National Assembly for Wales
Health and Social Care Committee

Inquiry into stroke risk reduction

December 2011

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Health and Social Care Committee
The Committee was established on 22 June 2011 with a remit to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters encompassing: the physical, mental and public health of the people of Wales, including the social care system.

Committee Membership

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Brecon and Radnorshire

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Chair's foreword

This, the first Committee report of the Health and Social Care Committee looks at services which help reduce the risk of stroke in Wales. We have made five primary recommendations, which we identified as the key issues arising from our inquiry. These are the issues that we feel the Welsh Government must address. They are supported by a further 10 propositions which set out areas which we believe need to be considered by the Welsh Government.

The human and financial cost of stroke is huge. It impacts on families across Wales. Yet we know there are actions which can help prevent strokes as well as treating them. We welcome the work the Welsh Government has already undertaken, especially in relation to acute stroke services, but now is the time for a renewed focus on stroke risk reduction.

The recommendations we have made in this report should not prove to be too costly to the NHS, and we are confident that they will actually save money in the longer term.

There was a clear theme running throughout all the strands of this inquiry: the need for clear leadership and ownership at all levels to bring about a reduction in strokes. There is a golden opportunity for the Welsh Government to do this with the development of the National Stroke Delivery Plan and we hope that our recommendations will help feed into this.

In all this, we are convinced that greater prominence must be given to raising awareness and improving identification and treatment of AF. Understanding of the scale and importance of AF has risen in recent years. We know that with early identification and effective management; stroke prevention can be significantly improved, with real longer term benefits. Opportunistic screening delivered in primary care offers the most effective mechanism to identify AF, and more support needs to be given to help ensure effective management of AF once diagnosed.

We were concerned to receive evidence that TIA treatment does not always, or reliably, meet the basic clinical guidelines. This needs to be addressed as a matter of high priority. A TIA is one of the clearest

indicators that somebody is at risk from a stroke. We know that early intervention is effective at reducing this risk and we need to ensure everybody in Wales is able to access this treatment within the recommended 48 hours.

More work must be done to increase public awareness, not only of generic stroke risk factors, but also of AF and TIAs. We have seen with the F.A.S.T campaign, that well-directed and clear public health messages can be very effective. We must now build on this in relation to stroke prevention, so that people are able to take more informed responsibility for their own health.

We must all play our part in working to reduce stroke risk, whether it is the Welsh Government providing effective leadership, primary care health practitioners identifying and ensuring effective management of AF or members of the public ensuring they are making healthy lifestyle choices.

Ever since 2000, Welsh health policy has been based on ambitions to move in the direction of public, primary and preventative services. Stroke prevention is, we believe, a very clear example of what could be achieved by exactly such a shift. Public health measures can engage people better in reducing their own risk of stroke; primary care is best placed to detect existing risk and to reduce it Taking action together, in a coherent, concerted and clearly organised way, would lead to a real reduction in this often devastating condition.

This report has been structured in a way which departs from some earlier conventions. The opening summary sets out a small number of key conclusions and key recommendations. The recommendations reflect those actions which the Committee believe the Government should adopt, as a priority. We hope that, by identifying and setting out our core messages in this the Report will be more accessible to a wide range of readers. The main body of the Report contains a further set of propositions which arise from our Inquiry, and which we believe the Welsh Government should consider.

Glossary of key terms

Throughout our report we use a number of recurring medical terms and acronyms, which we thought it would be useful to outline at the start of the report.

Atrial Fibrillation (AF): A common heart rhythm disorder, which causes episodes of irregular and often an abnormally fast heart rate.

Atrial Fibrillation Association (AFA): A registered charity which aims to raise public and professional awareness of AF and promotes research into AF management.

British Association of Stroke Physicians (BASP): A registered charity which aims to promote the advancement of stroke medicine within the UK.

British Medical Association (BMA): An independent trade union and professional association for doctors and medical students.

$CHADS_2$: A tool used by health professions to identify those patients most at risk from a stroke. It stands for Cardiac Failure, Hypertension, Age, Diabetes, Stroke [Doubled].

Guidance on Risk Assessment and Stroke Prevention for Atrial Fibrilation (GRASP-AF): A tool to help indentify patients with Atrial Fibrillation who could benefit from anti-cogulent treatment.

Quality Outcomes Framework (QOF): This framework is part of the General Medical Services Contract. It is a voluntary incentive scheme that, through indicators and a points based scoring system, provides financial incentives for GP practices to provide a high level of care to patients.

Transient Ischemic Attack (TIA): A transient ischaemic attack (TIA) is a set of symptoms that lasts a short time and occurs because of a temporary lack of blood to part of the brain, usually due to a tiny blood clot. It is sometimes called a mini-stroke. However, unlike a stroke, the symptoms are short-lived and soon go.

The Committee's Key Conclusions and Recommendations

Conclusions.

More could, and should, be done to reduce the risk of strokes in Wales. This includes both the risk of a first stroke and the risk of further strokes amongst those who have suffered a first incidence. Some relatively simple measures can be taken which would produce real advances.

Current stroke risk reduction services are not as effective as they could be partly, at least, because of a lack of clarity about ownership and leadership at all levels.

Professional responsibility for detection and treatment of Atrial Fibrillation (AF) at primary care is contested, and as a result does not yet deliver best outcomes for patients.

We will revisit the issues highlighted and recommendations made in this inquiry within the next twelve to eighteen months.

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. **(Page 15)**

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)**

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)**

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)**

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)**

1. Scope of the inquiry

1. The Health and Social Care Committee agreed on 13 July 2011 to undertake a short and focused inquiry into Stroke Risk Reduction.

2. The terms of reference were:

To examine the current provision of stroke risk reduction services and the effectiveness of Welsh Government policies in addressing any weaknesses in these services, including:

- scrutinising the implementation of the Welsh Government's Stroke Risk Reduction Action Plan, including the extent to which action to raise public awareness of the risk factors for stroke has succeeded;
- identifying those areas where there are particular problems in the implementation and delivery of stroke risk reduction actions;
- considering the evidence for an atrial fibrillation screening programme being launched in Wales.

3. A written consultation was launched in August 2011, and we received 28 responses from individuals and organisations. We would like to thank all those who responded. A list of all written submissions is provided in Annex C to this report.

4. We began taking oral evidence on 22 September 2011, and held five evidence sessions over the course of three Committee meetings. We would like to thank all those witnesses who gave us their time to help inform our considerations. A list of those who gave oral evidence is provided in Annex B to this report.

5. Our inquiry concluded when we took oral evidence from the Minister for Health and Social Services on 10 November 2011.

2. Introduction

6. Strokes are the third biggest killer in the UK and account for around 5-6% of the NHS budget every year.[1] In Wales, 11,000 people a year have a stroke,[2] while over 65,000 patients are on the GP Stroke / Transient Ischemic Attack (TIA) register.[3] Stroke is the single biggest cause of severe acquired disability.[4]

7. However, as we have been told during our inquiry, behind these statistics and the associated financial cost is the human cost for each stroke victim, survivor and their families. As the Atrial Fibrillation Association (AFA) explained to us at the start of our inquiry:

> "Stroke is a disaster, and surviving a stroke can seem worse than death, with victims facing an uncertain future and a life that may be severely damaged by disability."[5]

8. In 2010, Public Health Wales developed 'Promoting Cardiovascular Health: The Stroke Risk Reduction Plan' which focused on primary prevention. All actions within the Plan are scheduled to be completed by March 2012.[6]

9. We felt that it was timely to consider the effectiveness of the Stroke Risk Reduction Action Plan, and to look at the evidence for an Atrial Fibrillation (AF) screening programme. Our inquiry did not look at wider stroke services provision as our predecessor Committee in the third Assembly, the Health, Wellbeing and Local Government Committee, had recently completed an extensive inquiry into this subject.

