



Appendix 3 - Stroke Prevention

Version: 1

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Prevention of stroke

Background

The National Clinical Guideline for Stroke sets out what constitutes a good stroke service across the whole pathway, prevention is recognised as an important part of this pathway¹.

Prevention is the first step to improving care and outcomes for patients within BNSSG. Supporting people to live a healthy lifestyle and ensuring there is greater awareness of stroke and its symptoms will help to reduce the number of strokes.

Some causes of stroke are genetic, however up to 70% of strokes could be prevented by the detection and effective management of hypertension, atrial fibrillation, diabetes, weight management, cholesterol and lifestyle factors such as smoking, exercise and poor diet².

Deaths related to stroke have declined by 49% in the past 15 years.³ This has been accredited to a combination of better prevention, earlier treatment and more advanced treatment. Although this decline is a positive trend, stroke survivorship is creating significant challenges to the health and social care system, the economy, and for stroke survivors and their families and carers.

The BNSSG stroke programme continues to work closely with the Academic Health Science Network (AHSN) to develop and expand areas of opportunity to improve stroke prevention, as identified in NHS RightCare data.

With compelling evidence that lowering blood pressure reduces the risk of a stroke, there is a specific project being co-designed and developed linked to targeted blood pressure management through self monitoring, combined with a project linked to AF detection.

¹RCP, 2016 National clinical guideline for stroke Accessed: [https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-\(1\).aspx](https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx) National Clinical Guideline for Stroke

² <https://www.england.nhs.uk/ourwork/clinical-policy/stroke/>

³ BMJ, 2019 Determinants of the decline in mortality from acute stroke in England: linked national database study of 795 869 adults

Population Changes

The case for change highlights the increasing stroke incidence and prevalence. The following section explores this in more detail and highlights the specific predicted increases across BNSSG.

The Stroke Association in 2015 looked into the future burden of stroke for the UK⁴. Expert consensus was sought on stroke incidence and prevalence in the years 2025 and 2035.

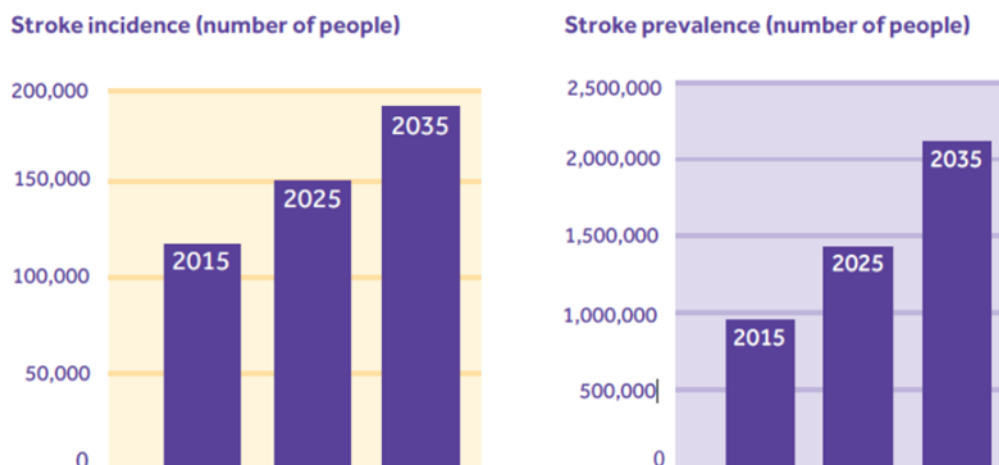
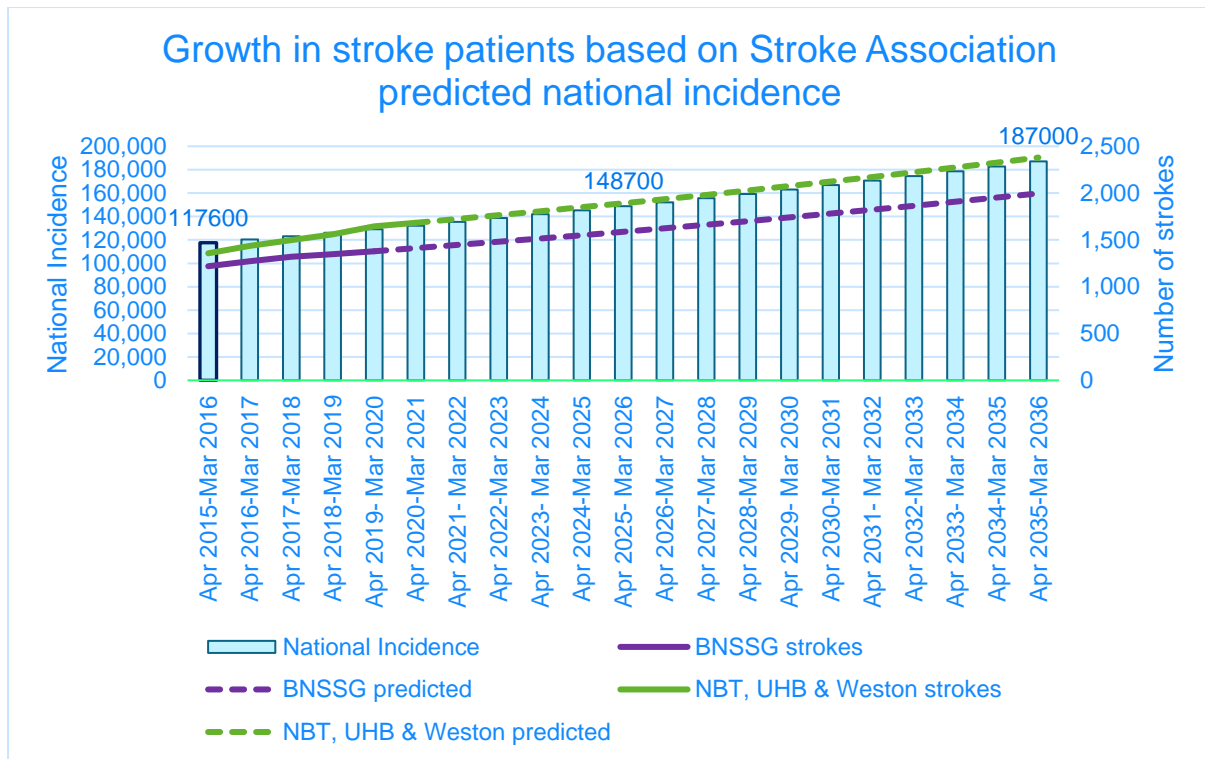


Figure 1 - Stroke Incidence & prevalence, now and in the future

	2015	2025	2035
Incidence	117600	148700	187000
Increase of 59% over 20 years			
First-time strokes among people aged 45 and over in the UK will rise from 117,600 in 2015 to 148,700 in 2025 and 187,000 in 2035.			
Prevalence	950200	1425000	2120000
Increase of 123% over 20 years			
This is based on the assumption that prevalence rates will rise by 1% per year for those aged 45 to 64, 1.5% per year for those aged 65 to 74, 2.0% per year (2.5% after 2025) for those aged 75 to 84 and 2.5% per year (3.0% after 2025) for those aged 85 and over.			

