

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 1 – y Senedd

Dyddiad:
Dydd Mercher, 23 Hydref 2013

Amser:
09:00

Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales



I gael rhagor o wybodaeth, cysylltwch â:

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Agenda

1 Cyflwyniad, ymddiheuriadau a dirprwyon

2 Lleihau'r risg o strôc – ymchwiliad dilynol: Panel 1 – Y sector gwirfoddol (09:00 – 09:35) (Tudalennau 1 - 43)

Jo Jerome, y Gymdeithas Ffibriliad Atriaidd

Ana Palazon, Cyfarwyddwr Cymru, y Gymdeithas Strôc

Paul Underwood, Dirprwy Gyfarwyddwr Cymru, y Gymdeithas Strôc

Lowri Griffiths, y Gymdeithas Strôc

3 Lleihau'r risg o strôc – ymchwiliad dilynol: Panel 2 – Cynghair Strôc Cymru (09:35 – 10:10) (Tudalennau 44 - 58)

Dr Anne Freeman, yr Arweinydd Clinigol ym maes Strôc yng Nghymru, yr Uned Gyflawni Genedlaethol

Dr Hamsaraj Shetty, Meddyg Ymgynghorol ym maes Strôc, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Egwyl (10:10–10:20)

4 Lleihau'r risg o strôc – ymchwiliad dilynol: Panel 3 – Byrddau Iechyd Lleol / Iechyd Cyhoeddus Cymru (10:20 – 11:00) (Tudalennau 59

- 73)

Mrs Jan Smith, Cyfarwyddwr Gweithredol ac Arweinydd Gweithredol ym maes Strôc, Bwrdd Iechyd Prifysgol Aneurin Bevan

Dr Yaqoob Bhat, Meddyg Strôc, Bwrdd Iechyd Prifysgol Aneurin Bevan

Dr Hugo van Woerden, Cyfarwyddwr Arloesi a Datblygu, Iechyd Cyhoeddus Cymru

Amanda Smith, Cyfarwyddwr Therapiau a Gwyddorau Iechyd, Ansawdd a Diogelwch, Bwrdd Iechyd Addysgu Powys.

5 Lleihau'r risg o strôc – ymchwiliad dilynol: Panel 4 – Cyrff proffesiynol (11:00 – 11:30) (Tudalennau 74 - 80)

Nicola Davis-Job, Cyfarwyddwr Cyswllt Dros Dro (Arfer Proffesiynol), y Coleg Nyrso Brenhinol

Carole Saunders, Nyrs Glinigol Arbenigol Strôc, Ysbyty Singleton

Dr Amer Jafar, BMA Cymru Wales ac Arbenigwr Cyswllt ym maes Meddyginiaeth Adsefydlu, Ysbyty Gwynllyw

Dr Phil White, BMA Cymru Wales, Meddyg Teulu, Gogledd Cymru

6 Lleihau'r risg o strôc – ymchwiliad dilynol: Panel 5 – Llywodraeth Cymru (11:30 – 12:00) (Tudalennau 81 - 99)

Mark Drakeford AC, y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

Chris Jones, y Dirprwy Brif Swyddog Meddygol (Gwasanaethau Iechyd)

7 Papurau i'w nodi

Llythyr gan y Gweinidog Iechyd a Gofal Cymdeithasol: y gyllideb ddiogelu iechyd ac imiwneiddio (Tudalennau 100 - 101)

Llythyr gan Fwrdd Rhaglen Cynllun De Cymru: gwybodaeth dilynol o'r cyfarfod ar 3 Hydref (Tudalen 102)

8 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y canlynol:

Eitem 9

Sesiwn breifat

9 Y Bil Gwasanaethau Cymdeithasol a Llesiant (Cymru): Sesiwn frifio ar Gyfnod 2 (12:00 – 12:30) (Tudalennau 103 - 113)

Eitem 2

Mae cyfyngiadau ar y ddogfen hon



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

20 September 2013

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[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 health 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
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As the 2011 Inquiry highlighted, atrial fibrillation (AF) is a major risk factor for stroke. Atrial fibrillation affects over 50,138¹ across Wales², 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 stroke⁵. Furthermore, AF-related strokes are more severe and cause greater disability than strokes in patients without AF. Half of patients will fail to survive more than twelve months following a stroke⁶; 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 carers⁷.

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.

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 outcomes⁸ 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 CHA₂DS₂-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

AF Association response to
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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." (Lesley¹⁰)

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 documented¹¹. It is essential that health care professionals (HCP) become better informed about:

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 tool¹² (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 resources¹³. 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 guidance¹⁵.

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

AF Association response to
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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 anticoagulant¹⁶.

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 study¹⁷ 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
- Manual 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.

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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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

Stroke Association

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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 TIAs 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 they follow 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' 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 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 evidence¹ 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.

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

Eitem 3

Committee Clerk

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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 WSA welcomes 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 National Clinical 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 today's requirements for effective leadership in health service developments.

Discussion

The Welsh Government Health 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 endarterectomy are adhered 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 today's 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 that 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 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*.*

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 along 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.

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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**

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Issues highlighted	Linkage with Delivery Plan	Progress made against the Stroke Inquiry Report
Stakeholders were not consulted on the risk reduction action plan	Yes	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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

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		<p>deliver a more systematic and co-ordinated approach to identifying those at risk of vascular disease and atrial fibrillation and managing that risk effectively.</p> <ul style="list-style-type: none"> • 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.
<p>Concerns around the implementation, leadership, management and monitoring of the Stroke Risk Reduction Action Plan</p> <p>Leadership and management of TIA/stroke services</p>	Yes	<ul style="list-style-type: none"> • 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.
<p>Stroke boards needs to have a comprehensive membership which should include representation from local authorities.</p>		<ul style="list-style-type: none"> • The Stroke Board within ABHB has comprehensive membership, including a local authority representative from Social Services
<p>Local authorities should be involved in the development and delivery of the Delivery Plan and especially in relation to the prevention of secondary strokes.</p>		<ul style="list-style-type: none"> • 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.
<p>The Delivery Plan should look at the full stroke pathway from risk reduction through to diagnosis, treatment, rehabilitation and prevention of secondary strokes.</p>	Yes	<ul style="list-style-type: none"> • 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

		<p>facilitate quicker functional recovery and discharge home. Separate work streams have been set up on acute care, early rehabilitation and TIA services.</p> <ul style="list-style-type: none"> • 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.		<ul style="list-style-type: none"> • 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		<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<p>ABHB has initiated a number of actions within the Delivery plan on early detection and treatment of TIA and AF including:</p> <ul style="list-style-type: none"> • Work with GPs to raise their awareness of symptoms

		<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

		<p>recognising and presenting symptoms promptly</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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		<p>All practices in ABHB 2013-2014 being offered QP AF pathway based on 1,000 Lives Plus AF pathway</p> <ul style="list-style-type: none"> • 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		<ul style="list-style-type: none"> • 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.

		<ul style="list-style-type: none"> • ABHB are developing and rolling out a Smoking Dashboard as part of the GMS Variation Project
Opportunistic pulse checks	Yes	<ul style="list-style-type: none"> • 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		<ul style="list-style-type: none"> ▪ Pulse checks – GPs will often check pulses opportunistically as there is no official programme.
Effective monitoring of treatment of AF		<ul style="list-style-type: none"> ▪ 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		<p>ABHB has 24/7 TIA advice service for primary care physicians</p> <p>ABHB has daily TIA clinics during the week days where patients are seen promptly in accordance of RCP guidelines.</p> <p>ABHB also has hot slot clinics where high risk patients are seen within 24 hours.</p>

		<p>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.</p> <p>ABHB provides the Information back to primary care physicians with plan and guidance on same day</p>
Risk reduction was not mentioned for a person who has already experienced a TIA or a stroke		<p>Almost all TIA patients' risk factors will be checked and discussed.</p> <p>Baseline electrocardiogram will be done in all patients to exclude AF</p> <p>Where risk factors been identified, advice and follow up is provided to patients</p> <p>Leaflet information is provided to patients on various issues related to TIA.</p>

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.