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[1] National Assembly for Wales, Health and Social Care Committee, HSC(4) 05-11: Paper 5 : Welsh Stroke Alliance, 6 October 2011 [accessed 18 November]
[2] National Assembly for Wales, Health and Social Care Committee, HSC(4) 03-11 Paper 2: The Stroke Association in Wales, 22 September 2011 [accessed 18 November]
[3] National Assembly for Wales, Health and Social Care Committee, HSC(4)-09-11 paper 4: Minister for Health and Social Services, 2 November 2011 [accessed 18 November]
[4] National Assembly for Wales, Health and Social Care Committee, HSC(4)05-11 Paper 3: British Medical Association Cymru, 6 October 2011 [accessed 18 November]
[5] National Assembly for Wales, Health and Social Care Committee, RoP [80], 22 September 2011
[6] National Assembly for Wales, Health and Social Care Committee, HSC(4)-09-11 paper 4: Minister for Health and Social Services, 2 November 2011 [accessed 18 November]

3. Stroke Risk Reduction

10. The evidence we have received during the course of this inquiry demonstrates that more can be done to make strokes preventable and treatable. Many of the risk factors can be related to lifestyle factors, such as smoking, obesity, poor diet and lack of exercise. Many of these are also contributory factors to other conditions, such as heart disease and cancer. Atrial Fibrillation (often referred to as AF) - a heart rhythm disorder - can also be a key stroke risk factor.

11. In recent years, there has been a renewed focus on the development of *acute stroke services* in Wales,[7] but evidence received during this inquiry suggests that this has not been matched with the same vigour *for stroke risk reduction* services. The general consensus amongst witnesses during this inquiry was that a similar level of focus and attention needs to be given to stroke risk reduction services.

Stroke Risk Reduction Action Plan

12. In July 2010 the Welsh Government launched the *Stroke Risk Reduction Action Plan*.[8] The Plan's aim is to reduce the number of cases of stroke and the number of stroke related deaths by supporting people to lead healthier lifestyles and raise awareness of the risk factors for stroke.

13. The Plan is due to end in March 2012 and contains actions, focused on primary prevention, which are due to be completed by this date. It also includes actions to raise public awareness of the risk factors for high-blood pressure, atrial fibrillation, transient ischaemic attack (TIA)[9] and stroke; and actions which will support health professionals in the diagnosis and treatment of stroke.

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[7] National Assembly for Wales, Health and Social Care Committee, HSC(4) 03-11 Paper 2: The Stroke Association in Wales, 22 September 2011 [accessed 18 November]

[8] Welsh Government, Stroke Risk Reduction Action Plan, July 2010 [accessed 13 September 2011]

[9] A transient ischaemic attack (TIA) is a set of symptoms that lasts a short time and occurs because of a temporary lack of blood to part of the brain, usually due to a tiny blood clot. It is sometimes called a mini-stroke. However, unlike a stroke, the symptoms are short-lived and soon go.

Ownership, leadership and monitoring delivery of the Plan

14. The actions that were detailed in the Plan were broadly welcomed by stakeholders during the inquiry, although concerns were raised during evidence about certain omissions. These omissions are considered in the next section of this report.

15. We heard a range of views about the implementation of the Stroke Risk Reduction Action Plan. The Welsh Government stated that, of the actions that were due to be completed by Autumn 2011, 11 had been completed, with only two on hold or superseded. Of those actions that are due to be completed by March 2012, 20 are on-going and a further two are on hold or superseded.[10]

16. We would welcome further information from the Minister on the four actions which are on hold and the reasoning for the delay. While the Minister confirmed in her written evidence that the Action Plan was being delivered, no detail or any information on implementation was offered.[11] This gap was only partly made good by the Minister during the oral evidence session on how she is ensuring an integrated and co-ordinated approach to the delivery of the Action Plan.

17. In terms of management of the Plan, the Welsh Stroke Alliance told us:

> "As far as [we are] aware – [we have] enquired about this – there is no mechanism for the LHBs to report back regularly as to how the implementation is taking place."[12]

18. This strikes us as curious when the Local Health Boards (LHBs) are a key organisation in delivering the Action Plan. It seems to confirm a critical problem with the management and monitoring of the Plan, and suggests to us that the level of leadership needed to deliver such a wide-ranging action plan has been lacking in this case.

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[10] National Assembly for Wales, Health and Social Care Committee, HSC(4)-05-11 Paper 7: Update from the Minister for Health and Social Services on the implementation of the Stroke Risk Reduction Action Plan, 12 October 2011 [accessed 18 November]

[11] National Assembly for Wales, Health and Social Care Committee, RoP [106], 2 November 2011.

[12] National Assembly for Wales, Health and Social Care Committee, RoP [113], 6 October 2011

19. During the course of our inquiry we heard a very clear message from all the witnesses, including the Stroke Association, relating to co-ordination of the Plan. The Stroke Association told us:

> "... we do not feel that there has been a comprehensive co-ordination of this plan to make it a reality. The plan has a number of sensible, well-thought-out, well-planned and welcome points to follow, with a timetable; however, many organisations that were attributed with actions were not necessarily consulted, so some of them may not even be aware that they are expected to deliver on this."[13]

20. We were concerned to hear of a general consensus amongst witnesses that there has been an apparent lack of leadership, co-ordination and communication during the Plan's implementation stage. For example, we were told by the Stroke Association that, although actions in the Plan have been attributed to them for their delivery, there has been no further correspondence or dialogue from the Welsh Government since the Plan's publication.[14]

21. We were also concerned to hear from the Royal College of Nursing Wales (RCN) that:

> "When we [the RCN] consulted our members on the evidence that we would put forward to this committee, we were quite surprised at the lack of awareness, even among specialist teams, of the stroke risk reduction plan. That is clearly worrying. So either that plan, or any future revised plan, needs to have a greater awareness and ownership among the people who will be delivering the actions."[15]

22. The Chartered Society of Physiotherapy told us:

> "The Action Plan should provide a performance management tool to check that activities have been undertaken but no report

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[13] National Assembly for Wales, Health and Social Care Committee, RoP [101], 22 September 2011.
[14] National Assembly for Wales, Health and Social Care Committee, HSC(4) 03-11 Paper 2: The Stroke Association in Wales, 22 September 2011 [accessed 18 November]
[15] National Assembly for Wales, Health and Social Care Committee, HSC(4)-05-11 Paper 6: Royal College of Nursing Wales, 6 October 2011, [accessed 22 November 2011]

on progress against the 40 action points in the plan has been seen by the profession to date."[16]

23. Age Cymru said they were "…uncertain on the level of progress that has been made on implementation".[17]

24. In contrast to the points outlined above, Public Health Wales did not agree with the concerns about a lack of ownership. They told us that, because of the high number of plans, it was inevitable that different plans would have different levels of prominence at different times. They also said that the changes to LHBs meant that public health issues now had prominence which they may not have had previously.[18]

25. In light of these comments, we are therefore curious as to how the Minister was able to state that the majority of actions have been completed or are on track for completion. While performance management and monitoring of the Action Plan may have been happening within the Welsh Government, without this being communicated to those responsible for delivery, it is our view that this has contributed to a lack of clarity and may have a detrimental impact on the Plan's effective delivery.

26. In light of this evidence, we would welcome further information about the delivery of the Action Plan being made publicly available. The paucity of information on its implementation – drawn to our attention by the very stakeholders who will be critical to its success – is a matter of significant concern to us.

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.

