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Health and Social Care Committee

Meeting Venue:
Committee Room 1 – Senedd

Meeting date:
23 October 2013

Meeting time:
09:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda

1 Introductions, apologies and substitutions

2 Stroke risk reduction – follow-up inquiry: Panel 1 – Voluntary sector (09:00 – 09:35) (Pages 1 - 43)
Jo Jerrome, Atrial Fibrillation Association
Ana Palazon, Director Wales, Stroke Association
Paul Underwood, Deputy Director Wales, Stroke Association
Lowri Griffiths, Stroke Association

3 Stroke risk-reduction – follow-up inquiry: Panel 2 – Wales Stroke Alliance (09:35 – 10:10) (Pages 44 - 58)
Dr Anne Freeman, Clinical Lead for Stroke in Wales, National Delivery Unit
Dr Hamsaraj Shetty, Consultant Stroke Physician, Cardiff and Vale University Health Board

Break (10:10 – 10:20)

4 Stroke risk-reduction – follow-up inquiry: Panel 3 – Local Health Boards / Public Health Wales (10:20 – 11:00) (Pages 59 - 73)
Mrs Jan Smith, Executive Director and Executive Lead for Stroke, Aneurin Bevan University Health Board
Dr Yaqoob Bhat, Stroke Physician, Aneurin Bevan University Health Board
Dr Hugo van Woerden, Director of Innovation and Development, Public Health Wales
Amanda Smith, Director of Therapies & Health Sciences, Quality and Safety, Powys

Teaching Health Board.

5 Stroke risk-reduction - follow-up inquiry: Panel 4 - Professional bodies (11:00 - 11:30) (Pages 74 - 80)

Nicola Davis-Job, Acting Associate Director (Professional Practice), Royal College of Nursing
Carole Saunders, Stroke Clinical Nurse Specialist, Singleton Hospital
Dr Amer Jafar, BMA Cymru Wales and Associate Specialist in Rehab Medicine, St Woolos Hospital
Dr Phil White, BMA Cymru Wales, General Practitioner, North Wales

6 Stroke risk-reduction - follow-up inquiry: Panel 5 - Welsh Government (11:30 - 12:00) (Pages 81 - 99)

Mark Drakeford AM, Minister for Health and Social Services
Chris Jones, Deputy Chief Medical Officer (Health Services)

7 Papers to note

Letter from the Minister for Health and Social Services: health protection and immunisation budget (Pages 100 - 101)

Letter from the South Wales Plan Programme Board: follow-up information from meeting on 3 October (Page 102)

8 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

Item 9

Private session

9 Social Services and Well-being (Wales) Bill: Stage 2 briefing (12:00 - 12:30) (Pages 103 - 113)

Agenda Item 2

Document is Restricted

AF Association response to
The Health and Social Care Committee's follow-up inquiry on
Stroke Risk Reduction in Wales

20 September 2013

National Assembly for Wales

Health and Social Care Committee

Stroke risk reduction – follow-up inquiry

Evidence from AF Association – SFU 12

AF Association Response to the Health and Social Care Committee's Follow-Up Inquiry into Stroke Risk Reduction: 20th September 2013

Following our response and involvement in 2011, we are pleased to respond to the Committee following their recommendations of December 2011.

The AF Association is a UK registered charity which works with patients, carers, healthcare professionals, service providers and all other stakeholders, to:

- Increase awareness of atrial fibrillation (AF)
- Increase access to reliable and robust educational resources about AF and provide on-line, telephone, email and focused meetings to support all those affected by or managing this heart rhythm disorder
- Support timely access to appropriate treatment
- Ensure the patient experience and outcome is central to all heath services

My role within the AF Association is Deputy CEO.

The AF Association welcomed the 2011 Inquiry into Stroke Risk Reduction and its recommendations and is supportive of the Committee's continued focus on stroke risk reduction in Wales. The AF Association believes that recognising where there have been improvements, highlighting effective actions and identifying what further steps are needed to extend this work, are all essential in protecting the Welsh population from avoidable disability, suffering and premature death.

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Providing information, support and access to established, new or innovative treatments for Atrial Fibrillation (AF)

AF Association response to
The Health and Social Care Committee's follow-up inquiry on
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20 September 2013

As the 2011 Inquiry highlighted, atrial fibrillation (AF) is a major risk factor for stroke. Atrial fibrillation affects over 50,138[1] across Wales[2], with prevalence in some areas as high as 2.02% [3] (NHS average prevalence of 1.8%[4]). Aside from many other symptoms and consequences, people with AF are five times more likely to suffer a stroke[5]. Furthermore, AF-related strokes are more severe and cause greater disability than strokes in patients without AF. Half of patients will fail to survive ore than twelve months following a stroke[6]; while for many survivors, disability, fear of death and increased risk of a further stroke, become constant companions. AF and stroke not only devastate patient's lives but also the lives of their families and carers[7].

The AF Association welcomed **Recommendation One,** which included a specific focus on atrial fibrillation, within the National Stroke Delivery Plan (2012). However, while this called for greater partnership in promoting awareness of risk factors for stroke, the AF Association believes that much more is needed in particular in increasing public awareness of AF, signs, symptoms, and AF-related stroke risks. The AF Association would recommend greater use of existing materials and campaigns to empower a more far-reaching, national public and patient education campaign utilising all stakeholder channels. The 'Know Your Pulse' campaign is an appropriate and effective educational campaign, which empowers individuals to play a proactive role by being aware of the signs of AF and the importance of then talking with a healthcare professional in order to take appropriate action *before* a stroke occurs.

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[1] The Office of Health Economics, Estimating the direct cost of atrial fibrillation to the NHS in the constituent countries of the UK, 2008/2009
[2] AF Infographic – Wales: http://www.afinfographic.co.uk
[3] AF Clinic in Llanelli: Healthcare Pioneers 2011, http://www.atrialfibrillation.org.uk/files/file/Publications_Medical_Only/111026-JF-FINAL-Healthcare%20Pioneers%20Booklet.pdf
[4] GRASP-AF data 2013
[5] Wolf PA, Abbot RD, Kannel WB: Framington Study. Stroke 1991;22:983-8

[6] 5. The AF Report 2011
[7] White CL, Poissant L, Cote-LeBlanc G et al. Long term care giving after stroke J Neurosci Nurs 2006;38;354-60

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Patient empowerment is associated with improved clinical outcomes[8] and has been made central to the current focus of the NHS. As an AF Association member's account highlights, a lack of awareness around the very simple ways to detect AF can and do lead to tragic outcomes:

Jenni's husband was 58 years old:

" The stroke was caused by an undiagnosed heart arrhythmia. I say undiagnosed but that's not strictly true, just a few weeks before … I had my head on his chest and I said 'God your heart's all over the place', I never gave it another thought until three weeks later when the doctor in A&E asked if he had any known heart problems…"
(Full account:
http://www.atrialfibrillation.org.uk/files/file/Case_Studies/Jenny%20AFA%20Article.pdf)

Recommendation two

AF Association strongly supports the report's recommendation that the National Stroke Delivery Plan give clear reference to the prevention of a secondary stroke, however we feel more is needed to ensure this is carried out to maximum effect, and that individuals with AF are risk scored using validated schema such the European Society of Cardiology (ESC) approved and recommended CHA_2DS_2-VASc and HAS-BLED systems. Patients who have already suffered a stroke or TIA are at much greater risk of a second event and so it is critical to the person's outcomes, that preventative, effective therapies are initiated. Too often, current and validated recommendations such as those issued by ESC (AF Guidelines 2011 and 2012) are not implemented, with devastating outcomes:

'AF symptoms caused Jane to go to her local A&E where she was diagnosed with AF. She was discharged without any medication. Two weeks later she woke up without vision in one eye – she

[8] Trummer U, Mueller U, Nowak P et al. Does physician-patient communication that aims at empowering patients improve clinical outcome? A case study. Pat Educ Couns 2006;61:299-306

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had suffered a TIA. She returned to hospital and this time was discharged with just a prescription of aspirin. Ten days later, she had a full stroke.'[9] (2012)

Far greater understanding of the vital importance of preventative therapy and validated tools that support clinical assessment need to be achieved to avoid suffering a preventable stroke. Increased adherence to guideline recommendations must also be central to managing stroke patients.

Recommendation four:

AF Association is supportive of this recommendation, although it does recognise that all healthcare practitioners should have and be aware of, clear guidance on identifying, risk assessing and managing AF.

"I was diagnosed with AF and had a consultant telling me I should go on warfarin and a GP telling me I didn't need to as my heart was still in NSR most of the time. I was offered cardioversion and I was waiting to go on the list. Within two weeks I had a clot form which went walkabout and I had a big stroke which left me unable to walk or talk." (Lesley[10])

It is important that primary care practitioners:

- Understand the impact and risks associated with AF and AF-related stroke
- Are fully aware and confident to use approved guidelines
- Have thorough understanding of the benefits of risk-reduction therapies and which therapies are appropriate for reducing the risk of an AF-related stroke
- Recognise the benefits of patient education and engagement in decision-making and how to discuss risks and benefits of treatment with patients

There is clear evidence that many AF patients are not being offered anticoagulation even when their risk factors are well documented[11]. It is essential that health care professionals (HCP) become better informed about:

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[9] AF Association Health Unlocked Forum, 2012
[10] AF Association Health Unlocked Forum 2013
[11] NICE AF: the management of atrial fibrillation. Costing report; Implementing NICE guidance. July 2006

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- AF-stroke risk
- The near absence of a role for aspirin to reduce this risk
- How to effectively assess an AF patient
- The importance of at least an annual review to reassess AF-stroke risk

It would also be extremely beneficial if HCPs were encouraged to provide approved patient information or/and direct patients to the NHS Patient Decision Making tool[12] (PDA) or the forthcoming PDA being developed by NICE.

The provision of appropriate anticoagulation for patients with AF, in line with modern clinical guidelines, will save lives as well as NHS Wales resources[13]. While it must be the responsibility of every clinician to ensure that each patient in their care is treated in line with the most up-to-date clinical guidelines, nationally supported audit tools can provide an efficient and effective way to audit GP data, identify those at risk and who would benefit from appropriate therapy. We are aware that in Wales, an audit tool for AF has been developed - 'Audit Plus'. There is good evidence that a similar tool available in England, has been an influential tool in supporting primary care to find, assess and review current AF patients who are at increased risk of stroke but are not receiving an appropriate therapy.

Audit Plus has been developed for Wales and we believe, should be actively encouraged by the Health and Social care Committee along with the Welsh Assembly, to encourage review and improved management of all AF patients in Wales to reduce their risk of an AF-related stroke. Furthermore, the Audit Plus tool would support the '1000 Lives Plus' campaign and could be delivered through the Primary Care Quality Information Services 'How to Guide for AF'[14].

While changes to QOF in 2011 have been welcomed by the AF Association, further amends are required to be in line with ESC update AF Guidelines 2012, in particular, an amendment to aspirin as a therapy option in line with the updated guidance[15].

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12 http://sdm.rightcare.nhs.uk/pda/stroke-prevention-for-atrial-fibrillation/
13 NHS Improvement – Heart in association with NPSA: Anticoagulation for AF: simple overview to commissioning quality services, 2011
14 http://www.wales.nhs.uk/sitesplus/888/page/59796
15 http://www.escardio.org/guidelines-surveys/esc-guidelines/GuidelinesDocuments/Guidelines_Focused_Update_Atrial_Fib_FT.pdf

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We also believe, that in line with the 2012 focused update of the ESC Guidelines for the management of atrial fibrillation, Left Atrial Appendix Occlusion (LAAO) should be considered as an option for AF patients with thromboembolic risk who cannot be managed in the long-term using any form of oral anticoagulant[16].

Recommendation five

AF Association supported the Committee's recommendation to implement opportunistic pulse checks. Furthermore opportunistic screening is supported by ESC updated AF Guidelines 2012.

However despite recommendation and intention, while prevalence of AF continues to grow, measures to detect and diagnose patients are still insufficiently delivered. As a consequence, not only are asymptomatic AF patients failing to be detected and diagnosed, and so remain at high risk of a AF-stroke, but also individuals who are at increased risk of developing AF are not being shown simple self monitoring techniques to raise their own awareness of the possible onset of AF.

The implementation of an effective, low cost AF screening programme as reflected in the SAFE study[17] clearly showed the cost benefit of targeting known at-risk patients aged over 65 years or presenting in chronic disease clinics. For this to be effectively implemented on a national scale, a policy requiring:

- An audit of all patients in general practice to determine and flag those at AF and stroke risk
- Manuel pulse checks for all risk-flagged patients when visiting their local GP or a medical appointment
- Prompt access to an ECG

With the development of a number of highly effective, accurate, low cost and approved modern technologies that take simple ECG readings, even greater sensitivity within an opportunistic screening policy is now easily possible.