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- 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.

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Evidence from Powys Teaching Health Board – SFU 4

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.



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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;

- 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



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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>.

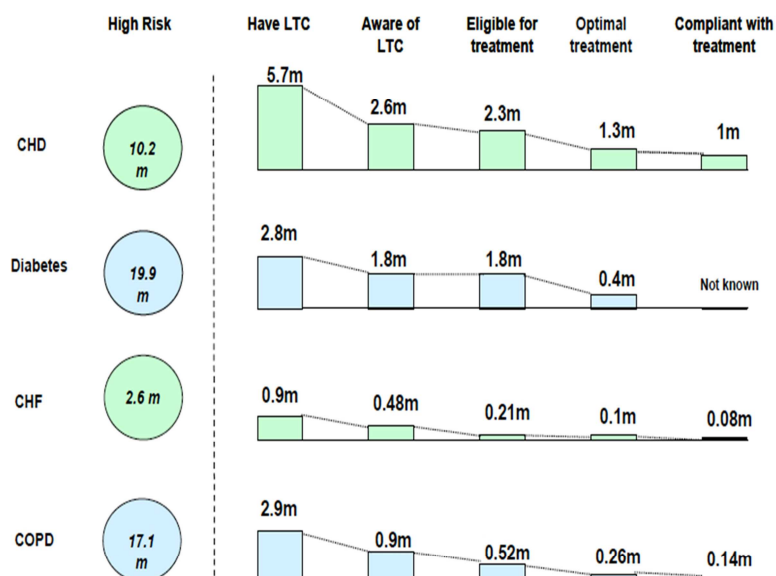
³ [http://www2.nphs.wales.nhs.uk:8080/PharmaceuticalPHTDocs.nsf/\(\\$All\)/AE4B8D7C67346D9E80257BC90037768A/\\$File/Stroke%20Campaign%20Evaluation%20Report%20%202013.pdf?OpenElement](http://www2.nphs.wales.nhs.uk:8080/PharmaceuticalPHTDocs.nsf/($All)/AE4B8D7C67346D9E80257BC90037768A/$File/Stroke%20Campaign%20Evaluation%20Report%20%202013.pdf?OpenElement)

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.

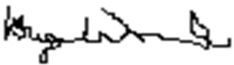
- Smoking – pursuing a tobacco display ban in shops that have floor space of less than 280 sq m.
- Healthy eating - challenging food retailers with the fact that the sale of unhealthy ingredients is contributing to avoidable mortality in Wales and emphasising that retailers have a moral duty to address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

Eitem 5

[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 wards¹. 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 Ireland². 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 2010³ 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

2

[https://audit.rcplondon.ac.uk/sentinelstroke/website/files/generic%20report%202010%20\(incl%20appendices\).pdf](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 Practice⁴.

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 2012⁵

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

Y Gymdeithas Feddygol Brydeinig
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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 2011 in addressing each of the recommendations of the Committee's original report:

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 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:
Dr Richard JP Lewis, CSU MB ChB MRCP Dip IMC RCS (Ed) PGDip FLM

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 2012¹.

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 procedure², 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
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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

David Rees AC
Cadeirydd
Y Pwyllgor Iechyd a Gofal Cymdeithasol
Cynulliad Cenedlaethol Cymru

11 Hydref 2013

Annwyl David

Ysgrifennaf atoch i'ch diweddaru ar y cynnydd ers ymateb Llywodraeth Cymru i Ymchwiliad y Pwyllgor Iechyd a Gofal Cymdeithasol i Leihau'r Risg o Strôc.

Gweler yn amgaaedig Atodiad sy'n dangos diweddariad ar bob un o argymhellion a chynigion yr Adroddiad.

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

Lleihau'r risg o strôc – ymchwiliad dilynol – diweddariad Llywodraeth Cymru yn erbyn Argymhellion a Chynigion

Argymhellion	Ymateb Llywodraeth Cymru	Cynnydd
<p>Argymhelliad 1. Rydym yn argymhell bod Llywodraeth Cymru yn cynnal gwerthusiad llawn a thrylwyr o'r modd y caiff Cynllun Llywodraeth Cymru i Leihau'r Risg o Strôc ei roi ar waith, gan gynnwys yr holl randdeiliaid. Dylid cyhoeddi'r gwerthusiad a defnyddio'r canlyniadau i ddatblygu Cynllun Cyflawni Cenedlaethol ar gyfer Strôc. (Tudalen 16)</p>	<p>Derbyn.</p> <ul style="list-style-type: none"> • Gofynnwyd i lechyd Cyhoeddus Cymru gynnal gwerthusiad o'r Cynllun Gweithredu i Leihau'r Risg o Strôc. Caiff hyn ei wneud yn yr ychydig fisoedd nesaf a bydd yn cynnwys amrywiaeth o randdeiliaid sy'n gyfrifol am gyflawni'r camau a nodir yn y Cynllun. Disgwylir i'r gwerthusiad hwn gael ei gwblhau ym mis Ebrill 2012 a bydd y canfyddiadau ar gael yn dilyn hynny. • Bydd y gwerthusiad o'r Cynllun Gweithredu i Leihau'r Risg o Strôc yn helpu i lywio gweithgareddau yn y dyfodol sy'n anelu at leihau'r risg o strôc. • Bydd y Cynllun Cyflawni Cenedlaethol ar gyfer gwasanaethau strôc (y disgwylir ymgynghori arno yn y Gwanwyn) yn ystyried y gwerthusiad a bydd yn nodi'r camau y mae angen eu cymryd i alluogi pobl i fwynhau ansawdd bywyd da heb gael clefyd fasgwlaidd na strôc. 	<p>Fe wnaeth lechyd Cyhoeddus Cymru gynnal gwerthusiad o'r modd y rhoddwyd y Cynllun Gweithredu i Leihau'r Risg o Strôc ar waith yng ngwanwyn 2012. Roedd y gwerthusiad hwn yn cynnwys ystyried cynnydd a wnaed wrth weithredu'r camau a gynhwysir yn y cynllun, yn ogystal â thrafodaeth gyda rhanddeiliaid perthnasol. Rhoddodd y gwerthusiad ystyriaeth i ymatebion ysgrifenedig a llafar yn ogystal â thrafodaeth mewn gweithdy rhanddeiliaid.</p> <p>Roedd adroddiad lechyd Cyhoeddus Cymru'n cefnogi'r farn fod cynnydd da'n cael ei wneud wrth weithredu'r camau yn y Cynllun Gweithredu i Leihau'r Risg o Strôc. Fe wnaeth nifer o argymhellion hefyd, a oedd yn canolbwyntio'n bennaf ar elfennau ataliol y Cynllun Cyflawni Cenedlaethol dilynol ar gyfer gwasanaethau strôc.</p> <p>Defnyddiwyd canfyddiadau gwaith lechyd Cyhoeddus Cymru wrth ddatblygu'r Cynllun Cyflawni ar gyfer strôc, a rhoddwyd sylw i'r mwyafrif o argymhellion lechyd Cyhoeddus Cymru yn y Cynllun. Fodd bynnag, mae'r Cynllun Cyflawni'n ddogfen lefel uchel ac felly nid oedd yn ceisio cynnwys y math o fanylder</p>

