Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd a Gofal Cymdeithasol
The Health and Social Care Committee

Dydd Mercher, 23 Hydref 2013
Wednesday, 23 October 2013

Cynnwys
Contents

Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Leighton Andrews	Llafur Labour
Rebecca Evans	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Yaqoob Bhat	Meddyg Strôc, Bwrdd Iechyd Lleol Aneurin Bevan Stroke Physician, Aneurin Bevan Local Health Board
Nicola Davis-Job	Cyfarwyddwr Cyswllt Dros Dro (Arfer Proffesiynol), y Coleg Nyrsio Brenhinol Acting Associate Director (Professional Practice), Royal College of Nursing
Mark Drakeford AC/AM	Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol The Minister for Health and Social Services
Dr Anne Freeman	Yr Arweinydd Clinigol ym maes Strôc yng Nghymru, yr Uned Gyflawni Genedlaethol Clinical Lead for Stroke in Wales, National Delivery Unit
Lowri Griffiths	Y Gymdeithas Strôc Stroke Association
Dr Amer Jafar	BMA Cymru Wales ac Arbenigwr Cyswllt ym maes Meddyginiaeth Adsefydlu, Ysbyty Gwynllyw BMA Cymru Wales and Associate Specialist in Rehab Medicine, St Woolos Hospital
Dr Chris Jones	Y Dirprwy Brif Swyddog Meddygol (Gwasanaethau Iechyd) Deputy Chief Medical Officer (Health Services)
Nigel Monaghan	Ymgynghorydd Iechyd Cyhoeddus, Iechyd Cyhoeddus Cymru Consultant in Public Health, Public Health Wales

Ana Palazon	Cyfarwyddwr Cymru, y Gymdeithas Strôc Director Wales, Stroke Association
Carole Saunders	Nyrs Glinigol Arbenigol Strôc, Ysbyty Singleton Stroke Clinical Nurse Specialist, Singleton Hospital
Dr Hamsaraj Shetty	Meddyg Ymgynghorol ym maes Strôc, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Consultant Stroke Physician, Cardiff and Vale University Health Board
Amanda Smith	Cyfarwyddwr Therapïau a Gwyddorau Iechyd, Ansawdd a Diogelwch, Bwrdd Iechyd Addysgu Powys Director of Therapies & Health Sciences, Quality and Safety, Powys Teaching Health Board
Mrs Jan Smith	Cyfarwyddwr Gweithredol ac Arweinydd Gweithredol ym maes Strôc, Bwrdd Iechyd Lleol Aneurin Bevan Executive Director and Executive Lead for Stroke, Aneurin Bevan Local Health Board
Paul Underwood	Dirprwy Gyfarwyddwr Cymru, y Gymdeithas Strôc Deputy Director Wales, Stroke Association
Dr Phil White	BMA Cymru Wales, Meddyg Teulu, Gogledd Cymru BMA Cymru Wales, General Practitioner, North Wales
Dr Hugo van Woerden	Cyfarwyddwr Arloesi a Datblygu, Iechyd Cyhoeddus Cymru Director of Innovation and Development, Public Health Wales

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Llinos Madeley	Clerc Clerk
Sarah Sargent	Dirprwy Glerc Deputy Clerk
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:31.
The meeting began at 09:31.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **David Rees:** Good morning. I welcome Members to this morning's session of the Health and Social Care Committee. I apologise for the delay in starting this morning; we have been experiencing some technical problems and have had to move committee rooms. Thank you all for bearing with us. I thank the witnesses for agreeing to merge the first two sessions so that we can give each group proportionate time in the questioning sessions. The session is to be held bilingually; the headphones can be used for translation from Welsh to English, on channel 1, or for amplification, on channel 0. I remind people to turn their mobile phones off. We are not scheduled for any fire drills today, so if there is a fire alarm, please follow the instructions of the ushers in leaving the building. We have received apologies from Darren Millar this morning, with no substitute. We have also received apologies from Gwyn Price and Lynne Neagle, who will be late arriving.