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[16] http://www.escardio.org/guidelines-surveys/esc-guidelines/GuidelinesDocuments/Guidelines_Focused_Update_Atrial_Fib_FT.pdf pg 2732

[17] SAFE study 2005

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Without doubt, opportunistic screening would ensure timely identification of AF. As a direct consequence this would enable early intervention to manage the condition and its risk factors, resulting in a significant reduction in the number of AF-strokes suffered. 'Population based opportunistic screening for AF – tried and evaluated business models for healthcare systems' is to be published by the AF Association in just a few weeks, intended as a supportive guide for service providers seeking to implement an opportunistic screening model. We believe opportunistic screening to be an integral part and first step to achieving a reduction in stroke and AF-related strokes.

In review of the 2011 'Inquiry into stroke risk reduction' the AF Association thanks and congratulates the Health and Social Care Committee for its work in bringing together the five recommendations. However, there remains an urgent need for coordinated action covering early awareness, timely diagnosis, implementation of audit and review and appropriate management of anticoagulation for all those at increased risk of ischemic including AF-related stroke.
We would now urge the Committee to ensure greater implementation of these areas across the whole of Wales.

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Providing information, support and access to established, new or innovative treatments for Atrial Fibrillation (AF)

National Assembly for Wales

Health and Social Care Committee

Stroke risk reduction – follow-up inquiry

Evidence from Stroke Association – SFU 10

National Assembly for Wales Health and Social Care Committee

One day inquiry into the implementation of the recommendations made during the Stroke Risk Reduction Inquiry in 2011

Written evidence to support oral evidence session to be held on

23rd October 2013

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Working for a world where there are fewer strokes and all those touched by stroke get the help they need.

Registered Charity No. 61274

Overview

This Inquiry provides us with an opportunity to remind ourselves that stroke is the third biggest killer in Wales and is the leading cause of adult disability. It is the second biggest killer world-wide and yet Wales is the only country in the UK which does not have an over-arching strategy.

In 2006, The Royal College of Physicians reported that Wales was one of the worst places in Europe to have a stroke. Since then, central Welsh Government financial investment in improving stroke services over the last seven years has been minimal, and improvement has relied largely on the commitment of those working within the stroke community.

In responding to this call for evidence, the Stroke Association has consolidated its position following discussions with stroke survivors, colleagues who work within the health and social care setting on a day-to-day basis and with clinicians who are seeking to deliver and drive improvements in stroke services across localities in Wales. We have also carried out an initial audit of each Local Health Board's Stroke Delivery plans.

In summary, our concerns about the implementation of the recommendations made by the committee inquiry in December 2011 are as follows:

- Anonymity and lack of leadership of those with responsibility for accountability within Welsh Government and Public Health Wales – leading to lack of ownership for outcomes.
- Severe lack of resources and capacity to deliver next tranche of improvements.
- The need to develop an overarching Stroke Network to give structure and support to the stroke community in Wales.

Recommendation 1

We recommend that the Welsh Government undertake a full and robust evaluation of the implementation of the Stroke Risk Reduction Action Plan, Involving all stakeholders. The evaluation should be published, and the results used to inform the development of the National Stroke Delivery Plan

It is with regret that, once again, we have to submit evidence to the National Assembly's Health Committee outlining our concerns that there is a clear lack of leadership in the delivery of the recommendations outlined so clearly in the December 2011 report. In the past two years, neither Welsh Government nor Public Health Wales have made any co-ordinated approach to evaluate the original 40 recommendations made in the 2010 Risk Reduction Action Plan. The Stroke Association has not been consulted even though it is one of the main Third sector delivery partners included in the plan. Whilst we accept the Minister's acknowledgement that many of the recommendations have now been incorporated into the NHS Five Year Stroke Delivery Plan, we would argue that many of the original 40 recommendations are yet to be evaluated for impact and we would implore the Health committee to put pressure on the Welsh Government and Public Health Wales to carry out recommendation 1 – that is to:

"undertake a full and robust evaluation of the implementation of the Stroke Risk Reduction Action Plan, involving all stakeholders"

This evaluation would provide the benchmark and should be cross referenced to the now live national Stroke Delivery Plan and to the individual Local Health Boards' Stroke Delivery plans.

Key to this is the importance of laying the overarching responsibility for this activity at the door of the Health Minister's department. Furthermore, we would recommend that the Minister incorporates this work into the role of specific officers who will be responsible for holding all stakeholders to account in delivering the agreed outcomes.

At a time when health and social care costs are spiralling and the NHS is under severe pressure due to an increasing burden of poor health, never has prevention activity been so important. It is unfathomable that the Stroke Risk Prevention Action plan has laid idle year on year and that inaction is passed off in the argument that one delivery plan supersedes another.

We welcome the inclusion of prevention activity as a key tenet of the Social Services and Wellbeing Bill and we will be seeking to monitor the benefits of this as social services take on this area of responsibility. Social services, like public health, have a key role in both primary and secondary prevention. Collaboration between agencies will be fundamental in easing the burden of stroke amongst the population in Wales.

An example of best practice in this area comes from Ysbyty Cwm Rhondda where a pilot model has been developed that enables Community Occupational Therapists (COTs) to 'in-reach' into hospitals to identify patients whose discharge they can support. Patients are seen jointly by the in-hospital and Community OTs allowing them to share goals, ensure a smooth transition and facilitate better communication with the patient at the centre. Patients are able to get home earlier and identify ways

to lessen their chances of suffering a secondary stroke and start working to make changes in their lifestyle faster than they would otherwise.

Recommendation 2

We recommend that the Welsh Government includes within the National Stroke Delivery Plan clear references to the prevention of secondary strokes and the treatment and diagnosis of TIASs as they relate to stroke risk reduction work.

We welcome that this recommendation has been included in the National Stroke Delivery Plan. However, nine months since the launch of the plan, there are no clear indications of how the recommendation is being implemented across Wales. Lack of financial and human resources is also a concern; please refer to comments below.

Recommendation 3

We recommend that by April 2012 and in line with its published expectations, the Welsh Government ensures patients have access to seven day TIA clinics and that clinical guidelines in relation to carotid endarterectomies are adhered to across Wales

In relation to the two recommendations above, an initial audit of the Health Boards' Stroke Delivery plans reveals that preventing non-communicable diseases are high on the agenda and there is much reference to smoking cessation, tackling obesity and reducing alcohol and substance misuse. We welcome all of these actions as they will undoubtedly improve population health.

However, these recommendations specifically address stroke prevention in relation to TIA and the delivery of carotid endarterectomies. Upon reading the local action plans it appears that many health boards lack the staff capacity and resources to target specifically the deficiencies which surround the diagnosis and prompt referral to these clinics and procedures.

At this point it is important to note that many improvements have been made in the delivery of stroke services across Wales. However, only so much improvement can be made through re-aligning procedures. A time comes when the next tranche of improvements can only be made through the allocation of resources to attract a highly skilled and motivated workforce who can make real inroads to saving lives and preventing strokes. It is unrealistic to expect the growth of seven day TIA clinics given the allocation of resources available to run such services comprehensively across Wales.

There is a serious and real concern amongst the clinical community in Wales that the severe lack of resources is impacting upon the ability to research and innovate. This in turn is resulting in an inability to attract the highest calibre practitioners into stroke services. This lack of capacity and resource results in growing pressure that inevitably impacts upon prevention services.

Recommendation 4

We recommend that the Welsh Government develops clear guidance for primary care and community resource teams on the diagnosis, treatment and management of AF and clearly identifies professional responsibilities in each area.

When the original Stroke Risk Reduction Action plan was published in 2010, the Stroke Association delivered its Atrial Fibrillation (AF) awareness campaign in partnership with Public Health Wales. Since then we have contributed to ensuring that the dialogue on AF is maintained through the work of the Cross Party Group on Stroke. Additionally, the Stroke Association has also developed a practical implementation in partnership with community pharmacies. In fact, in September 2013 we launched a stroke risk factors awareness campaign that includes screening for high blood pressure and irregular heart beat (including AF) with an independent corporate chain of pharmacies.

We understand that as part of the 1000Lives+ programme, Public Health Wales has developed an improvement initiative for Atrial Fibrillation (AF). To date it has proven challenging to secure a dialogue with the relevant personnel involved in this programme to highlight the benefits of the campaigning work we have undertaken and explore potential areas of collaboration. We will continue to pursue collaboration in this area, but, given the limited level of dialogue and the available evidence, we cannot offer further comment on the effectiveness of this activity in relation to this recommendation.

Recommendation 5

We recommend that the Welsh Government ensures that pulse checks are offered as standard to patients presenting stroke risk factors when attending primary care, Any necessary treatment which them follows should comply with NICE guidelines, and further action by the Welsh Government is needed to ensure that this take place. Compliance should be monitored through Public Health Wales' audit of primary care record data.

There is an argument that whilst pulse checks fall outside of the Quality Outcomes Framework (QOF), only the most pro-active GPs will offer pulse checks as standard practice. The Stroke Association would like to see the Welsh Government working to influence QOF in relation to opportunistic pulse checking so that those presenting with stroke risk factors in primary care, be given a pulse check alongside a blood pressure check. This would significantly help with the detection of AF which places individuals five times more at risk of having a stroke.

It is encouraging that the Betsi Cadwalader Health Board's draft Stroke Delivery plan includes an action for 'GPs to carry out pulse tests on all patients to screen for AF via an addition to the screening template to ensure automatic pop – up'. It will be of much interest to learn whether this particular health board is successful in implementing this action. Similarly, despite not being currently included as a QOF staple, it will be revealing whether GPs in north Wales deliver this simple screening mechanism. We look forward to learning the outcomes of increased detection rates and corresponding actions in relation to stroke reduction in this particular region.

As stated above, the Stroke Association is continuing to work with Community Pharmacy Wales and with individual pharmacy chains to encourage them to provide blood pressure and pulse checks. We are also collaborating with pharmacies to ensure Medicines Use Reviews incorporate stroke prevention messaging for those who are on medication for hypertension and atrial fibrillation.

In addition, we are collaborating with Public Health Wales in the development of a an on-line stroke risk reduction calculator as part of the Health Checks for the Over 50s programme. We maintain that there is a role not only for GP surgeries, but also for community pharmacies in delivering the practical implementation of high blood pressure, pulse and wider health checks as part of the Health Check Wales programme. This area warrants further investigation and we will continue to drive this agenda forward.

Propositions

As well as making five robust recommendations as part of its report, the Health Committee also made 10 additional propositions. The Stroke Association welcomes each and every one. The most significant being the development of a fully funded Stroke Network. The proposition is for a joint network – however, we would advocate that, given the level of need, stroke warrants its own protected infrastructure.

We also want to highlight that the role of social services is key – both to primary and secondary stroke prevention. We very much welcome the scope of the Social Service and Wellbeing Bill setting an onus on Local Government to develop prevention services and we look forward to continue to contribute to and learning about the detail of this area of the Bill as it develops. In the meantime, a number of

the Local Health Boards' Stroke Delivery plans outline the importance of having social work representation at their multi-disciplinary team meetings and there is certainly an opportunity to develop terms of reference for social work involvement in secondary prevention. Again, we look forward to seeing this area develop as per our earlier example from Ysbyty Cwm Rhondda.

Research evidence[1] recognises that for the prevention and reduction of stroke to be effective, it is required to adopt a life-course approach. Therefore, in line with co-production principles, the Stroke Association continues to maintain that stroke prevention programmes, as part of reducing health inequalities, can only translate into tangible outcomes through longitudinal strategic collaboration of multidisciplinary agencies that include the NHS, social care, education and economic development.

In conclusion

Whilst this document raises many areas for improving leadership and accountability, we would like to close by acknowledging the work of the NHS Delivery Support Unit (DSU) for its continued drive to improve stroke services in Wales. The leadership from DSU has been instrumental in bringing this overarching programme for improvement to the forefront.

Similarly, we wish to acknowledge the co-ordinated work that is being developed across Wales by the Wales Stroke Alliance and the wider stroke community. It is worth noting that improvements in stroke services in Wales have been achieved by sheer will and professional determination and, in the absence of dedicated new resources. However, the recommendations from the Stroke Risk Reduction plan and the programme of work contained within the Stroke Action plan are unlikely to be implemented successfully unless clear leadership and appropriate resources are provided both nationally and at local level.