		a awgrymwyd mewn rhai argymhellion.
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Argymhellion	Ymateb Llywodraeth Cymru	Cynnydd
<p>Argymhelliad 2. Rydym yn argymhell bod Llywodraeth Cymru yn cyfeirio'n glir at atal strôc eilaidd yn y Cynllun Cyflawni Cenedlaethol ar gyfer Strôc, ac at drin a gwneud diagnosis o TIA, o ran ei gysylltiad â'r gwaith i leihau'r risg o strôc. (Tudalen 18)</p>	<p>Derbyn.</p> <ul style="list-style-type: none"> • Bydd y Cynllun Cyflawni Cenedlaethol ar gyfer gwasanaethau strôc yn nodi camau clir y mae angen eu cymryd o ran atal, canfod a thrin strôc a Phyliau o Isgemia Dros Dro. • Eir ati i geisio atal strôc eilaidd pan fydd y claf yn gwella ar ôl cael y strôc gyntaf a rhoddir pwyslais ar hynny pan y'i rhyddheir drwy feddyginiaeth atal strôc eilaidd briodol a chyingor ar reoli'r risgiau. • Mae'r Rhaglen 1000 o Fywydau a Mwy wedi llunio pecyn cymorth i wella gwasanaethau i'r rheini sydd wedi cael TIA i atal strôc lawn. Mae'r gwaith hwn, sy'n ystyried y modd y caiff TIA ei asesu a'i reoli, eisoes wedi dechrau ymdrin â lleihau'r risg o strôc ddilynol. • Dylai pob Bwrdd Iechyd yng Nghymru allu asesu, fel mater o drefn, TIA risg isel o fewn wythnos a TIA risg uchel o fewn 24 awr (rhwng dydd Llun a dydd Gwener). Mae gwaith yn mynd rhagddo gyda'r Bwrdd Iechyd i sicrhau y gellir asesu TIA risg uchel o fewn 24 awr saith diwrnod yr wythnos a chaiff hyn ei gefnogi a'i gydgysylltu gan yr 	<p>Mae un o'r themâu cyflawni o fewn y Cynllun Cyflawni ar gyfer gwasanaethau strôc a gyhoeddwyd ar 6 Rhagfyr 2012 yn canolbwyntio ar atal strôc gan gynnwys pwl o isgemia dros dro (TIA), ffibriliad atrïaidd a strôc eilaidd. Mae'n cynnwys camau clir i Fyrddau Iechyd weithredu arnynt.</p> <p>Mae Fy Ngwasanaeth Iechyd Lleol (mylocalhealthservice.wales.gov.uk), a lanswyd gan Brif Weinidog Cymru ar 30 Medi 2013, yn rhan o gynlluniau Llywodraeth Cymru ar gyfer gwella tryloywder yn y system iechyd a darparu gwybodaeth a fydd ar gael i'r cyhoedd ar wasanaethau iechyd yn eu hardal leol. Cafodd dau ddangosydd, sy'n berthnasol i strôc, eu rhyddhau yn y gyfran gyntaf o ddata. Y cyntaf yw'r gyfradd o bobl rhwng 35 a 74 oed a gafodd dderbyniad brys am strôc a fu farw yn yr ysbyty o fewn 30 diwrnod. Yr ail yw dangosydd o ofal sylfaenol o'r Fframwaith Canlyniadau Ansawdd. Cafodd y wefan ei lansio'n llwyddiannus ac mae cynlluniau'n cael eu datblygu i gyhoeddi a diweddarau mwy o ddata.</p> <p>Er enghraifft, ym Mwrdd Iechyd Prifysgol Caerdydd a'r Fro mae clinigwyr gofal sylfaenol yn rhoi blaenoriaeth i reoli ffactorau risg cardiofasgwlaidd ee rheoli Pwysedd Gwaed, rhoi'r gorau i ysmegu, rheoli ffordd o fyw (pwysau ac ymarfer corff) yn ogystal â rheoli TIA fel yr amlinellir yn y Fframwaith Ansawdd a Chanlyniadau.</p> <p>Mae Bwrdd Iechyd Prifysgol Caerdydd a'r Fro wedi mabwysiadu fframwaith gwella canlyniadau sydd ac iddo'r nod o sicrhau bod pobl sy'n cael eu hatgyfeirio am lawdriniaeth fel mater o drefn yn mynychu rhaglen ffordd o fyw (os oes ganddynt Fynegai Màs y Corff</p>

	<p>Uned Cyflenwi a Chymorth.</p>	<p>uchel) – mae hyn yn arwydd o’u bwriad i ganolbwyntio ar hunan-reoli risgiau ffordd o fyw, a fydd yn lleihau achosion o strôc os rheolir hwy’n well.</p> <p>Mae staff meddygol gofal sylfaenol ac eilaidd Bwrdd Iechyd Aneurin Bevan yn cydweithio gydag addysg ar rôl gwrthgeulo mewn ffibriliad artiaidd. Mae tair sesiwn addysg yn cael eu cynllunio ar hyn o bryd ac yn cael eu cyflwyno gan feddygon gofal eilaidd yn flynyddol trwy sesiynau addysg sefydledig gofal sylfaenol. Ceisir cyllid ar gyfer gwaith gyda Gwasanaeth Ambiwlans Cymru a Bwrdd Iechyd Aneurin Bevan i wella’r ffordd y mae cleifion yr amheuir eu bod yn dioddef strôc neu TIA yn cael eu hadnabod yn gynnar trwy ddefnyddio algorithmau wedi’u dilysu a systemau asesu sgoriau megis ‘FAST’ (prawf i adnabod symptomau strôc) a ‘ROSIER’ (dull o asesu a yw person wed cael strôc) ac ‘ABCD2’ (dull rhagweld ar gyfer y cleifion sy’n fwyaf tebygol o ddiodes TIA). Mae awydd penodol i adnabod cymaint ag sy’n bosibl o gleifion TIA posibl i drefnu gofal sylfaenol ac eilaidd dilynol er mwyn atal achosion pellach o TIA a strôc bosibl.</p>
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Argymhellion	Ymateb Llywodraeth Cymru	Cynnydd
<p>Argymhelliad 3. Rydym yn argymhell bod Llywodraeth Cymru, erbyn Ebrill 2012, ac yn unol â'r hyn a gyhoeddwyd, yn sicrhau bod clinigau TIA ar agor saith diwrnod yr wythnos a bod canllawiau clinigol mewn perthynas ag endarterectomi carotid yn cael eu dilyn ledled Cymru. (Tudalen 23)</p>	<p>Derbyn mewn egwyddor.</p> <ul style="list-style-type: none"> • Caiff asesiadau TIA eu cynnal ar yr un safle lle y darperir gwasanaethau strôc aciwt, a dylai pob Bwrdd lechyd yng Nghymru allu asesu, fel mater o drefn, TIA risg isel o fewn wythnos a TIA risg uchel o fewn 24 awr (rhwng dydd Llun a dydd Gwener). Mae gwaith yn mynd rhagddo gyda Byrddau lechyd i sicrhau y gellir asesu TIA risg uchel o fewn 24 awr saith diwrnod yr wythnos drwy'r gwasanaeth asesiadau meddygol aciwt drwy naill ai dderbyn claf neu gyflwyno cynllun boddhaol ar gyfer ei asesu, ymchwilio iddo a'i drin. Mae protocol yn cael ei ddatblygu a bydd yn galluogi Byrddau lechyd i gael gafael ar dimau meddygol ar alw. Caiff y protocol ei gymeradwyo gan Gyfarwyddwyr Meddygol a'i weithredu o fis Ebrill 2012. • Mae canllawiau clinigol NICE yn nodi'n glir bod angen i gleifion endarterectomi carotid (CEA) gael llawdriniaeth ar rydweliâu'r gwddf cyn gynted â phosibl er mwyn atal strôc. Mae'n ofynnol cynnal llawdriniaethau mewn 	<p>Mae pob Bwrdd lechyd bellach yn gallu asesu fel mater o drefn TIA risg isel o fewn wythnos a TIA risg uchel o fewn 24 awr.</p> <p>Mae 1000 o Fywydau a Mwy wedi cynhyrchu Canllawiau i wneud Gwasanaethau TIA yn fwy dibynadwy. Mae o fewn y rhain ddiagram gyrru sy'n cynnwys y 4 elfen o ofal ar gyfer asesu a rheoli TIA. Disgwylir i Fyrddau lechyd gasglu'r data ac anelu at welliant parhaus fis ar ôl mis.</p> <p>Mae'r gyfran o gleifion TIA risg uchel a reolir yn briodol yn feddygol ac yn llawfeddygol yn y fframwaith canlyniadau a gyhoeddir gyda'r cynllun cyflawni.</p> <p>Mae holl gynlluniau gweithredu'r Byrddau lechyd yn crybwyll asesu a rheoli TIA.</p> <p>Yn ogystal, mae Coleg Brenhinol y Ffisigwyr bellach wedi lansio'r Rhaglen Archwiliad Strôc Genedlaethol (SSNAP) ac rydym yn ei gyflwyno'n raddol. Nid yw'r archwiliad yn cynnwys adran ar reoli TIA ond bydd yr RCP yn cyflawni rhywfaint o archwiliadau penodol ychwanegol a bydd TIA yn un o'r rhain. Byddwn yn sicrhau bod yr archwiliadau penodol hyn hefyd yn cael eu gwneud ar safleoedd yng Nghymru.</p> <p>Mae Bwrdd lechyd Aneurin Bevan yn asesu'r mwyafrif o gleifion TIA risg uchel o fewn 24 awr a'r rheini sydd angen sgan Doppler ar yr un diwrnod. Asesir pob claf risg isel o fewn 7 diwrnod.</p> <p>Mae gan Fwrdd lechyd Hywel Dda wasanaethau ym mhob un o'i ysbytai i wasanaethau a atgyfeirir gyda TIA. Mae asesiad a thriniaeth gychwynnol ar gyfer TIA ar gael bob</p>