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[16] National Assembly for Wales, Health and Social Care Committee, Consultation Response SRR 8: Chartered Society of Physiotherapy [accessed 18 November]
[17] National Assembly for Wales, Health and Social Care Committee, Consultation Response SRR11: Age Cymru [accessed 18 November]
[18] National Assembly for Wales, Health and Social Care Committee, RoP [18], 6 October 2011.

Omissions within the Plan

27. We heard from a range of consultees that the Action Plan had some important omissions. In written evidence, the British Association of Stroke Physicians (BASP) told us:

> "…the Action Plan is not comprehensive and has not stated any action on early detection and treatment of transient cerebral ischemic episodes or atrial fibrillation."[19]

28. The British Medical Association Cymru (BMA) supported this view, stating:

> "The Stroke Risk Reduction Action Plan does not mention risk reduction for a person who has already experienced a TIA or a stroke. This is an unfortunate omission since TIAs increases the risk of a future stroke."[20]

29. Public Health Wales explained why Transient Ischaemic Attacks (TIAs) and secondary strokes had not been included:

> "…A risk reduction plan such as this, which has been written from a public health point of view, will inevitably focus on how, long before you get to the point of a TIA – which in itself is a illness – we can reduce the risk of it ever happening. That's what the plan focuses on. The TIA work has been part of the mainstream care delivery processes, but it is clearly part of stroke prevention."[21]

30. However, Dr Anne Freeman (Welsh Stroke Alliance), explained that this omission was being addressed and that TIAs have now been included in the intelligent targets. We also heard that there is on-going work to help with the improvement of services to people who have suffered a TIA.[22]

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[19] National Assembly for Wales, Health and Social Care Committee, HSC(4)-05-11 Paper 4 – Evidence from the British Association of Stroke Physicians, 6 October 2011 [accessed 18 November]
[20] National Assembly for Wales, Health and Social Care Committee, HSC(4)05-11 Paper 3: British Medical Association Cymru, 6 October 2011 [accessed 18 November]
[21] National Assembly for Wales, Health and Social Care Committee, RoP [21] 6 October 2011
[22] National Assembly for Wales, Health and Social Care Committee, RoP [137] 6 October 2011

31. The specific issue of treatment of TIAs is considered later in this chapter however the evidence we have gathered clearly suggests that there are two significant omissions in the Plan: the prevention of stroke following a TIA and prevention of secondary strokes.

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.

Stroke Risk Reduction Services

32. Many witnesses told us that the focus on delivery of acute stroke services had not yet been matched by a similar focus on stroke risk reduction services. The Stroke Association stated:

> "With a focus on working to remedy the failure of Wales to meet standards set out in the RCP National Stroke Audit which has been critical of Wales in terms of its delivery of stroke services, within the acute setting; the work around stroke prevention has had less focus and resource, and yet it is vitally important if we are to prevent some of the 11,000 strokes which happen in Wales each year."[23]

33. We heard that there were a number of factors that different witnesses identified as impacting on the delivery of stroke risk reduction services, including;

- a lack of trained specialists;
- a lack of leadership;
- delays in necessary treatment;
- services not targeting the most at risk groups;
- no central funding to develop services; and
- limited control at the local level.

34. The evidence we have gathered during this inquiry suggests that the solutions to some of these problems should not prove too costly

[23] National Assembly for Wales, Health and Social Care Committee, HSC(4) 03-11 Paper 2: The Stroke Association in Wales, 22 September 2011 [accessed 18 November]

and, when off-set against the savings made from preventing strokes, could prove to be very cost effective.

Resourcing

35. The BMA and the British Association of Stroke Physicians (BASP) highlighted concerns about a lack of appropriately trained staff to deliver stroke risk reduction services. The BMA told us that "…there is a real issue about consultant gaps and consultant vacancies"[24] with BASP highlighting "a lack of consultant stroke physician sessions in Wales".[25]

36. The RCN highlighted concerns about the lack of a Consultant Nurse for Stroke Services in Wales, which they told us is important for providing strategic leadership and ensuring a clinical nurse voice is present at Health Board level.[26]

37. We support the BMA's call for the development of robust workforce plans which link public health, local authorities and primary and secondary care providers,[27] to ensure that there is a consistent and effective delivery and support provided to patients.

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

38. In addition to concerns about staffing levels, the level of funding available to support stroke risk reduction work was also highlighted in evidence as a matter of concern. BASP were of the view that that financial resources in Wales did not match the funding available in England, and that they are looking to different and more imaginative ways of working, to ensure service delivery. Concern was also raised that a lack of clarity exists as to how much money is available for such services:

> "The third aspect is ring-fenced budgeting, because the budget is still not very clear. It is quite limited and it is in small pockets, rather than it being across Wales. For instance, rural

[24] National Assembly for Wales, Health and Social Care Committee, RoP [148] 6 October 2011
[25] Ibid [150]
[26] Ibid [177]
[27] Ibid [164]

areas do not get the same amount of resources as some other places do."[28]

39. We heard examples of the work in Llanelli,[29] where an AF clinic was established with no additional funds, yet has resulted in improved outcomes. We welcome the fact that LHBs and individual healthcare professionals are looking at how best to deliver services within a difficult financial climate We acknowledge that, in a period of austerity, improvement will depend on reprioritisation of existing resources, rather than any expectation that additional funding can be found. We believe, however, that this is an area where just such a shift to prevention can be achieved within current funding. Leadership and management of stroke services

Leadership and Management of Stroke Services

40. Critical to the effective delivery of stroke risk reduction services, is effective leadership and management. It was clear that there is too much inconsistency in service delivery across Wales, and that one solution to this is a consistent approach to leadership and management of stroke risk reduction services. The importance of this was particularly emphasised by BASP in both their written and oral evidence.[30] This also links to our concerns about the leadership and management of the Stroke Risk Reduction Action Plan.

41. All Health Boards have an executive and clinical lead for stroke, but we heard that GP and public health are not always represented at stroke steering planning meetings.[31] We know that Aneurin Bevan LHB have a Stroke Board, with GP representation and work is being developed on primary care, strokes and TIAs. As BASP told us:

"As a group, we now have a clear remit and responsibilities from the executive to take this agenda forward right across

[28] National Assembly for Wales, Health and Social Care Committee, RoP [96] 6 October 2011
[29] National Assembly for Wales, Health and Social Care Committee, RoP [31, 64] 22 September 2011
[30] National Assembly for Wales, Health and Social Care Committee, HSC(4)-05-11 Paper 4 – Evidence from the British Association of Stroke Physicians, 6 October 2011 [accessed 18 November] and Health and Social Care Committee, RoP [115] 6 October
[31] ibid RoP [115]

primary and secondary care and public health issues. There are solutions available if there is clear leadership and direction." [32]

42. It is clear that there is a need to ensure a co-ordinated approach across Wales in relation to such Stroke Boards. There should be a more consistent approach to Stroke Boards, with guidance provided to LHBs on the optimum composition and structures. It is our view that Stroke Boards need to have a comprehensive membership, which should include representation from local authorities.

Proposition: 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 LHBs should adhere.

43. One mechanism to provide effective leadership and help improve patient outcomes could be the establishment of Joint Cardiac-Stroke Networks. BASP explained that these networks would meet the three key mechanisms which they have identified for improving stroke risk reduction services,

> "We need a very co-ordinated approach with a clear network, clear clinical leadership and a ring-fenced budget."[33]

44. Joint Cardiac-Stroke Networks are led by a clinical director who is remitted to reduce the burden of stroke and heart disease through improving prevention and treatment. They have a ring-fenced budget with which to do this.