09:32

Lleihau'r Risg o Strôc—Ymchwiliad Dilynol: Paneli 1 a 2—Y Sector Gwirfoddol a Chynghrair Strôc Cymru
Stroke Risk Reduction—Follow-up Inquiry: Panels 1 and 2—The Voluntary Sector and Wales Stroke Alliance

[2] **David Rees:** I thank the witnesses for coming this morning. We have apologies from Jo Jerrome of the Atrial Fibrillation Association. Thank you and good morning to Ana Palazon, Paul Underwood and Lowri Griffiths from the Stroke Association. I also welcome Dr Anne Freeman and Dr Hamsaraj Shetty from the Wales Stroke Alliance. Thank you again for allowing us to merge the two sessions. Given the time, we are going to move straight into questions, if that is okay. This morning's session is revisiting the work done by the committee at the beginning of the fourth Assembly on stroke care. We are revisiting the recommendations of the report and the Welsh Government's responses to that report.

[3] I will ask the first question. Both of your written submissions—thank you for them—have identified several common points. One of those was a question on leadership, particularly the reference to the establishment of a network. Could we have comments from each group on those? We will start with Ana, and then we will come back to Dr Freeman.

[4] **Ms Palazon:** The comments that we made around leadership were in two parts. On the one hand, we have acknowledged in our submission—we would like to reiterate it this morning—that individual practitioners and individuals who have been given leadership responsibility have, indeed, done that. For example, the delivery unit that has been co-ordinating the work for improving stroke services across Wales has definitely provided leadership. However, what we believe has not happened in terms of leadership at the systemic level—it is not individuals, who have done their upmost—is the Welsh Government and the NHS providing a robust leadership in terms of implementation and the evaluation of the results of what has been recommended. We feel that there is quite a significant void there.

[5] **Dr Freeman:** Stroke, cardiac and cancer are the biggest killers in the UK and the world. We have a network for cancer and cardiac, but we do not have a network to support stroke service development. The precedent has been set for network development with cancer and cardiac, and we are asking that stroke should be given equal support, infrastructure and resources. England set up its stroke improvement programme and developed 28 stroke networks. Some were joined with cardiac in the smaller areas, but the majority were stroke-specific networks.

[6] In Scotland, they developed 14 managed clinical networks, so we do have models of networks already working in the UK. Hamsaraj may well want to add something on the value that we had in south-east Wales where we developed a more informal network to oversee the development of thrombolysis. That worked really well. As you know, we now have 24/7 thrombolysis cover in the whole of Wales. That grouping together of just three health boards worked extremely well. So, we have seen models of networks working and the value of them, and we see that a network would bring together all of the different organisations that are working to drive forward stroke services. You would get a much more comprehensive service development and delivery through a network.

[7] **David Rees:** Lindsay, do you want to follow that?

[8] **Lindsay Whittle:** Yes. Thank you. This question was initially just to the Stroke Association, but I am sure that the Welsh Stroke Alliance can chip in, as appropriate. Thank you, Dr Freeman, I think that you almost answered the question that I wanted to ask. In the evidence submitted to us, it said that the time has come when the next tranche of improvement can only be made through allocation of resources to attract a highly skilled,

motivated workforce to ensure that we save lives and prevent more strokes. However, are there any specific areas where you feel that additional resources are needed and could be allocated, and are there any areas of good practice in some parts of Wales that other parts of Wales could learn from?

[9] **Ms Palazon:** I think, as you might expect, the answer is that the investment needs to be given across the pathway, really, right from prevention through to acute, emergency and life—

[10] **Lindsay Whittle:** I did say in our pre-meeting that I think that I could predict the answer.

[11] **Ms Palazon:** Having said that, and to be more specific, in order to provide services in stroke, you need personnel. It is not so much equipment, although that is part of it; equipment is a one-off investment and then it depreciates. With people, that is not the case. You need to have therapists across the various disciplines—occupational, speech and language, physiotherapy, dietetics, et cetera. You need to have the specialisms and you need to look at it across Wales in an equitable way. Without the specialisms, stroke services can only do so much improvement. So, that is one of the main areas where we believe that investment should be made.