	<p>achosion brys o fewn saith diwrnod ac mewn achosion eraill, o fewn 14 diwrnod i'r symptomau ddechrau.</p> <ul style="list-style-type: none"> • Ysgrifennodd Dr Chris Jones, Cyfarwyddwr Meddygol GIG Cymru, at y Byrddau Iechyd ym mis Mehefin 2011 yn gofyn am sicrwydd eu bod yn mynd i'r afael â chanfyddiadau adroddiad archwilio RCS ym maes endarterectomi carotid ac yn sicrhau bod y llawdriniaeth hon ar gael yn haws fel rhan o'u gwaith parhaus i wella gwasanaethau strôc. Disgwyliaf i'r rownd nesaf o archwiliadau clinigol ddangos gwelliant sylweddol. 	<p>dydd drwy eu hadrannau brys. Mae "clinigau poeth" TIA i'r cleifion sydd mewn mwyaf o risg wedi eu datblygu'n helaeth yn Sir Gaerfyrddin a blaenoriaeth allweddol o fewn eu cynllun datblygu lleol yw gwella gwasanaethau TIA drwy'r Bwrdd Iechyd, yn enwedig gwneud archwiliadau carotid yn fwy hygrych. Maent yn gweithio'n agos hefyd gyda'u Bwrdd Iechyd cyfagos, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg, trwy'r rhwydwaith fasgwlaidd fel bod llawdriniaeth carotid ar gael yn fwy amserol.</p> <p>Rydym yn siomedig mai ychydig o welliant sydd wedi bod yng nghyfraddau cyfranogi Cymru yn yr archwiliad SSNAP ac er bod rhywfaint o welliant wedi bod tuag at gydymffurfio â'r gofyniad i gyflawni llawdriniaeth o fewn 14 diwrnod o symptomau (7 diwrnod mewn achosion brys), rydym yn dal i fod yn gyffredinol ar ôl gwledydd eraill yn y DU. Bydd Dr Chris Jones, y Dirprwy Brif Swyddog Meddygol, yn codi'r mater hwn gyda Byrddau Iechyd Lleol.</p>
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Argymhellion	Ymateb Llywodraeth Cymru	Cynnydd
<p>Argymhelliad 4. Rydym yn argymhell bod Llywodraeth Cymru yn sicrhau ei bod yn arfer safonol mesur pwls cleifion sy'n ymweld â lleoliad gofal cychwynnol os daw ffactorau risg cysylltiedig â strôc i'r amlwg. Os oes angen unrhyw driniaeth yn dilyn hynny, dylai'r driniaeth gydymffurfio â chanllawiau NICE, ac mae angen i Lywodraeth Cymru gymryd camau ychwanegol i sicrhau bod hyn yn digwydd. Dylid monitro i ba raddau mae'r canllawiau'n cael eu dilyn drwy ddefnyddio archwiliadau lechyd Cyhoeddus Cymru o ddata cofnodion gofal cychwynnol. (Tudalen 31)</p>	<p>Derbyn mewn egwyddor.</p> <ul style="list-style-type: none"> • Mae canllawiau NICE yn argymhell y dylid mesur pwls cleifion sydd â symptomau diffyg anadl neu dyspnoea, crychguriadau, llesmair neu bendro, anesmwythder yn y frest neu strôc/TIA. • Ar hyn o bryd, nid yw polisi Pwyllgor Sgrinio Cenedlaethol y DU (UK NSC) yn argymhell y dylid sgrinio ar gyfer ffibriliad atrïaidd. Mae'r argymhelliad hwn yn destun adolygiad ar hyn o bryd a ddylai ddod i ben erbyn mis Mawrth 2012. Bydd swyddogion ac arbenigwyr sgrinio yn ystyried argymhellion adolygiad UK NSC a'r goblygiadau i Gymru pan fyddant ar gael. • Mae Llywodraeth Cymru yn disgwyl i bob clinigwr ystyried canllawiau o'r fath er mwyn gwneud penderfyniadau clinigol priodol wrth asesu a rheoli cyflyrau o'r fath. • Mae'r Byrddau lechyd yn cynnal digwyddiadau Datblygiad Proffesiynol Parhaus rheolaidd i sicrhau bod canllawiau o'r fath yn cael eu cynnwys mewn arfer lleol. • Mae ymarferwyr hefyd yn cynnal arfarniad blynyddol i adolygu anghenion dysgu a nodir a gweithgareddau addysgol a gynhelir, er 	<p>Mae'r Cynllun Cyflawni ar gyfer gwasanaethau strôc yn ei gwneud hi'n ofynnol i Fyrddau lechyd weithredu canllawiau NICE sy'n ymwneud â strôc a sicrhau trwy archwilio fod gwasanaethau'n cael eu cyflawni'n unol â'r canllawiau.</p> <p>Bydd y rhaglen Ffibriliad Atrïaidd 1000 o Fywydau yn edrych ar ffyrdd o gyflwyno dull sgrinio tebyg i GRASP-AF (dull haenau risg) i'r rheini sy'n adnabyddus eisoes i feddygon teulu fel rhai â Ffibriliad Atrïaidd. Mae Pwyllgor Sgrinio Cenedlaethol (NSC) y DU wedi amcangyfrif y cwblheir yr adolygiad o sgrinio Ffibriliad Atrïaidd ym mis Tachwedd 2013. Cynhelir cyfarfod o NSC y DU ym mis Tachwedd; bydd swyddogion yn ceisio cael diweddariad ar gynnydd yn y cyfarfod hwnnw.</p> <p>Ym mis Mai 2013 cyflwynwyd ymgyrch genedlaethol ymwybyddiaeth strôc drwy'r 712 o fferyllfeydd cymunedol yng Nghymru. Cefnogwyd yr ymgyrch gan y Gymdeithas Stôc, Byrddau lechyd a Fferylliaeth Gymunedol Cymru ac fe'i cydgysylltwyd gan lechyd Cyhoeddus Cymru.</p> <p>Yn ystod yr ymgyrch roedd fferyllfeydd yn darparu cyngor ar fesurau ffordd o fyw a allai leihau'r risg o</p>