The Stroke Association calls for the Welsh Government and Public Health Wales to take the lead nationally in making the necessary investment in stroke prevention to avoid new strokes and achieve better outcomes for stroke survivors across Wales.

We believe that a fully resourced stroke network with clear leadership would be a logical first step, coupled with the participation of stroke survivors in local and national stroke prevention awareness raising campaigns. The Stroke Association looks forward to continuing working in this area as a key Third sector partner.

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[1] United Nations General Assembly, Prevention and control of non-communicable diseases, Report of the Secretary-General, 19 May 2011.

National Assembly for Wales

Welsh Stroke Alliance

Health and Social Care Committee

Stroke risk reduction – follow-up inquiry

Evidence from Welsh Stroke Allaince – SFU 13

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13 September 2013

STROKE RISK REDUCTION – FOLLOW-UP INQUIRY

Response from the Welsh Stroke Alliance to the National Assembly for Wales' health and social care committee follow-up inquiry into stroke risk reduction

Made up of members representing multi-disciplinary expertise in stroke care and stakeholders interested in the improvement of stroke care in Wales, the Welsh Stroke Alliance (WSA) acts as a voluntary all-Wales forum to provide expert advice and support to NHS Wales, its Local Health Boards, the Welsh Government, Royal Colleges, interested parties, and other associated bodies on all aspects of stroke service delivery.

The WSA welcomes this opportunity to respond to the follow-up inquiry into stroke risk reduction, and representatives are happy to give oral evidence if required. If you would like more information, please contact Dr Anne Freeman, Chair WSA at anne.freeman@wales.nhs.uk or on 07889976288.

Yours sincerely

Dr A. Freeman

Chair - Welsh Stroke Alliance

Overview

As part of a national drive to tackle the third biggest cause of death in Wales and the largest single cause of adult disability, the WSAwelcomes the renewed focus on stroke prevention and supports all efforts to prioritise the improvement of all stroke services in Wales.

The WSA remains well-placed to support these efforts with clinical and expert leadership in the field but, as it is currently constituted only as an affiliated group of volunteer members, do not have the resources to do so to its full potential.

As such, our overarching recommendation to the committee is that WSA be recognised by Welsh Government as the National Clinical Network for stroke and be established with appropriate managerial support, resources, and accountability in

line with the established clinical networks seen across the two other major causes of death in Wales cancer and cardiac disease.

Our response

Our response is informed by our members across Wales including representatives from NHS Wales, Local Government, clinical experts, patient groups and charity organisations.

Key recommendations

1. The Welsh Stroke Alliance (WSA) recommends that a resourced National Clinical Network for stroke be established in line with existing cancer and cardiac network models in Wales, and that appropriate managerial support, resources and governance be put in place to support the effective development and delivery of improved stroke services in line with the expectations within *Together for Health: A Stroke Delivery Plan for Wales.*

2. WSA recommends a programme of service development for TIA services, including effective national measurement and assurance be established as a matter of urgency.

3. The WSA recommends that Welsh Government establish clear protocols and processes surrounding the national monitoring of stroke clinical audits through a newly established National Clinical Network for Stroke

4. The WSA recommends that Welsh Government develop clear guidelines for TIA services for both high-risk and low-risk patients in line with best clinical practice and that assurance on this service development be driven through the proposed national stroke network.

5. The WSA recommends the initial work undertaken by Public Health Wales and its 1000LivesPlus Atrial Fibrillation (AF) programme (designed to aid the management of pre-identified AF patients) be supported through the proposed NationalClinical network for Stroke to further enhance its reach and impact.

6. The WSA recommends that Welsh Government / NHS Wales consider how QOF information within Primary Care is best used by Health Boards to inform further working in stroke prevention within primary care.

7. The WSA recommends that a training and education programme of work be undertaken by the proposed clinical network on all aspects of stroke risk reduction in primary and community care, working in partnership across providers in Wales.

8. The WSA recommends a workforce gap analysis be undertaken for each Health Board and for that analysis to include all key staff required to deliver stroke care for their local populations. Further, where significant shortfalls are identified, Health Boards and Welsh Government work together and develop clear recruitment and retention programmes for stroke-trained staff for NHS Wales.

9. The WSA calls for the existing roles of Health Board clinical lead for stroke and executive lead for stroke be formally recognised, standardised and made explicit across NHS Wales. It also calls for the designation of a lead therapist and lead nurse within each Health Board.

10. The WSA recommends that Welsh Government work with the proposed National Clinical Network for Stroke to establish a robust training programme for all stroke staff in Wales and for this programme to reflect todays requirements for effective leadership in health service developments.

Discussion

The Welsh GovernmentHealth and Social Care Committee originally reported on stroke risk reduction in December 2011. In the published report were five recommendations and ten propositions from the committee. Below are a list of the original recommendations and propositions with comments from Welsh Stroke Alliance as to their current status and recommendations for further development.

Recommendation 1: We recommend that the Welsh Government undertake a full and robust evaluation of the implementation of the Stroke Risk Reduction Action Plan, involving all stakeholders. The evaluation should be published, and the results used to inform the development of the National Stroke Delivery Plan.

WSA understand that an evaluation was completed by Public Health Wales and forwarded to Welsh Government but are not aware of any subsequent action.

The WSA is disappointed this evaluation was not made available but acknowledges this was superseded by the publication of the Stroke Delivery Plan – in which Public Health Wales was involved – in 2012.

The WSA would welcome from Welsh Government steps to ensure lessons are learned from this situation, and that a robust evaluation of the subsequent Stroke Delivery Plan for NHS Wales, including the section on stroke risk reduction is put in place.

Recommendation 2: We recommend that the Welsh Government includes within the National Stroke Delivery Plan clear references to the prevention of secondary

strokes and the treatment and diagnosis of TIAs as they relate to stroke risk reduction work.

The prevention of strokes, including secondary strokes, is one of the six identified themes within *Together for Health Stroke Delivery Plan: A Delivery Plan for NHS Wales and its Partners* published in 2012.

In particular, it requires Local Health Boards to work with its strategic partners to:

- Promote better public awareness of stroke risk factors and the importance of recognising and presenting symptoms promptly.
- Work through their locality networks to plan and deliver a more systematic and coordinated approach to identifying those at risk of vascular disease and atrial fibrillation and managing that risk effectively,
- Reduce smoking, obesity and excess alcohol intake
- Implement all elements of the All Wales Obesity Pathway
- Encourage healthy schools and workplace environments to take action to reduce smoking, obesity and harmful alcoholic consumption.

WSA welcomes the inclusion of prevention, including secondary prevention, into the Stroke Delivery Plan, but remains concerned as to the structure and resources in place to support its effective implementation. WSA recommends the introduction of a resourced National Clinical Network for Stroke to support Health Board teams in the delivery of the Stroke Delivery Plan.

In addition, the 1000LivesPlus Programme have developed a toolkit for Health Boards to monitor the services received by those patients suffering a TIA. This tool was handed over to the Health Boards for internal monitoring and improvement in line with the 1000LivesPlus methodology.

WSA are concerned that no national assurance mechanism currently exists to assess the effective application of this approach or its impact. In addition, no supportive programmes for the development of improved TIA services currently exist within Wales.

> *WSA recommends a programme of service development for TIA services, including effective national measurement and assurance be established as a matter of urgency.*

In Spring 2014, the next round of the Royal College of Physicians Stroke Audit will once again provide external examination of our stroke services, including TIA, against these guidelines. In addition, the newly-created prospective clinical side of this audit will also monitor TIA services through its 'spotlight' audit scheme. The results will be made publicly available by the RCP. As with other clinical audits of stroke services, no formal national support for monitoring or further service development has been identified.

> *The WSA recommends that Welsh Government establish clear protocols and processes surrounding the national monitoring of stroke clinical audits through a newly established National Stroke Network.*

Recommendation 3: We recommend that by April 2012 and in line with its published expectation, the Welsh Government ensures patients have access to seven day TIA clinics and that clinical guidelines in relation to carotid endarterectomise are adhere to across Wales.

WSA would like to propose a rewording of this recommendation to a "seven day TIA service" and a recognition of the clinical guidelines for both high-risk and low-risk TIA patients be incorporated into any future recommendations. It does not feel there is clarity around the expectations of Welsh Government surrounding TIA services in Wales.

> *WSA recommends that Welsh Government develop clear guidelines for TIA services for both high-risk and low-risk patients in line with best clinical practice and that assurance on this service development be driven through the proposed national stroke network.*

Recommendation 4: We recommend that the Welsh Government develops clear guidance for primary care and community resource teams on the diagnosis, treatment and management of atrial fibrillation and clearly identifies professional responsibilities in each area.

Recommendation 5: We recommend that the Welsh Government ensures that pulse checks are offered as standard to patients presenting stroke risk factors when attending primary care. Any necessary treatment which then follows should comply with NICE guidelines, and further action by the Welsh Government is needed to ensure that this takes place. Compliance should be monitored through Public Health Wales' audits of primary care data.

As these two recommendations are so closely linked, the following response applies to both. As with the development of TIA services, the strategic and coordinated development of Atrial Fibrillation services in Wales across both primary and secondary care is much needed.

Acknowledging the initial work undertaken by Public Health Wales and the 1000LivePlus AF programme, the WSA recommends this work (designed to aid the management of pre-identified AF patients) be supported through the proposed National Clinical Network for Stroke to further enhance its reach and impact.

The WSA also recommends that Welsh Government / NHS Wales consider how QOF information within Primary Care is best used by Health Boards to inform further working in stroke prevention within primary care.

The WSA also recommends that further training and education work be undertaken by the clinical network on all aspects of stroke risk reduction in primary and community care, working in partnership across providers in Wales.

Proposition 1: **The Welsh Government should consider the shortfall in trained stroke physicians through the use of effective workforce planning.**

A survey of stroke consultant sessions across Wales was undertaken by the WSA last year. The results of which demonstrated a significant shortfall from the number

recommended by the British Association of Stroke Physicians (BASP) through their stroke consultant workforce planning document. This document provides guidance on the number of sessions of direct clinical care required each week by a consultant according to the local population served and the number of strokes admitted per year. In addition to this information, WSA is aware of the additional difficulties of recruiting to existing vacant posts.

The WSA recommends a workforce gap analysis be undertaken for each Health Board and for that analysis to include all key staff required to deliver stroke care for their local populations. Further, where significant shortfalls are identified, Health Boards and Welsh Government work together and develop clear recruitment and retention programmes for stroke-trained staff for NHS Wales.

Proposition 2: That the Welsh Government considers best practice for providing stroke leadership at Local Health Board level and develops good practice guidance to which all LHBs should adhere.

The WSA are aware that each Health Board in Wales now has a designated clinical lead for stroke as well as an Executive-level lead for stroke.

The WSA calls for these roles to be formally recognised, standardised and made explicit across NHS Wales. It also calls for the designation of a lead therapist and lead nurse within each Health Board.

Members of WSA have sought stroke leadership training from English providers in the past and raised concerns around the ability of Wales to develop 'in-house'

stroke leadership. Concerns around what this means for recruitment and retention of stroke staff were also raised in connection.

> *The WSA recommends that Welsh Government work with the proposed National Clinical Network for Stroke to establish a robust training programme for all stroke staff in Wales and for this programme to reflect todays requirements for effective leadership in health service developments.*

Proposition 3: That the Welsh Government considers establishing a National Clinical Network for Stroke - across Wales.

Unlike the two other leading causes of death in Wales, cancer and cardiac, stroke does not have a clinical network to support national service development. Although some benefits may arise from working with the two existing cardiac networks in Wales (North and South), members felt strongly than a separate stroke-specific clinical network, aligned with the objectives of *Together for Health – Stroke Delivery Plan* would be the most effective model to support evidence-into-practice in Wales.

> *The WSA recommends that a resourced National Cinical Network for Stroke be established in line with existing cancer and cardiac network models in Wales, and that appropriate managerial support, resources and governance be put in place to support the effective development and delivery of improved stroke services in line with the expectations within Together for Health: A Stroke Delivery Plan for Wales.*

Proposition 4: That the Welsh Government ensures that the National Stroke Delivery Plan encompasses all elements of the stroke care pathway from risk reduction through to rehabilitation and re-ablement.

The WSA welcomes the inclusion of all aspects of stroke care long the entire stroke pathway from prevention through to palliative care and longer-term management. These elements of the Stroke Plan have been reflected in each subsequent Health Board local action plan for stroke. However, it has noted the lack of reference in the document to workforce development (education and recruitment and retention).