[12] Investment should also be made in terms of building the capacity of some of our leading clinical practitioners. We know that our stroke consultants are not getting the time, for example, to do the research and development that will then drive improvements, because they are so overworked because they do not have the personnel resources to support their everyday work. So, we are very much in a circle that we are not going to get out of until new investment is made. So, that is around the area of investment. Could you repeat the second part of your question?

[13] **Lindsay Whittle:** I wondered whether there were any areas of good practice that other parts of Wales could benefit from.

[14] **Ms Palazon:** Another area of investment where, perhaps, some good practice is beginning is around not only the multidisciplinary teams, but the early discharge support teams. We have had some models emerging in Wales, but there is no sufficient robust evidence as to how they are truly working. For example, in Wrexham, we have had, in Betsi Cadwaladr, one model that appears to be working, but because it is the only one, we have nothing to compare it with other than examples from outside of Wales. The evidence, through those comparisons, demonstrates that the model that we have in Betsi Cadwaladr is not the best practice that we could have. Again, that falls back to the fact that the full complement of team members is not there to make it a gold standard model.

[15] Having said that, there is a move towards working in that way and we did provide an example of good practice from Cwm Taf in our written evidence, which is about allocating resource to be able to follow patients who are discharged once they are home, to ensure that not only are they receiving a patient-centred service, but that they are also able to prevent a secondary stroke. That was provided in our evidence from Cwm Taf.

[16] **Mr Underwood:** We are quite privileged in some respects; we do sit on the stroke boards—all seven of the stroke fora—across Wales, acting, I suppose, as a critical friend, too, and working, in some cases, in close partnership with the health boards. However, there is a total lack of engagement, I would say, across all seven health board areas in terms of the partnership with local authorities. Despite efforts on our part, and efforts on behalf of the health board, there is very little representation. If there is representation, it would appear that the representation is not at the strategic level to make decisions that will move support

networks or opportunity. One thing that we would like to see would be strategic and operational representation at all stroke delivery groups, fora or steering groups to ensure that there is a robust partnership. That, of course, would also include third sector involvement.

[17] **Lindsay Whittle:** I have a small comment and a tiny question. I have spoken at a support group in my own region, and I know the valuable work that it does, but it is all done by volunteers who have friends and family that are victims of stroke. Ana Palazon, you mentioned stroke consultants. We are always told in the Assembly that there is a shortage of consultants. I guess, therefore, that there is a shortage in Wales. Is that true? How do we attract them?

[18] **David Rees:** I will ask Dr Freeman to answer.

[19] **Dr Freeman:** There is a shortfall of stroke consultants in Wales. Geriatric medicine has always been the parent body for stroke medicine. The majority of our stroke physicians in Wales are geriatricians who have a special interest in stroke. The British Association of Stroke Physicians did a review, which was updated last year, looking at how many stroke physician sessions are required per population to run a good service that covers the whole of the pathway—acute rehab and the thrombolysis service. Looking at the population of Wales, taking 3 million as the ballpark figure, extrapolating from BASP data, we actually need 18 whole-time stroke physicians in Wales to run a good service. We have nowhere near 18 full-time consultants. If you add up all of the direct clinical care sessions of all of the consultants who contribute to stroke medicine, you will find that there is a significant shortfall. We did this piece of work through the Welsh Stroke Alliance and we sent a paper to the Welsh Government indicating that shortfall. There is the shortfall, but, having said that, there is also the difficulty in recruitment. We have vacant posts now in several of our sites around Wales. Two posts in north Wales have recently been appointed, but there is still a shortfall in other centres. It is a problem about attracting staff. I am actually on the medical recruitment champions network. It is very difficult to attract people into Wales at the moment. There are other areas that we are looking at, such as improving the educational and research opportunities in Wales, which will actually help to attract people. They have to see an infrastructure that is appealing to them. Certainly, developing stroke research is one of the ways that we can attract people.