⁴ https://www.stroke.org.uk/sites/default/files/costs_of_stroke_in_the_uk_report_-_executive_summary_part_1_v2.pdf

The following graph applies the predicted overall increase in stroke incidence set out above to the situation in BNSSG. The graph shows both the number of strokes predicted in BNSSG, and those predicted to be treated in BNSSG hospitals (which is a higher number due to out of area patients):



Data table:

	2015/16	2016/17	2017/18	2018/19	2019/20	2025/26	2035/36
BNSSG strokes	1,219	1,272	1,320	1,347		1,587	1,996
NBT, UHB & Weston strokes	1,357	1,437	1,498	1,561	1,644	1,893	2,380
National Incidence	117,600					148,700	187,000
Compound growth rate						26.45%	25.76%
Annual growth rate						2.37%	2.32%

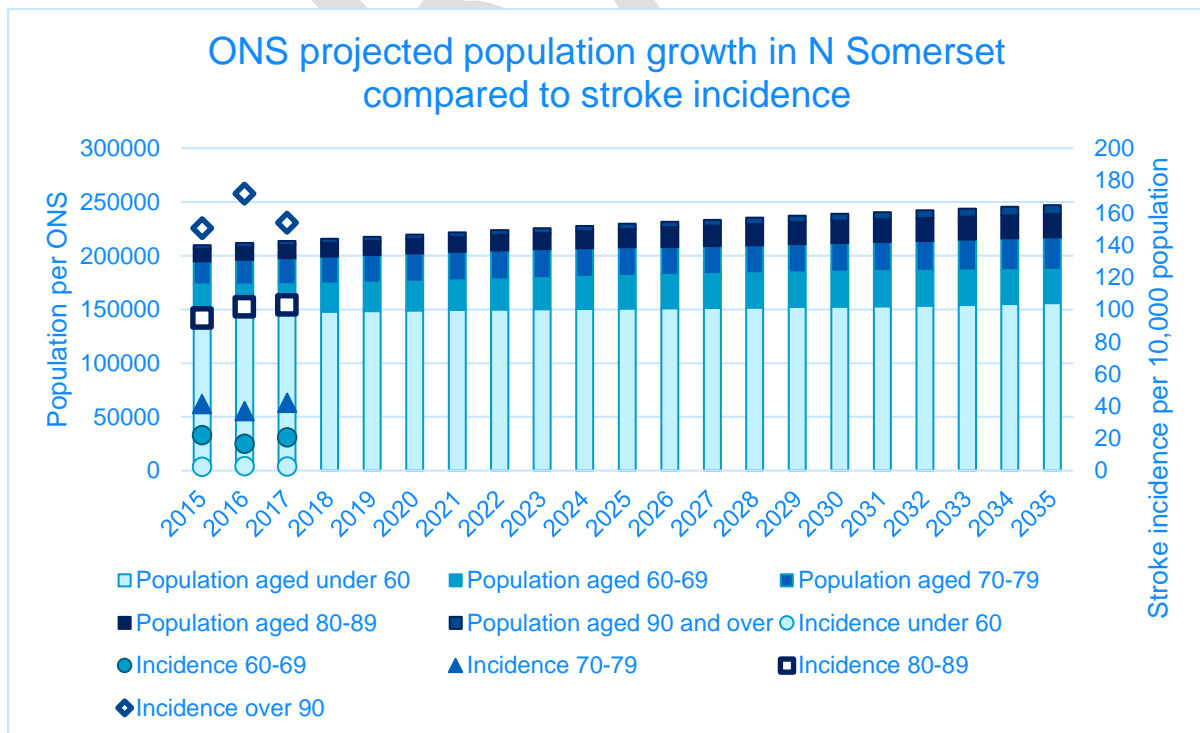
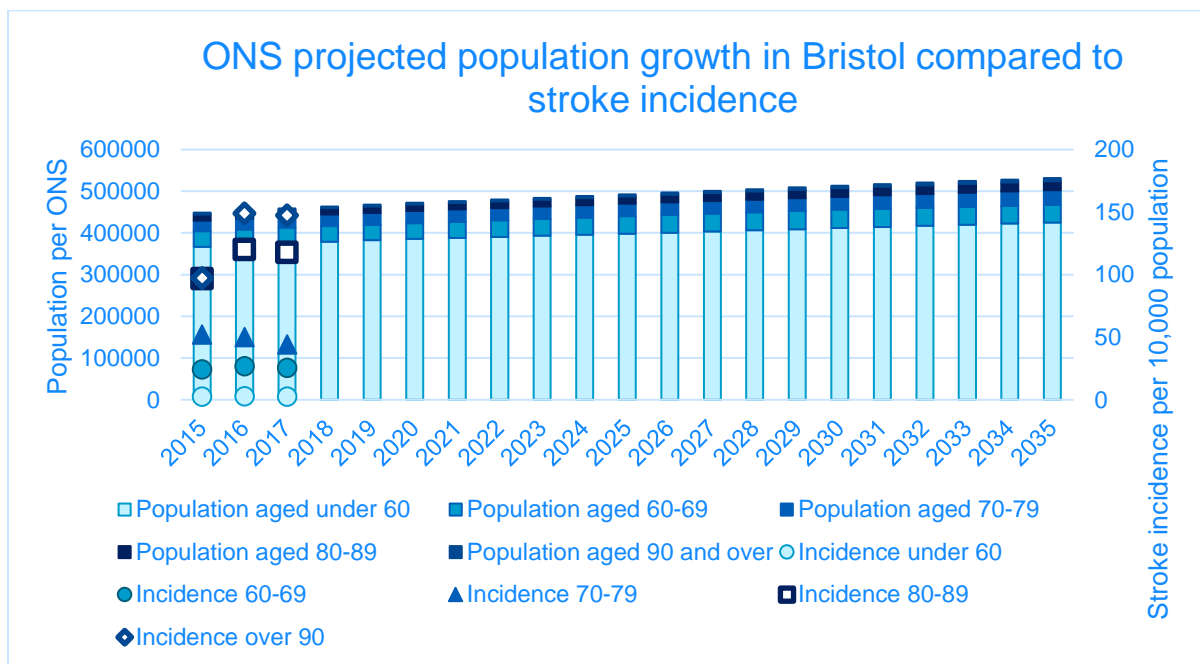
Data source:

