24%). Over the last 5 years, CHD prevalence has been similar to statistical neighbours.

Average age at diagnosis for CHD patients is similar across Herefordshire & Worcestershire (figure 22). There are also similar proportions of total CHD patients being diagnosed at each age group. Approximately 14% of patients in both Herefordshire & Worcestershire resident cohorts are diagnosed between 40-50 years old.

Figure 22: Age at CHD diagnosis

**Age at CHD Diagnosis (Age at registration for all patients registered to GP CHD registers as of 29/09/2021)**

● Herefordshire ● Worcestershire

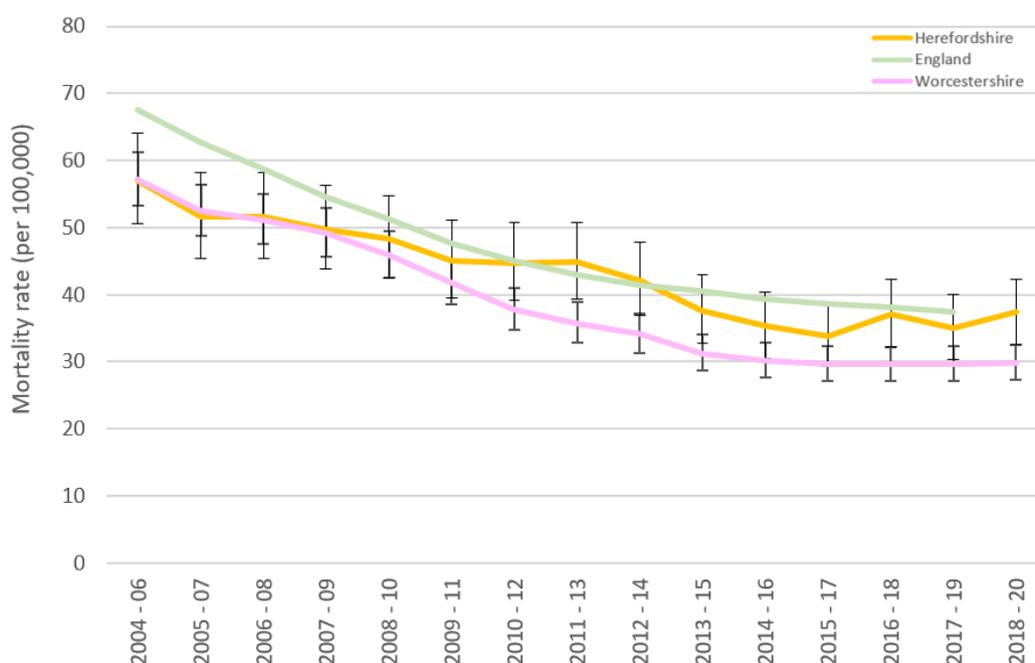


**Total patients on CHD register as of 29/09/2021:**  
 Herefordshire- 7065  
 Worcestershire- 20677

**Average age at diagnosis:**  
 Herefordshire- 62  
 Worcestershire- 61

Data: Taurus GP Federation and H&W CCG

Figure 21: Standardised CHD premature mortality rate (age <75) 2004-2020



Data source: under 75 mortality DSR 2004/06 to 2017/19 from Fingertips 2018/20 calculated from PCMD

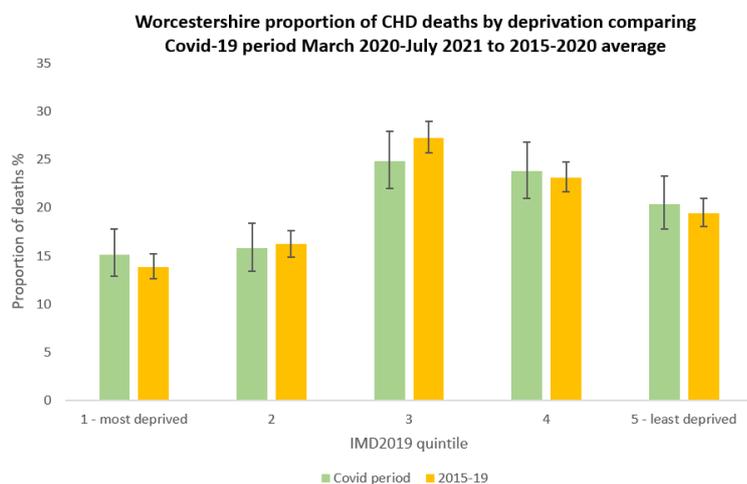
The premature mortality rate (under 75 years of age) due to CHD in Worcestershire has a generally downward trend evident from 2004-06. In 2015-2017 the figure was 29.7 per 100,000, which is almost half that of what it was in 2004-2006. However between 2015 and 2020, this rate has plateaued and stayed constant, with the most recent rate 2018-20 being 29.8 per 100,000. Although no improvement is seen, Worcestershire rate has been consistently lower than national average and Herefordshire rates over this 16 year period.

The premature mortality rate due to CHD in Herefordshire has shown more variability than Worcestershire, with a generally downward trend evident between 2004 and 2017. The figure in 2015-2017 was 33.9 per 100,000, considerably less than 2004 (57). However, after this time there are two spikes seen in 2016-2018 and most recently in 2018-2020 when the rate was 37.5 per 100,000 population.