[20] **Lindsay Whittle:** Thank you for that, and thank you for all of the good work that you do, by the way.

[21] **David Rees:** Elin, do you want to come in on this? I am sorry; I will ask Dr Shetty first.

[22] **Dr Shetty:** You might ask why we need specialist stroke physicians to run a TIA and stroke service. The important thing to recognise is that there has been a tremendous amount of research and developments that have happened in the last 15 years in the field of stroke. Now, it is a truly specialist subject. If stroke and TIA patients are seen by a general physician, we have seen in our own practice that 60% of the time the diagnosis is wrong or the GP is dealing with something else that is not stroke. Stroke and TIA have great mimics. It is difficult for a non-specialist to pick up TIA, in particular, and that is a valuable opportunity to prevent a catastrophic disease. This is where a specialist would really be the person who should be dealing with such patients, and this is why we need specialists. We have been running a stroke prevention clinic in Cardiff since 1995. I am sure that we have prevented a lot of strokes because we are able to see them fairly promptly and take appropriate action. There are things like carotid artery surgery. If we send somebody for carotid artery surgery we are reducing the risk of stroke by about 80%, and if you recognise that somebody has got atrial fibrillation and start them on warfarin or anti-coagulation medicines, you reduce the risk by about 65%. These are simple things that can be done in any hospital. However, the important

thing is that, when somebody comes with the symptom, one has to be able to see why they have that symptom. So, what is the underlying pathology? Only a stroke physician can do it properly.

09:45

[23] **Elin Jones:** I wanted to go back to the point that you made about the clinically managed network, and how you would like to see that set up in Wales. You mentioned various models in Scotland and in England, and some work with the Cardiff network. I just wanted to ask you to give us a little more of a flavour for how you want to see that network set up, and by whom and when would you like to see it set up.

[24] **Dr Freeman:** We would like to see it set up as soon as possible, but obviously there will be a lead-in time, and we have to sort out the resources and funding for such a network. It has got to be adequately staffed, with sessions for clinical staff input, managerial support, a network manager, et cetera. Obviously, we have got the models from cardiac and cancer, and I am sure that the Welsh Government will have a template for how networks are set up and resourced. We have put down some points about what we feel the purpose of the network should be, and its activities, which we could easily share. We feel that it would bring representatives from all the organisations involved in the planning, commissioning and delivery of stroke care across Wales together to promote rapid and continuous improvement in quality stroke services, and that is across the board, from prevention right through to continuing stroke care; to scrutinise, challenge and develop clinical practice in stroke across Wales; to develop integrated service planning across the whole of the public sector; to act as an all-Wales forum to provide expert multidisciplinary advice and support to NHS Wales, local health boards, Welsh Government, royal colleges, and all interested parties; to review the clinical aspects of professional and organisation audits related to stroke care; to advise on the national clinical standards, best practice and emerging research; and to support local health boards, the ambulance service, local government and third sector stakeholders to plan, monitor and deliver quality stroke services, in line with Government expectations and all clinical guidelines.

[25] We currently have the Welsh Stroke Alliance, which we are representing, which is a multiprofessional body that I set up in about 2006, when we realised that we had to have that multidisciplinary approach. Now, the Welsh Stroke Alliance is an independent, voluntary group; it is not aligned to anybody at the moment. We do not report anywhere, but it acts as the clinical advisory mechanism to the stroke delivery group. Now, the membership and the representation on the Welsh Stroke Alliance would form a network. You would, obviously, have to look again at the membership and at who is representing the different specialties, but you have got an almost ready-made network, and if that had the appropriate support in terms of administrative, managerial—

[26] **Elin Jones:** It would need to be a managed network.

[27] **Dr Freeman:** It would be a managed clinical network, covering the whole of stroke services. Paul talks about inequities across Wales, and you would be able to bring in examples of good practice, you would be able to bring up the poorer practice, and you would set a uniform level of stroke service across Wales.