Number of strokes: SSNAP; Stroke Incidence: Stroke Association; Growth rates - calculated

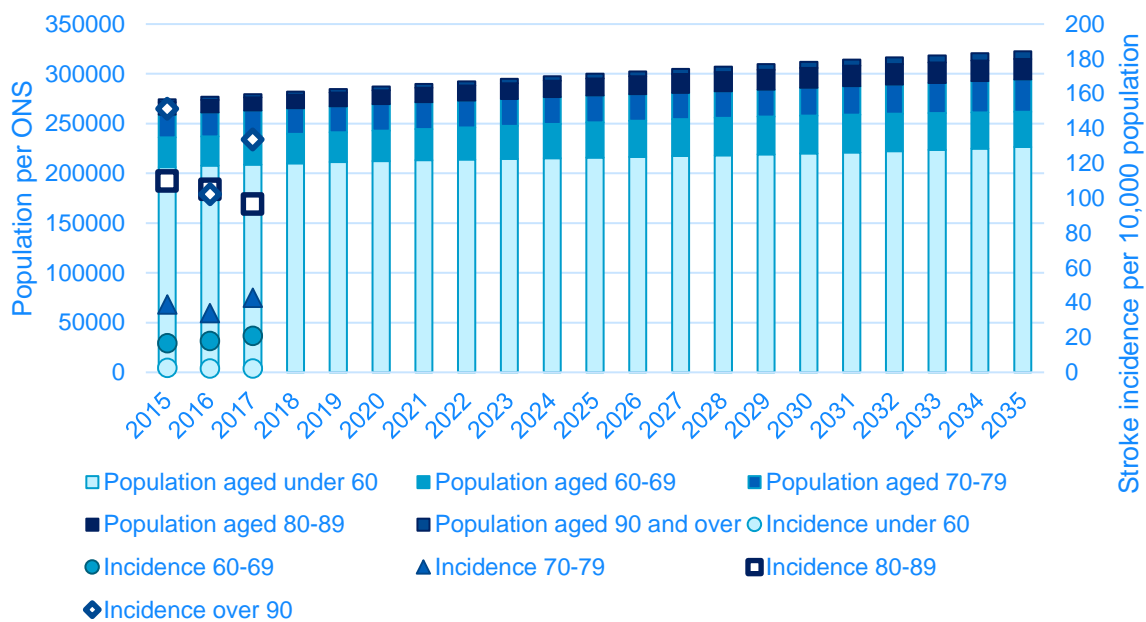
The Stroke Association report also predicts that incidence rates will stay the same up to 2035 for those aged 45 to 84, and rise by 0.5% per year for those aged 85 and over.

BNSSG population and stroke incidence data is available split by age and locality for 2015 to 2017 (2015/16 to 2017/18). This data has been used to calculate local incidence rates. The following charts compare projected locality population growth by age to incidence.

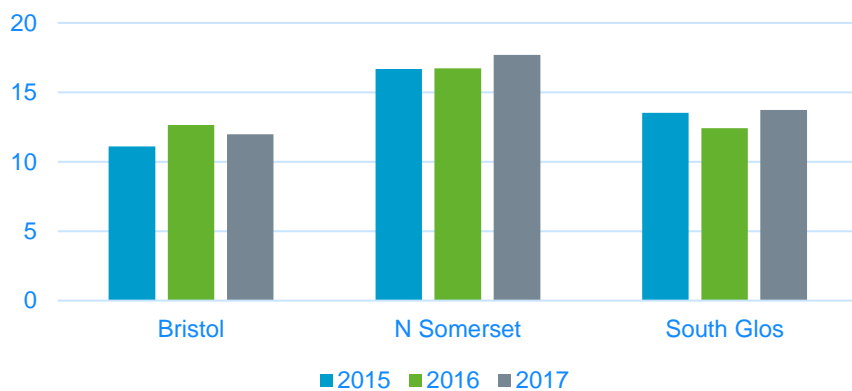
These graphs demonstrate how the population aged over 60 is predicted to increase most markedly in North Somerset, and also South Gloucestershire. Stroke incidence is also highest in North Somerset, particularly for the older population.



ONS projected population growth in South Glos compared to stroke incidence



Overall stroke incidence per 10,000 population



Financial and capacity planning

In 2019/20, SSNAP records that 1,644 strokes were treated in BNSSG hospitals. It is estimated that 1,683 stroke patients were treated in BNSSG hospitals in 2020/21. The baseline exercise has calculated that the cost of delivering the stroke service in secondary and community care is £29.7m. This works out at an average cost per stroke of £17.6k per annum.

Further health service costs (for example ambulance, primary care and continuing health care) would also have been incurred. In addition, there would also have been a social care cost associated with stroke patients.

Based on the activity growth forecast by the Stroke Association, the cost of delivering an acute and community stroke service would increase from the baseline cost of £29.7m to £42.5m in 2035/36 if no intervention were to take place.

Further detailed financial and capacity planning can be found in the PCBC document.

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How to meet the challenge of increasing incidence and prevalence

1. Invest in research for
 - Improvements in rehabilitation strategies which would help lower disability and care needs so stroke survivors would need less health care, social care and unpaid care; and they would be more likely to remain in employment.
 - Improvements in rehabilitation for cognitive difficulties.
 - Improvements in emergency treatments.
 2. The Stroke Association assume that the incidence rate of stroke would be reduced by 5% from 2025 onward due to better detection and management of small vessel disease. The number of people living with stroke in 2035 would on this basis be some 70,000 lower.
 3. Thrombectomy: the Stroke Association assume that a further 5% of people experiencing a stroke between 2025 and 2029 and a further 10% of those experiencing a stroke from 2030 onward would receive thrombectomy. On this basis 115,000 stroke survivors in 2035, (5.5% of stroke survivors in 2035), will have received this intervention. The assumed benefits being less need for health, social care and unpaid care; and more likely to remain in employment.
 4. Evidence-based practice: many effective clinical interventions are not implemented as well or as widely as they could be. The future BNSSG Stroke Service will be designed to follow evidence-based practice which should lead to improved outcomes for stroke survivors in terms of care needs and in prevention recurrence of stroke. This should lead to cost savings for the health and social care systems.
 5. The reconfiguration and centralising of Stroke Services should allow for consistent, evidence based practice and allow for improvements in thrombectomy and thrombolysis rates as well as the improvements which will follow from the Integrated Community Stroke Service. These should reduce morbidity and mortality with resulting reduction in health and social care needs as well as preventing further strokes through advocating secondary prevention and working with primary care.
 6. Stroke Prevention is discussed in detail later in this document. If it assumed that better implementation of successful evidence-based measures, such as blood pressure control, could reduce the incidence of stroke by 5% from 2025 to 2029 and by 10% from 2030 onward, there would be around 114,000 fewer people living with stroke in 2035 than if these measures were not put in place.
- Atrial Fibrillation is another risk factor for stroke: There could be an additional 3025 people with undiagnosed atrial fibrillation in BNSSG. Continued strategies to increase anticoagulation rates and to maintain such individuals on optimised medication regimes will help to reduce future stroke events.
7. Focus on reducing health inequalities. Black people are twice as likely to have a stroke compared to white people. The incidence of stroke appears to be highest in the most deprived populations.