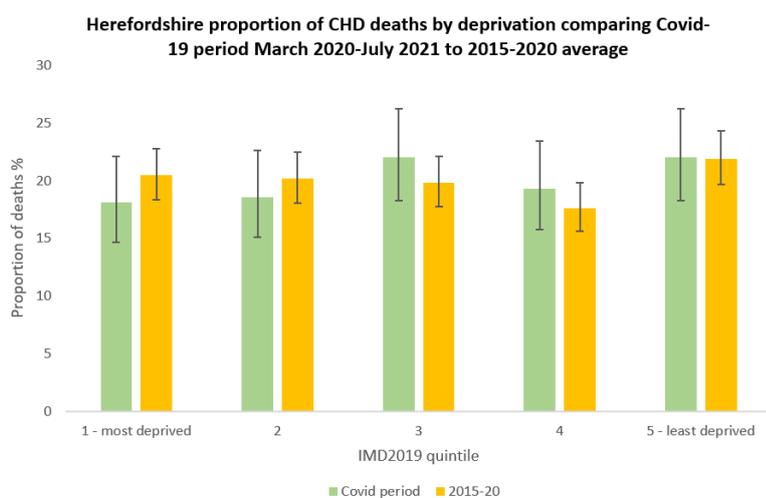
Between the years 2015 to 2020, the average age of death from CHD for females is higher than for males both in Worcestershire and Herefordshire (Appendix 6). In terms of directly standardised mortality rates

by gender, there is a clear pattern across both counties of a significantly higher mortality rate amongst males than females.

Figures 22 and 23: CHD mortality by deprivation quintile comparing 2015-2020 to Covid-19 period March 2020-July 2021



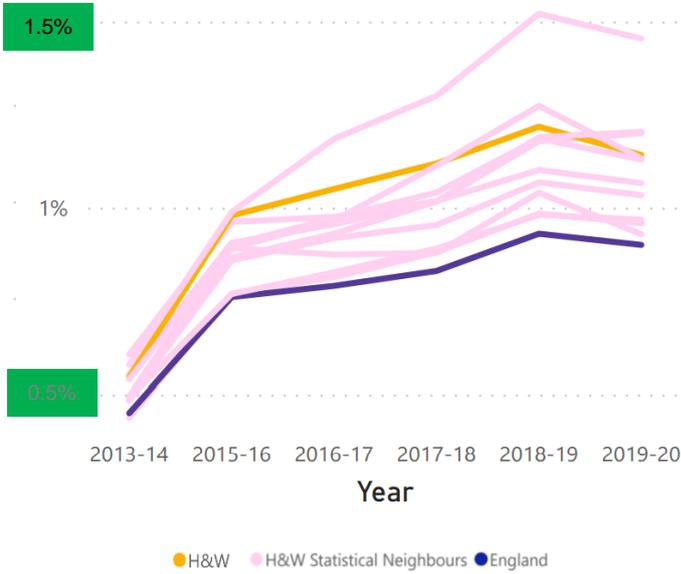
In Worcestershire, during the time period 2015-2020, there was no clear link between deprivation and increased mortality. During the Covid period, increasing CHD mortality was experienced by the least and most deprived groups.



In Herefordshire, during the time period before Covid in 2015-2019, there was a slight gradient of increasing CHD mortality associated with increased deprivation, although this pattern did not extend to the least deprived group (5). Interestingly, during the covid period the most deprived groups experienced a drop in mortality, whilst there was no change in the least deprived group.

*Data source: mortality DSR 2004/06 to 2017/19 from Fingertips 2018/20 calculated from PCMD*

Figure 24: HF prevalence in H&W over time compared to statistical neighbours (2013-2020)



7.3

HEART FAILURE

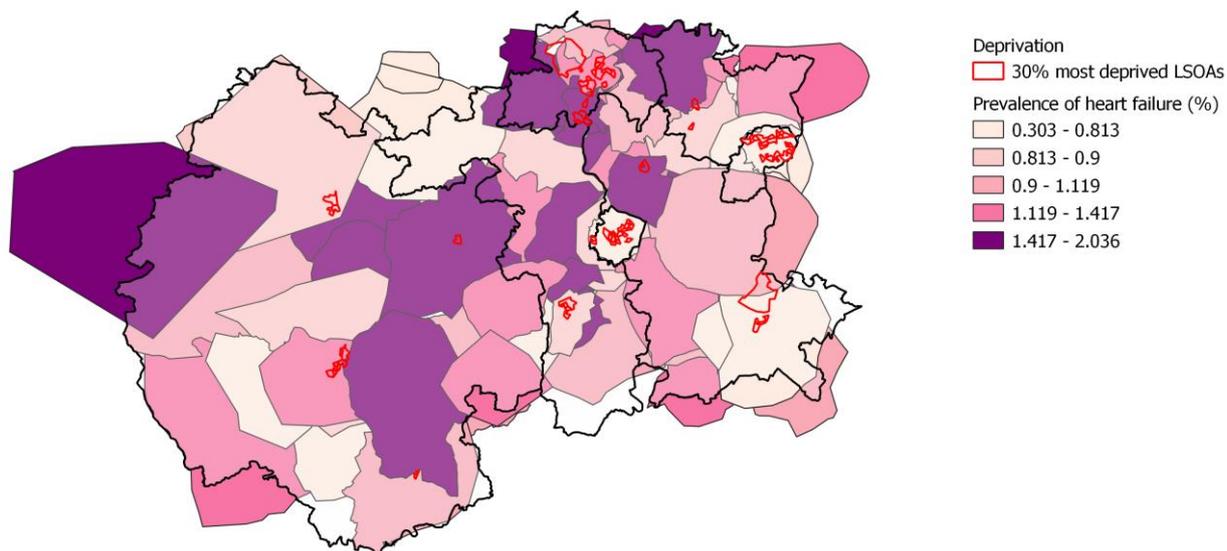
Across the ICS, Heart failure (HF) prevalence in 2019/20 was 1.14%, which was higher than the national average of 0.9%.