45. We agree that such networks could provide the co-ordinated leadership that is so clearly needed to ensure consistency in stroke risk reduction services throughout Wales. It correlates with the evidence that we have heard from a range of stakeholders about the need for a co-ordinated and strategic approach to reducing strokes.

Proposition: That the Welsh Government considers establishing Joint Cardiac-Stroke Networks across Wales.

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[32] National Assembly for Wales, Health and Social Care Committee, RoP [114] 6 October 2011]

[33] National Assembly for Wales, Health and Social Care Committee, RoP [96], 6 October 2011

Transient Ischaemic Attack (TIA)

46. A TIA can be a clear indicator that a patient is at risk from a stroke. The omission of TIAs in the Stroke Risk Reduction Action Plan has been referred to earlier in this report, however we were very concerned to hear evidence about the difficulties faced by patients with respect to receiving timely and appropriate treatment following a TIA.

47. The Welsh Stroke Alliance told us that "…TIA is now considered a medical emergency and should be dealt with as such". They also told us that patients who have a TIA will often go on to have a stroke within two weeks, yet adherence to clinical guidelines can help minimise this risk.[34]

48. BASP, on the other hand, disagreed with the comments made by the Welsh Stroke Alliance and said that "…TIAs are still not recognised as emergency and this ignorance and 'culture' needs to be tackled".[35] They believed that resourcing is the key barrier to the development of a seven day TIA service, both in terms of staffing and equipment.

49. Clinical guidance developed by the Royal College of Physicians state that patients who have a TIA should have cartoid endarterectomy (surgery of the neck arteries) within 48 hours of the attack. In Wales there can be a two week wait.[36] We are very concerned about this and believe that action needs to be taken to address this urgently.

50. We heard there were a number of factors attributed to this delay, including lack of public and professional awareness about TIA and its severity,[37] and that TIA assessment is only available 5 days a week. Once more, we heard the recurring theme that a lack of leadership also played a part.[38] It is our view that prompt action is needed to ensure that seven day TIA assessment is available across Wales.

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[34] National Assembly for Wales Health and Social Care Committee, HSC-05-11 Paper 5: Welsh Stroke Alliance [accessed 25 November 2011]
[35] National Assembly for Wales, Health and Social Care Committee, HSC(4)-05-11 Paper 4 – Evidence from the British Association of Stroke Physicians, 6 October 2011 [accessed 18 November]
[36] National Assembly for Wales, Health and Social Care Committee, RoP [138], 6 October 2011
[37] ibid [108-109]
[38] Ibid [143-144]

51. The Welsh Government told us that they recognise the importance of TIA as a warning sign of a stroke, and that patients need to be seen more quickly. We welcome the inclusion of TIA services in the 1000 Lives campaign and the development of an intelligent target.[39] Service gaps need to be addressed now to minimise the risk of potentially preventable strokes occurring.

52. We were told that the Welsh Government expects that by April 2012, that

> "…we will have excellent TIA services and we should perform well in international comparison terms in the national clinical audit for carotid endarterectomy."[40]

53. While welcoming this, we feel more information is needed on how this will be achieved and how it will be monitored.

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.

[39] National Assembly for Wales, Health and Social Care Committee, RoP [85-88] 2 November 2011
[40] National Assembly for Wales, Health and Social Care Committee, RoP [85-88] 2 November 2011

4. All Wales Stroke Strategy

54. Our predecessor Committee in the third Assembly, the Health, Wellbeing and Local Government Committee recommended in their inquiry into Stroke Services that an all-Wales Stroke Strategy should be developed. The then Minister for Health and Social Services accepted this recommendation in May 2010, however such a Strategy has not yet been published.

55. The Welsh Government is currently developing a National Stroke Delivery Plan for 2011-2016.[41] Dr Anne Freeman (Welsh Stroke Alliance), who has been working on the development of the Plan, told us that prevention would play a major h part in the Plan.[42] We welcome this assurance.

56. The importance of such an over-arching Strategy was emphasised by the Stroke Association in their oral evidence to us:

> "…the word 'strategy' brings with it the invisible word 'commitment', and the recognition that people need to move to make a difference and to improve outcomes[….] If you are asking why we need a strategy, and why that might be important, at the highest strategic level, it does make people move, and it does ensure that actions get acted upon[….] Achievements are now coming forward in Wales as well, but maybe a strategy would take that forward further."[43]

57. In oral evidence, the Welsh Government gave us more information on the purpose of the Plan:

> "It [the plan] is about laying out our expectations on organisations and what we will measure and hold them to account on. The idea is that these delivery plans are not necessarily new initiatives, but that they integrate all the

[41] National Assembly for Wales, Health and Social Care Committee, HSC(4)-09-11 paper 4: Minister for Health and Social Services, 2 November 2011 [accessed 18 November]
[42] National Assembly for Wales, Health and Social Care Committee, RoP [82], 6 October 2011
[43] National Assembly for Wales, Health and Social Care Committee, RoP [16], 22 September 2011

current policy and strategy standards into one delivery expectations summary."[44]

58. We welcome the development of this Plan, and understand that it will supersede the Stroke Risk Reduction Action Plan.[45] We hope that the recommendations and observations that we have made in this report will help inform the development of the Delivery Plan.

59. From the evidence we have received, it is clear that the Delivery Plan must look at the full stroke pathway from risk reduction through to diagnosis, treatment, rehabilitation and prevention of secondary strokes. The BMA made it clear in their written evidence to us that this was essential to ensure full integration of stroke services across all sectors.[46]

Proposition: 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.

60. Additionally, local authorities should be involved in the development of the Delivery Plan. We were repeatedly told of the important role that local authorities play in the delivery of stroke risk reduction services, and especially in relation to the prevention of secondary strokes. However, all witnesses highlighted that there was inconsistency across Wales in relation to the involvement of local authorities in stroke risk reduction work and that this was a significant area for improvement.

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

61. We see the development of the National Stroke Delivery Plan as a critical opportunity to help improve stroke risk reduction services. We hope it ensures a clear pathway for all patients with involvement from the appropriate professional sector starting with risk reduction through to reablement. We hope that the Government seizes this

[44] National Assembly for Wales, Health and Social Care Committee, RoP [108], 2 November 2011
[45] ibid [106]
[46] National Assembly for Wales, Health and Social Care Committee, HSC(4)05-11 Paper 3: British Medical Association Cymru, 6 October 2011 [accessed 18 November]

opportunity, and we are likely to revisit this issue once the Delivery Plan has been published.

5. Atrial Fibrillation

62. Atrial Fibrillation (AF) is a common heart disorder which affects around 75,000 people in the UK, and is the most common heart disorder in Wales. It means that the heart is not pumping effectively, and this can lead to blood clots forming. If a blood clot dislodges itself from the heart, it can travel to the brain and cause a stroke.[47]

63. Providing oral evidence to us, the Atrial Fibrillation Association (AFA) told us about the worryingly increasing prevalence of AF:

> "Currently, anybody above the age of 40 has a one in four chance of developing atrial fibrillation. With emerging medicines and with people surviving for longer, those younger than 30 have closer to a one in two chance of developing atrial fibrillation in the future."[48]

64. We heard from the AFA that the impact of AF can be significant, and that it increases the likelihood of suffering a stroke by five times. We were also told that, of the 1,325 fatal strokes in Wales every year, it is estimated that AF is responsible for a quarter.[49] The AFA written evidence stated:

> "The strokes suffered by people with AF are also more severe, they are more frequently fatal and they are more likely to lead to disability, increased health costs and extended hospital care than stokes in patients without AF. Moreover, AF related strokes are more likely to happen again, adding not just to the risk of future strokes, but also to the potential for increased patient anxiety and a further reduction in quality of life. AF-related strokes kill nearly twice as frequently as non-AF strokes."[50]