8. Public Health Strategies and Campaigns on:
 - recognising the early signs of stroke and seeking help
 - healthy lifestyles eg alcohol, smoking and dietary advice.
 - Improving blood pressure and AF recognition and management.
9. NHS England Long Term Plan for cardiovascular disease eg CVDPrevent which looks to address risk factor identification and management.
10. May be necessary as the stroke population increases to reassess acute and rehabilitation provision with a possible need to increase bed numbers and community services as incidence rises over next 20 years.
11. Investment in social care.

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Public Health Approach

Local Public Health Services are aware of the burden of stroke and have noted that many chronic diseases, including stroke, are more common and persistent in our BAME communities, thus exacerbating health inequalities. BAME individuals are less likely to use GP services and therefore more likely to report poor general health than the white British population. Public Health view this as an opportunity to highlight Institutional barriers that impair BAME communities access to public services in general, and health services.

BAME communities are disproportionately affected by risk factors, particularly the impact of blood pressure. Public Health locally are currently designing community-centred programmes to tackle this such as offering blood pressure testing and raising awareness amongst black African and Caribbean males. Public Health are also encouraging adoption of the National Diabetes Programme and NHS Health Checks amongst all members of the community. It is hoped such preventative strategies will reduce future incidences of cardiovascular disease.

Public Health is also involved in staff training in recognising cardiovascular risk factors. Examples include Making Every Contact Count Healthy Conversations Skills training.

The Stroke HIT will work with our local Public Health colleagues to help design programmes aiming to help prevent stroke.

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Right Care Data

NHS RightCare data packs allow local health systems to consider information from across patient pathways to identify the greatest potential improvements in spend and outcomes.



Figure 2 - NHS RightCare Methodology

As most health conditions are linked to demographic factors such as deprivation and age, NHS RightCare compares systems to their closest demographically similar geographies. This is to provide realistic comparisons, taking into account the need for healthcare of different populations. Comparing 10 demographically similar CCGs, ensures that comparisons are fair and meaningful.

Benchmarking key information:

The table below illustrates the key areas of stroke benchmarking identified by RightCare and QOF (Quality of Outcomes Framework):

BNSSG Summary	Detail
Same stroke prevalence as the rest of England	QOF data from 2018-19 estimated stroke prevalence within BNSSG to be 1.8% which is the same as England as a whole.
Fewer people with hypertension	RightCare highlights BNSSG CCG as having an estimated prevalence of 4402 fewer people with hypertension compared to the best 5 of 10 similar CCGs.
Lower prevalence of hypertension	RightCare highlights BNSSG CCG as having a reported to estimated prevalence of 4402 fewer people with hypertension compared to the best 5 of 10 similar CCGs ⁴ . Across BNSSG, 12.6% of patients have a diagnosis of hypertension (lower than the England average of 14%)
Opportunity regarding blood pressure target levels	Right Care data for 2017-18 states that there is an opportunity for 386 stroke/TIA patients to have blood

	<p>pressure to target levels of 150/90 or less for BNSSG CCG to reach similar standards to the best performing similar 10 CCGs.</p> <p>For those with a history of stroke or TIA the percentage with a last recorded blood pressure of less than or equal to 150/90 was 82.6% which was lower than 83.9% for England as a whole.</p>
Comparable AF detection rates	<p>RightCare data suggests BNSSG is comparable to similar CCGs in its detection of atrial fibrillation. The diagnosed prevalence of atrial fibrillation (AF) in BNSSG CCG is 2.1% and the estimated prevalence is 2.4%. There could be an additional 3025 people with undiagnosed atrial fibrillation in BNSSG.</p>
Higher numbers of patients admitted to hospital, not prescribed anticoagulation drugs	<p>In BNSSG, 44.7% of stroke patients admitted who had a history of atrial fibrillation were not prescribed anticoagulation: this is higher than the England rate (38.9%) and the South West average (38.7%).</p>
<p>Similar mortality rates with comparable CCG's and lower than the rest of England</p> <p>Varied mortality rates across localities</p>	<p>RightCare Data from 2014-16 suggests stroke mortality rates are similar to comparable CCGs.</p> <p>Stroke mortality rates, under 75 years (rate per 100,000) was 10.6 compared to 12.8 for England as a whole.</p> <p>Stroke mortality rates, over 75 years (rate per 100,000) was 459.6 compared to 506.3 in England as a whole.</p> <p>Mortality rates for stroke in BNSSG CCG were significantly lower than the England rate. Data from Bristol's Joint Strategic Needs Assessment provides more detailed information about this⁵. The early death rate⁶ from stroke is highest in the Inner City. For males it is almost as high in Bristol East and for females it is similar in North & West (outer). Overall in Bristol, over 50% more men than women die early from stroke.</p>

⁵ Joint Strategic Needs Assessment 2018 Data Profile.
file://bnssg.xswhealth.nhs.uk/CCG/Home/phil.simons/Desktop/Stroke%20Case%20for%20Change%20Dec%2019/JSNA.pdf

⁶ 2013-15 locality data provided by Bristol Public Health Knowledge Service (2018)

Disease Prevalence

Prevalence is the number of people in a given population with a particular condition at a point in time. The diagnosed prevalence of stroke and transient ischaemic attack (TIA) and atrial fibrillation (AF) is calculated from the returns submitted to NHS Digital as part of the Quality and Outcomes Framework (QOF) by each GP practice. Practice returns are combined to calculate a prevalence rate for the local CCG.

The prevalence for stroke (1.8%) and AF (2.1%) across BNSSG is similar to England as a whole although there is variation of stroke prevalence across local GP practices.