[28] **Ms Palazon:** It would also help in terms of leadership.

[29] **Dr Freeman:** Yes. We would have many clinical leaders involved, using different levels of expertise.

[30] **David Rees:** Could I ask the Stroke Association, then—obviously, the current system

is with the Welsh Stroke Alliance. How do you view the current role of the alliance, and would it actually be in a position to take on the network?

[31] **Ms Palazon:** We are actually also members of the Welsh Stroke Alliance, but the Welsh Stroke Alliance as a clinical advisory group has, I think, a very strong base to be able to develop into a network. What we would have to really work on, as Paul mentioned earlier, is bringing the missing partners to the table. It needs to be seen as a worthwhile network where the missing partners can identify that their contribution is valid. So, it would have to be more than just a clinical network; it would have to be a network that also looks into life after stroke, for example, which goes beyond medicine; it goes into social care, everyday life and the everyday needs that a stroke survivor will have in his or her life. That network would need to be recognised with the status that it deserves; it would have to be resourced and it would have to be given the status of expertise to be able to advise, to lead, to co-ordinate and to improve the current state of play. At the moment, there has been a voluntary, and very willing, contribution by all its members.

[32] **David Rees:** Thank you. Lowri, do you want to add to that?

[33] **Ms Griffiths:** Yes, I just wanted to add to that, really. We had the cross-party group here at the Assembly on stroke the other week, which you kindly attended, and we had the Minister for health there as well, who said that there is no money. We were trying to think of ways in which we could be innovative, I suppose, and, while I do not think that there would be much of a cost to a stroke network, we need to be really mindful of where it would sit in the whole structure of the evaluation and monitoring of some of the delivery plans that have been put out there at the moment. We have gone through a great exercise in terms of reading all those delivery plans and trying to see how they will be developed and reported on, and that is key to ensuring improvements across the board, not just in health, but also in social services, which we feel is a massive part of stroke rehabilitation and reablement.

[34] Going back to the whole point of this session, which is around reviewing the recommendations that came from this committee, one of our biggest arguments is that we seem to have plan after plan that subsumes the recommendations of the previous plans, going back to 2010 and 2009. So, at some point, we need to actually start delivering on those plans, as opposed to developing a new plan that will then incorporate the previous plan. My fear for when I go away from here today is about the recommendations that you make after this inquiry into the last inquiry: what is going to happen to those recommendations? I think that to have a stroke network would be great.

[35] Some of our issues around leadership within Welsh Government and Public Health Wales, where things seem to fall through the gaps, need to be addressed, and we need to find some kind of robust mechanism whereby we integrate the whole thing. Who would do that and who would be responsible for it—would it be the Minister, the director, or Chris Jones? I do not know the answer, but somebody somewhere needs to take hold of this and make sure that it is given a robust framework, so that we get the results and so that the clinicians who are working so hard on the ground can do their jobs with enough space to make real improvements. We will then stop getting stories from our stroke survivors, whom we meet day in, day out, in their hundreds, and who tell us that things are not working for them. Something has to change, and we hope that this committee can drive some of those changes.

[36] **David Rees:** Okay. Thank you. Kirsty, do you want to ask a question?

[37] **Kirsty Williams:** Just to say that we are aware of general problems with recruiting medical staff to Wales. Is there anything specific in the field of stroke medicine that makes it difficult to recruit the consultants whom we need?

[38] **Dr Freeman:** The other thing to mention that has happened is that, until last year, we did not actually have any stroke trainees in Wales, but then the postgraduate deanery initially gave us one specialist registrar training post, and the person filling it has been through a year of training now. We now have four stroke SpR posts. So long as those people who are training stay in Wales for a consultant job, that is one way to improve the recruitment of stroke physicians. Previously, we had SpRs going to England for their stroke training and then getting a job there. Now, we are hoping that we are going to be able to train our own and that they will remain in Wales. So, that is one way that we can improve on the consultant recruitment.