Over the past 5 years, H&W has been consistently higher than statistical neighbours (figure 24).

There is variation seen among PCNs, with highest prevalence seen in Wyre Forest HP 1.66% and lowest in HMG 0.95%.

Source: PHE Fingertips Quality Outcomes Framework

Figure 25: Heart failure prevalence by GP boundary against 30% most deprived LSOAs 2019/20



When looking at deprivation by LSOA mapped against heart failure prevalence by GP practice, there is no clear link between increased deprivation and HF prevalence. However, there are some of the 30% most deprived LSOAs which also have higher prevalence which could be focused on (figure 25).

## 7.4 CVD MORTALITY AND IMPACT OF COVID-19

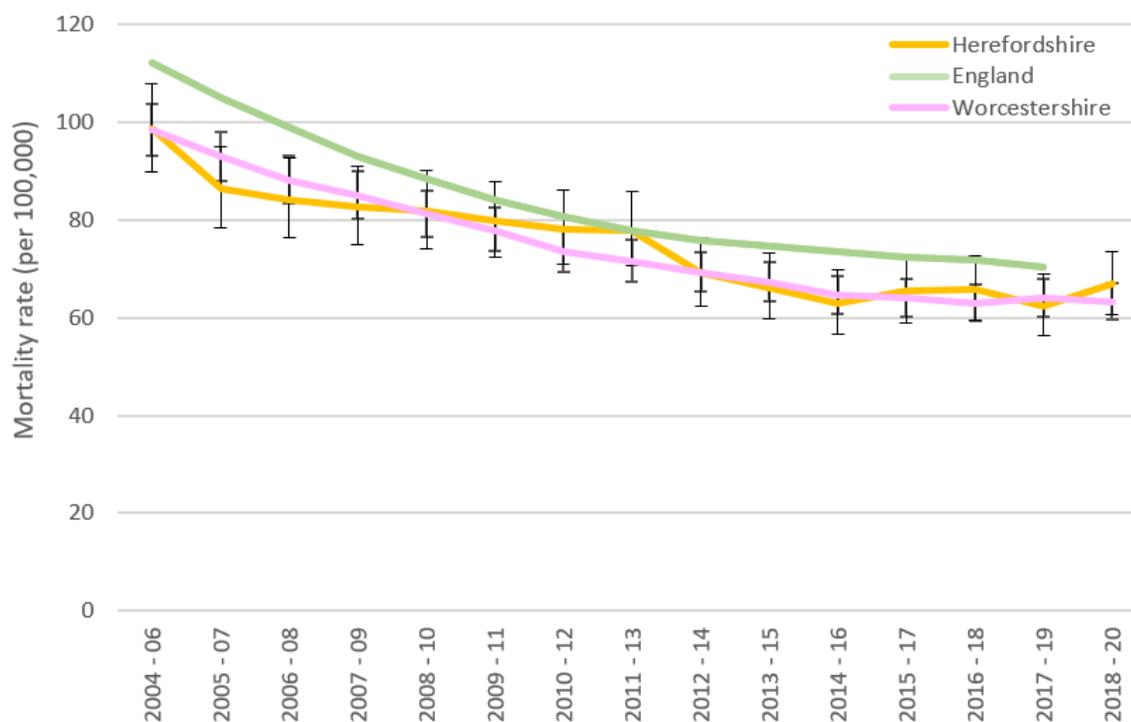


Figure 26: Standardised CVD premature mortality rate (age <75) 2004-2020

Data source: under 75 mortality DSR 2004/06 to 2017/19 from Fingertips 2018/20 calculated from PCMD

By looking at crude mortality rates for residents during March 2020 - July 2021 compared with the 5 year average rate for 2015-2020 (March to February), the impact of covid can be reviewed on the primary underlying causes of death (Appendix 4).

In Herefordshire, between March 2020 and July 2021, Ischaemic Heart Disease has been the leading cause of death and Covid-19 has been the second leading cause of death (accounting for 9%). Covid-19 appears to have been the underlying factor in a fall in mortality rates for most other causes. Notable drops have been seen in mortality from ischaemic heart disease and cerebrovascular disease.

In Worcestershire, between March 2020 and July 2021, Covid-19 has been the leading cause of death, followed by Ischaemic Heart Disease. It is likely that Covid-19 will also have been the underlying factor in a fall in mortality rates for most other causes. Notable drops have been seen in mortality from Influenza and Pneumonia and organic dementia related illnesses. However, there have also been increases in ischaemic heart disease and other forms of heart disease.