	<p>mwyn datblygu sgiliau a gwybodaeth briodol. Bydd trafodaethau arfarnu yn cyfeirio at archwiliadau a gynhaliwyd o fewn y feddygfa, a allai gynnwys y defnydd o becyn cymorth lechyd Cyhoeddus Cymru.</p> <ul style="list-style-type: none"> • Rydym wedi derbyn mewn egwyddor er nad ydym yn derbyn yr argymhelliad y dylid monitro cydymffurfiaeth drwy ddefnyddio archwiliadau lechyd Cyhoeddus Cymru o ddata cofnodion gofal sylfaenol. Mae'r archwiliadau hyn yn canolbwyntio ar wella ansawdd, nid monitro penderfyniadau clinigol. 	<p>gael strôc ac yn cynnig ymgynghoriadau adolygiad o'r defnydd o feddyginiaethau i bobl a oedd yn cymryd meddyginiaeth at bwysedd gwaed uchel neu feddyginiaeth gwrthgeulo trwy'r geg i leihau eu risg o strôc. Roedd yr ymgynghoriad hwn yn rhoi cyfle i wella dealltwriaeth a defnydd cleifion unigolion o feddyginiaethau ac yn cadarnhau pwysigrwydd glynu at feddyginiaethau fel ffordd y gellid lleihau eu risg o gael strôc. Roedd fferyllwyr yn cael eu hannog i flaenoriaethu cleifion a oedd yn cymryd meddyginiaeth at bwysedd gwaed uchel neu feddyginiaeth gwrthgeulo trwy'r geg ar gyfer ymgynghoriadau adolygu defnydd o feddyginiaethau yn ystod cyfnod yr ymgyrch.</p> <p>Yn ystod cyfnod yr ymgyrch cyflawnwyd 10,059 o ymgynghoriadau adolygu'r defnydd o feddyginiaethau gyda phobl yr oedd eu meddyginiaeth yn dangos eu bod mewn risg uwch o strôc.</p>
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Argymhellion	Ymateb Llywodraeth Cymru	Cynnydd
<p>Argymhelliad 5. Rydym yn argymhell bod Llywodraeth Cymru yn datblygu arweiniad clir ar gyfer timau gofal cychwynnol a thimau adnoddau cymunedol o ran gwneud diagnosis o ffibriliad atrïaidd a thrin a rheoli'r cyflwr a'i bod yn cynnig diffiniad clir o gyfrifoldebau proffesiynol ym mhob maes. (Tudalen 42)</p>	<p>Derbyn mewn egwyddor.</p> <ul style="list-style-type: none"> • Mae canllawiau eisoes ar gael. Mae canllawiau NICE ar nodi achosion o ffibriliad atrïaidd a'u rheoli ar gael i bob aelod o staff clinigol a lluniwyd canllaw i gleifion hefyd. • Fel rhan o 1000 o Fywydau a Mwy, mae'r Gwasanaeth Ansawdd a Gwybodaeth Gofal Sylfaenol wedi llunio canllaw i helpu meddygfeydd i reoli ffibriliad atrïaidd mewn modd amserol. • Bydd y Cynllun Cyflawni Cenedlaethol ar gyfer Strôc hefyd yn nodi'n glir yr hyn a ddisgwylir wrth ddarparu gwasanaethau strôc. • Ar hyn o bryd, nid yw polisi Pwyllgor Sgrinio Cenedlaethol y DU (UK NSC) yn argymhell y dylid sgrinio ar gyfer ffibriliad atrïaidd. Mae'r argymhelliad hwn yn destun adolygiad ar hyn o bryd a ddylai ddod i ben erbyn mis Mawrth 2012. Bydd swyddogion ac arbenigwyr sgrinio yn ystyried argymhellion adolygiad UK NSC a'r goblygiadau i Gymru pan fyddant ar gael. • Bydd cyfrifoldebau proffesiynol yn dibynnu ar sgiliau a gwybodaeth aelodau'r tîm, strwythur y tîm a threfniadau llwybr lleol. Er enghraifft, meddygon teulu sy'n cyfrifol am nodi a 	<p>Fe wnaeth 1000 o Fywydau a Mwy/lechyd Cyhoeddus Cymru gyhoeddi'r Canllawiau Gwella Cyflym Gofal Sylfaenol Ffibriliad Atrïaidd ym mis Mehefin 2013.</p> <p>Mae'r dull rhagfynegi clinigol "CHADsVASC" ar gyfer risg strôc i gleifion â ffibriliad atrïaidd bellach ar gael i benderfynu'r angen am wrthblatennau neu wrthgeulyddion a bydd yn dilyn ymlaen o'r rhaglen 1000 o Fywydau fel y bydd yn cael ei ddefnyddio i benderfynu ar y rheolaeth broffylactig gywir.</p> <p>Bydd cyflwyno gwrgelyddion mwy newydd trwy'r geg hefyd yn cyfrannu at wella gofal cleifion ffibriliad atrïaidd.</p>