Stroke and Atrial Fibrillation prevalence, 2018/19 (per cent)



Source: Quality and Outcomes Framework, 2018/19

Variation by general practice of stroke prevalence, 2018/19 (per cent)



Source: Quality and Outcomes Framework, 2018/19

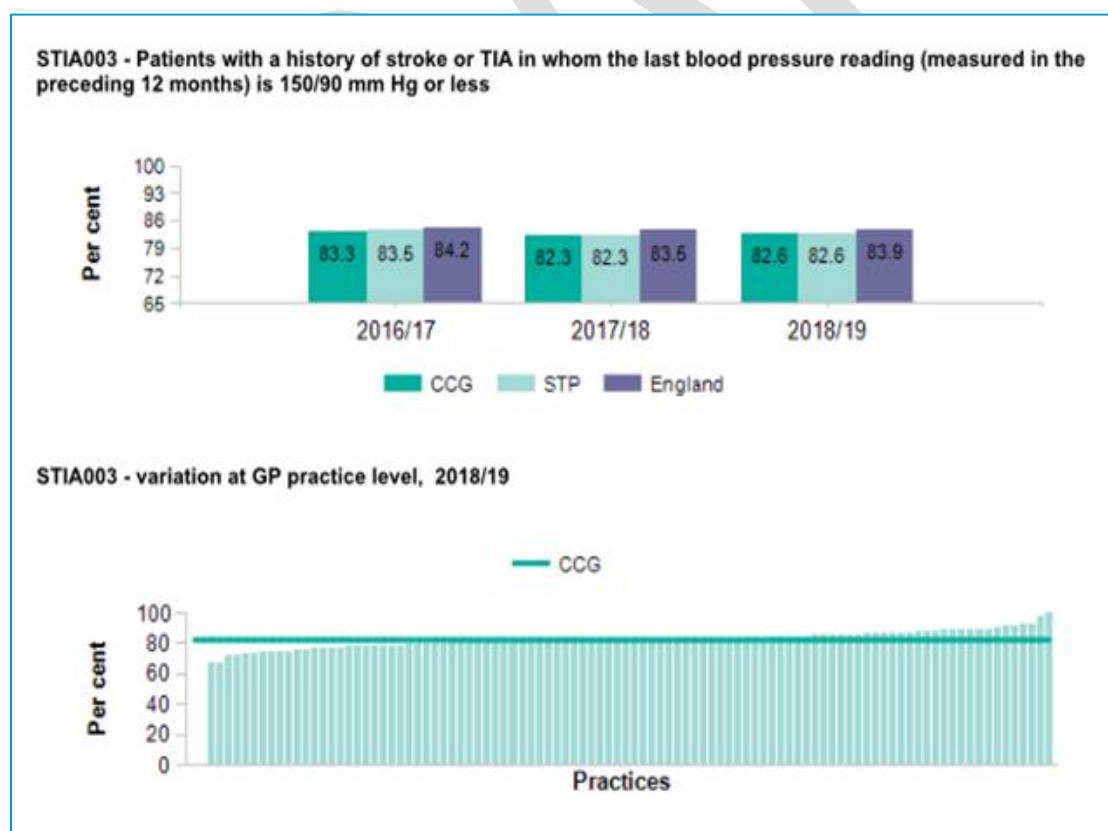
Hypertension

Over 24% of people in England are estimated to have hypertension⁷, with high blood pressure being one of the leading causes of premature death and disability in England. At least half of all heart attacks and strokes are associated with high blood pressure and it is a major risk factor for chronic kidney disease, heart failure and cognitive decline.

There is robust evidence that action to lower blood pressure does reduce the risk to health. A major systematic review in the Lancet⁸ found that in the populations studied, every 10mmHg reduction in blood pressure resulted in:

- a 27% reduction for stroke
- a 17% reduction for coronary heart disease
- a 28% reduction for heart failure
- a significant 13% reduction in all-cause mortality

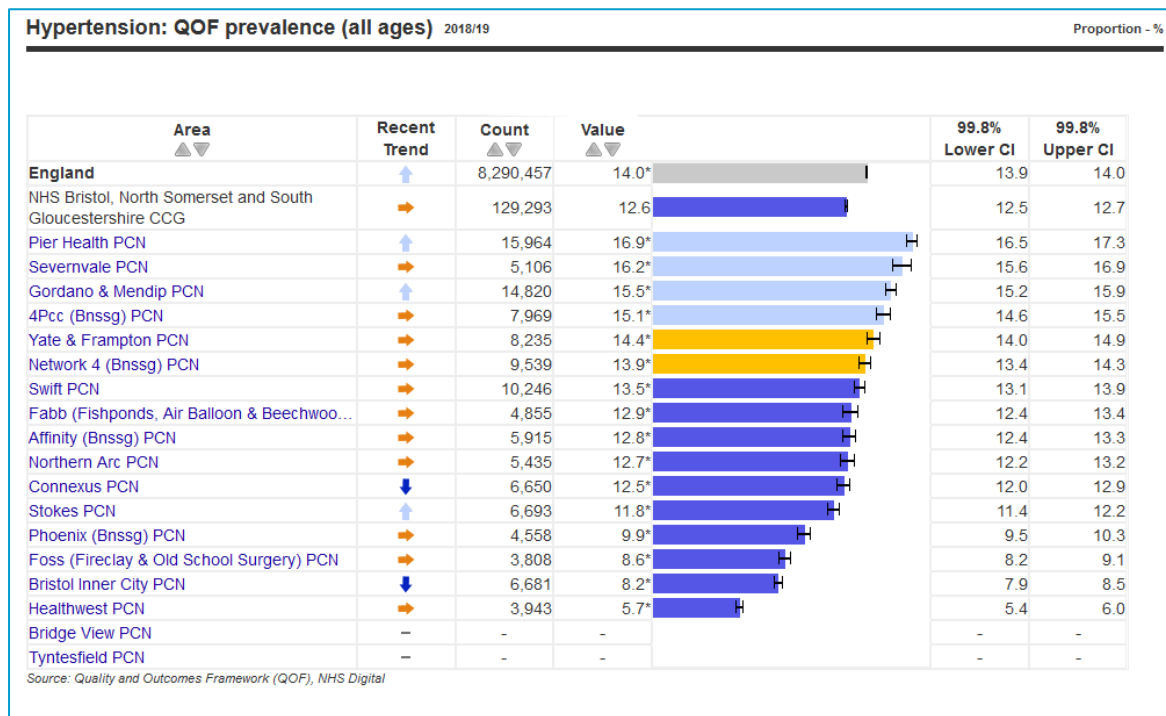
GP QOF data provides information about prevalence of diagnosed hypertension and on treatment targets. For 2018-19 this indicates that in BNSSG 12.6% of patients have a diagnosis of hypertension (lower than the England average of 14%), and of these 77.9% had a record of BP less than or equal to 150/90 compared to 79.7% for England as a whole.