## 8 HYPER ACUTE AND ACUTE STROKE CARE

### 8.1 SSNAP INDICATORS

Hyper-acute care typically covers the first 72 hours after admission. Every patient with acute stroke should gain rapid access to a stroke unit (<4 hours), be seen by a stroke specialist clinician within 60 minutes of arrival and receive an early multidisciplinary assessment (physiotherapist, occupational therapist, speech and language therapist) within 24 hours of admission.

Sentinel Stroke National Audit Programme (SSNAP) data provides a high quality overview of many hyper-acute and acute stroke care indicators. ICS acute providers use this data to inform stroke care decisions and optimise stroke care pathways. There is an evident improving trend in admission to a hyper acute stroke unit (HASU) within 4 hours in both providers, however in 2019-20 this was still below national rate. The WVT stroke team is currently implementing a live dashboard for key hyper-acute and acute care SSNAP indicators to provide a timely overview of stroke care.

Table 1: SSNAP Hyper-Acute and Acute care indicators 2016-2020

Wye Valley NHS Trust- Hyper-Acute and Acute care indicators					National
	2016-17	2017-18	2018-19	2019-20	2019-20
% patient with acute stroke admitted to a stroke unit (<4 hours)	39.2	33.7	23.3	41.1	55
Assessed by a stroke specialist consultant physician (in person) within 24h of clock start	62.4	66.6	73.3	71.6	83.7
If applicable, swallow screening within 4 hours of clock start	85.5	88.2	82.5	80.2	74.8
If applicable, assessed by occupational therapist within 72 hours of clock start	94.4	92.8	92.6	93	92.9
If applicable, assessed by physiotherapist within 72 hours of clock start	96	93.4	95	93.4	95.2
If applicable, assessed by speech and language therapist for communication within 72 hours of clock start	82.8	75.9	86.3	88.9	90

Worcestershire Acute Hospitals NHS Trust- Hyper-Acute and Acute care indicators					National
	2016-17	2017-18	2018-19	2019-20	2019-20
% patient with acute stroke admitted to a stroke unit (<4 hours)	18.1	25.8	27.8	36.7	55
Assessed by a stroke specialist consultant physician (in person) within 24h of clock start	55.7	65.8	66.8	79.2	83.7
If applicable, swallow screening within 4 hours of clock start	37.1	79.8	91.9	94.8	74.8
If applicable, assessed by occupational therapist within 72 hours of clock start	90.4	93.4	95.1	96.1	92.9
If applicable, assessed by physiotherapist within 72 hours of clock start	91.7	93.8	94.9	96.1	95.2
If applicable, assessed by speech and language therapist for communication within 72 hours of clock start	70.5	72.2	79.1	92.7	90

Source: Sentinel Stroke National Audit Programme (SSNAP)

## 8.2 IN-HOSPITAL AND OUT-OF-HOSPITAL DEATHS

Hospital Episode Data (HED) has been presented in tables 2 and 3 to provide a detailed review of Acute Cerebrovascular Disease (ACD) mortality outcomes at provider level. Temporal trends in number of deaths and crude mortality rates for inpatient and out of hospital deaths (up to 90 days) is presented for both Wye Valley Trust (WVT) and Worcestershire Acute (WA).

The diagnostic group 'Acute cerebrovascular disease' was used when extracting data, with 'TIAs', 'Other' and 'ill-defined' cerebrovascular disease groups excluded. These groups were excluded from data extraction because of small numbers likely needing to be redacted. It is important to note that the ACD code is not the registered cause of death, but is the code that describes the diagnosis on admission.

Table 2: HED data for Wye Valley Trust

<b>Acute Cerebrovascular Disease</b>	<b>2018/2019</b>	<b>2019/2020</b>	<b>2020/2021</b>
Number of Discharges	518	493	463
Number of Inpatient Deaths	62	83	69
Crude Mortality Rate (In-Hospital)	12%	17%	15%
Number of out-of-hospital deaths (up to 90 Days)	33	22	25
Crude Mortality Rate (out-of-hospital)	6%	4%	5%
Combined crude mortality rate (up to 90 days)	18%	21%	20%

Table 3: HED data for Worcestershire Acute

<b>Acute Cerebrovascular Disease</b>	<b>2018/2019</b>	<b>2019/2020</b>	<b>2020/2021</b>
Number of Discharges	815	792	868
Number of Inpatient Deaths	112	112	122
Crude Mortality Rate (In-Hospital)	13.70%	14.10%	14.10%
Number of out-of-hospital deaths (up to 90 Days)	51	52	66
Crude Mortality Rate (out-of-hospital)	6.30%	6.60%	7.60%
Combined crude mortality rate (up to 90 days)	20%	20.70%	21.70%