	<p>diagnosio achosion o ffibriliad atriaidd i gychwyn, a chaiff cleifion sydd newydd gael diagnosis eu hatgyfeirio am ecocardiograffi a bydd cardiolegwyr yn helpu i reoli cleifion.</p>	
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Cynnig	Ymateb Llywodraeth Cymru	Cynnydd
<p>Cynnig 1: Dylai Llywodraeth Cymru ystyried y prinder meddygon strôc hyfforddedig drwy ddefnyddio cynlluniau gweithlu effeithiol. (Tudalen 19)</p>	<ul style="list-style-type: none"> • Yng Nghymru, caiff bron yr holl wasanaethau gofal ac adsefydlu aciwt o ran strôc eu darparu gan geriatregwyr isarbenigol sydd â chyfrifoldebau meddygol ychwanegol. • Mae Cymru wedi cytuno ar y swydd hyfforddi benodedig gyntaf ar gyfer strôc, sydd wedi'i hysbysebu'n genedlaethol fel blwyddyn ychwanegol o hyfforddiant mewn meddygaeth strôc. • Hefyd, mae meddygon gofal strôc penodedig wedi'u penodi mewn rhai unedau sydd â mynediad i hyfforddiant strôc arbenigol i ôl-raddedigion. • Caiff yr angen am feddygon strôc yn y dyfodol ei ddiwallu drwy'r cynlluniau gweithlu ar gyfer staff meddygol. 	<p>Mae datblygiadau wedi bod mewn lefelau staffio meddygol yng Nghymru. Fe wnaeth y Cofrestrwydd Arbenigol (StR) cyntaf mewn strôc a oedd yn cyflawni swydd hyfforddi un flwyddyn yn arwain at Dystysgrif Cwblhau Hyfforddiant Arbenigol (CCST) mewn meddygaeth strôc gwblhau ei flwyddyn yng Nghaerdydd a'r Fro ym mis Awst 2013 ac mae'n disgwyl i ymgeisio am y swydd yn Nhreforys. Bydd yn gymwys i ymgeisio o gwmpas mis Rhagfyr eleni neu ar ôl hynny.</p> <p>Ers mis Awst 2013, mae gennym bellach 4 o swyddi hyfforddi StR yng Nghymru, a'r rheini ym Myrddau Iechyd Caerdydd a'r Fro, Aneurin Bevan, Abertawe Bro Morgannwg a Phrifysgol Betsi Cadwaladr.</p> <p>Yn ogystal, mae gennym bellach 2 ymgynghorydd strôc llawn amser yn eu swyddi yng Nghaerdydd a'r Fro ac yn Aneurin Bevan sydd wedi cyflawni swyddi hyfforddiant yn Llundain ac Aberdeen ac sydd â CCST mewn strôc. Mae 2 ymgynghorydd arall wedi cael eu penodi ym Mwrdd Iechyd Betsi Cadwaladr (yn Wrecsam a Bangor) a bydd strôc yn rhan o gynlluniau swydd y ddau hyn.</p> <p>Mae StR Gofal yr Henoed arall ym Mwrdd Iechyd Betswi Cadwaladr eisoes wedi cyflawni swydd hyfforddiant mewn strôc yn Lloegr.</p>

<p>Cynnig 2: Bod Llywodraeth Cymru yn ystyried arfer gorau wrth sicrhau bod Byrddau Iechyd Lleol yn cynnig arweinyddiaeth ym maes strôc ac yncyflwyno canllawiau arfer da y dylai pob Bwrdd Iechyd Lleol lynu wrthynt. (Tudalen 21)</p> <p>Cynnig 3: Bod Llywodraeth Cymru yn ystyried sefydlu Cydrwydweithiau'r Galon a Strôc ledled Cymru. (Tudalen 21)</p>	<ul style="list-style-type: none"> • Mae Llywodraeth Cymru wedi gweld bod lle i gryfhau gwasanaethau presennol i atal clefyd cardiofasgwlaidd, sy'n cynnwys strôc a chlefyd y galon. Rydym wedi gofyn i Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru weithio ar draws Cymru i helpu Byrddau Iechyd i ddatblygu dull mwy systematig a chydgyssylltiedig o nodi'r rhai sydd â risg o ddatblygu clefyd cardiofasgwlaidd a rheoli'r risg honno'n effeithiol. Caiff y gwaith hwn ei adlewyrchu yn y Cynllun Cyflawni Cenedlaethol ar gyfer Strôc. • Mae Cyfarwyddwr Meddygol y GIG wedi penderfynu'n ddiweddar i gydnabod Cynghrair Strôc Cymru fel Grŵp Cynghori Arbenigol Cenedlaethol ffurfiol, a fydd yn gyfrifol am ddarparu arweinyddiaeth a chyngor clinigol amlddisgyblaethol ledled Cymru. Bydd y Grŵp Cynghori Arbenigol hwn yn rhan o'r Grŵp sy'n arwain ac yn goruchwyllo ymdrechion y Byrddau Iechyd i wella gwasanaethau strôc ledled Cymru, gan gynnwys gwasanaethau i atal strôc. Bydd y Bwrdd Cyflawni Cenedlaethol ar gyfer Strôc yn awyddus i gael arweinwyr clinigol 	<p>Mae Adam Cairns, Prif Weithredwr Bwrdd Iechyd Prifysgol Caerdydd a'r Fro wedi cael ei benodi fel y Prif Weithredwr Arweiniol ar gyfer Strôc a Chadeirydd y Grŵp Cyflawni ar gyfer Strôc.</p> <p>Rydym wrthi ar hyn o bryd yn adolygu'r trefniadau ar gyfer arweinyddiaeth glinigol gwasanaethau strôc yng Nghymru a byddwn yn ystyried yr angen am Rwydwaith Strôc fel rhan o'r gwaith hwn.</p>
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	<p>cryfach er mwyn sicrhau y caiff y disgwyliadau mewn perthynas â gwasanaethau strôc eu bodloni.</p> <ul style="list-style-type: none"> • Yn lleol, mater i'r Byrddau lechyd yw sicrhau bod ganddynt arweinyddiaeth glinigol effeithiol a strwythurau i gydweithio â Byrddau lechyd eraill i gynllunio a darparu gofal strôc effeithiol, megis Rhwydweithiau. Fodd bynnag, mae gan bob Bwrdd lechyd arweinydd gweithredol sy'n gyfrifol am strôc, arweinydd clinigol ar gyfer strôc a Bwrdd Cyflawni ar gyfer Strôc eisoes. • Mae canllawiau arfer da ar gael eisoes drwy Ganllawiau Clinigol Cenedlaethol RCP ar gyfer Strôc a chanllawiau NICE. 	
<p>Cynnig 4: Bod Llywodraeth Cymru yn sicrhau bod y Cynllun Cyflawni Cenedlaethol ar gyfer Strôc yn cynnwys yr holl elfennau sydd ynghlwm wrth ofal strôc, o leihau risg i adsefydlu ac ailalluogi cleifion. (Tudalen 25)</p>	<p>Bydd y Cynllun Cyflawni Cenedlaethol ar gyfer Strôc yn cynnwys yr holl elfennau sydd ynghlwm wrth ofal strôc gan gynnwys atal, diagnosis, trin, adsefydlu a bywyd ar ôl strôc.</p>	<p>Bydd y themâu cyflawni o fewn y Cynllun Cyflawni ar gyfer Strôc yn cynnwys y llwybr gofal cyfan sydd ynglŷn â strôc, o atal at fywyd ar ôl strôc.</p>
<p>Cynnig 5: Bod Llywodraeth Cymru yn sicrhau bod awdurdodau lleol yn cael eu cynnwys yn y gwaith o ddatblygu a chyflwyno'r Cynllun Cyflawni Cenedlaethol ar gyfer Strôc. (Tudalen 25)</p>	<p>Mae awdurdodau lleol yn bartneriaid allweddol i'r Byrddau lechyd o ran sicrhau bod pobl sydd wedi cael strôc yn cael gofal effeithiol. Felly, ymgynghorir ag awdurdodau lleol fel rhan o'r broses o ddatblygu Cynllun Cyflawni'r GIG ar gyfer Strôc.</p>	<p>Rhodddwyd cyfle i awdurdodau lleol roi sylwadau ar y cynllun cyflawni ar gyfer strôc yn ystod yr ymgynghori ac fe'u cynrychiolir ar y Grŵp Cyflawni ar gyfer Strôc.</p>
<p>Cynnig 6: Bod Llywodraeth Cymru yn ystyried ffyrdd newydd o</p>	<p>Mae canllawiau NICE yn allweddol er mwyn darparu gofal clinigol.</p>	<p>Mae gwaith yn parhau ar ddatblygu cynlluniau gofal personol gyda phwyslais ar</p>