65. The National Institute for Health and Clinical Excellence (NICE) published clinical guidance on AF in 2006, which stated that

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[47] National Assembly for Wales, Health and Social Care Committee, HSC(4) 03-11 Paper 2: The Stroke Association in Wales, 22 September 2011 [accessed 18 November]
[48] National Assembly for Wales, Health and Social Care Committee, RoP, [80], 22 September 2011
[49] National Assembly for Wales, Health and Social Care Committee, HSC(4)-03-11 Paper 1 Atrial Fibrillation Association, 22 September 2011, [accessed 22 November 2011]
[50] ibid

opportunistic screening of symptomatic patients or those with additional stroke risk factors could aid diagnosis. It also stated that patients with certain types of AF should be on an anti-coagulation drug. However, it was the view of some witnesses, including the AFA, the Stroke Association and Age Cymru that this guidance was not being adhered to.[51]

Identification and Diagnosis of AF

66. We heard in a range of evidence that many patients with AF are not being detected and diagnosed.[52] The AFA suggested that as many as half of patients with AF may never be identified and noted that this has a significant impact on attempts to reduce stroke risk.[53]

67. We heard that AF can be difficult to diagnose because the symptoms are confused for other conditions and it is often asymptomatic. However, we were told by the AFA that, following a pulse check, it can be diagnosed reasonably easily with an ECG.[54] The AFA also emphasised their view that diagnosis need not be costly and can be done when a patient presents at primary care for other reasons.[55]

68. The initial pulse check could be undertaken by a range of different healthcare professionals within the primary care setting; we heard, for example, of the role that nurses,[56] pharmacies and even the emergency services[57] could play in AF detection. However, from the evidence we received, we believe that the key issue is ensuring that the initial pulse check is followed up, as necessary, and that this action is

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[51] National Assembly for Wales, Health and Social Care Committee, HSC(4)-03-11 Paper 1 Atrial Fibrillation Association, 22 September 2011, [accessed 22 November 2011], National Assembly for Wales, Health and Social Care Committee, HSC(4) 03-11 Paper 2: The Stroke Association in Wales, 22 September 2011 [accessed 18 November] and National Assembly for Wales, Health and Social Care Committee, Consultation Response SRR11: Age Cymru [accessed 18 November]

[52] Evidence from the AFA, Stroke Association, Age Cymru, Cardiff and Vale University Health Board and Bayer.

[53] National Assembly for Wales, Health and Social Care Committee, HSC(4)-03-11 Paper 1 Atrial Fibrillation Association, 22 September 2011, [accessed 22 November 2011]

[54] National Assembly for Wales, Health and Social Care Committee, RoP [19] 22 September 2011

[55] Ibid [61-64]

[56] National Assembly for Wales, Health and Social Care Committee, HSC(4)-05-11 Paper 6: Royal College of Nursing Wales, 6 October 2011, [accessed 22 November 2011]

[57] National Assembly for Wales, Health and Social Care Committee, RoP [56-59], 22 September 2011

reflected in the patient's healthcare record to ensure effective management of the condition.

69. The RCN told us that the nursing profession could play a key role, based on evidence they provided which shows that nurses are the most likely professional group to take a leading role in the prevention of primary and secondary strokes.[58] This was supported by the Stroke Association who stated that primary care nurses could easily integrate pulse checks into their clinics with little or no additional costs to the NHS.[59]

70. We also heard evidence from both the AFA and the RCN about the Wrexham primary care AF model pilot which was conducted by two arrhythmia nurse specialists, who integrated manual pulse checks into GPs routine chronic conditions clinics. This resulted in seven new AF patients being identified and 68 patients found to be on inappropriate or no thromboprophylaxis, which lead to a further review by the GP.[60] It was suggested to us by the AFA that this model could be adapted for other Health Boards, and that a pro-active approach could ultimately lead to a reduction in AF related GP appointments:

> "The model used by the nurses in Wrexham shows that you can not only detect more cases but look at those who have already been diagnosed and reassess their risk reduction appropriately, and you can then enable practices to better manage the patients in their care."[61]

71. Based on the evidence we have received during this inquiry, we believe greater clarity is needed on which professional group should take the lead for identifying and ensuring appropriate follow on care and treatment for those with AF. We do not necessarily feel that it must be the GP who undertakes this initial diagnosis, but the evidence we have collected clearly shows that the identification of a patient

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[58] National Assembly for Wales, Health and Social Care Committee, HSC(4)-05-11 Paper 6: Royal College of Nursing Wales, 6 October 2011, [accessed 22 November 2011]
[59] National Assembly for Wales, Health and Social Care Committee, HSC(4) 03-11 Paper 2: The Stroke Association in Wales, 22 September 2011 [accessed 18 November]
[60] National Assembly for Wales, Health and Social Care Committee, HSC(4)-03-11 Paper 1 Atrial Fibrillation Association, 22 September 2011, [accessed 22 November 2011]
[61] National Assembly for Wales, Health and Social Care Committee, RoP [21] 22 September 2011

must then be reported back so that the patient's GP medical record is updated and the patient receives appropriate treatment.[62]

72. Public Health Wales told us that there are reasonably simple ways of auditing primary care health records that would show how many patients had their stroke risk assessed. They told us that:

> "It is an effective population-based way of seeing whether the things that we write in plans happen in practice. We are already doing that, but we would like to build on this work in implementing the programmes."[63]

73. We believe that monitoring whether or not these pulse checks are undertaken is vital to ensuring that there is a consistent approach across Wales to AF identification.

Screening

74. A key strand of our inquiry was to consider the evidence for an AF screening programme.

75. The UK National Screening Committee (UK NSC) is responsible for advising the NHS and Ministers on screening programmes and supporting the implementation of such programmes. They reviewed the evidence for AF screening and concluded that screening should not be offered. However, they are now reviewing their guidance, and this work will be completed by March 2012. Public Health Wales made it clear that,

> "Population screening programmes should not be introduced in the NHS if they are not recommended by the NSC[….]Wales should not make any plans for a systematic population based screening programme for atrial fibrillation until the outcomes of the NSC policy review is published."[64]

76. It is in this context, that we considered the benefits of introducing opportunistic screening, as opposed to a population based screening programme.

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[62] National Assembly for Wales, Health and Social Care Committee, RoP [64], 6 October 2011
[63] ibid [16]
[64] National Assembly for Wales, Health and Social Care Committee, HSC(4)-05-11 Paper 2: Evidence from Public Health Wales, 6 October 2011 [accessed 24 November 2011]

77. Almost all witnesses supported a targeted, opportunistic approach to AF screening, with the British Heart Foundation (BHF) saying:

> "BHF Cymru believes that the Welsh Government should support opportunistic pulse checks when people potentially at risk are in contact with the health service. Pilots offering pulse checks for patients attending flu clinics and integrating pulse checks into chronic disease management templates in England have demonstrated that this is an effective and cost effective way to ensure that people living with undetected AF are identified."[65]

78. The Screening for Atrial Fibrillation in the Elderly (SAFE) study, the AFA said, had shown that targeting those assessed as high-risk was an 'effective and efficient manner of trying to find AF in the community'.[66] The SAFE study compared opportunistic risk assessment, targeted screening and population based screening, and it found,

> "The opportunistic risk assessment identified more people at risk of atrial fibrillation than the other two options."[67]

79. Witnesses told us that opportunistic screening could be offered during routine visits to primary care, such as flu clinics or chronic disease checks, with little or no additional costs being incurred by the NHS.[68] Such opportunistic screening clearly links to some of the issues we have raised when looking at the identification of AF, earlier in this chapter.