Proposition 5: That the Welsh Government ensure that local authorities are involved and included in the development and delivery of the National Stroke Delivery Plan.

The WSA is unaware if Local Authorities were consulted on the development of the National Stroke Delivery Plan.

Proposition 6: That the Welsh Government consider new ways in which to ensure that GPs are complying with the NICE guidelines, and that patients have the information to make an informed choice. Compliance should be monitored through Public Health Wales' audits of primary care record data.

- See recommendations 4 and 5 above

Proposition 7: That the Welsh Government considers supporting the proposals for changes to the AF related QOF indicators, and ensure that the QOF indicators distinguish between the prescription of anticoagulation and anti-platelet therapies for AF patients.

The WSA is unaware if, or how, this has been undertaken by Welsh Government, and suggests this may be another role for the proposed stroke clinical network, working in conjunction with Welsh Government colleagues.

Proposition 8: That the Welsh Government considers supporting the introduction and use of the GRASP-AF tool in GP practices.

- See recommendations 4 and 5 above

Proposition 9: That the Welsh Government consider a systematic evaluation system for all part, or fully funded, Welsh Government health promotion campaigns, with the findings directly feeding into the planning and development of future campaigns. Evaluations should be shared with partners to all the dissemination of good practice and lessons learnt.

The WSA are unaware of any developments with this proposition but continues to support it.

Proposition 10: That the Welsh Government consider how the current training and development programmes for all healthcare professionals could best raise awareness and knowledge of AF.

- See recommendations 4 and 5 above, as well as proposition 2.

National Assembly for Wales

Health and Social Care Committee

Stroke risk reduction – follow-up inquiry

Evidence from Aneurin Bevan University Health Board University – SFU 5

ANEURIN BEVAN HEALTH BOARD

The Health and Social Care Committee Inquiry into Stroke Risk Reduction
Report on progress against the recommendations from the 2011 Report

Issues highlighted	Linkage with Delivery Plan	Progress made against the Stroke Inquiry Report
Stakeholders were not consulted on the risk reduction action plan	Yes	• A key objective of the Delivery Plan is to engage stakeholders on risk reduction through LSBs. This will ensure appropriate population outcomes are identified within Single Integrated Plans and that the actions of all partners are clearly set out, monitored and measured. • There is a continuous process of engagement with patients, staff and stakeholders to inform stroke services re-design.
There needs to be greater awareness and ownership among the people who will be delivering the actions	Yes	• ABHB is working with partners through LSBs to implement local action to prevent stroke. • The risk reduction actions of partners are set out in Single Integrated Plans and are being measured and monitored using indicators/targets aligned to the health and well being themes. • ABHB is working through locality networks (NCNs) to plan and

		deliver a more systematic and co-ordinated approach to identifying those at risk of vascular disease and atrial fibrillation and managing that risk effectively. • There is a PHW Consultant in Public Health Medicine on the Stroke Board to ensure risk reduction is a key feature of the Delivery Plan.
Concerns around the implementation, leadership, management and monitoring of the Stroke Risk Reduction Action Plan Leadership and management of TIA/stroke services	Yes	• There has been engagement of a wide range of stakeholders/clinical staff in discussions regarding Stroke Services Re-design. • The PHW Consultant in Public Health Medicine and the NCN clinical lead for cardiovascular disease are working through the Stroke Board to provide leadership for the implementation and monitoring of stroke prevention actions within the Delivery Plan.
Stroke boards needs to have a comprehensive membership which should include representation from local authorities.		• The Stroke Board within ABHB has comprehensive membership, including a local authority representative from Social Services
Local authorities should be involved in the development and delivery of the Delivery Plan and especially in relation to the prevention of secondary strokes.		• Local authorities are involved in setting the strategic direction for stroke risk reduction through their involvement in the LSBs. • There is local authority representation on the Stroke Board and at NCN levels to ensure a more integrated approach to operational delivery at local level.
The Delivery Plan should look at the full stroke pathway from risk reduction through to diagnosis, treatment, rehabilitation and prevention of secondary strokes.	Yes	• ABHB have reviewed current stroke services and used outcome indicators to inform the local Stroke Delivery Plan. • The Stroke Board has been implementing the 1,000 Lives Plus care bundles to reduce the morbidity following a stroke and

		facilitate quicker functional recovery and discharge home. Separate work streams have been set up on acute care, early rehabilitation and TIA services. • Secondary prevention has been included in the Delivery Plan • The ABHB Delivery Plan includes stroke telemedicine to improve timely access to thrombolysis for appropriate patients.
Development of robust workforce plans which link public health, local authorities and primary and secondary care providers, to ensure that there is a consistent and effective delivery and support provided to patients.		• ABHB has held a series of workshops on re-design options to deliver "Best in Class" Stroke services with the aim of providing "World Class" Stroke services.
Establishment of Joint Cardiac-Stroke Networks in order to provide a co-ordinated leadership to ensure consistency in stroke risk reduction services throughout Wales		• ABHB is not aware of discussion between Welsh Government and the existing South Wales Cardiac Network in terms of establishing a Joint Cardiac-Stroke Network
TIA		
Lack of public and professional awareness about TIA and its severity.	Yes	• ABHB will be working together with partners to raise awareness of the symptoms of Stroke/TIA and the importance of accessing WAST/medical care promptly, using the FAST test. This is supported by the TV public awareness campaign "Stroke - Act FAST"
No action stated on early detection and treatment of transient cerebral ischaemic episodes or atrial fibrillation	Yes	ABHB has initiated a number of actions within the Delivery plan on early detection and treatment of TIA and AF including: • Work with GPs to raise their awareness of symptoms

		• GP reception pathway based on "FAST" roll out • Public awareness of stroke risk factors and the importance of recognising and presenting symptoms promptly • Use of TIA and AF intelligent target bundles in order to improve compliance • TIA Quality and Productivity (QP) pathways offered to GP practices. • Use of the 1,000 Lives Plus/PCQIS "How To" Guide on early detection and management of AF • Consensus and shortlisted options to deliver a single admission point for the hyper-acute stroke service which should enable direct admission for patients with suspected stroke and achievement of stroke bundles. • QP TIA pathway - the pathway is based on the national stroke bundle. In terms of update – practices didn't have to undertake the pathway but many did – anecdotally compliance with the national TIA bundle has improved markedly – ABCD2 scoring especially
TIA's not being recognised as medical emergency	Yes	• ABHB will be reviewing public health education campaigns as part of the Stroke Delivery Plan • ABHB will continue to work with GPs to raise their awareness of TIA symptoms • ABHB will continue work on the GP reception pathway based on "FAST" roll out • ABHB will work with partners (e.g. Stroke Association) to promote public awareness of stroke risk factors and the importance of recognising and presenting symptoms promptly
People need to seek medical attention early (TIA) – raise awareness like chest pain	Yes	• ABHB will be reviewing public health education campaigns as part of the Stroke Delivery Plan • ABHB will work with partners (e.g. Stroke Association) to promote public awareness of stroke risk factors and the importance of

		recognising and presenting symptoms promptly • ABHB will continue work on a GP reception pathway based on "FAST" roll out and consider modelling on the Cardiac Network Chest Pain Awareness project
Barrier may be resourcing to the development of a 7 day TIA service – staffing and equipment	Yes	• ABHB is looking at options for development of 7 day TIA service • ABHB is re-designing the service to ensure appropriate management of patients not diagnosed with a stroke (e.g. TIA)
RCP state that patients who have a TIA should have carotid endarterectomy within 48 hours of the attack. There can be a 2 week wait in Wales.		Work ongoing with Vascular Surgeons.
Atrial Fibrillation		
A clear need for improvement in the identification, diagnosis and treatment of AF		All practices in ABHB 2013-2014 being offered QP AF pathway based on 1,000 Lives Plus AF pathway • The GRASP AF is not being introduced in practices in ABHB. It has been developed in England and there is a cost to implementation – however Audit + has developed an AF module which is very similar. Practices are to be offered the AF pathway as part of QP this year and will need to use this software if the undertake the pathway.
A greater need for public and professional awareness surrounding risk factors (including AF) for stroke		• ABHB will be reviewing public health education campaigns as part of the Stroke Delivery Plan • ABHB will work with partners (e.g. Stroke Association) to promote public awareness of stroke risk factors and the importance of recognising and presenting symptoms promptly • Primary care staff (i.e. GPs, Practices Nurses and Health Visitors) trained in multi topic brief intervention – smoking cessation, alcohol misuse, obesity.

		• ABHB are developing and rolling out a Smoking Dashboard as part of the GMS Variation Project
Opportunistic pulse checks	Yes	• The “Healthy Heart” cardiovascular risk assessment programme includes a radial pulse of all patients screened and refers patients with irregular pulse for GP follow-up • ABHB is exploring options for primary care nurses opportunistically undertaking pulse checks (e.g. flu clinics, chronic conditions clinics) and are awaiting results of pilot scheme in Carmarthen • Raising awareness –w e have developed a poster in surgery for receptionists – similar to MINAP poster – plans to roll
Follow up of pulse check is reflected in patients healthcare records to ensure effective management of the condition		▪ Pulse checks – GPs will often check pulses opportunistically as there is no official programme.
Effective monitoring of treatment of AF		▪ Rate of identification of AF – we have this data as part of QOF and if practices undertake the QP pathway we will be able to see if the incidence is increasing.
Prevention of primary and secondary strokes		
A need for an improved emphasis on preventing strokes following a TIA or initial stroke		ABHB has 24/7 TIA advice service for primary care physicians ABHB has daily TIA clinics during the week days where patients are seen promptly in accordance of RCP guidelines. ABHB also has hot slot clinics where high risk patients are seen within 24 hours.

		ABHB has got on site vascular facility where all TIA patients will have vascular imaging done on same day. And if vascular occlusion been identified then arrangements are in place to be referred to vascular surgeons on same day. ABHB provides the Information back to primary care physicians with plan and guidance on same day
Risk reduction was not mentioned for a person who has already experienced a TIA or a stroke		Almost all TIA patients' risk factors will be checked and discussed. Baseline electrocardiogram will be done in all patients to exclude AF Where risk factors been identified, advice and follow up is provided to patients Leaflet information is provided to patients on various issues related to TIA.

Additional information: Considerations for Welsh Government

- That the Welsh Government undertake a full and robust evaluation of the implementation of the Stroke Risk Reduction Action Plan, involving all stakeholders. The evaluation should be published and the results used to inform the development of the National Stroke Delivery Plan
- Welsh Government includes within the National Stroke Delivery Plan clear references to the prevention of secondary strokes and the treatment and diagnosis of TIAs as they relate to stroke risk reduction work
- That by April 2012 and in line with its published expectation, the Welsh government ensures patients have access to seven day TIA clinics and that clinical guidelines in relation to carotid endarterectomies are adhered to across Wales
- Welsh Government develops clear guidance for primary care and community resource teams on the diagnosis, treatment and management of AF and clearly identifies professional responsibilities in each area.
- Welsh Government ensures that pulse checks are offered as standard to patients presenting stroke risk factors when attending primary care. Any necessary treatment which then follows should comply with NICE guidelines, and further action by the Welsh Government is needed to ensure that this takes place. Compliance should be monitored through Public Health Wales' audits of primary care record data.

- The shortfall in trained stroke physicians
- Establishing Joint Cardiac-Stroke Networks across Wales
- Ensuring that the National Stroke Delivery Plan encompasses all elements of the stroke care pathway from risk reduction through to rehabilitation and re-ablement
- Consider new ways in which to ensure that GPs are complying with the NICE guidelines, and that patients have the information to make an informed choice. Compliance should be monitored through Public Health Wales' audits of primary care record data.
- Consider how the current training and development programmes for all healthcare professionals could best raise awareness and knowledge of AF
- Supporting the proposals for changes to the AF related QOF indicators and ensure that the QOF indicators distinguish between the prescription of anti-coagulation and anti-platelet therapies for AF patients.
- Supporting the introduction and use of the GRASP-AF tool in GP practices.
- Consider a systematic evaluation system for all part, or fully funded, Welsh Government health promotion campaigns, with the findings directly feeding into the planning and development of future campaigns. Evaluations should be shared with partners to allow the dissemination of good practice and lessons learnt.
- Produce a progress report on "seek opportunities to provide a national co-ordinated approach to introductory public health/community health development training to Communities First staff".
- Inform the impact of the Welsh Network of Health School Scheme. It provides the framework for a whole school approach to health and that includes action around stroke risk factors.