<p>sicrhau bod meddygon teulu'n cydymffurfio â chanllawiau NICE, a bod cleifion yn cael y wybodaeth i ganiatáu iddynt wneud penderfyniad deallus. Dylid monitro i ba raddau y maent yn cydymffurfio drwy ddefnyddio archwiliadau lechyd Cyhoeddus Cymru o ddata cofnodion gofal cychwynol. (Tudalen 34)</p>	<p>Mae'r Byrddau lechyd yn gyfrifol am sicrhau y caiff canllawiau o'r fath eu defnyddio'n briodol. Fodd bynnag, nid yw canllawiau yn disodli cyfrifoldeb clinigol; felly, ni fyddai'n briodol i geisio monitro 'cydymffurfiaeth'.</p> <p>Mae'n bwysig bod cleifion yn cael gwybodaeth dda drwy ddulliau priodol fel y gallant gyfrannu mewn modd deallus i benderfyniadau am eu cynlluniau triniaeth eu hunain. Croesewid camau i wneud penderfyniadau ar y cyd.</p> <p>Mae data'r QOF yn rhoi gwybodaeth i feddygfeydd unigol fel y gallant asesu a gwella eu perfformiad eu hunain. Mae'r Byrddau lechyd yn cael data cymharol i'w helpu i gynnal adolygiadau cymheiriaid lleol a datrys unrhyw bryderon ynghylch perfformiad. Mae lechyd Cyhoeddus Cymru yn cefnogi gwaith dadansoddi o'r fath drwy ddarparu pecynnau cymorth ar gyfer archwiliadau.</p>	<p>gleifion yn gallu cyfrannu mewn modd deallus at y dewisiadau a'r penderfyniadau.</p> <p>Mae Byrddau lechyd yn parhau i fonitro data rhagnodi er mwyn dadansoddi'r nifer sy'n cymryd amrywiaeth o ddewisiadau therepiwtig. Bydd y gwaith hwn yn cael ei symud ymlaen trwy'r Grŵp Cyflawni ar gyfer Strôc.</p>
<p>Cynnig 7: Bod Llywodraeth Cymru yn ystyried cefnogi'r cynigion i newid dangosyddion y QOF sy'n ymwneud â ffibriliad atrïaidd, a sicrhau bod dangosyddion y QOF yn gwahaniaethu rhwng darparu triniaeth gwrthgeulo a thriniaeth gwrthblatennau i gleifion ffibriliad atrïaidd. (Tudalen 35)</p>	<p>Byddwn yn ystyried y cyngor a roddwyd gan NICE ar gyfer unrhyw newid arfaethedig i'r QOF. Penderfyniad clinigol yw dewis rhwng triniaethau gwrthblatennau a gwrthgeulo - rydym am i gleifion gael dewis yn y mater hwn gyda chymorth trafodaeth ar y dystiolaeth briodol, gan gynnwys risgiau a manteision y ddwy driniaeth.</p>	<p>Nid oes unrhyw gynlluniau gan NICE ar hyn o bryd i ddiwygio dangosyddion perthynasol y QOF.</p> <p>Mae canllawiau'r QOF yn defnyddio'r system haenu risg CHADS 2 i arwain y cynnig o ddewisiadau triniaeth – mae hyn yn unol â Chanllawiau'r Gymdeithas Gardioleg Ewropeaidd.</p>
<p>Cynnig 8: Bod Llywodraeth Cymru yn ystyried cefnogi'r syniad o gyflwyno a defnyddio</p>	<p>O fis Ebrill 2012, bydd newidiadau i'r Fframwaith Ansawdd a Chanlyniadau yn cynnwys dangosydd</p>	<p>Mae Gwasanaeth Ansawdd a Gwybodaeth Gofal Sylfaenol lechyd Cyhoeddus Cymru wedi</p>

<p>system GRASP-AF mewn meddygfeydd. (Tudalen 37)</p>	<p>newydd i sicrhau bod pob claf sydd ar Gofrestr Ffibriliad Atriaidd yn cael asesiad rheolaidd gan ddefnyddio system sgorio haeniad risg ffurfiol. Gellir gwneud hyn drwy chwiliad cyfrifiadurol (fel yn achos system GRASP-AF) neu drwy adolygu'r cofnod clinigol ar bapur. Bydd disgwyl i'r Byrddau Iechyd drafod â meddygfeydd y prosesau sydd ar waith i wneud y cyfrifiadau hyn a rhannu'r wybodaeth â chleifion er mwyn eu helpu i wneud penderfyniadau ar sut i reoli eu cyflwr yn y dyfodol.</p>	<p>cynhyrchu pecyn cymorth i helpu practisau unigol i adolygu'r ffordd y maent yn cyflwyno gofal ffibriliad atriaidd er mwyn hyrwyddo gwelliant mewn ansawdd. Mae'r gwaith hwn yn cynnwys defnyddio data lleol atodol.</p> <p>Mae'r Rhaglen 1000 o Fywydau newydd yn defnyddio fersiwn Cymreig o GRAPS-AF i'r rheini y gwyddys eu bod yn dioddef o ffibriliad atriaidd.</p>
<p>Cynnig 9: Bod Llywodraeth Cymru yn ystyried system werthuso systematig ar gyfer pob ymgyrch hybu iechyd y bydd yn ei hariannu'n rhannol, neu'n llawn, a'i bod yn bwydo'r casgliadau'n uniongyrchol i'r gwaith o gynllunio a datblygu ymgyrchoedd yn y dyfodol. Dylid rhannu'r wybodaeth â phartneriaid er mwyn rhannu arfer da a gwersi a ddysgir. (Tudalen 39)</p>	<p>Mae Llywodraeth Cymru yn cydnabod ei bod yn bwysig gwerthuso ymgyrchoedd hybu iechyd yn effeithiol, er mwyn sicrhau gwerth am arian a mesur effeithiolrwydd yr ymgyrchoedd. Mae gwaith gwerthuso o'r fath hefyd yn allweddol o ran llywio cynlluniau ar gyfer ymgyrchoedd yn y dyfodol a'u cynnwys. Mae'r egwyddorion hyn yn elfen bwysig o'r gwaith o gynllunio pob ymgyrch gwella iechyd a ariennir yn llawn neu'n rhannol gan Lywodraeth Cymru.</p> <p>Caiff y pwys a roddir ar werthuso ei adlewyrchu yn yr ymgyrchoedd gwella iechyd cyfredol canlynol:</p> <p><i>i) Ymgyrch i godi ymwybyddiaeth o beryglon ysmegu mewn ceir gyda phlant</i></p> <p>Mae gwerthusiadau o ymgyrchoedd torfol blaenorol i roi'r gorau i ysmegu wedi dangos y gallant gael amrywiaeth o effeithiau cadarnhaol, a all</p>	<p>Mae gwerthuso'n dal i ffurfio elfen bwysig o ymgyrchoedd gwella iechyd a ariennir yn llawn neu'n rhannol gan Lywodraeth Cymru. Cydnabyddwn bwysigrwydd gwerthuso trylwyr wrth alluogi i lwyddiant gael ei fesur yn briodol, ac er mwyn darparu tystiolaeth werthfawr fel gwybodaeth ar gyfer ymgyrchoedd yn y dyfodol.</p> <p>Gellir darlunio dull Llywodraeth Cymru o werthuso trwy gyfeirio at nifer o ymgyrchoedd cyfredol:</p> <p>Mae ymgyrch Cychwyn Iach Cymru i dynnu sylw at beryglon ysmegu mewn ceir lle mae plant yn cael ei gwerthuso ar hyn o bryd. Mae'r gwaith wedi cynnwys comisiynu Arolygon Omnibws i fonitro ymwybyddiaeth o'r ymgyrchu, yn ogystal â chomisiynu Prifysgol Caerdydd i gynnal astudiaeth o'r graddau y</p>