[39] However, as you know from the royal college audit, we are under the median according to the royal college guidelines on all aspects of stroke staffing, across nursing and therapy, as well as doctors.

[40] **David Rees:** Paul, did you want to come back on that?

[41] **Mr Underwood:** Just to build on what Lowri was saying, and support what she said, the other inequity, and something that we are very concerned about, is the lack of engagement and representation of general practice within the secondary care community discussions that are taking place at stroke boards and stroke fora et cetera. If there is a drive to manage complex patient needs, which there will be, and if the GP is going to be the clinical lead within the community, then there needs to be ownership. I do not want to use the word 'incentivise' in any way, shape or form, but GPs and the community resource teams would really need to draw people out of secondary care and manage their complex needs in the community. I do not see on any of the seven stroke steering boards regular representation from general practice. Indeed, a lot of the recent national fora, where we have come together as third sector organisations involved in community care, have not had any GP representation at all. So, they would need to be involved as equal partners to drive the whole agenda. If stroke survivors are not being accepted into the community safely, they are delaying hospital discharge, they are not receiving the proactive therapies that they could do and need to live a meaningful life after stoke, and the delay in hospital is affecting their recovery. It all hinges on the partnership with general practice and the development of the pathways to support the individuals.

[42] **David Rees:** We will come back to GPs in another question. I will move on to Rebecca, at the moment, because I am conscious of time, for a question.

[43] **Rebecca Evans:** You describe the lack of robust evaluation and analysis of the 2010 stroke reduction action plan. Do you think that this has impacted on the development of the delivery plan and what do you think needs to change in terms of the way that the Welsh Government evaluates and undertakes analysis of the progress of its plans?

[44] **David Rees:** I call on someone from the Welsh Stroke Association.

[45] **Ms Palazon:** I think that it goes back to what Lowri was saying earlier on. We have moved the aspiration of one plan into the next one, without having taken stock of what has changed and what has not. So, our baseline is not robust. We have the audit from the Royal College of Physicians and the work that Dr Freeman leads on every year to ensure that, across Wales, we are reporting against targets. However, that has not given us the framework to evaluate whether or not the Welsh plans per se are delivering what they are intended to. We have a problem in Wales—Dr Freeman has already mentioned the lack of investment, and I think that it is an investment matter—in terms of research, for example. While we have very good world-leading research in some areas of neurological and cardiovascular conditions, we do not in stroke. Until we are able to build infrastructure, we will not be attracting the calibre of practitioners that we need. Having said that too, what we do not have in Wales is a stroke

register. So, our data are not reliable. We are not really working in the full light—our eyes are half-closed, and we are guessing. The data that are coming out, even from the Welsh Government, are not necessarily that robust. So, we need to do some work on a very basic level to be able to understand where we are at and start measuring against the aspirations that each of these plans has had.

[46] For example, if we look at the local plans, we see that the template that they have been asked to follow in order to build their own plan has a section that acknowledges the key risks to not achieving the plan. However, what it does not offer is a section to address those key risks, how they are going to be mitigated and how they are going to be addressed. That is not there. So, while we have every local health board telling us that a common key risk is the lack of capacity, for example, or the lack of resources, we do not have anywhere in those plans saying how that can be addressed, how we can work differently or what money needs to be invested. So, we will keep going in circles without really addressing the point.

[47] **David Rees:** Dr Freeman, do you want to come back on those points?

[48] **Dr Freeman:** Yes, may I pick up on a couple of those points? First, we have talked a lot about resources, money and investment et cetera. As you will be aware, the budget for stroke is about 4% of the NHS budget. If you look at the spend in Wales, we must be spending at the moment about £285 million on direct NHS clinical care for stroke. At the present moment, we do not know where that is being spent.