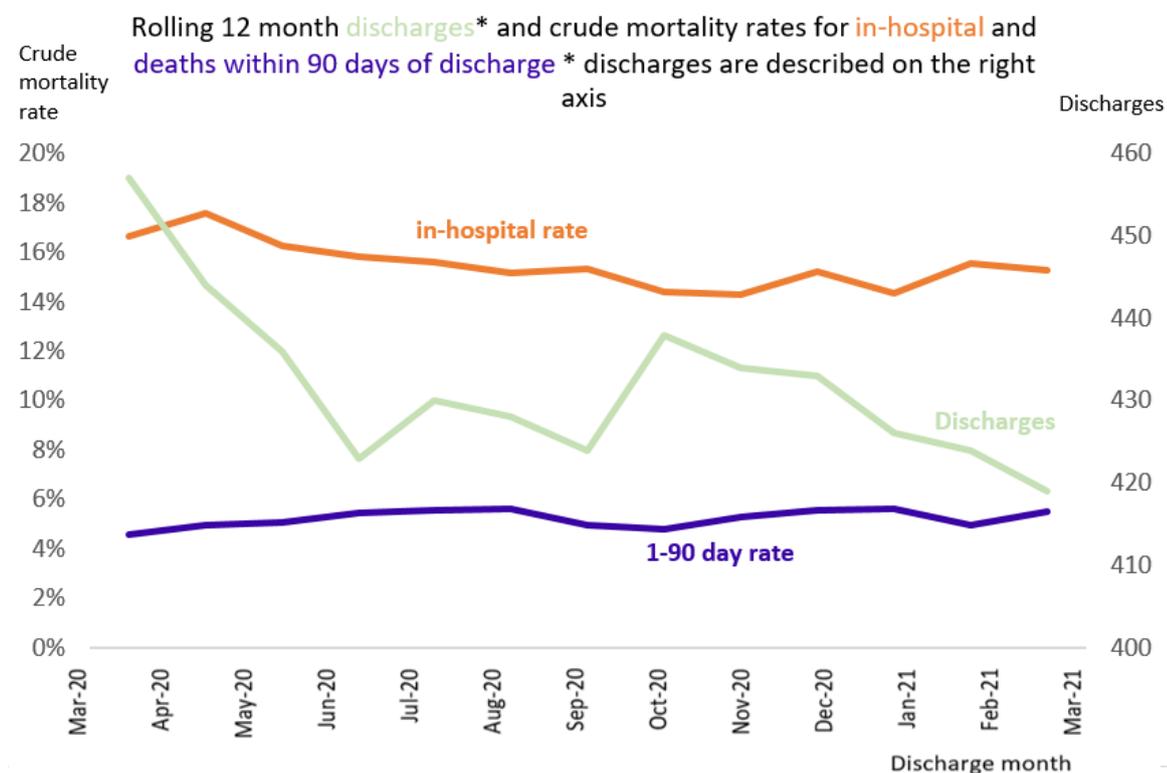
*Hospital Episode Data provided by WV NHS Trust and WA NHS Trust Intelligence teams*

As can be seen in tables 2 and 3, there are no obvious year on year trend in terms of stroke patients (discharges) for WA whereas there is a decreasing trend in patients at WVT. Although there were more inpatient deaths in 2020/21 at WA, the in-hospital crude mortality rate remained the same to the previous year. However, at WVT, 2020/21 saw a decrease in inpatient deaths as well as in-hospital crude mortality rate to the previous year.

At WA, crude mortality rate for out-of-hospital deaths within 90 days of discharge appears to have risen in consecutive years since 2018/2019. This upwards trend is not seen at WVT. Although unlikely, whether this is a statistically significant increase in crude rate, or related to the COVID-19 pandemic would need to be investigated further.

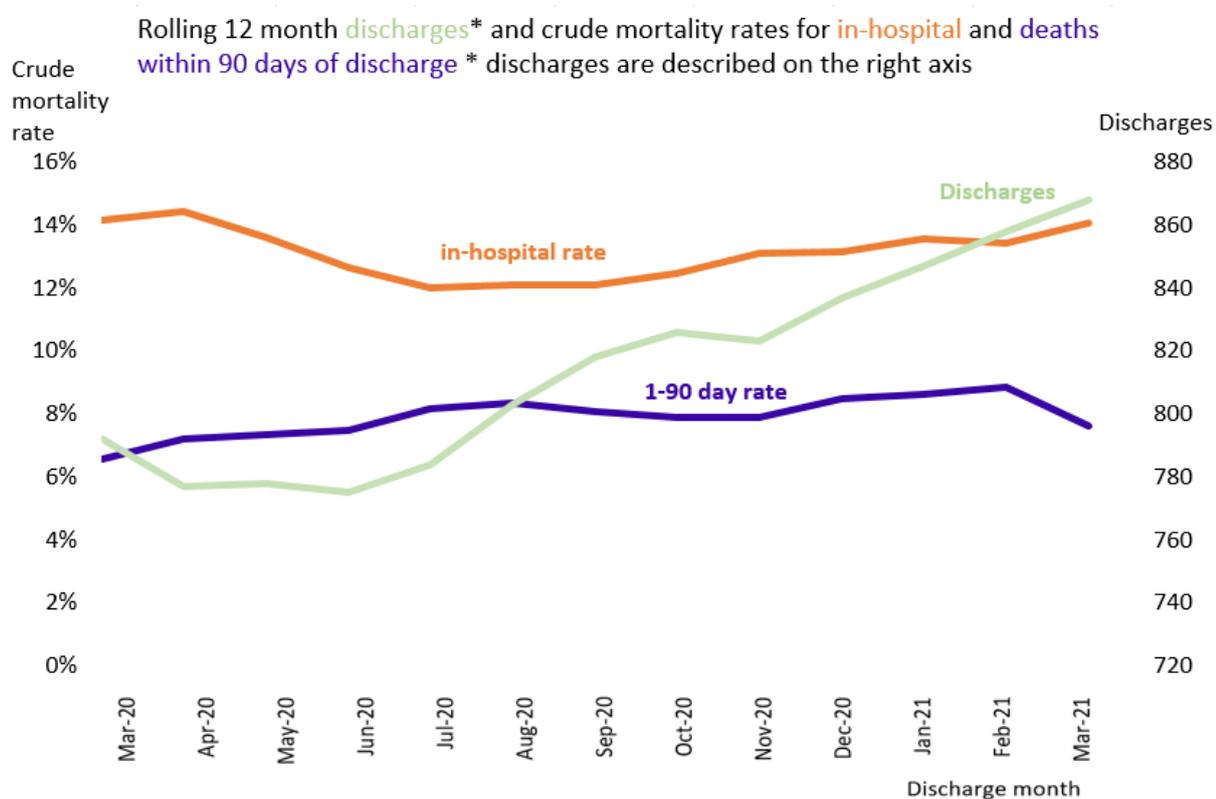
Figure 27 and figure 28 show the rolling 12-month trend (March 2020-March 2021) in crude mortality rates for in-hospital and out-of-hospital, set against number of discharges. A rolling 12-month rate is used as this tends to better display any trends and avoids the issue of small monthly numbers where information may need to be redacted.