80. We are aware, however, that while such opportunistic screening may have a limited financial impact, there will be additional costs resulting from treatment of those patients who are identified as a result of the screening. However, we believe that these costs would be off-set by the savings made by preventing a stroke.

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[65] National Assembly for Wales, Health and Social Care Committee, Consultation Response: SRR7: British Heart Foundation Cymru [accessed 24 November 2011]
[66] National Assembly for Wales, Health and Social Care Committee, RoP [27] 22 September 2011.
[67] National Assembly for Wales, Health and Social Care Committee, RoP [59], 6 October 2011.
[68] National Assembly for Wales, Health and Social Care Committee, Consultation Response SRR11: Age Cymru [accessed 18 November]

81. The Welsh Government told us that while doing such pulse checks were a matter of good clinical practice, it was still largely an educational issue to ensure that the primary care team is undertaking them.[69] We believe the introduction of systematic opportunistic screening, along with the other recommendations we are making, will help embed this as good clinical practice and ensure a consistent approach across Wales.

82. We are aware, as already identified, that there are a number of primary care professionals who may be best placed to undertake pulse checks. We are not identifying who should be doing this, but recommend that the Welsh Government give consideration as to who is best placed to do this, and how they will be co-ordinated.

83. Additionally, consideration needs to be given as to the monitoring of the pulse checks, as discussed in the previous section.

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.

Treatment of AF

84. In clinical trials, warfarin has been associated with a stroke risk reduction in AF patients of 50-70%, and is currently recommended as first line therapy for those patients with a moderate or high risk of developing stroke.[70]

85. Not all of those who are diagnosed are receiving the recommended drug treatment, and adherence to national guidelines is poor. The AFA highlighted that NICE's data indicated that of those patients who should be on warfarin, almost half were not.[71] We heard that there were a number of factors that contributed to this non-

[69] National Assembly for Wales, Health and Social Care Committee, RoP [163], 2 November 2011
[70] National Assembly for Wales, Health and Social Care Committee, HSC(4)-03-11 Paper 1 Atrial Fibrillation Association, 22 September 2011, [accessed 22 November 2011]
[71] ibid

compliance, including concerns, amongst patients, about the associated risk from warfarin.[72]

86. In oral evidence, however, the Welsh Government said that using the Quality Outcomes Framework (QOF) performance measures, there was 99% compliance with the AF QOFs in Wales.[73] However, we heard evidence from the AFA and Stroke Association that because the QOFs do not differentiate between anti-coagulant treatment and anti-platelet treatment, this is not the most reliable indicator to assess levels of anti-coagulation.[74] QOFs in relation to AF are considered in more detail in the next section of this report.

87. We heard that the reluctance to prescribe warfarin can be for a number of reasons, such as fear of bleeding and the additional complexity of managing patients on warfarin.[75] We were told that. while the unit cost of warfarin is cheaper than one of the main alternatives, aspirin, the additional management requirements, means it can be more expensive.[76] However, we also heard that the additional costs of warfarin are likely to be off-set by the cost of preventing a stroke, which has been estimated to cost approximately £44,000.[77]

88. The BMA told us that it was often patients who are reluctant to take warfarin:

> "…GPs know that warfarin is the gold standard. It is all well and good to say that everyone with atrial fibrillation should be on warfarin, but the reality is that patients do not always want it[….]Warfarin is not always right for patients – warfarin can be very dangerous for patients, and we have to make the right choice for the patient."[78]

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[72] National Assembly for Wales, Health and Social Care Committee, RoP [100], 6 October 2011.
[73] National Assembly for Wales, Health and Social Care Committee, RoP [121] 2 November 2011
[74] National Assembly for Wales, Health and Social Care Committee, HSC(4)-03-11 Paper 1 Atrial Fibrillation Association, 22 September 2011, [accessed 22 November 2011]
[75] ibid
[76] National Assembly for Wales, Health and Social Care Committee, RoP [13], 22 September 2011.
[77] Ibid [62]
[78] National Assembly for Wales, Health and Social Care Committee, RoP [100-101], 6 October 2011

89. We were told by the AFA that, to help ensure effective treatment of AF, it is vital that there is an increased professional and public awareness of the link between AF and stroke risk. They told us:

> "…we believe that the education of clinicians, but also of patients and the general public is critical. The decision to go on an anticoagulant, or an understanding of any risk factors in atrial fibrillation and the disease itself, has to come from a two-way conversation, with both parties understanding the disease."[79]

90. The AFA described training and development events which they have run with clinicians and feel more work could be done and that it could be linked to appraisals within the surgery.[80] The BMA disagreed saying that GPs were well aware of the links between strokes and AF.[81]

91. We feel strongly that it is vital to ensure that patients are given enough information and guidance to make an informed choice. GPs need to ensure that patients understand the potential impact of their decisions regarding treatment. The BMA acknowledged this in their oral evidence, stating that they could use risk assessment scores and that the decision should be regularly revisited to improve patient's understanding of their conditions and risks. We believe that this is particularly important given the apparent evidence that, when appropriately prescribed, warfarin can have such a big impact on reducing the stroke risk.[82]

92. As with monitoring of AF identification, similar mechanisms should be put in place to ensure effective monitoring of treatment of AF. The role QOFs can play in this is considered in the next section of the report, but the Welsh Government should consider introducing regular audits of primary care records to ensure that there is consistent adherence across Wales with regard to the NICE guidelines.

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[79] National Assembly for Wales, Health and Social Care Committee, RoP [51] 22 September 2011
[80] ibid
[81] National Assembly for Wales, Health and Social Care Committee, RoP [105-106], 6 October 2011.
[82] National Assembly for Wales, Health and Social Care Committee, HSC(4)-03-11 Paper 1 Atrial Fibrillation Association, 22 September 2011, [accessed 22 November 2011]

Proposition: 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.

Quality and Outcomes Framework

93. The Quality and Outcomes Framework (QOF) was introduced in 2004 and is a voluntary scheme that provides financial incentives for GP practices to provide a high level of care to patients. It uses indicators and a points scoring system, with GPs able to secure up to 1,000 points, which result in additional payments. It is managed by NICE throughout the UK. In Wales, Local Health Boards are responsible for quality assurance of the QOF process and work with GPs to reduce variations and improve outcomes.

94. The QOF indicators are currently being reviewed and negotiations are on-going to the final revision of the new indicators.

95. We heard from a number of people that the current QOF indicators may not help support the diagnosis and treatment of AF, and that the current review of the QOF indicators was an opportunity for this to be rectified. [83]

96. The Minister for Health and Social Services told us there is currently high compliance with the AF related QOFs.[84] However, organisations such as the AFA, the Stroke Association and BASP have indicated that the current QOFs do not adequately support pro-active screening and appropriate treatment with anti-coagulants.

97. The key concern is that the QOFs as currently devised, do not make a distinction between anti-coagulant therapy (warfarin) and anti-platelet therapy (aspirin). As the AFA told us,

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[83] National Assembly for Wales, Health and Social Care Committee, HSC(4) 03-11 Paper 2: The Stroke Association in Wales, 22 September 2011 [accessed 18 November]

[84] National Assembly for Wales, Health and Social Care Committee, RoP [120], 2 November 2011.

> "QOF today provides virtually no incentive for GPs to put patients on warfarin in accordance with the NICE 2006 or ESC 2010 guidelines."[85]

98. As we understand, one of the new proposed QOF indicators will monitor the percentage of patients with AF and at a high risk of stroke who are receiving an anti-coagulant.

Proposition: 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 anti-coagulation and anti-platelet therapies for AF patients.

Stroke Risk Stratification Tools

99. Health professionals use stroke risk stratification tools to help identify those patients most at risk from a stroke. A common tool used throughout Wales is the Cardiac Failure, Hypertension, Age, Diabetes, Stroke [Doubled] score, also referred to as"$CHADS_2$".