Powys Teaching Health Board Evidence to Health and Social Care Committee on Stroke Risk Reduction

The Committee has requested evidence of progress in relation to the recommendations made in the 2011 Report, and where progress is still required. Powys has responses to recommendations 2 and 3 below:

Recommendation 2. We recommend that the Welsh Government includes within the National Stroke Delivery Plan clear references to the prevention of secondary strokes and the treatment and diagnosis of TIAs as they relate to stroke risk reduction work.

There are clear requirements in the National Stroke Delivery Plan for health boards to address both primary and secondary prevention issues in their local action plans. Powys has several actions relating to these areas and has reported against them in their Annual Report.

Recommendation 3. We recommend that by April 2012 and in line with its published expectation, the Welsh Government ensures patients have access to seven day TIA clinics and that clinical guidelines in relation to carotid endarterectomies are adhered to across Wales.

It is difficult to ascertain from Powys' perspective if this has been achieved. We as a health board are unable to access the data that is collected by the TIA services in Wales. The most recent data for the Carotid Endarterectomy Audit showed some improvement, but there appear to be significant gaps in the data.

GIG CYMRU NHS WALES

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Adam Cairns
Chief Executive

4 October 2013

David Rees AM
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Dear David

Thank you for your letter of 23 July 2013 requesting a follow up on the Stroke Risk Reduction Inquiry in December 2011. As a UHB we recognise the importance of stroke reduction and this is a key element of our stroke delivery plan. Our Stroke Lead Dr Hamsaraj Shetty has also provided evidence on behalf of his Royal College and he will be giving verbal evidence.

I can therefore provide the following information:

- Every high risk TIA patient is seen within 24 hours at the Stroke Prevention Clinic on week days and at Medical Assessment Unit over weekends (followed by early review in Stroke Prevention Clinic);
- Non-high risk Transient Ischaemic Attack (TIA) patients are seen mostly within a week, almost all of them within 2 weeks;
- Facilitating early anticoagulation for Atrial Fibrillation (AF) patients at the Stroke Prevention Clinic;
- Currently collecting data on the prevalence and the management of AF primary care in selected Surgeries;
- The stroke physicians work very closely with Vascular Surgeons to facilitate early Carotid Endarterectomy in suitable patients;
- Consultant clinical lead provides telephone advice to GPs during week days on suspected TIA patients;
- The stroke physicians seek advice of Diabetologists and Medical Biochemists in managing complex diabetic and hyperlipidemic patients;
- We hold a public education program at the Concourse, UHW on the World Stroke Day annually (29TH October this year);
- Facilitate smoking cessation through the smoking cessation Counsellor;
- Dietary advice provided through Dietetics department for selected patients;
- The Stroke coordinator gives health education to patients and carers on encounter at UHW;
- Primary care clinicians prioritise the management of cardio vascular risk factors eg BP management, smoking cessation, lifestyle management (weight and exercise) as well as TIA management as outlined in the Quality and Outcomes Framework;

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro yw enw gweithredol Bwyrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board is the operational name of Cardiff and Vale University Local Health Board

POSITIVE ABOUT DISABLED PEOPLE

- The UHB has adopted an optimising outcomes framework which aims to ensure that people being referred for routine surgery are required to attend smoking cessation (if they are a smoker) and attend a lifestyle programme (if they have a high BMI) – this signals our intention to focus on self management of lifestyle risk factors, which if better controlled will reduce stroke incidence;
- The UHB further extended our no smoking policy on UHB sites after our September Board meeting.

Yours sincerely

Adam Cairns
Chief Executive

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Hugo van Woerden

National Assembly for Wales

Health and Social Care Committee

Stroke risk reduction – follow-up inquiry

Evidence from Public Health Wales – SFU 14

Health and Social Care Committee

28 September 2012

Dear Sir

RE: Inquiry into Stroke Risk Reduction

Thank you for the opportunity to provide evidence to the committee on Stroke Risk Reduction.

Public Health Wales NHS Trust provides independent public health advice. It also delivers services that protect and improve the health and wellbeing of the population of Wales. Comments are made below in relation to a number of the committee's previous recommendations.

Recommendation 1: We recommend that the Welsh Government undertake a full and robust evaluation of the implementation of the Stroke Risk Reduction Action Plan, involving all stakeholders. The evaluation should be published, and the results used to inform the development of the National Stroke Delivery Plan.

Public Health Wales undertook the evaluation that was recommended by the Health and Social Care committee on behalf of the Welsh Government. The report has been made via the NHS Stroke Prevention web pages[1]. A copy is attached. The report summarises the views of a range of stakeholders and was referenced in a presentation to the Stroke Delivery Group in December 2012.

Recommendation 2: We recommend that the Welsh Government includes within the National Stroke Delivery Plan clear references to the prevention of secondary strokes and the treatment and diagnosis of TIAs as they relate to stroke risk reduction work.

Together For Health – Stroke Delivery Plan: A Delivery Plan for NHS Wales and its Partners was launched in December 2012. This has a number of outcome indictors for diagnosis, treatment and secondary prevention of disease including TIAs and recurrent strokes.

[1] http://www.wales.nhs.uk/strokeprevention

Her Iechyd Cymru Health Challenge Wales

The plan also makes reference to Public Health Wales providing Local Health Boards with information and advice to inform service planning. To this end a number of Cardiovascular Disease and Vascular Assessment web pages have been developed[2].

Recommendation 4: We recommend that the Welsh Government ensures that pulse checks are offered as standard to patients presenting stroke risk factors when attending primary care. Any necessary treatment which then follows should comply with NICE guidelines, and further action by the Welsh Government is needed to ensure that this takes place. Compliance should be monitored through Public Health Wales' audits of primary care record data.

Public Health Wales has recommended a two stage risk assessment through primary care:

- an initial records based assessment that estimates risk, based on existing routinely available data using a validated risk assessment tool in the practice system, allowing prioritisation of the order in which people should be called in for full risk assessment
- a protocol-driven response to ensure those at increased risk are invited for full risk assessment, with those at the highest estimated risk given priority and invited to a face-to-face full risk assessment, followed over time by those at lower predicted risk

The Stroke Association, Community Pharmacy Wales and Public Health Wales ran a "Lower your Risk of Stroke" campaign across all seven Local Health Boards to reduce stroke risk. Details of the campaign evaluation are available[3]. Pharmacists completed over 10,000 Medicine Use Reviews with people taking medication which indicated that they were at increased risk of stroke, and discussed their stroke risk with them. Community pharmacies were able to improve the quality of the information they were using with these target patients due to the updated literature provided by the Stroke Association Cymru.

Public Health Wales is involved in some collation and presentation of information provided as part of the cardiovascular risk pages[4] and in the context of information on GP clusters[5]. A Primary Care Atrial Fibrillation Rapid Improvement Guide has been developed[6]. This includes an audit tool that can be used by GP practices. However, the use of this tool is voluntary and wider uptake of the tool needs to be encouraged.

Health outcomes could be strengthened by greater use of the 'audit loop', focusing on those areas where there is the greatest gap between expected and actual rates of stroke prevalence, morbidity and mortality. The diagram below illustrates that there are several steps in care pathway where patients may fail to receive treatment, resulting in avoidable harm. The figures quoted below are for the UK as a whole.

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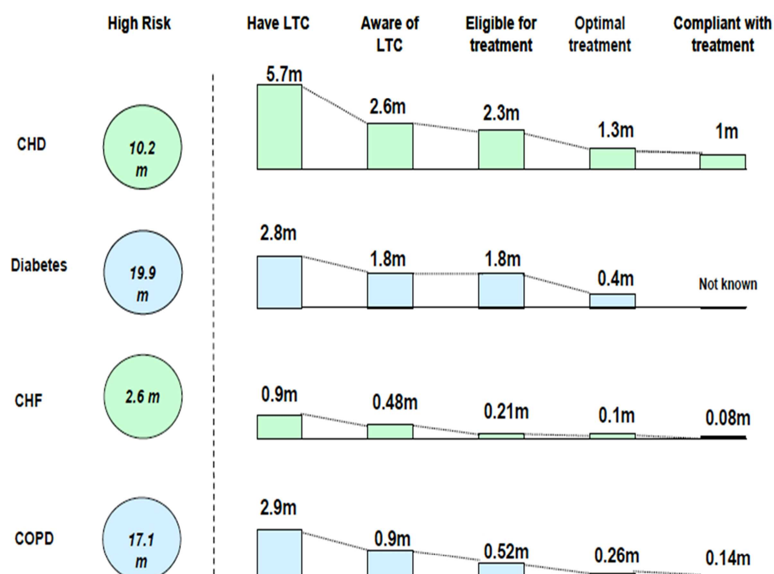
[2] http://howis.wales.nhs.uk/sitesplus/888/page/55970.

[3] http://www2.nphs.wales.nhs.uk:8080/PharmaceuticalPHTDocs.nsf/($All)/AE4B8D7C67346D9E80257BC90037768A/$File/Stroke%20Campaign%20Evaluation%20Report%20%202013.pdf?OpenElement

[4] http://www.wales.nhs.uk/sitesplus/922/news/28495

[5] http://www.wales.nhs.uk/sitesplus/922/page/67714

[6] http://www2.nphs.wales.nhs.uk:8080/primarycareqitdocs.nsf/($all)/5bf587948ffb0a4080257b830036cd61/$file/rapidh2g%20af%20final%20version%201%20june%202013.doc



Similar work could be undertaken in Wales in relation to stroke using healthcare improvement methodologies[7].

Work on the wider determinants of stroke

Risk factors for stroke are common to a number of other leading causes of death, disease, and disability. Common modifiable risk factors include smoking, physical inactivity, poor diet, high alcohol intake, poor mental wellbeing, obesity, diabetes, high blood pressure, and raised lipid levels. Primary prevention in relation to these risk factors is best approached from a broad perspective rather than in the context of a single disease. However, there is a case for secondary prevention work focused on stroke, targeting high risk groups and those with early evidence of disease.

Public Health Wales undertakes a wide range of work to reduce the wider determinants of stroke at each stage of the life course. A description of this work can be provided if required.

Exploring novel ideas for the future

Primary and secondary prevention designed to reduce stroke morbidity and mortality appear to be having some impact. However, there may be a case for exploring innovative ideas which could have a more dramatic population level impact. Some novel approaches are presented below. It is acknowledged that these ideas are based on a particular interpretation of the evidence and would require more work before being implemented. However, they may be of interest to the committee.

- Smoking – pursuing a tobacco display ban in shops that have floor space of less than 280 sq m.
- Healthy eating - challenging food retailers with the fact that the sale of unhealthy ingredients is contributing to avoidable mortality in Wales and emphasising that retailers have a moral duty to address this issue. A five year concordat may be possible between Welsh Government and the ten largest food retailers in Wales, which agreed a 10% reduction in total sales per year, of sugar, saturated (animal) fat and salt.

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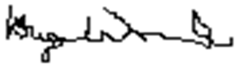
[7] Presentation by Professor Chris Bentley http://vimeo.com/21023658

- Keeping active – providing free mobile phone apps that allow individuals to assess whether they have walked 10,000 steps per day. Promoting the presence of cycle lanes on all roads and streets unless there is a clear reason for their absence.
- Drinking sensibly – creating an alcohol licensing framework which places a responsibility on licensing boards to progressively reduce alcohol sales in their locality to the level sold in Norway – that is from 10.6 to 6.6 litres of 100% alcohol per person per year.

Further expansion of these ideas can be provided if required.

Yours faithfully,



Dr Hugo van Woerden

Director of Innovation and Development

National Assembly for Wales

Health and Social Care Committee

Stroke risk reduction – follow-up inquiry

Evidence from Royal College of Nursing – SFU 8

Royal College Of Nursing

Response to Health and Social Care Committee's Follow up Inquiry into stroke risk reduction.

ABOUT THE ROYAL COLLEGE OF NURSING (RCN)

The RCN is the world's largest professional union of nurses, representing over 400,000 nurses, midwives, health visitors and nursing students, including over 23,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

HSCC Recommendation 1
We recommend that the Welsh Government undertake a full and robust evaluation of the implementation of the Stroke Risk Reduction Action Plan, involving all stakeholders. The evaluation should be published, and the results used to inform the development of the National Stroke Delivery Plan.