⁷ <https://www.gov.uk/government/publications/health-matters-combating-high-blood-pressure/health-matters-combating-high-blood-pressure>

⁸ Blood pressure lowering for prevention of cardiovascular disease and death: a systematic review and meta-analysis. Ettehad et al. Lancet 2016; 387: 957–67.
[https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(15\)012](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)012)

Whilst QOF data for 2018/19 shows BNSSG CCG having a lower prevalence of hypertension than the England average (12.6% vs 14.0% nationally) there is significant variation in the prevalence of hypertension across PCNs within the CCG.



It is possible that many people with hypertension are undiagnosed with the true prevalence being higher than recorded. Lower prevalence in a locality could be an indicator of higher undiagnosed hypertension rather than true lower prevalence.

Hypertension actions:

- For secondary prevention there is potentially an opportunity to treat more patients to reach target levels
- Need for programmes to encourage blood pressure checks whether in a general practice setting (through NHS Health Checks, chronic disease monitoring or opportunistic testing), pharmacy setting, through patient initiated checks, and through community staff checks to encourage patients to be aware of their blood pressure targets and to seek help in reaching these.
- Improved blood pressure identification and management gives an opportunity to reduce health inequalities. Programmes should be designed to explore differences in hypertension identification and management across all members of the community within BNSSG with special regard to ethnicity and deprivation. Long term outcomes should be measured to see whether this impacts on stroke incidence.
- Public Health campaigns regarding the importance of blood pressure recognition and management including healthy lifestyle guidance. Targeting of more at risk communities will help drive reductions in health inequality.
- Continue use of primary care audits, for example through the Quality and Outcomes Framework, to refine and improve hypertension management.

- Use of Population Health Data gives an opportunity to link and analyse the different threads of information that exist across the health and social systems to improve stroke and hypertension management.

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Atrial Fibrillation (AF)

There are 1.2 million people with known AF in the UK, as well as an estimated further half a million people with undiagnosed AF. The risk of stroke increases five-fold for people with the condition and it contributes to one in five strokes in the UK. It is therefore essential that AF is better detected, diagnosed and treated⁹. Strokes suffered by patients with AF tend to be severe, compared to strokes in non AF patients. An AF related stroke means¹⁰ a patient is twice as likely to die, more likely to become seriously disabled and more likely to end up bed ridden and in a nursing home.

Treatment with an anticoagulant significantly reduces the risk of stroke in people with AF.

Across BNSSG 44.7% of stroke patients admitted who had a history of atrial fibrillation were not prescribed anticoagulation: this is higher than the England rate (38.9%) and the South West average (38.7%).

Stroke admissions with history of atrial fibrillation not prescribed anticoagulation prior to stroke 2018/19 Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↗	5,755	38.9	-	-
South West NHS Region	↘	669	38.7*	36.4	41.0
NHS Bristol, North Somerset and South Glouces	↔	115	44.7	-	-
NHS Bath And North East Somerset CCG	↗	21	44.7	-	-
NHS Gloucestershire CCG	↗	83	44.4	-	-
NHS Somerset CCG	↗	92	42.2	-	-
NHS Swindon CCG	↗	19	41.3	-	-
NHS Kernow CCG	↗	83	41.1	-	-
NHS Wiltshire CCG	↗	56	37.3	-	-
NHS Dorset CCG	↗	135	37.2	-	-
NHS Northern, Eastern And Western Devon CC	↗	129	35.8	-	-
NHS South Devon And Torbay CCG	↗	51	32.7	-	-

Outcome at discharge for stroke patients with prior AF who were not on anticoagulation

Outcome data at discharge for patients with prior AF who were not on anticoagulation in 2018/19, (per cent)



Source: SSNAP, Apr 2018 - Mar 2019

⁹ <https://www.stroke.org.uk/professionals/stroke-prevention>

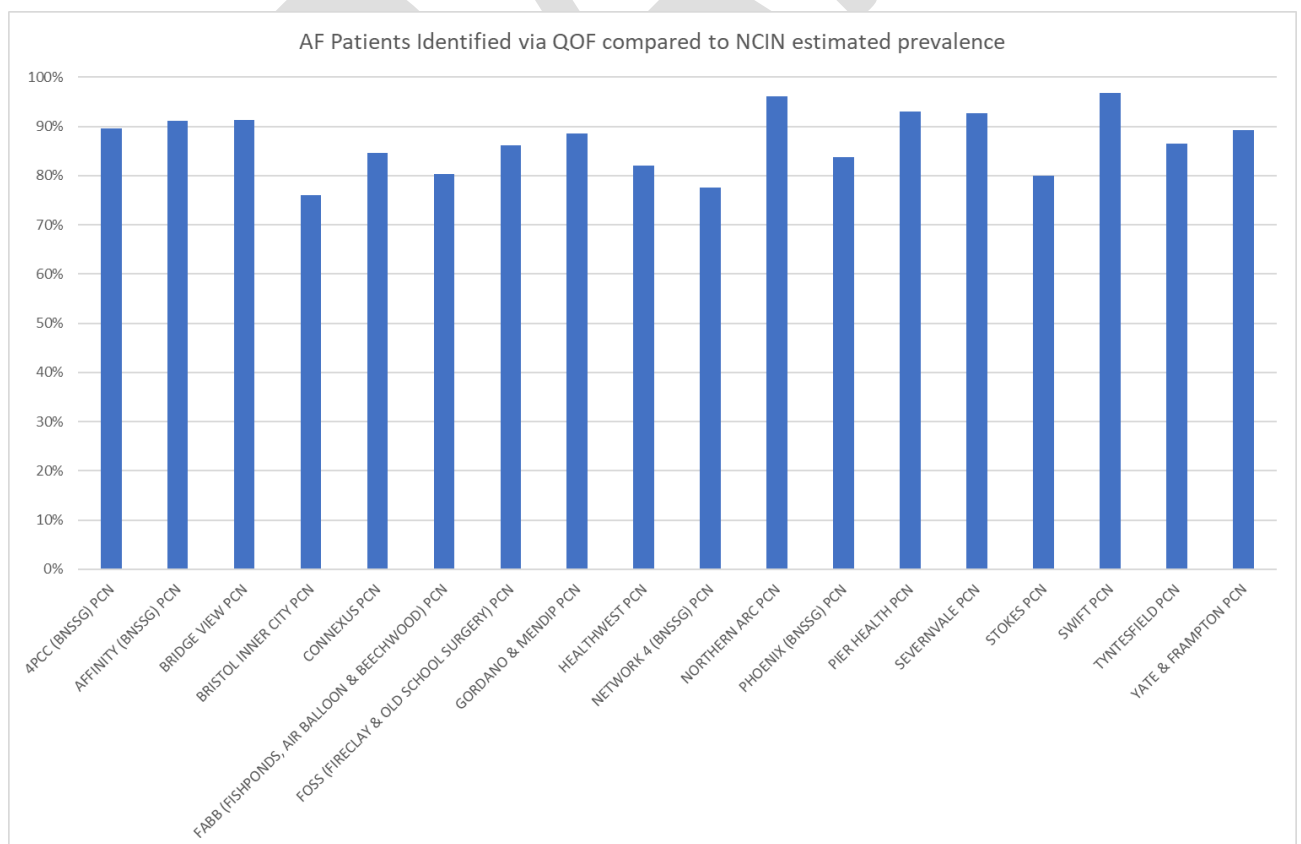
¹⁰ Lin H et al. Stroke Severity in Atrial Fibrillation: The Framingham Study. Stroke. 1996.