100. A point is scored for each of the factors (age is 75 or older), with a previous stroke or TIA scoring two points. The overall score then identifies the level of risk, with 0 being low risk and a score over two as high risk.

101. The European Society of Cardiology (ESC) have further developed $CHADS_2$, and for patients with a score less than two, they recommend they are assessed using "CHA_2DS_2-VASc", which takes into account further stroke risk factors such as vascular disease, age 65-75 and sex category. This slightly more sophisticated tool helps doctors identify those patients at low / moderate risk who may benefit from anti-coagulant treatment.

102. In England, a new tool has been developed which identifies those patients on the AF register with a $CHADS_2$ score of more than 2 who are not on anti-coagulant treatment. This is called Guidance on Risk Assessment and Stroke Prevention for Atrial Fibrillation (GRASP-AF). The AFA told us:

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[85] National Assembly for Wales, Health and Social Care Committee, HSC(4)-03-11 Paper 1 Atrial Fibrillation Association, 22 September 2011, [accessed 22 November 2011]

> "The GRASP-AF tool…has raised [detection] prevalence from 1.2 to 1.7 per cent…"[86]

103. The BMA also confirmed that such tools can be very powerful when discussing treatment options with patients:

> "…the proposed changes to the QOF, if accepted, will introduce more scoring to general practice, which means using additional tools within the consultation for us to assess an individual's risk. That can work and it can be quite a powerful message to patients, so that we can then say, 'Okay, you don't want to take warfarin, but here's your score – you're really at risk of having a stroke or a mini-stroke, and you really don't want that, do you?' That will help us much of the time."[87]

104. Additionally, Cwm Taf Health Board said that:

> "Services for AF assessment for stroke prevention remains poorly developed. In Wales, the GRASP-AF initiative to assist primary care that was introduced in England does not seem to be supported".[88]

105. We feel that this may be a missed opportunity and that the Welsh Government should consider supporting the introduction and use of the GRASP-AF tool to help GPs in identifying those patients who may benefit from an anti-coagulant treatment. As we have seen, an increase in appropriately prescribed warfarin, could have a significant impact on reducing stroke.

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

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[86] National Assembly for Wales, Health and Social Care Committee, RoP [28], 22 September 2011.
[87] National Assembly for Wales, Health and Social Care Committee, RoP [102], 6 October 2011.
[88] National Assembly for Wales, Health and Social Care Committee, Consultation response, SRR 9 Cwm Taf Health Board [accessed 24 November 2011]

6. Awareness

Public awareness

106. Public health campaigns can play a critical role in raising awareness of the risks associated with stroke. We are particularly worried about the low level of public awareness of AF. It concerns us that the BMA said:

> "Many people still do not realise that strokes are preventable, do not know the symptoms or risk factors, or how to manage them."

107. The Government agreed that the public was not sufficiently aware of AF, considering its level of prevalence.[89]

108. More generally, there is a lack of awareness of stroke risk factors.[90] We heard that, while people were more familiar with the risk factors for heart attacks and cancer, there was a much lower awareness about stroke risks.[91]

109. We are aware that, in the Welsh Government's Programme for Government, there is a commitment to deliver an annual campaign to tackle the five biggest public health issues, three of which directly link to stroke risk (obesity, smoking, and drug and alcohol misuse).[92] This is to be welcomed, particularly given the concerning information provided to us by Chief Medical Officer who said that, of the four risk factors of smoking, alcohol, unhealthy diets and physical exercise, it is estimated that less than 3% of the population adhere to advice on all four areas.[93] We believe that this shows what a steep mountain we have to climb in relation to improving the health of the nation.

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[89] National Assembly for Wales, Health and Social Care Committee, RoP [130] 2 November 2011
[90] National Assembly for Wales, Health and Social Care Committee, Consultation Response SRR11: Age Cymru [accessed 18 November]
[91] National Assembly for Wales, Health and Social Care Committee, HSC(4)-05-11 Paper 6: Royal College of Nursing Wales, 6 October 2011, [accessed 22 November 2011]
[92] National Assembly for Wales, Health and Social Care Committee, HSC(4)-09-11 paper 4: Minister for Health and Social Services, 2 November 2011 [accessed 18 November]
[93] National Assembly for Wales, Health and Social Care Committee, RoP [149-150] 2 November 2011.

110. We acknowledge that it is difficult for people to make lifestyle changes, but it is vital that the Welsh Government ensures that people have the right information and support to assist them in making these changes. Public awareness campaigns are a key mechanism in trying to do this.

111. The Stroke Association described a number of stroke prevention campaigns which have been funded by the Welsh Government, including Weigh up your Risk of Stroke, the F.A.S.T campaign and the recent Ask First campaign.[94] They told us that the evaluation of the Ask First campaign has shown that it was effective and saved lives.

112. We agree with the Stroke Association and other stakeholders who stressed the importance of ensuring a planned and co-ordinated approach to awareness campaigns:

> "However, these [stroke prevention campaigns] should be delivered more strategically. This can be achieved by allowing longer planning periods and more collaboration across organisations and functionalities, as well as ensuring that adequate levels of funding are available to deliver integrated campaigns."[95]

113. Public health campaigns should build on their predecessors, and should provide a consistent and easy to understand message to the public. When planning a health promotion campaign, it is important that consideration is given to the purpose, aim and intended audience. This should then inform the best means and mechanisms for effective delivery of the campaign.

114. At the end of each Welsh Government supported campaign, we believe that it is important that a full evaluation is undertaken, so that this can inform the development of future campaigns.

Proposition: 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.

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[94] National Assembly for Wales, Health and Social Care Committee, HSC(4) 03-11 Paper 2: The Stroke Association in Wales, 22 September 2011 [accessed 18 November]
[95] Ibid

Evaluations should be shared with partners to allow the dissemination of good practice and lessons learnt.

115. We are aware that work needs to be done to target the most hard-to-reach groups, who are often the most vulnerable to stroke. Public Health Wales told us that there is recognition of health inequalities in Wales, and that these need to be tackled,

> "There are effective interventions that we can employ to help people to change their behaviours and to promote healthy behaviours, but those need to be delivered in an effective way. They are probably inconsistently delivered at the moment. They need to be given the same kind of prominence and importance that we attach to treatment and care interventions."[96]

116. We are concerned that those in particularly deprived areas, or in remoter communities are not always reached in awareness raising campaigns, and special consideration needs to be given to ensure that they have access to information to help inform their lifestyle choices. The Stroke Association highlighted this in their written evidence,

> "The Welsh Assembly Government needs to take a wider view to implementing successful health promotion campaigns and integrate thinking with the social inequalities that come about as a result of the wider determinants of ill health which exist across parts of Wales."[97]

117. We know that within the Stroke Risk Reduction Action Plan there was an action to "seek opportunities to provide a national co-ordinated approach to introductory public health/community health development training to Communities First staff".[98] This was due to be completed by March 2012. No report on progress is yet available.

118. Specific consideration must be given to addressing those health inequalities which play such a key role in stroke risk. We would like to see these issues prioritised by the Welsh Government.

