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[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 pages¹. 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 indicators for diagnosis, treatment and secondary prevention of disease including TIAs and recurrent strokes.

¹ <http://www.wales.nhs.uk/strokeprevention>



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 developed².

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 available³. 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 pages⁴ and in the context of information on GP clusters⁵. A Primary Care Atrial Fibrillation Rapid Improvement Guide has been developed⁶. 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.

²<http://howis.wales.nhs.uk/sitesplus/888/page/55970>.

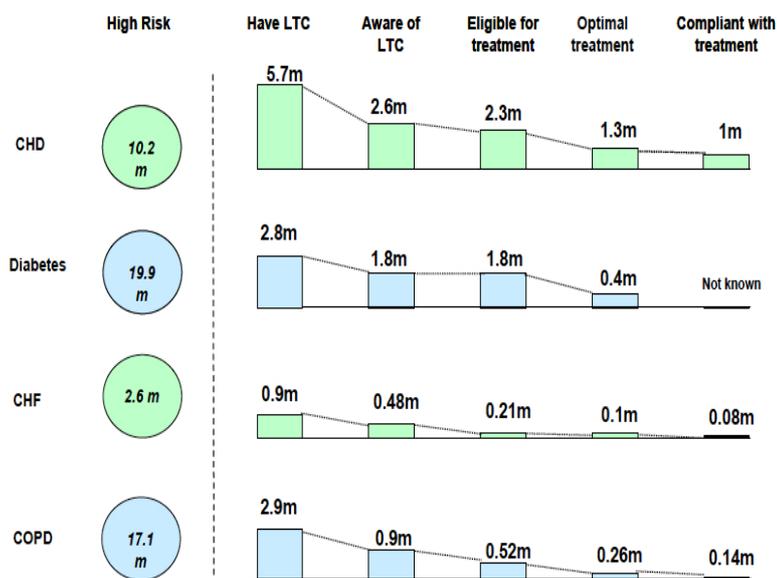
³[http://www2.nphs.wales.nhs.uk:8080/PharmaceuticalPHTDocs.nsf/\(\\$All\)/AE4B8D7C67346D9E80257BC90037768A/\\$File/Stroke%20Campaign%20Evaluation%20Report%20%202013.pdf?OpenElement](http://www2.nphs.wales.nhs.uk:8080/PharmaceuticalPHTDocs.nsf/($All)/AE4B8D7C67346D9E80257BC90037768A/$File/Stroke%20Campaign%20Evaluation%20Report%20%202013.pdf?OpenElement)

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

Disease management provided according to evidence-based protocols e.g. NSFs or NICE guidance



NOTE: Figures are for UK. Taken from Harrison W, Marshall T, Singh D & Tennant R "The effectiveness of healthcare systems in the UK – scoping study"; Department of Public Health & Epidemiology and HSMC University of Birmingham, July 2006.

Similar work could be undertaken in Wales in relation to stroke using healthcare improvement methodologies⁷.

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.

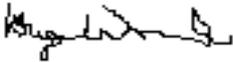
- Smoking – pursuing a tobacco display ban in shops that have floor space of less than 280 sq m.
- Healthy eating - challenging food retailers with the fact that the sale of unhealthy ingredients is contributing to avoidable mortality in Wales and emphasising that retailers have a moral duty to address 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.

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