The Welsh Government published Together For Health- Stroke Delivery Plan in 2012. At the consultation phase the Royal College of Nursing had a number of concerns:

- The plan failed to discuss the workforce required to deliver services to a high standard. We urged the Welsh Government to look at guidance issued by the Royal College of Nursing on safe Staffing for Older People's wards[1]. This guidance states that there should be at least 1 registered nurse for 5 patients (depending on acuity) and never exceeding 1 registered nurse for 7 patients. The National Sentinel Stroke Audit 2010 showed that Staffing levels in Wales are somewhat lower than in England

[1] http://www.rcn.org.uk/__data/assets/pdf_file/0010/439399/Safe_staffing_for_older_people_V3.pdf

and Northern Ireland[2]. Thrombolysed patients need 1:1 nursing for first 24 hours so staffing levels need to reflect this.

- The plan failed to discuss the value or the role of nursing in stroke prevention or care. Evidence from Millar 2010[3] suggests that nurses are the most likely professional group to take prominent leadership role in the primary and secondary prevention of strokes. Millar emphasises the importance of prevention on all inpatient and outpatient units and establishing workplace staff health promotion programs to reduce modifiable stroke risk factors, given the increasing incidence of stroke in younger adults. At present there is a lack of training and education opportunities in Wales for Stroke for medical and nursing and therapy staff at all levels, and where courses are available there is insufficient cover so staff are not able to be released.

- We were concerned that the proposed performance indicators for the NHS were too broad and far reaching and would have liked to see measurable actions for Health Boards, e.g. Are GPs in the locality clear of referral pathways for AF, have primary care practices been offered education and training on AF. Stroke specific educated staff at all levels will provide better care and outcomes for patients.

- The plan fails to address the critical need for thrombolysis within a 4.5 hour period for under 80's and 3 hrs and at medical discretion for over 80's based on current guidance, instead the plan makes reference to LHBs providing timely access. We suggested that achieving the care bundle targets is instead clearly set out.

- LHBs are also asked to provide timely access to diagnostic procedures, vascular surgery and tertiary services. The RCN is concerned about the impact of the various reconfiguration plans on this.

HSCC Recommendation 2
We recommend that the Welsh Government includes within the National Stroke Delivery Plan clear references to the prevention of secondary strokes and the treatment and diagnosis of TIAs as they relate to stroke risk reduction work.

HSCC Recommendation 3

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[2] https://audit.rcplondon.ac.uk/sentinelstroke/website/files/generic%20report%202010%20(incl%20appendices).pdf

[3] Rehabilitation Nursing Vol35 no.3 May/June 2010

We recommend that by April 2012 and in line with its published expectation, the Welsh Government ensures patients have access to seven day TIA clinics and that clinical guidelines in relation to carotid endarterectomies are adhered to across Wales.

Welsh Government Delivery Plan states on p5 that LHBs should ensure to fully functional services for stroke and TIA. SENTINEL Audit 2012 shows that most areas are providing a robust 5 day a week service however our members tell us that there are areas that do not have access to specialists or scanning 7 days per week.

HSCC Recommendation 4

We recommend that the Welsh Government develops clear guidance for primary care and community resource teams on the diagnosis, treatment and management of AF and clearly identifies professional responsibilities in each area.

HSCC Recommendation 5

We recommend that the Welsh Government ensures that pulse checks are offered as standard to patients presenting stroke risk factors when attending primary care. Any necessary treatment which then follows should comply with NICE guidelines, and further action by the Welsh Government is needed to ensure that this takes place. Compliance should be monitored through Public Health Wales' audits of primary care record data.

The Welsh Government accepted these in principle but stated that they would ask officials to consider the findings of the UK National Screening Committee were current review into systematic screening for atrial fibrillation (The review process began in Jan 2010 and is estimated to be completed by Nov 2013).

In our original submission we called for:

- A specialist nurse should be championing AF detection in each LHB.
- GP services in each LHB area should have knowledge of how to refer patients with AF and the importance of this.
- Practice nurses and HCSWs may need education in stroke risk reduction. Even if this is provided by the LHB the employees the GP may not be released to attend. LHBs could examine this provision and need in their area.
- The Chronic Conditions team in each LHB should consider AF as a chronic condition.
- Prompt treatment is needed for people once AF has been diagnosed.

Screening could be carried out cost effectively by the nursing/ primary care team. This could simply be done by carrying out manual pulse checks when doing other routine work for example during flu clinic or routine health check.

We recommended the Committee examine the service recently developed in Cwm Taff. An AF Specialist Nurse is developing a nurse led clinic and works closely with Cardiologists and Stroke Physician. Referrals come from Primary Care and from within the Hospital.

Other area of best practice from which evidence may be drawn are the SAFE project study - a small study which investigated the role of practice nurses systematically screening practice population or the pilot study conducted by 2 arrhythmia nurse specialists in North Wales looked at integrating manual pulse checks into a routine chronic conditions clinic within General Practice[4].

Stroke specialists from across the United Kingdom called for a national screening programme for all people over 65 to be developed as a matter of urgency to improve detection of atrial fibrillation and prevent up to 2000 premature deaths a year at a two day consensus conference organized by the RCP in 2012[5]

In terms of the prevention and public health agenda the RCN believes that more could be done to inform the public of the benefits of lifestyle change in relation to stroke. Risk factors such as smoking, lack of physical activity, high blood pressure etc are recognised as relating to cancer and heart disease but not to strokes. Preventative activity by health professionals needs to be joined up and not disease specific.

[4] Both of these examples are taken from Keeping our finger on the Pulse August 2010

[5] *BMJ 2012;344:e1644*

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18 September 2013

FOLLOW-UP INQUIRY INTO STROKE RISK REDUCTION

Consultation by National Assembly for Wales' Health and Social Care Committee

Response from BMA Cymru Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the follow-up inquiry into stroke risk reduction by the National Assembly for Wales' Health and Social Care Committee.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

Please see below the BMA Wales Cymru view on progress made since December 2011in addressing each of the recommendations of the Committee's original report:

Recommendation1: We recommend that the Welsh Government undertake a full and robust evaluation of the implementation of the Stroke Risk Reduction Action Plan, involving all stakeholders. The evaluation should be published, and the results used to inform the development of the National Stroke Delivery Plan.

It is the view of BMA Cymru Wales that there has been a leadership problem within NHS Wales which led to problems in implementing the Stroke Risk Reduction Action Plan. This stemmed for instance from the lack of a clear timetable being put in place, as well as a lack of clear definitions being provided regarding the roles of individuals responsible for implementation of both the action plan and the implementation strategy. We therefore believe there was a lack of clarity regarding when targets were to be achieved and who was tasked with the responsibility for ensuring they were met.

Furthermore, the plan itself did not appear to be comprehensive and, in our view, contained notable gaps. This would suggest it was drawn up without sufficient involvement of clinicians.

Ysgrifennydd Cymreig/Welsh Secretary:
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BMA Cymru Wales fully supports the undertaking of a high-level, full and robust evaluation of the implementation of any plan in the NHS. Indeed, we are aware that an evaluation of the action plan was undertaken by Public Health Wales in 2012[1].

On this occasion, it appears to our members that the plan has not yet been effectively implemented.

Recommendation 2: We recommend that the Welsh Government includes within the National Stroke Delivery Plan clear references to the prevention of secondary strokes and the treatment and diagnosis of TIAs as they relate to stroke risk reduction work.

Preventing secondary strokes is a separate issue from the treatment and diagnosis of transient ischaemic attacks (TIAs). In our view, we should be careful not to treat the two concepts as being one and the same.

Primary prevention of TIAs and strokes means that we need to work on identifying the risk factors for strokes and TIAs, and try to prevent them from occurring by focusing on these risk factors. If a stroke nonetheless occurs, then the relevant risk factors should be identified and managed more actively as there is always a high risk within those patients who have suffered from a stroke that they will go on to have another one. (The risk in such cases is about 30-40% after a year if the risk factors remains unidentified and have not been dealt with.)

Transient ischaemic attacks (TIAs) are different. While there is no treatment for TIAs, most clinicians would agree that the risk factors should be investigated thoroughly to help ensure their prevention. That is exactly why we need a daily TIA clinic. In addition, we need to be careful with the diagnosis of TIA as, from clinical experience in South Wales, about 50% of those referred to the TIA clinic are ultimately diagnosed with a different condition, known as a TIA mimic.

Recommendation 3: Government ensures patients have access to seven day TIA clinics and that clinical guidelines in relation to carotid endarterectomies are adhered to across Wales.

Establishing a seven day TIA clinic is not an easy task. There is currently no health board in Wales which is running a TIA clinic on a seven-days-a-week basis. The main reason for this is a lack of sufficient staffing resource. As such, provision of even Monday-Friday TIA clinics is not yet routine in some parts of Wales, including in North Wales where staffing issues also mean there are problems in providing a thrombolysing service for ischaemic stroke patients. Members feel that access to thrombolysis is patchy across Wales. It should however be noted that it is possible to have a TIA assessment service outside of the provision of a dedicated TIA clinic, and this could for instance be provided on weekends and bank holidays alongside a dedicated TIA clinic operating Monday-Friday.

The role of GPs in diagnosing patients with TIA and then referring such patients to a TIA clinic is also a vital part of the process. However, quick access to a TIA assessment service may be required for this to be effective. GPs feel that they require clearer and simpler guidance to enable them to deal with suspected strokes in a primary care setting, and on the urgency and appropriateness of treatments such as anticoagulation.

An audit carried out by the Royal College of Surgeons regarding the endarterectomy procedure[2], as well as local Welsh studies, have shown that there is a need for more to be done regarding operating on stenotic internal carotid arteries in patients who are judged to be at risk of TIA or stroke.

Recommendation 4: We recommend that the Welsh Government ensures that pulse checks are offered as standard to patients presenting stroke risk factors when attending primary care. Any necessary treatment which then follows should comply with NICE guidelines, and further action

[1] http://www.wales.nhs.uk/document/220816/info/?02FB00BB-CB24-F842-E58895262220CDEB

[2] http://www.rcseng.ac.uk/news/docs/UK%20Audit%20of%20Vascular%20Surgical%20Services.pdf/view?searchterm=stroke

by the Welsh Government is needed to ensure that this takes place. Compliance should be monitored through Public Health Wales' audits of primary care record data.

We would note that a manual pulse check conducted as part of a primary care consultation would be sufficient to diagnose persistent atrial fibrillation (AF) but is not always adequate for the diagnosis of paroxysmal AF. In fact guidance published in 2012 by the Royal College of Physicians (*National Clinical Guidelines for Stroke - fourth edition*)[3] differentiates clearly on clinical ground between paroxysmal AF and persistent AF but suggests anticoagulation should be given to patients with either condition as they are both a risk factor for stroke.

The use of a Holter monitor, or 24 hours tape, is important and we would note that the diagnosis of AF is often done in a hospital setting (although, as indicated above, some types of AF are diagnosed by GPs in a primary care setting.) Some GPs report, however, that waiting lists for these procedures may currently be unacceptably long, as may be the wait for TIA assessments.

Recommendation 5: We recommend that the Welsh Government develops clear guidance for primary care and community resource teams on the diagnosis, treatment and management of AF and clearly identifies professional responsibilities in each area.

Such guidance is part the Royal College of Physicians guidelines that we have already referred to in our response to recommendation 4.

We would certainly agree that better identification of professional responsibilities in relation to the diagnosis, treatment and management of AF is required but, in our view, there has been a problem with such a requirement being addressed. This relates to views we have expressed earlier in this response that the issue of leadership needs to be addressed through the establishment of clearer timetables, clearer definitions regarding roles for the individuals involved in implementing the Stroke Risk Reduction Action Plan and clearer allocation of responsibilities for meeting targets. We would further stress that we believe this needs to be done as a matter of priority.

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[3] http://www.rcplondon.ac.uk/resources/stroke-guidelines

Mark Drakeford AC / AM
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Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/3446/13

David Rees AM
Chair
Health and Social Care Committee
National Assembly for Wales

11 October 2013

Dear David

I am writing to provide you with an update on progress since the Welsh Government's response to Health and Social Services Committee's Inquiry into Stroke Risk Reduction.

Please find attached an Annex setting out an update on each of the Report's recommendations and propositions.