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[96] National Assembly for Wales, Health and Social Care Committee, RoP [33], 6 October 2011.
[97] National Assembly for Wales, Health and Social Care Committee, HSC(4) 03-11 Paper 2: The Stroke Association in Wales, 22 September 2011 [accessed 18 November]
[98] Promoting Cardiovascular Health: The Stroke Risk Reduction Action Plan, Welsh Government [accessed 29 November 2011]

119. The Stroke Association highlighted that tackling unhealthy choices is becoming more complex. They cited the example that high levels of alcohol consumption is now affecting more professional and affluent people, so a lifestyle change which is not linked to health inequality. They used this as an example of how complex the issue of health promotion is becoming.[99]

120. We recognise the force of argument put forward by those witnesses who said that health promotion must start at the earliest age, to prevent unhealthy habits becoming entrenched, because often public health interventions can be 'too late.'[100] As the Stroke Association told us:

> "We have to start at school age[….] we must also work generically across the whole pathway and at the youngest age to prevent deterioration of condition."[101]

121. The Welsh Government told us that the Welsh Network of Health School Schemes provides the framework for a whole school approach to health and that includes action around stroke risk factors, however, we do not have more information on what impact this is having.[102]

122. Another important strand is increasing public awareness of TIAs, so that people understand that this can be an early stroke indicator. We have already looked at the importance of ensuring swift treatment following TIA, but this can only happen if people seek medical attention. BASP told us people need to know the symptoms and that people should 'take it as if it was chest pain'.[103]

123. All the evidence that we heard demonstrated the need for health promotion activity to be effectively planned, co-ordinated and evaluated. Raising the public awareness of the risk factors, would help reduce stroke risk, along with risks associated with other conditions such as heart disease. While we understand the importance of ensuring generic health promotion messages, we feel specific

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[99] National Assembly for Wales, Health and Social Care Committee, RoP [167] 22 September 2011
[100] National Assembly for Wales, Health and Social Care Committee, RoP [121] 22 September 2011
[101] ibid
[102] National Assembly for Wales, Health and Social Care Committee, HSC(4)-09-11 paper 4: Minister for Health and Social Services, 2 November 2011 [accessed 18 November]
[103] National Assembly for Wales, Health and Social Care Committee, RoP [109], 6 October 2011.

consideration needs to be given to those campaigns which directly target those at risk with stroke, and the clear need to make the public more aware of AF as a condition and the risks associated with the condition.

Professional awareness

124. As highlighted in sections 68-69, it is vital that healthcare professionals are aware of the link between AF and stroke. We know that health staff are aware of the broader risk factors for stroke, but feel that more can be done to increase the understanding of AF.

125. While the BMA told us that GPs are "only too aware of strokes and atrial fibrillation and many other risk factors"[104] the evidence we have heard throughout the inquiry has suggested that this knowledge may not consistently manifest itself in the identification and diagnosis of AF.

126. We are also aware that it is often other healthcare professionals, such as nurses who often have a critical role in identifying AF patients.[105] There is also the cohort of care staff who provide support to those most likely to have AF, yet may be unaware of the condition. It is important that further work, which could build on the work already undertaken by organisations such as the AFA to help increase awareness in medical staff is considered by the Welsh Government.

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.

127. The AFA said that they would like to see a regular appraisal event within each surgery, to ensure at least one member of the practice staff is up to date with the latest developments in relation to AF.[106] This is certainly an idea that we feel should be considered by the Welsh Government, alongside consideration of including a mandatory component in GPs Continuing Professional Development (CPD) programme on AF.

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[104] National Assembly for Wales, Health and Social Care Committee, RoP [105], 6 October 2011.
[105] Ibid [64]
[106] National Assembly for Wales, Health and Social Care Committee, RoP [51] 22 September 2011

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

7. Conclusions

128. The key issues arising from our inquiry have been:

- concerns around the implementation, leadership, management and monitoring of the Stroke Risk Reduction Action Plan;
- a clear need for improvements in the identification and treatment of AF;
- an need for an improved emphasis on preventing strokes following a TIA or initial stroke; and
- a greater need for public and professional awareness surrounding risk factors (including AF) for stroke

129. We repeatedly heard that strokes are preventable and treatable, and it is vital that we all take every step to try and reduce the number of people having a stroke. We welcome the work that has been on-going to improve the acute stroke services, and hope that there will now be a renewed focus on stroke prevention services.

130. There are clearly lessons that can be learnt from the implementation of the Stroke Risk Reduction Action Plan, which we hope will inform the development and delivery of the National Stroke Delivery Plan.

131. As AF can be a key stroke risk factor, it is important that there are improvements in the identification rate. The evidence that we considered has suggested that this can be done in a cost effective way and can be integrated into services already delivered in primary care. Once identified, NICE guidelines for treatment must be adhered to, and it is vital that patients have information to help them make an informed choice about their treatment.

132. Underpinning all of this is the importance of increased public and professional awareness about stroke risk factors. We must ensure that people have access to appropriate information to help them make informed choices about their lives. We must all work together to try and reduce the prevalence and impact of this, often, devastating condition.

Annex A: Propositions

These set of propositions support the recommendations made by the Committee, and outline a number of issues which we feel the Government should give further consideration to.

Proposition 1: The Welsh Government should consider the shortfall in trained stroke physicians through the use of effective workforce planning. **(Page 18)**

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 LHBs should adhere. **(Page 20)**

Proposition 3: That the Welsh Government considers establishing Joint Cardiac-Stroke Networks across Wales. **(Page 20)**

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)**

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)**

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)**

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 anti-coagulation and anti-platelet therapies for AF patients. **(Page 35)**

Proposition 8: That the Welsh Government considers supporting the introduction and use of the GRASP-AF tool in GP practices. (**Page 36)**

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)**

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. **(Page 42)**

Annex B: Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at http://www.senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=1309

22 September

Jo Jerrome	Atrial Fibrillation Association
Lowri Griffiths	The Stroke Association
Ana Palazon	The Stroke Association
Paul Underwood	The Stroke Association

6 October

Dr Julie Bishop	Public Health Wales
Nicola Davies-Job	Royal College of Nursing
Dr Anne Freeman	Welsh Stroke Alliance
Dr Charlotte Jones	British Medical Association Cymru
Professor Pradeep Khanna	British Association of Stroke Physicians
Dr Richard Lewis	British Medical Association Cymru
Denise Llewellyn	Aneurin Bevan Local Health Board
Lisa Turnbull	Royal College of Nursing

2 November 2011

Lesley Griffiths AM	Minister for Health and Social Services, Welsh Government
Dr Tony Jewell	Chief Medical Officer, Welsh Government
Dr Chris Jones	Medical Director, NHS Wales

Annex C: List of written evidence

The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full at http://senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=1531

Organisation	*Reference*
Minister for Health and Social Services	HSC(4)-09-11 Paper 4
Dr Neil McKenzie	SRR 1
Association of British Neurologists	SRR 2
Atrial Fibrillation Association	SRR 3
Royal College of Nursing	SRR 4
Welsh Therapies Advisory Committee	SRR 5
All Wales Dietetic Managers Committee	SRR 6
British Heart Foundation Cymru	SRR 7
Chartered Society of Physiotherapy	SRR 8
Cwm Taf Health Board	SRR 9
Public Health Wales NHS Trust	SRR 10
Age Cymru	SRR 11
ASH Wales	SRR 12
British Association of Stroke Physicians	SRR 13
College of Occupational Therapists	SRR 14
Community Pharmacy Wales	SRR 15
Royal College of Physicians	SRR 16
Abertawe Bro Morgannwg University Health Board	SRR 17
Welsh Stroke Alliance	SRR 18
British Dietetic Association Welsh Board	SRR 19
Cardiff and Vale University Health Board	SRR 20
Welsh Refugee Council	SRR 21
Bayer	SRR 22

Aneurin Bevan Health Board	SRR 23
South East Wales Regional Stroke Forum	SRR 24
Hywel Dda Health Board	SRR 25
Royal College of General Practitioners Wales	SRR 26
Powys Teaching Health Board	SRR 27
The Royal Pharmaceutical Society	SRR 28