	<p>gyfrannu at leihad cyffredinol yn y defnydd o dybaco a chynnydd yn nifer y bobl sy'n rhoi'r gorau i ysmegu. Fel rhan o'r ymgyrch newydd i godi ymwybyddiaeth o beryglon ysmegu mewn ceir gyda phlant, comisiynwyd arolwg omnibws i bennu faint o wybodaeth sydd ar gael ar hyn o bryd am ysmegu mewn ceir ac agweddau at hynny. Ailadroddir yr Arolwg ddwywaith y flwyddyn dros y tair blynedd nesaf. Caiff data sydd eisoes yn bodoli ei ddadansoddi hefyd a gwneir rhagor o waith ymchwil i gynnal arolwg ymhlith plant oed ysgol er mwyn amcangyfrif i ba raddau y maent yn dod i gysylltiad â mwg ail-law mewn ceir. Ar y cyd, bydd y camau hyn yn helpu Llywodraeth Cymru i asesu pa mor llwyddiannus fu'r ymgyrch o ran lleihau'r graddau y mae plant yn dod i gysylltiad â mwg mewn ceir.</p> <p><i>ii) Newid am Oes</i> Mae <i>Newid am Oes</i> yn rhan o ymateb ehangach Llywodraeth Cymru i helpu pobl Cymru i sicrhau pwysau corff iach a chynnal y pwysau hwnnw; bwyta'n iach, symud mwy a byw bywydau hwy. Mae'r ymgyrch yng Nghymru yn adeiladu ar ddatblygiadau yn Lloegr, ac mae'r dull gwerthuso yng Nghymru yn defnyddio'r hyn a ddysgwyd o fuddsoddiad sylweddol Lloegr mewn gwaith i werthuso a monitro'r ymgyrch. Mae hyn yn cynnwys monitro nifer yr ymweliadau â'r</p>	<p>mae plant oedran ysgol gynradd yn agored i fwg ail law mewn ceir ac mewn mannau eraill. Defnyddir tystiolaeth a gesglir trwy waith gwerthuso ac unrhyw ymchwil cysylltiedig wrth lywio'r ymgyrch a'n cyfeiriad polisi – ac mae hyn yn digwydd yn barhaus.</p> <p>Mae <i>Newid am Oes Cymru</i> yn parhau i ddilyn y rhaglen a ddefnyddir yn Lloegr ac mae wedi ehangu i feysydd newydd yn ddiweddar (megis alcohol a halen). Rydym yn parhau i ddefnyddio'r hyn a ddysgir o weithgareddau gwerthuso ac ymchwil Lloegr, ac i gasglu gwybodaeth sy'n seiliedig ar nifer o ddangosyddion gan gynnwys cofrestriadau ac ymweliadau ar y we. Yn ogystal, ail-gysylltwyd yn 2012 â theuluoedd a ymunodd â'r rhaglen yn 2010, er mwyn asesu effaith ar y rhaglen ar yr ymddygiadau a adroddwyd am eu plant, a chynhwyswyd cwestiynau sy'n anelu at fesur ymwybyddiaeth o'r ymgyrch mewn Arolwg Omnibws Cymreig diweddar. Defnyddir yr wybodaeth a gesglir trwy'r gwaith hwn ar gyfer rheoli'r rhaglen yn barhaus.</p> <p>Yn ogystal ag mewn ymgyrchoedd gwella iechyd penodol, mae ystyriaethau gwerthuso'n cael eu hymgorffori hefyd mewn rhaglenni a mentrau newydd. Mae hyn yn ein galluogi ni i fonitro effeithiolrwydd nifer o ymyraethau. Er enghraifft, mae gwerthuso'n cael ei</p>
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	<p>wefan ac ystadegau iechyd, ac ym mis Ebrill 2012, bydd teuluoedd yng Nghymru sydd wedi bod yn rhan o'r rhaglen ers dros 12 mis yn cael yr un holiadur ffordd o fyw y gwnaethant ei gwblhau'n wreiddiol ar gyfer pob plentyn. Yna caiff y canlyniadau eu cymharu i weld a ydynt wedi newid eu hymddygiad o ran bwyta'n iach a gweithgarwch corfforol.</p>	<p>wau i mewn i ddatblygiad ein rhaglen gwiriadau iechyd ar gyfer pobl dros 50 oed yng Nghymru.</p> <p>Dros y flwyddyn ddiwethaf mae Iechyd Cyhoeddus Cymru wedi cynnal adolygiad o nifer o raglenni gwella iechyd, megis Dim Ysmygu Cymru a'r Cynllun Cenedlaethol i Atgyfeirio Cleifion i Wneud Ymarfer Corff, sy'n cyfrannu at leihau risg o strôc. Mae adroddiad yr adolygiad wedi cael ei gyhoeddi ac mae gwaith ar y gweill i ddatblygu cynllun gweithredu a fydd yn adeiladu ar argymhellion yr adroddiad.</p>
<p>Cynnig 10: Bod Llywodraeth Cymru yn ystyried y ffordd orau i'r rhaglenni hyfforddi a datblygu presennol ar gyfer gweithwyr gofal iechyd proffesiynol godi ymwybyddiaeth o ffibriliad atrïaidd ac ychwanegu at eu gwybodaeth am y cyflwr. (Tudalen 43)</p>	<p>Yn ei rôl fel y comisiynydd addysg anfeddygol, bydd yr Asiantaeth Genedlaethol Arwain ac Arloesi mewn Gofal Iechyd (NLIAH) yn ystyried cyfleoedd gyda darparwyr iechyd fel ateb hirdymor.</p> <p>Yn y tymor byr i'r tymor canolig, bydd y Byrddau Iechyd yn defnyddio'r broses Adolygu Datblygiad Personol i nodi anghenion datblygu staff mewn meysydd clinigol.</p> <p>Mae rhwydweithiau'r galon wedi cynnal digwyddiadau gyda'r Cynghrair Arhythmia a'r Cynghrair Ffibriliad Atrïaidd ar hyn. Gellid datblygu hyn ymhellach yn rhanbarthol i sicrhau y caiff mwy o feddygfeydd eu cynnwys.</p> <p>Bydd Llywodraeth Cymru yn parhau i feithrin cydberthnasau gyda'r Cynghrair Strôc/y Grŵp Cynghori Arbenigol Cenedlaethol i gefnogi</p>	<p>Mae Fforwm Hyfforddiant Strôc y DU wedi cynhyrchu Fframwaith Addysgol cynhwysfawr sy'n benodol ar gyfer Strôc (SSEF) er mwyn helpu atgyfnerthu'r gwaith o gyflwyno Strategaeth Strôc Lloegr. Mae is-grŵp Addysg Cynghrair Strôc Cymru wedi cael ei ailffurfio, ac maent yn ystyried sut y gellir cyflwyno Fframwaith Addysgol Penodol ar gyfer Strôc yng Nghymru a darparu'r hyfforddiant a'r addysg angenrheidiol ar gyfer yr elfennau angenrheidiol o hyn i Gymru.</p>

	ymwybyddiaeth, hyfforddiant a datblygiad.	
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Eitem 7a

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



Llywodraeth Cymru
Welsh Government

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

A handwritten signature in black ink, appearing to read 'David Rees'.

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

Eitem 7b



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Together for Health:
South Wales Programme
Law yn Llaw at Iechyd:
Rhaglen De Cymru

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

A handwritten signature in blue ink, appearing to read 'P. Hollard'.

Paul Hollard
Programme Director
South Wales Programme

Eitem 9

Mae cyfyngiadau ar y ddogfen hon