At least 7,000 strokes per annum in the UK might be prevented if patients were anticoagulated according to national guidelines¹¹. From EMIS data collected in July 2020, within BNSSG there are 3,662 patients diagnosed with AF who are not anticoagulated (18% of total AF patients).

QOF data suggest BNSSG CGG anticoagulation rates are similar to England as a whole with 91.7% of patients with a non-haemorrhagic stroke or history of TIA being on an anti-platelet agent or anticoagulation in 2018/19.

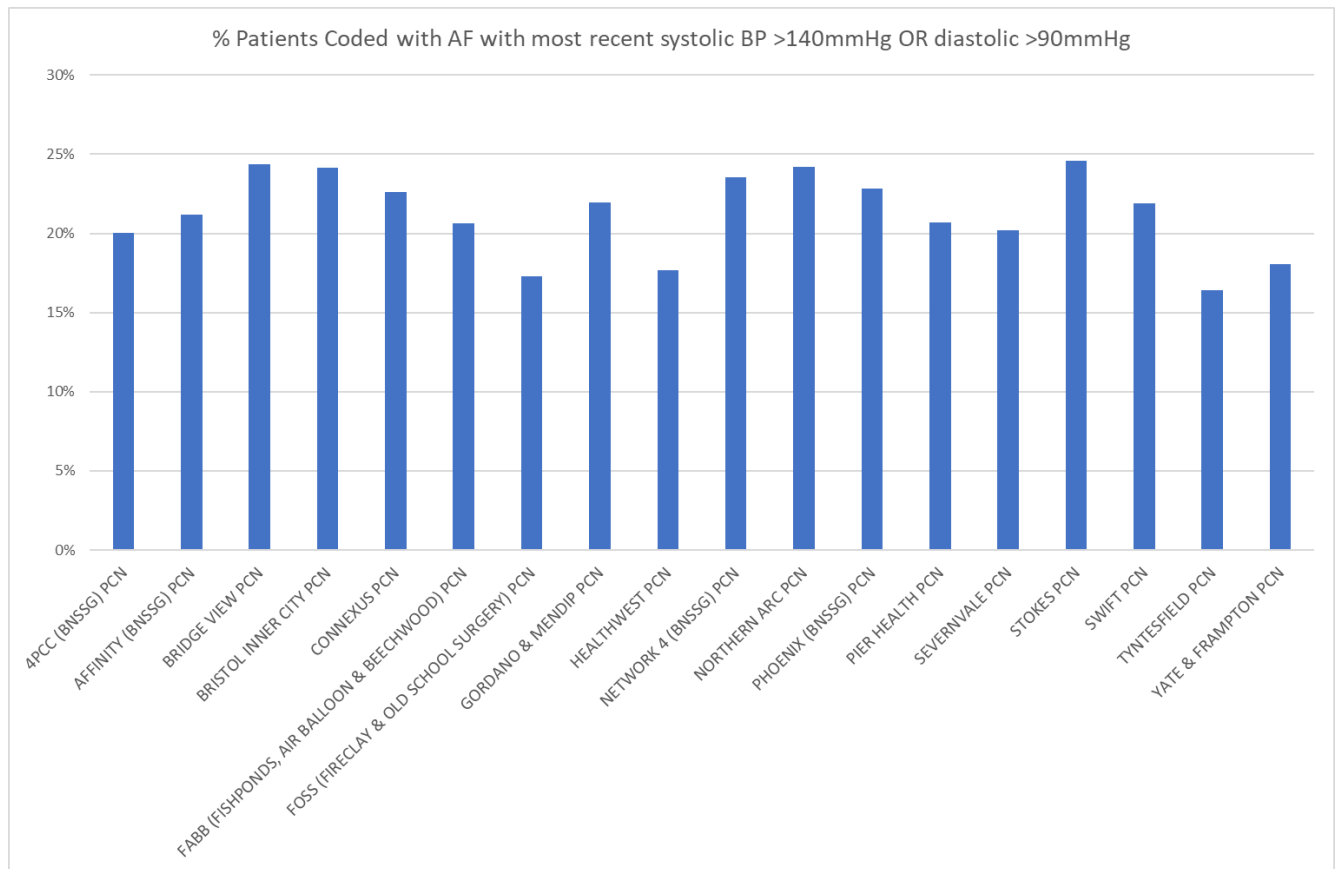


A comparison showing the expected prevalence of AF as estimated by the National Cardiovascular Intelligence Network (NHS Digital/NCIN, 2019) and the prevalence as reported under QOF is shown below at BNSSG PCN level:



¹¹ Department of Health. Cardiovascular Disease Outcomes Strategy. Improving outcomes for people with, or at risk of, cardiovascular disease. March 2013.