10:00

[49] The first thing that we need to do is have a full economic analysis of exactly where that money is being spent to see whether we can improve the expenditure of the money that we spend on stroke. Then, we can decide whether investing a small amount of additional money would actually save money. Work has already been done by Omar Ishrak at King's College London for England about four or five years ago when a full economic analysis was done. There are people such as Omar and Marcus Longley at the University of South Wales who can calculate that if you invest this much you will save that much. We have to look at whether a small amount of additional investment would save in the long term. If you invest in staffing et cetera, you will reduce length of stay, improve clinical outcomes and reduce life-after-stroke expenditure on social care and benefits et cetera. We need to see where we are at the moment. I know that there is no additional money. We have to try to use what we have more effectively as well as looking at smaller investment.

[50] In terms of monitoring, we have developed the intelligent targets for the acute side of stroke. We have the sentinel stroke national audit programme by the Royal College of Physicians now, which is looking at the pathway. We have the five-year delivery plan and we have, as you know, on the back page of that, the outcome framework, where we are looking at some indicators to monitor the improvement in prevention, acute care and life after stroke. At the present moment, the health boards and the Welsh Government are putting out the baseline report of where we are, so that, with the quarterly reports and the forthcoming annual report next year, hopefully, we can see where there has been improvement. That is what we currently have.

[51] **David Rees:** Thank you, your answers have enthused Members to ask some questions. I have Kirsty, Leighton and Elin to come back.

[52] **Kirsty Williams:** I will wait until later on TIAs.

[53] **Leighton Andrews:** On the finances, you have just said that you estimate that around £285 million is currently being spent in the system.

[54] **Dr Freeman:** That is looking at 4% of the health budget.

[55] **Leighton Andrews:** Right. You said that you think that we need to spend a small additional amount. How small and how additional?

[56] **Dr Freeman:** I think that we need to do an analysis first and then we would come up with—

[57] **Leighton Andrews:** What would be the cost of providing the integrated service that you are talking about, overall?

[58] **Ms Griffiths:** I can give you an example of where a small investment would be really—

[59] **Leighton Andrews:** No, I want to know the total cost that you think would be necessary to deliver a service. What would be the total cost?

[60] **David Rees:** Have you been able to identify such costs?

[61] **Dr Freeman:** I could not give a figure at the moment.

[62] **Leighton Andrews:** Okay. You cannot give a figure, but, if you were going to invest in stroke risk reduction, where should the money be going? Should it be in developing the integrated network that you are talking about or should it be in public health education?

[63] **Dr Freeman:** Well, of course, public health would very much be part of an integrated network for stroke.

[64] **Leighton Andrews:** What should the balance be?

[65] **Ms Griffiths:** I can give you an example, if you just let me cut across here. We have been doing some work with Public Health Wales—this is the Stroke Association now. We are working with a chain of pharmacies across Gwent and the National Pharmaceutical Association to put together a proposal to seed fund a small pilot study looking at 3,000 people to see whether we can entice, through a marketing campaign, people to go into their pharmacies to get their blood pressure checked and have a pulse check all in one go, which would identify those who potentially have AF. The small chain of pharmacies has said that its pharmacists could also carry out electrocardiograms. This is nothing to do with their contract; it is all based on goodwill. If we could get members of the public to walk into their pharmacies and carry out these kinds of checks, we could save the NHS thousands if not millions of pounds. It is known that up to 40% of all ischaemic strokes are caused by high blood pressure, yet time and again there is no drive by Public Health Wales to look at these initiatives. It is relying on others. We wanted to carry out a similar initiative as part of our community pharmacy campaigns, of which we have now had two, and Public Health Wales was not interested in having a hands-on approach. Health checks for the over-50s are now done online. How can you identify high blood pressure and AF through an online health check? I do not understand. Those are just two initiatives.

[66] **Leighton Andrews:** Sure, okay. I would go in and have that check if it was offered in my local chemist. However, what I want to understand is what you think the cost of doing that would be. It is all very well coming to us and saying, 'This should happen and that should happen', but, at the end of the day, the Minister for health needs to see a figure on some of this stuff, and I am not getting any of that here.

