Response to Consultation on Better Coronary Heart Disease and Stroke Care
South Edinburgh Health Forum – October 2008

Consultation Questions

SECTION 3: HEALTHY LIFESTYLES

QUESTION 1

What further actions should we take to encourage healthy choices that can reduce the risk of CHD and stroke and cardiovascular disease more generally?

We recognize that the issues recommended in para 3.7 are those which the health service has under its own control. However we suggest it must be recognized that it is not the health service alone which can promote actions which have an impact on CHD and stroke. The education service, working with police and other local authority agencies all need to work to the same messages.

For example, an issue which affects the use of leisure facilities in Edinburgh, is that Edinburgh Leisure (a hands-off company), have increased their charges for the use of facilities and have withdrawn or started charging for the creche. A lot of the people who use these facilities are those from the surrounding areas, which are disadvantaged areas. It now costs them a lot more to try and keep themselves fit. This is so that EL can balance their budget.

There is also the problem with schools built under PPP/PFI where the (community) leisure facilities cannot be used out of hours or the charges for use are so high that small groups now cannot afford their use. Again it defeats the purpose of people trying to keep themselves fit.

We also suggest that the Councils should adopt a policy whereby planners ensure that 'spatial planning' decisions encourage 'active travel' (ie walking and cycling). However such decisions also would need to take into account the need for excellent bus services and safe environments for walking and cycling.

- Make provision for more long-term counselling for smoking cessation for patients in maternity units and in acute care settings where necessary;
- As well as removing soft drinks with high sugar content from hospitals, also encourage schools to do the same;
- Encourage and give support to all staff working in the health service to be good examples of a healthy lifestyle to the rest of the community;
- On alcohol, encourage police, homeless charities and licensing officers (due in Sep 2009) to work together with the same messages and offers of support; and
- Keep sports centres and swimming facilities open for as many of the public as possible.

SECTION 4: TACKLING HEALTH INEQUALITIES

QUESTION 2

What further actions should we take to tackle the impact of inequalities on CHD and stroke?

We suggest that again it is the education service, or adult community settings, which will have the greater influence on how people eat and exercise and influence what they do in their everyday lives to adopt healthier lifestyles.

- Promote learning to cook – after school clubs, "Pass-it-on" (as Jamie Oliver has tried in Rotherham) with adults to encourage better cooking skills and healthier eating; diet posters and advice in hospitals – part of prevention.
- Radically – make school meals (using a healthy menu) compulsory!

SECTION 5: SERVICES FOR CHD

QUESTION 3

What further actions should we take to improve the range and quality of CHD services in Scotland and how should these actions be prioritised?

SECTION 6: STROKE SERVICES

QUESTION 4

What further actions should we take to improve the range and quality of stroke services in Scotland and how should these actions be prioritized?

6.8 'There is a role for CHPs to work with MCNs etc. We agree: the model in Edinburgh is exceptionally good, with excellent liaison between the Stroke Unit in the WGH and the Community Rehabilitation team. One of our members was provided with brilliant, thoughtful and genuinely holistic care, and again there was liaison with the Council's home care team when the 6 weeks of intensive support was phased out. Information was also excellent, with links to benefits, voluntary organizations etc.

- We suggest that the Edinburgh model of discharge and rehabilitation is copied elsewhere.

6.12 **Thrombolysis**

This is the big issue. At the moment the necessary brain scanning cannot be done 24/7: One of our members with direct experience is of the opinion that the problem is shortage of staff (particularly at consultant level) rather than shortage of machines. Scanning is essential before administering thrombolysis to ascertain whether the stroke is caused by a clot rather than a bleed.

As an example, as experienced by one of our members, a patient who had a stroke at 6.00 a.m. on a **Saturday** and went within minutes in an ambulance to the WGH, where there is a Stroke Unit, did not have a scan till the next day, and though the patient was then found to have a clot and so might have benefited from thrombolytic drugs, did not in fact receive them. Medication was only revised after a considerable delay.

However, on this occasion it was most helpful that the patient had had the 'bottle in the fridge', giving the ambulance crew and the hospital staff details of all current medication. Recommendations:

- Publicize the Bottle in the Fridge scheme widely among all GP practices, emergency departments, and ambulance crews. It should be provided routinely for all elderly patients (say, over 70) and all patients with chronic conditions of whatever age.

- Ensure that 24/7 brain scanning facilities and staff are made available in all emergency departments without delay.

SECTION 7: IMPROVING THE EXPERIENCE OF CARE

QUESTION 5

What further actions should we take to improve the patient experience of care for both CHD and stroke?

We strongly recommend that follow-up appointments are offered to stroke patients, say 6 weeks after discharge, and thereafter annually. This should surely give patients some greater feeling of security, and also be educative for healthcare professionals, who must feel encouraged to see the progress that people can make. (In the experience of one of our members no follow-up appointment was offered: it had to be asked for.)

SECTION 8: IT INFRASTRUCTURE

QUESTION 6

What further actions should we take to develop the IT infrastructure that is needed to support CHD and stroke services?

While IT is very important, the gathering of statistics for statistics' sake should not overburden the staff and divert them from the clinical job in hand. A computer cannot save a life but a person can.

We noted the references to e-Health IT governance. This is of the utmost importance particularly when dealing with medical records and access should be very strictly controlled. Although not explicitly mentioned in the paper, we would hope that any patient should be able to opt out of computerised record -keeping if they wish or are so advised.

Until there is a fully implemented and working computerized system of patient records, a further low-tech solution to the problem of record-keeping would be to allow patients to keep their own paper records, as happens in a limited way in maternity care. This would be of particular value when patients are passed from one hospital to another (which does happen in CHD and stroke care, as well as in other areas such as cancer care). Records can even be mislaid between one department and another of the same hospital, in our experience.

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