Mark Drakeford AC/AM
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Stroke risk reduction – follow up inquiry – Welsh Government update against Recommendations and Propositions

Recommendations	Welsh Government Response	Progress
Recommendation 1. We recommend that the Welsh Government undertake a full and robust evaluation of the implementation of the Stroke Risk Reduction Action Plan, involving all stakeholders. The evaluation should be published, and the results used to inform the development of the National Stroke Delivery Plan. (Page 15)	**Accept.** • Public Health Wales (PHW) has been asked to undertake an evaluation exercise on the Stroke Risk Reduction Action Plan. This exercise will take place in the next few months and will involve a range of stakeholders with a role in delivering the Plan's actions. It is anticipated this exercise will be completed in April 2012 and the findings will be made available following that date. • The evaluation of the Stroke Risk Reduction Action Plan will help to inform future activity aimed at reducing the risk of stroke. • The National Delivery Plan for stroke services (which is scheduled for consultation in the Spring) will take account of the evaluation and will set out the action that needs to be undertaken to allow people to enjoy a good quality life without developing vascular disease and stroke.	Public Health Wales undertook an exercise to evaluate the implementation of the Stroke Risk Reduction Action Plan in spring 2012. This exercise involved consideration of progress made in implementing the actions contained in the plan, as well as discussion with stakeholders involved in its delivery. The exercise took account of written and verbal responses as well as discussion at a stakeholder workshop. Public Health Wales' report supported the view that good progress was made in implementing the actions in the Stroke Risk Reduction Action Plan. It also made a number of recommendations, which mainly focused on informing the prevention elements of the subsequent National Stroke Delivery Plan. The findings of Public Health Wales' work were used to inform the development of the Stroke Delivery Plan, and the majority of Public Health Wales' recommendations were addressed in the Plan. However, the Delivery Plan is a high level document and so did not seek to address the level of detail suggested in some recommendations.

Recommendations	Welsh Government Response	Progress
Recommendation 2. We recommend that the Welsh Government includes within the National Stroke Delivery Plan clear references to the prevention of secondary strokes and the treatment and diagnosis of TIAs as they relate to stroke risk reduction work. (Page 17)	**Accept.** • The National Delivery Plan for stroke services will set out clear action that needs to be undertaken in relation to the prevention, diagnosis and treatment of strokes and Transient Ischaemic Attacks (TIAs). • The reduction in secondary strokes is addressed during the recovery phase of the initial stroke and emphasised at time of discharge with appropriate secondary prevention medication and advice about risk factor management. • The 1000 Lives Plus Programme has developed a toolkit to improve services for those who have had a TIA to prevent a full stroke. This work, which looks at the assessment and management of TIA, has already started to address this issue of subsequent stroke risk reduction. • All Health Boards in Wales should now be able routinely to assess a low risk TIA within a week and a high risk TIA within 24 hours (Monday to Friday). Work is ongoing with the Health Board to ensure that the assessment of a high risk TIA can take	One of the delivery themes within the Stroke Delivery Plan published on 6 December 2012 focusses on preventing strokes including Transient Ischaemic Attack (TIA), Atrial Fibrillation and secondary strokes. It contains clear actions for Health Boards to take forward. My Local Health Service (mylocalhealthservice.wales.gov.uk), launched by the First Minister for Wales on 30th September 2013, is part of the Welsh Government's plans to enhance transparency in the health system and provide public access to information on health services in their local area. Two indicators, relevant to stroke, were released in the first tranche of data. The first is the rate of people aged between 35 and 74 who had an emergency admission for a stroke that died in hospital within 30 days. The second is an indicator of primary care from the Quality and Outcome Framework. The launch of the site was successful and plans are being developed to publish and update more data. For example, in Cardiff and Vale University Health Board primary care clinicians prioritise the management of cardio vascular risk factors e.g. Blood Pressure management, smoking cessation, lifestyle management (weight and exercise) as well as TIA management as outlined in the Quality and Outcomes Framework (QoF). Cardiff and Vale University Health Board has adopted an optimising outcomes framework which aims to ensure that people being referred for routine surgery are required to attend smoking cessation (if they are a smoker) and attend a lifestyle programme (if they have a high

	place within 24 hours on a 7 day a week basis and is being supported and co-ordinated by the Delivery & Support Unit.	Body Mass Index) – this signals their intention to focus on self management of lifestyle risk factors, which if better controlled will reduce stroke incidence. Primary and secondary care medical staff at Aneurin Bevan Health Board are working together with education on the role of anticoagulation in atrial fibrillation. Three education sessions are currently planned and being delivered by secondary care physicians annually through established primary care education sessions. Funding is being sought for work with the Welsh Ambulance Service and Aneurin Bevan Health Board to improve early identification of patients with suspected stroke or TIA using validated algorithms and scoring assessment systems such as 'FAST' (test to recognise stroke symptoms) and 'ROSIER' (tool for assessing whether a person has had a stroke and 'ABCD2' (prediction tool for patients most likely to have a TIA). There is particular concern to identify as many potential TIA patients as possible for follow-up in primary and secondary care to prevent further episodes of TIA and possible stroke.

Recommendations	Welsh Government Response	Progress
Recommendation 3. We recommend that by April 2012 and in line with its published expectation, the Welsh Government ensures patients have access to seven day TIA clinics and that clinical guidelines in relation to carotid endarterectomies are adhered to across Wales. (Page 22)	**Accept in principle.** • TIA assessment takes place on the same site that provide acute stroke services, and all Health Boards in Wales should now be able routinely to assess a low risk TIA within a week and a high risk TIA within 24 hours (Monday to Friday). Work is ongoing with Health Boards to ensure the assessment of a high risk TIA can take place within 24 hours on a 7-day a week basis through the acute medical assessment service with either admission or a satisfactory plan for assessment, investigation and treatment to be instigated. A single protocol is being developed and will enable Health Boards to have access to on-call medical teams. The protocol will be approved by Medical Directors with implementation from April 2012. • The need for carotid endarterectomy (CEA) patients to undergo surgery of the neck arteries as quickly as possible to prevent stroke is clearly outlined in NICE clinical guidance. This requires urgent cases to be operated on within 7 days and other cases within 14	All Health Boards are now able to routinely assess low risk TIA within a week and a high risk TIA within 24 hours. 1000 Lives Plus have produced a How to Guide to improve the reliability of TIA Services. There is in this a driver diagram comprising the 4 bundles of care for TIA assessment and management. Health Boards are expected to collect the data and aim for continual improvement month on month. The proportion of high risk TIA patients managed appropriately both medically and surgically is in the outcome framework published with the delivery plan. All the Health Boards action plans mention TIA assessment and management. In addition, the Royal College of Physicians (RCP) have now launched the Sentinel Stroke National Audit Programme (SSNAP) and we are in a phased entry. The audit does not include a section on TIA management but the RCP will be performing some additional spotlight audits and TIA will be one of these. We will be ensuring that these spotlight audits are also done at Welsh sites. Aneurin Bevan Health Board assesses the majority of high score TIA patients within 24 hours and those needing a Doppler scan on the same day. All low risk patients are assessed within 7 days. Hywel Dda Health Board has services in all of their hospitals for patients referred with a TIA. Assessment and initiation of treatment for a TIA is available every day through their emergency

	days of the onset of symptoms. • Dr Chris Jones, NHS Wales Medical Director, wrote to Health Boards, in June 2011, seeking assurance that they address the findings the RCS carotid endarterectomy audit report and improve access to this surgery as part of their ongoing work to improve stroke services. I expect the next round of clinical audit to show a significant improvement.	departments. TIA “hot clinics” for patients most at risk are well developed in Carmarthenshire and a key priority within their local development plan is to improve TIA services throughout the Health Board, in particular to increase access to carotid investigations. They also work closely with their neighbouring Health Board, Abertawe Bro Morgannwg University Health Board, through the vascular network to improve timely access for carotid surgery. We are disappointed that been little improvement in Welsh participation rates in the SSNAP audit and whilst there has been some improvement towards meeting the requirement to undertake surgery within 14 days of symptoms (7 days for urgent cases), we still generally lag behind other countries in the UK. Dr Chris Jones, Deputy Chief Medical Officer, will be raising this issue with Health Boards.

Recommendations	Welsh Government Response	Progress
Recommendation 4. We recommend that the Welsh Government ensures that pulse checks are offered as standard to patients presenting stroke risk factors when attending primary care. Any necessary treatment which then follows should comply with NICE guidelines, and further action by the Welsh Government is needed to ensure that this takes place. Compliance should be monitored through Public Health Wales' audits of primary care record data. (Page 31)	**Accept in principle.** • NICE guidance recommends that a pulse check is performed for patients who present with breathlessness or dyspnoea, palpitations, syncope or dizziness, chest discomfort or stroke/TIA. • The UK National Screening Committee's (UK NSC) current policy position is that it does not recommend screening for atrial fibrillation. This position is currently under review and due to be completed by March 2012. The recommendations from the UK NSC review and the implications for Wales will be considered by officials and screening experts when they become available. • The Welsh Government expects all clinicians to consider such guidance to make appropriate clinical judgements in the assessment and management of such conditions. • Health Boards provide regular Continuing Professional Development events to ensure that local practice is informed by such guidance. • Practitioners also undertake an annual appraisal to review identified learning needs and educational	The Stroke Delivery Plan places a requirement on Health Boards to implement NICE guidance relating to stroke and ensure through audit that services are performed in line with the guidance. 1000 Lives Atrial Fibrillation (AF) programme will be looking at introducing a screening tool similar to GRASP –AF (risk stratification tool) for those already known to GPs as having AF. The UK NSC has estimated the review of AF screening will be completed in November 2013. A UK NSC meeting is taking place in November; officials will seek an update on progress at that meeting. In May 2013 a nation wide stroke awareness campaign was delivered through the 712 community pharmacies in Wales. The campaign was supported by the Stroke Association, Health Boards and Community Pharmacy Wales and was coordinated by Public Health Wales. During the campaign pharmacies provided advice on lifestyle measures that could reduce the risk of having a stroke and offered medicines use review (MUR) consultations for people who were taking antihypertensive or oral anticoagulant medication

	activities undertaken, to develop appropriate skills and knowledge. Appraisal discussions will include reference to audits undertaken within the GP practice, which may include use of the Public Health Wales toolkit. • We have accepted in principle although we do not accept the recommendation that compliance be monitored through Public Health Wales' audits of primary care record data. The focus of these audits is in relation to quality improvement, not monitoring of clinical judgement.	to reduce their stroke risk. The MUR consultation provided an opportunity to improve individuals' understanding and use of medicines and reinforce the importance of medicines adherence as a way in which their risk of having a stroke could be reduced. Pharmacists were encouraged to prioritise patients taking antihypertensive or oral anticoagulant medication for MUR consultations during the campaign period. During the campaign period 10,059 MUR consultations were with undertaken with people whose medication indicated they were at an increased risk of stroke.

Recommendations	Welsh Government Response	Progress
Recommendation 5. We recommend that the Welsh Government develops clear guidance for primary care and community resource teams on the diagnosis, treatment and management of AF and clearly identifies professional responsibilities in each area. (Page 41)	**Accept in principle**. • There is already guidance in place. NICE guidance for the identification and management of atrial fibrillation is available to all clinical staff and a patient guide is also produced. • As part of 1000 Lives Plus, the Primary Care Quality and Information Service has designed a guide to support practices to achieve the timely management of atrial fibrillation. • The National Delivery Plan for Stroke will also clearly set-out expectations in relation to provision of stroke services. • The UK National Screening Committee's (UK NSC) current policy position is that it does not recommend screening for atrial fibrillation. This position is currently under review and due to be completed by March 2012. The recommendations from the UK NSC review and the implications for Wales will be considered by officials and screening experts when they become available. • Professional responsibilities will depend upon the skills and knowledge of team members, team structure and local pathway arrangements. For example, GPs have	1000 Lives Plus/Public Health Wales published the Primary Care AF Rapid Improvement Guide in June 2013. The "CHADsVASc" clinical prediction tool for stroke risk for patients with atrial fibrillation is now available to determine need for antiplatelets or anticoagulants and will follow on from the 1000 Lives programme as will be used to determine correct prophylactic management. The introduction of the newer oral anticoagulants will also be contributing to the better care of AF patients.

	responsibility for the initial identification and diagnosis of atrial fibrillation, with newly diagnosed patients being referred for echo-cardiography and cardiologists provide support in the management of patients.	