Figure 27: Wye Valley NHS Trust Acute Cerebrovascular Disease mortality 2020/21



Hospital Episode Data provided by WV NHS Trust and WA NHS Trust Intelligence teams

Figure 28: Worcestershire Acute Hospitals NHS Trust Acute Cerebrovascular Disease mortality 2020/21



Hospital Episode Data provided by WV NHS Trust and WA NHS Trust Intelligence teams

At WA, the number of in-hospital deaths and associated crude mortality rate appear to have risen slightly over the course of the latter part of 2020/21, and does not correlate to discharges. This variation could be seasonal or due to another reason. This trend is not seen at WVT. Noticeably at the end of the second COVID-19 pandemic wave there is a rise in in-hospital deaths and a fall in deaths for days 1-90 at WA, which could warrant some further investigation.

There are small numbers when it comes to age, gender and ethnicity which make them difficult to describe and comment on. In 2020/21, at both providers, there are more male deaths <75 in hospital and <90 days than female <75s. Similarly, at both WA and WVT there are more female deaths >75 both in-hospital and out of hospital <90 days than male deaths >75. On average, men and women dying in-hospital and <90 days are older at WVT than WA.

## 9 REHABILITATION

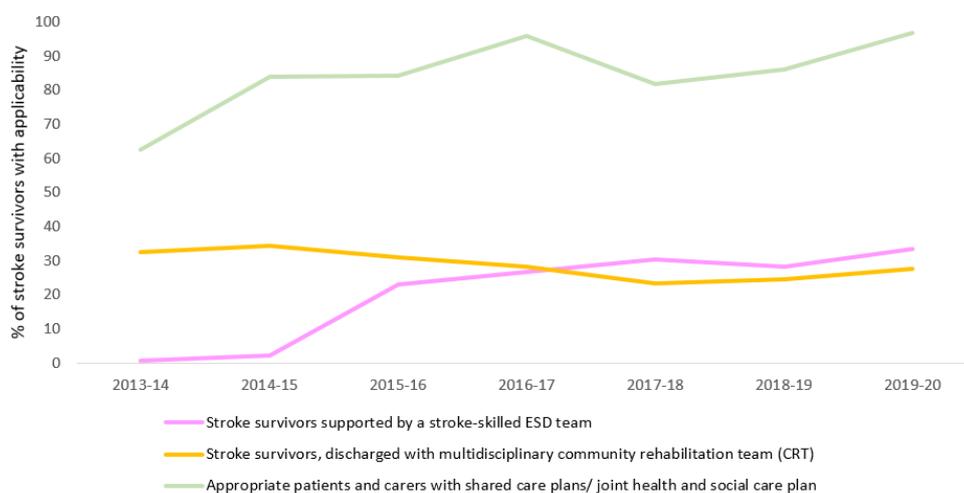
The new national stroke service model states that community stroke rehabilitation should now be provided by an integrated community stroke service (ICSS) model, details of which will be published in the near future.

People who have had a stroke should currently have timely access to high quality rehabilitation appropriate to their need and desired outcomes. The MDT must work in partnership with the stroke survivor and those important to them, so they can maximise their recovery, independence and overall quality of life. Early Supported Discharge (ESD) is available at both acute providers, facilitating early transfer of care who fit ESD criteria to a community setting- therapy is usually provided over a six week time period. SSNAP data is presented to look at rehabilitation indicators; discharge and 6 month review indicators. SSNAP data is of high quality and has multiple indicators beyond those presented here.