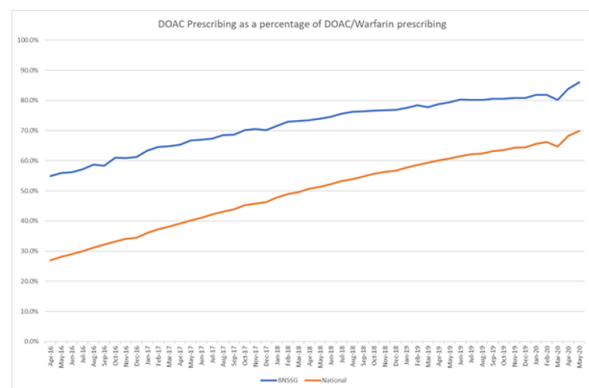
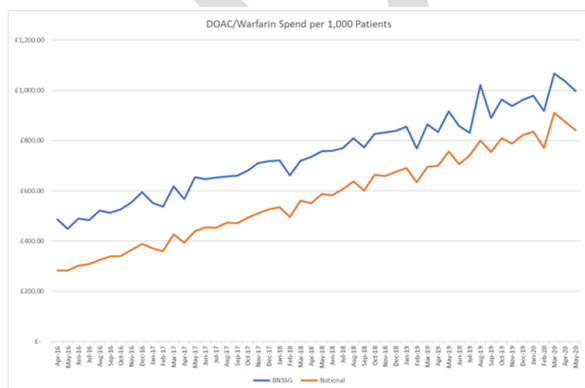
Data from EMIS shows the percentage of patients with AF who had elevated systolic or diastolic blood pressure on their last recorded observation:



Anticoagulant Spend

Anticoagulant Prescribing Comparisons (from ePACT) BNSSG has historically spent significantly above the national average on anticoagulation per patient

This has been driven by the rapid uptake and continued increase in DOACs in place of warfarin, with ePACT data showing BNSSG has the 5th highest rate nationally of DOAC prescribing as a percentage of all anticoagulant prescribing.



AF and Anticoagulation Actions

- Review people with AF and hypertension not treated to target

- Continue campaigns such as “Don’t Wait to Anticoagulate” which focused upon supporting patients to optimise the management of AF related stroke prevention in primary and secondary care
- Target at risk and harder to reach individuals and communities.
- Educate patients, carers and health staff on the importance of anticoagulation.
- Audits to look at anticoagulation rates for those with AF which will also explore the effectiveness of treatment eg ensure warfarin dosing maintains therapeutic levels of protection and that patients on direct-acting oral anticoagulants (DOACs) are prescribed the optimal medication and correct dose for their personal circumstances.
- Review patients admitted with a Stroke or TIA with AF and understand if opportunities were missed to optimise treatment

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Other factors such as Cholesterol levels and Smoking

Lowering cholesterol can reduce the risk of cardiovascular disease. Right Care data from 2016 suggested BNSSG CCG performance in this area was comparable to similar CCGs. The importance of statin medication in primary and secondary stroke prevention is well recognised³.

Smoking is a major risk factor for stroke. The number of smokers in Bristol is falling. In 2017, 11.1% of Bristol adults smoke¹², down from 21% in 2012. It is now better than the national average for 2017 of 14.9%. Women (13%) were significantly less likely to smoke than men (16.8%) in 2017. Local Quality of Life Survey¹³ data shows the number of households with a smoker is 21.6%. However, this is significantly higher in the most deprived areas (29.1%). Variation across the city is from 3% of households in Hotwells and Harbourside to 40% in Hartcliffe & Withywood.

For North Somerset the level of smoking have been estimated at 12%. Those in manual occupations had nearly 2.5 times the odds of being smokers compared to those who worked in managerial or professional occupations.

In South Gloucestershire Public Health England data from 2018 stated that 10.6% of adults smoked with those in manual occupations having nearly 3 times the odds to be smokers compared to those who worked in managerial or professional occupations¹⁴. High smoking rates among people with mental health problems are the single largest contributor to their 10 to 20-year reduced life expectancy. For South Gloucestershire 33.6% of people living in the community diagnosed with a Serious Mental Illness (SMI; schizophrenia, bipolar affective disorder and other psychoses) smoke¹⁵.

Additional actions

- Smoking rates have declined over the years. There may be value in considering smoking cessation schemes which target hard to reach groups who are at increased risk of chronic disease such as stroke.
- Public Health will be central in directing and supporting healthy lifestyle campaigns looking to reduce levels of smoking, obesity and alcohol consumption whilst encouraging healthy lifestyle choices such as exercise and improved dietary choices.

CVD Long Term Plan

The NHS Long Term Plan identifies CVD as a clinical priority and the single biggest condition where lives can be saved over the next 10 years. Stroke prevention will be part of this strategy. Currently both nationally and within BNSSG there are programmes looking to address risk factor management of cardiovascular diseases.

¹² Annual Population Survey (APS) 2016, via PHOF, Feb 2018

¹³ Bristol Quality of Life survey 2017/18

¹⁴ <https://fingertips.phe.org.uk/profile/tobacco-control/data#page/0/gid/1938132885/pat/6/par/E12000009/ati/102/are/E10000013/iid/93382/age/183/sex/4>

¹⁵ JSNA South Gloucestershire smoking data- personal communication

Whilst across BNSSG the identification and management of stroke risk factors is encouraging, there is room for improvements. By increased the identification and treatment of AF and hypertension we can reduce the incidence of stroke.

Areas being looked into include:

- Working towards people routinely knowing their “ABC” numbers- (AF, blood pressure and cholesterol).
- Improving the effectiveness of approaches such as NHS Health Checks to rapidly treat those identified with the high risk conditions, including AF, high blood pressure and high cholesterol.
- Supporting pharmacists and nurses in Primary Care Networks to find and treat people with high risk conditions and offer treatment in a timely way.
- Commissioning a new national CVD prevention audit for primary care called ‘CVDPrevent’¹⁶ which will extract routinely recorded but anonymised GP data, making it easier for practices and Primary Care Networks to systematically identify people whose treatment could be improved and risk reduced.

In February 2019, NHS England published the new GP contract; the first step in the implementation of the Long Term Plan. As well as the commissioning of CVDPrevent, the contract includes CVD specific announcements around CVD case finding and Quality and Outcomes Framework (QOF) changes for blood pressure control.

Future aims from such programmes should be:

- Reducing health inequalities and variations in care
- Improve hypertension management and increase number treated to target.
- Through review of patients who have had a stroke or TIA with AF, try to understand if there are opportunities to improve the patient pathway
- Fewer people at risk of stroke from undiagnosed high blood pressure
- Fewer people at risk of stroke from undertreated high blood pressure
- Maintain and improve the pick-up rate of undiagnosed AF
- Ensure all patients diagnosed with AF have had appropriate thorough assessment and discussion/decision made re: anticoagulation
- Improve the recognition and treatment of hypertension in those at high risk of stroke
- Using shared decision making tools review patients with known atrial fibrillation not on anticoagulants

¹⁶ <https://www.england.nhs.uk/ourwork/clinical-policy/cvd/cvdprevent/>

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