Proposition	Welsh Government Response	Progress
Proposition 1: The Welsh Government should consider the shortfall in trained stroke physicians through the use of effective workforce planning. (Page 18)	• Within Wales virtually all acute stroke care and rehabilitation is delivered by stroke sub specialist geriatricians who have additional medical responsibilities. • Wales has agreed the first dedicated stroke training post, which has been advertised nationally as an additional year of training in stroke medicine. • In addition, dedicated stoke care physicians have been established in some units via access to postgraduate specialist stroke training. • The need for stroke physicians going forward will be addressed within the workforce plans for medical staff.	There have been developments in medical staffing levels in Wales. The first Speciality Registrar (StR) in stroke undertaking a one year training post leading to a Certficate Completion of Specialist Training (CCST) in stroke medicine finished his year in Cardiff and Vale in August 2013 and is waiting to apply for the post in Morriston. He will be eligible to apply on or after Dec of this year approx. As from August 2013, we now have 4 StR training posts in Wales based in Cardiff and Vale, Aneurin Bevan, Abertawe Bro Morgannwg and Betsi Cadwaladr University Health Boards. In addition, we now have 2 full time stroke consultants in post in Cardiff and Vale and in Aneurin Bevan who have done training posts in London and Aberdeen and who have CCST in stroke. 2 more consultants have been appointed in Betsi Cadwaladr (Wrexham & Bangor) and both of these will have stroke in their job plans. Another Care of the Elderly StR in Betsi Cadwaladr has already done a stroke training post in England.
Proposition 2: That the Welsh Government considers best practice for providing stroke leadership at Local Health Board (LHB) level and develops good practice guidance to which all	• Welsh Government has recognised the scope for strengthening current services to preventing cardiovascular disease, which includes stroke and	Adam Cairns, Chief Executive of Cardiff and Vale University Health Board has been appointed as the Lead Chief Executive for Stroke and Chair of the Stroke Delivery Group.

LHBs should adhere. (Page 20) **Proposition 3**: That the Welsh Government considers establishing Joint Cardiac-Stroke Networks across Wales. (Page 20)	cardiac disease. We have tasked Public Health Wales NHS Trust with undertaking work at an all Wales level to support Health Boards in developing a more systematic and co-ordinated approach to identifying those at risk of developing cardiovascular disease and managing that risk effectively. This work will be reflected in the National Stroke Delivery Plan. • The NHS Medical Director has recently decided to recognise the Wales Stroke Alliance as a formal National Specialist Advisory Group (NSAG), whose role is to provide multi disciplinary clinical leadership and advice at an all Wales level. This NSAG will be part of the Group which leads and oversees Health Board efforts to improve stroke services across Wales, including services to prevent stroke. The National Stroke Delivery Board will look to have strengthened clinical leaders to ensure the expectations relating to stroke services are achieved. • At a local level, effective clinical leadership and structures for collaborating with other Health Boards to plan and deliver effective stroke care such as Networks are a matter for Health Boards.	We are currently reviewing the arrangements for the clinical leadership of stroke in Wales and will be considering the need for a Stroke Network as part of this work.

	However, each Health Board already has an executive lead with responsibility for stroke, a clinical lead for stroke and a Stroke Delivery Board. • Good practice guidance is available already through the RCP National Clinical Guidelines for Stroke and NICE guidance.	
Proposition 4: That the Welsh Government ensures that the National Stroke Delivery Plan encompasses all elements of the stroke care pathway from risk reduction through to rehabilitation and re-ablement. (Page 24)	The National Stroke Delivery Plan will encompass all elements of the stroke care pathway including prevention, diagnosis, treatment, rehabilitation and life after stroke.	The delivery themes within the Stroke Delivery Plan cover the entire stroke pathway from prevention to life after stroke.
Proposition 5: That the Welsh Government ensure that local authorities are involved and included in the development and delivery of the National Stroke Delivery Plan. (Page 24)	Local authorities are key partners for Health Boards in ensuring effective care for people who have had a stroke. Local authorities will, therefore, be consulted as part of the process to develop the Stroke Delivery Plan for the NHS.	Local authorities were provided with opportunity to comment on the stroke delivery plan during the consultation and are represented on Stroke Delivery Group.
Proposition 6: That the Welsh Government consider new ways in which to ensure that GPs are complying with the NICE guidelines, and that patients have the information to make an informed choice. Compliance should be monitored through Public Health Wales' audits of primary care record data. (Page 34)	NICE guidance is a key source for the delivery of clinical care. Health Boards are responsible for ensuring that appropriate use is made of such guidance. However, guidance does not replace clinical responsibility; therefore, it would not be appropriate to attempt to monitor 'compliance'. It is important for patients to be well informed through appropriate mechanisms so that they can make an informed contribution to decisions	There is continuing work on the development of personal care plans with an emphasis on informed patient choice and shared decision making. Health Boards continue to monitor prescribing data to analyse the uptake of a variety of therapeutic options. This work will be taken forward through the Stroke Delivery Group.

	about their own treatment plans. A move towards a shared-decision process would be welcomed. The QOF data provides individual practices with information to assess and improve their own performance. Health Boards are provided with comparative data to support local peer review and to address any performance concerns. Public Health Wales supports such analysis by the provision of audit toolkits.	
Proposition 7: That the Welsh Government considers supporting the proposals for changes to the AF related QOF indicators, and ensure that the QOF indicators distinguish between the prescription of anticoagulation and anti-platelet therapies for AF patients. (Page 35)	We will consider the advice provided by NICE for any proposed changed to QOF. The choice between anti-platelet and anti-coagulant is a clinical decision- we support patient choice in this matter supported by discussion of the appropriate evidence, including the risks and benefits of either approach.	There are currently no proposals from NICE to amend the relevant QOF indicators. The QOF guidance uses the CHADS2 risk stratification system to guide the offer of treatment options - this is in line with European Society of Cardiology Guidelines.
Proposition 8: That the Welsh Government considers supporting the introduction and use of the GRASP-AF tool in GP practices. (Page 36)	From April 2012, changes to the Quality and Outcomes Framework will include a new indicator to ensure that all patients on Atrial Fibrillation Registers have a regular assessment using a formal risk stratification scoring system. This work may be undertaken through a computerised search (as in the GRASP AF approach) or through a review of the paper clinical record. Health Boards will be expected to discuss with practices the processes in place to perform these calculations and to share such information with patients to	The Public Health Wales Primary Care Quality and Information Service has produced a toolkit to support individual practices to review the delivery of AF care to support a quality improvement. This work includes support local data extraction. The new 1000 Lives Program utilises a Welsh version of GRASP – AF for those already known to have AF.

	support decisions about future management.	
Proposition 9: That the Welsh Government consider a systematic evaluation system for all part, or fully funded, Welsh Government health promotion campaigns, with the findings directly feeding into the planning and development of future campaigns. Evaluations should be shared with partners to allow the dissemination of good practice and lessons learnt. (Page 38)	The Welsh Government recognises the importance of evaluating health promotion campaigns effectively, both to ensure value for money and to measure the effectiveness of campaigns. Such evaluation is also key in informing the planning and content of future campaigns. These overall principles form an important element of the planning of all health improvement campaigns funded or part funded by the Welsh Government. The importance given to evaluation is reflected in the following current health improvement campaigns: *i) Campaign to raise awareness of the dangers of smoking in cars carrying children* Evaluations of previous mass media smoking cessations have indicated that they can have a range of positive effects, which can contribute to overall decreases in tobacco consumption and increases in smoking cessation. As part of the new campaign to raise awareness of the dangers of smoking in cars carrying children, an omnibus survey has been commissioned to establish current knowledge and attitudes towards smoking in cars. The Survey will be repeated twice a year in each of the next three years. Existing data will also be analysed and additional research will be undertaken to survey	Evaluation continues to form an important component of health improvement campaigns funded or part funded by the Welsh Government. We recognise the importance of robust evaluation in enabling success to be measured appropriately, and in providing valuable evidence to inform future campaigns. The Welsh Government's approach to evaluation can be illustrated with reference to a number of current campaigns: Evaluation of the Fresh Start Wales campaign to raise awareness of the dangers of smoking in cars carrying children is ongoing. Work has included the commissioning of Omnibus Surveys to monitor awareness of the campaign, as well as commissioning Cardiff University to carry out a study of primary school age children's exposure to second hand smoke in cars and elsewhere. Evidence collected through evaluation work and any associated research is used to inform the campaign and our policy direction on an ongoing basis. Change4Life Wales continues to mirror the programme in England and has recently expanded into new areas (such as alcohol and salt). We continue to utilise learning from

	primary school aged children to estimate their exposure to second-hand smoke in cars. These combined steps will assist the Welsh Government to assess how successful the campaign has proved in reducing exposure to smoke in cars. *ii) Change4Life* *Change4Life* forms part of the Welsh Government's broader response to help the people of Wales achieve and maintain a healthy body weight; to eat well, move more and live longer. The campaign in Wales is building on developments in England, and the approach to evaluation in Wales utilises learning from England's substantial investment in evaluation and monitoring the campaign. This includes monitoring of web visits and health statistics, and in April 2012, families in Wales who have been part of the programme for over 12 months will be reissued with the lifestyle questionnaire that they completed for each child. The results will then be compared to determine if they have made changes to their behaviour in relation to healthy eating and physical activity.	England's evaluation and research activities, and collect information based on a number of indicators including registrations and web visits. In addition, families who joined the programme in 2010 were contacted again in 2012 to assess the impact of the programme on the reported behaviours of their children, and questions aimed at measuring awareness of the campaign were included in a recent Welsh Omnibus survey. The information collected through this work is used to inform the ongoing management of the programme. In addition to specific health improvement campaigns, evaluation considerations are also incorporated into new programmes and initiatives. This enables us to monitor the effectiveness of a number of interventions. For example, evaluation is being built in to the development of our health checks programme for people aged over 50 in Wales. Over the past year Public Health Wales has conducted a review of a number of health improvement programmes, such as Stop Smoking Wales and the National Exercise Referral Scheme, which contribute to stroke risk reduction. The review report has been published and work is underway to develop an implementation plan which will build on the report's recommendations.
Proposition 10: That the	As the commissioner of	The UK Forum for Stroke

Welsh Government consider how the current training and development programmes for all healthcare professionals could best raise awareness and knowledge of AF. (Page 42)	non-medical education, the National Leadership & Innovation Agency for Healthcare (NLIAH) will explore opportunities with education providers as a long-term solution. In the short to medium term, Health Boards will utilise the Personal Development Review (PDR) process to identify staff development needs in clinical areas. Cardiac networks have hosted events with Arrhythmia Alliance and AF Alliance on this. This could be developed further on a regional basis to ensure more practices are included. Welsh Government will continue to develop relationships with the Stroke Alliance/NSAG to support awareness, training and development.	Training produced a comprehensive - Stroke Specific Educational Framework (SSEF) to help to underpin the introduction of the English Stroke Strategy. The Education subgroup of Welsh Stroke Alliance, has been reformed and are considering how SSEF can be introduced into Wales and provide the necessary training and education to cover the necessary elements of this for Wales.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Ein cyf/Our ref: SF/MD/3460/13

David Rees AM
Chair
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay

16 October 2013

Thank you for your letter dated 30 September 2013 on the subject of the Health Protection and Immunisation budget.

The figure of £1.9m referred to in the WAO report on 'Health Finances 2012-13 and Beyond' was not a budget reduction as such but was predominantly made up of one off in-year savings against a number of budget lines. The report refers to them as "low and medium risk spending reductions". £1.1m of this figure related directly to the central DHSS budget for immunisation.

The DHSS central budget for immunisation for 2012-13 was initially set at £7.737m. This budget figure was based on a full year spend on a set of assumptions around costs of vaccines and uptake levels on each vaccination programme. When the internal review of budgets took place in 2012-13 it was acknowledged that the full budget was unlikely to be needed in 2012-13. This was due to a range of factors, but was predominantly driven by lower than anticipated uptake in certain programmes and savings achieved on the price of vaccines.

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The central budget for immunisation was not reduced but it was acknowledged that an amount of £1.1m could be released on a one off basis, to be re-directed towards other priorities within the Department.

The impact of the measles outbreak and the related increase in vaccines required by health boards was fully funded from within existing health boards' budgets.

The expected spend from the DHSS central budgets on the all Wales vaccination programme for 2013-14 will rise significantly to around £14.5m. This is as a result of further investment in new vaccination initiatives and improved uptake rates on existing programmes. The funding for this has been provided from the additional allocation to DHSS that was recently announced by the Finance Minister.

Best wishes

Mark.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Mr D Rees AM
Chair, Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
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CF99 1NA

17th October 2013

Dear Mr Rees

Thank you for your letter dated 9th October 2013 following our attendance at the Health and Social Care Committee.

I can confirm that the written evidence submitted by the National Clinical Forum (NCF) to the Programme through the consultation process will be made public following the Programme Board meeting being held on 22nd October.

The NCF submission will be published at the same time as all other responses received during the consultation; this will be undertaken prior to decision making by the Community Health Councils and Local Health Boards.

I hope this reassures members. I will respond to the financial assessment within the timeframe laid down by the Committee.

Yours sincerely

Paul Hollard
Programme Director
South Wales Programme

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