### 9.1 EARLY SUPPORTED DISCHARGE & COMMUNITY REHABILITATION

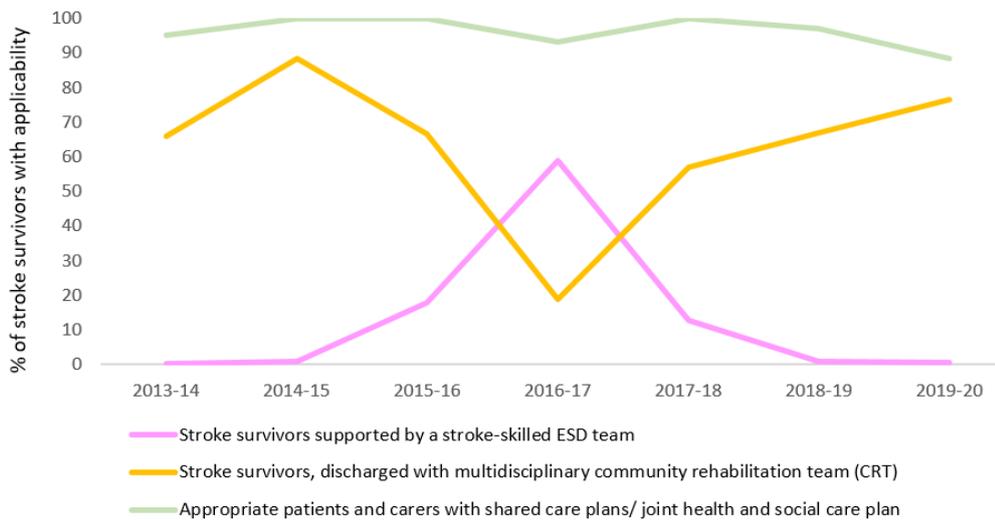
There is a generally increasing trend for % of stroke survivors supported by an ESD team at WVT, with the rate 33.6% in 2019-20. This was below the national rate of 41.5%. However, this indicator should be read in the context of ESD and Community Rehabilitation Team teams being a combined service and working in tandem in Herefordshire to size of county and rurality. There is a similar increasing trend for % of patients and carers with a shared health and social care plan on discharge, the rate in 2019/20 was 96.8%. In the most recent published quarter Jan-March 2021, this reached 100%. The % of stroke survivors who were discharged with the community rehabilitation team has stayed steady over time, with the rate in 2019/20 27.7%.

Figure 29 Wye Valley NHS Trust- ESD & CRT SSNAP indicators 2013-2020



At WA, data for stroke survivors supported by an ESD team or discharged with a CRT team follow an inverse pattern over the years, suggesting a difference in classification in team, rather than less service provision. Supporting this, is the fact that in the most recent published quarter Jan-March 2021, patients discharged with an ESD team reached 98.2%, which was significantly above national rate. Similarly to WVT, the patients with a shared health and social care plan on discharge has remained consistently high over the years, reaching 100% in Jan-March 2021.

Figure 20: Worcestershire Acute Hospitals NHS Trust- ESD & CRT SSNAP indicators 2013-2020



## 9.2 STROKE SURVIVOR REVIEW AT SIX MONTHS

Stroke survivors are required to have a six month review following discharge if this is applicable (table 4). The % of patients who received this in 2019/20 was similar across both providers in 2019/20, with variability (or not recorded) compared to previous years. Above the national rate of 40.6%.

At this 6 month review, the % of stroke survivors who were in AF but not on anticoagulation was 16.7% at WVT and 14.6% at WA. This offers an opportunity to further optimise secondary prevention of stroke and CVD.

Table 4: WVT and WA 6 month review indicators

Wye Valley NHS Trust- 6 month review indicators			
	2017-18	2018-19	2019-20
Applicable patients who are assessed at six months following a stroke	-	20.4	72.3
If patient is in AF at six month follow-up assessment, then taking anti-coagulant	-	75	83.3

Worcestershire Acute Hospitals NHS Trust- 6 month review indicators				
	2016-17	2017-18	2018-19	2019-20
Applicable patients who are assessed at six months following a stroke	72.9	50	64.3	78.4
If patient is in AF at six month follow-up assessment, then taking anti-coagulant	100	83.3	87.5	85.4

## 10 LIFE AFTER STROKE

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Life after stroke (LAS) services provide the ongoing personalised care and support that people need to rebuild their lives and minimise risk of future cardiovascular events. They should be considered a vital and integrated part of the end-to-end stroke pathway to ensure that multidisciplinary person-centred care can be provided to all people affected by stroke. Ensuring that local populations have equitable access to LAS is key to improving patient outcomes and reducing health inequalities. A service description and care pathway for LAS has been highlighted as a key part of the stroke pathway within the National Stroke Service model.

Secondary prevention considerations should continue in the community after a person has a stroke/ TIA and into the longer-term to ensure adequate and ongoing risk reduction. LAS have a key role in supporting PCNs by helping people affected by stroke to understand the risk factors associated with secondary stroke and what they can do to reduce their risk.

### 10.1 WORCESTERSHIRE LAS SERVICES

Stroke Association provides a commissioned LAS service for stroke survivors and carers in Worcestershire, providing stroke specific information, support and signposting to stroke survivors and their carers/family members for up to 12 months from date of referral.

In 2020/21, the service adapted to provide virtual support during the Covid-19 pandemic. This new blended and supportive model has been welcomed by service users and staff with positive feedback, as it means that the service can be more person-centred. A downside of less in-person services has been the ceased drop-in sessions at Evesham Hospital for carers during the pandemic, meaning that less carers were reached over this time. It is noted that many carers prefer 'soft support' without having the label of carer and an official open case with Stroke Association.

Referrals to Stroke Association come from various sources but the majority are directly from Evesham Hospital Stroke Unit and the Community Stroke Team (CST) [19]. The service operates an open referral system and also accepts self and family referrals, as well as from other health, social care and voluntary sector services.

In 2020/21, the active maximum caseload was 279 service users. Approximately 92% of new referrals were acted on within 3 working days.

In 2020/21, approximately 70% of new service users were over the age of 59 (this includes stroke survivors and carers). There were slightly more new female service users than male.

93% were of a White ethnic group, which is reflective of the demographic of the local population. 3.5% were unknown or not recorded. Deprivation markers are not collected as of yet, but there are plans for this to be done. Language line support is provided where needed.

A person-centred needs assessment is conducted at first contact with a service user, and a holistic approach taken with each case. There are many identified needs. Top 5 attributed outcomes achieved

throughout 2020/21 by quarter are shown. These are collected through conversations with service user and carer. Secondary prevention is also completed with every service user and carer and signposting completed where appropriate.

## 10.2 HEREFORDSHIRE LAS SERVICES

In Herefordshire, patients are referred to specialist NHS services for acquired brain injury (HABIT) and neuro rehabilitation and physiotherapy if needed. Voluntary sector support is provided by referral to Headway- a charity offering support to patients and families after a brain injury. However, this is not formally organised or commissioned by the CCG, and there is no commissioned LAS service in Herefordshire similar to Stroke Association in Worcestershire.

The national Stroke Association 'Stroke Connect' is a voluntary sector service which is open to all areas. Stroke survivors and carers can be referred for a two phone call check in service- the national team can provide signposting to local services in the months after a stroke, and can be helpful if stroke survivors are initially discharged and identify needs later on. This service can be made more use of across the ICS. These referrals are best placed down from acute hospital services so as not to interrupt the normal community referral pathway.

# 11 CVD USER AND STAKEHOLDER VOICES

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In the context of the new National Stroke Service Model for ISDNs, a communication and engagement plan for stroke is currently in the process of being agreed. An engagement gap analysis and equality impact assessment will be conducted to highlight where engagement needs to be focused to support this work. For this reason, bespoke engagement work has not been undertaken for this JSNA, rather, relevant engagement regarding CVD with service users and stakeholder will be summarised here.

## 11.1 MEN'S HEALTH REPORT 2020- HEALTHWATCH HEREFORDSHIRE

Men tend to be lower users of health services than women generally. Between July 2019 and March 2020 Healthwatch Herefordshire carried out a valuable piece of work, engaging with Herefordshire men in venues such as pubs, clubs, shops, and leisure facilities [20]. The aim was to understand whether there were specific barriers that prevented or put men off from accessing preventative services relevant to CVD and men's ideas about improving access and improving health messaging. Some of the key findings showed:

- Almost 1 in 5 men revealed that they saw no point in going for health checks because they believe they are not unwell

- 1 in 16 men were more fatalistic about preventative services “if you are going to get something you will whether you have a check or not”.
- 1 in 40 men were sceptical about the benefits of preventative services “does it really prevent anything?”
- In terms of how they would like to receive preventative information, almost half were interested in apps to improve health and wellbeing, 1 in 5 men favoured TV, TV role models and radio. 1 in 7 mentioned being informed through their GP /doctor/ nurse/ health professional, either through email, messaging, letter or at the practice and suggested age appropriate advice.

This indicates that services need to do more to sell the preventative benefits of health checks. Using social settings, employers and workplaces to offer health tests, and use direct and strong messages back by role models.

## 11.2 EARLY SUPPORTED DISCHARGE (ESD) EVALUATION- HEALTHWATCH HEREFORDSHIRE

The ESD service was introduced at Wye Valley Trust in 2015, and Healthwatch Herefordshire and Herefordshire Carers Support evaluated this service by interviewing patients and carers about their experience of the therapy, care and support they received. This engagement provided an overall positive review of the service.

A few common areas that patients and carers felt could be improved:

- The way in which hospital discharge and related pharmacy liaison is agreed, related and timed, as well as how medication is timed to be available upon discharge.
- The way in which the views, concerns and information needs of both patients and carers are discovered, considered and served.

## 11.3 HEALTHWATCH WORCESTERSHIRE HOSPITAL DISCHARGE REPORT 2021

Although not specifically looking at stroke patients, some general recommendations from this engagement piece of work around discharge are relevant [21]:

- Improve communication and involvement with family and carers early on in admission to enable them to participate in decisions made during and after the discharge process.
- Ensure that individuals and their families are provided with the information supplied by NHS England, or a local equivalent, about leaving hospital and are fully informed of next steps.
- Consider whether inpatient discharge after 8 p.m. is appropriate for any patient, and consider placing limits on weekend discharge which are determined by capacity in the system.

## 11.4 H&W CCG COMPLAINTS

The complaints and responses relating to stroke care from H&W CCG ranging from 2017 to 2021 stroke services were reviewed (three were shared with consent from complaints team). Theme were:

- Communication and lack of information regarding discharge
- Discharge from a care home setting during Covid-19 pandemic following national directive was issued to move patients from hospital settings who were assessed as clinically safe to be discharged either to their own home or a care home setting
- Discharge from hospital after a stroke to care home setting and compromised rehabilitation and follow up support

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