[67] **Ms Griffiths:** Like I said, this proposal that we are currently working on is in a very draft format. We have just managed to get the buy-in of all the parties and we are in a process of drafting something to send to the Minister. It would cost £10,000 to carry out this pilot. It is peanuts, but it will have a have a massive impact.

[68] **Leighton Andrews:** What I do not understand from the evidence that you have given is the cost of what you are demanding. I have not understood that at all.

[69] **Mr Underwood:** We need the initial investment to do the research, to show what that cost analysis is. We are always being asked to provide services. Is it invest-to-save or is it return on investment? Sometimes it is very subjective, but if there was an agreement that we had some centralised financing to do some research on that, I think you would be happy with the rigour of the outcome of that, as opposed to us saying that or it being said through the groups.

[70] **Ms Griffiths:** We also have Marcus Longley, who has agreed to meet with us and to carry out this economic assessment, and NSC has indicated that there is possible money for funding it as well. So, we are in the early stages, but it is being driven through by people who just want to make a difference, as opposed to being driven top-down through Government.

[71] **David Rees:** Can I therefore assume that, at some point, you will be able to present something on your analysis?

[72] **Ms Griffiths:** Yes, absolutely.

[73] **Elin Jones:** I am a little bit unclear now as to what you are asking for. I want to take it back to the clinically managed network, which is where we started some of this conversation, though I think maybe Leighton took us to another place. In terms of the clinically managed network, the models exist with cardiac and cancer already, so that is something that could be quantified in terms of how it could be built and resourced in Wales. I wanted to ask you whether, in terms of issues around recruitment in Wales on stroke services and medically, the fact that we do not have a properly established, go-getting clinical network for Wales is a disincentive to recruitment. When you think about some of the areas in Wales, maybe in the area I represent, which is in the Hywel Dda area, they may feel as though they go into one district general hospital and are left there on their own, rather than feeling part of an all-Wales clinical network that is exciting for a medic to be part of. Do you think that it is a disincentive to recruitment that we do not have that kind of set-up in Wales?

[74] **Dr Shetty:** Stroke medicine as a specialty is relatively new. We came into existence around 2006. Until then, we did not have a stroke medicine service. The stroke service in Wales was delivered by geriatricians. The other important thing is that we did not have a stroke training programme in Wales until last year. Now, we have three trainees in post. When we had people who were interested in training in stroke, they went to England and they never came back. Nobody from England ever applies for a consultant post in Wales, for some reason. This is a reason why we are having difficulty in recruiting doctors, particularly for senior consultant posts in Wales. Hopefully, with our own trainees now in Wales, we should be able to recruit people into senior posts. I think that having an organised clinical network is certainly an incentive for people to work in that kind of environment. We have already shown that in south-east Wales, where we have developed a thrombolysis service. For example, Cwm Taf would never have been able to deliver a thrombolysis service without our collaboration. We are providing the service now from the University Hospital of Wales. We are going to make that into an even bigger network, hopefully involving Abertawe Bro Morgannwg as well. We have already shown that, with this kind of network arrangement, we can develop services, exchange ideas, develop research ideas and so on. So, we have shown strong evidence already that this is something that we need to be doing.

[75] **David Rees:** I am conscious of the time. We have three Members with specific questions. We have Leighton on GPs and Kirsty on the seven-day TIA service. William also has some questions.

[76] **Leighton Andrews:** In its evidence to us, Cwm Taf LHB talks about the risk factors for stroke being very similar to risk factors for cardiac disease, diabetes and other factors. Do you agree with that?

[77] **Dr Shetty:** Yes. We are dealing with the same vascular risk factor, but stroke has some specific areas that have potential to have a major impact. The most important one is probably atrial fibrillation, where we have very effective preventative treatment for both primary and secondary prevention. As to the other risk factors, such as smoking, about 19% of the burden of stroke is due to smoking. Similarly, if somebody has a healthy lifestyle, they are 80% less likely to have a first-time stroke. So, all of the things that we normally do for cardiac risk prevention also apply for stroke prevention. However, smoking, hypertension and atrial fibrillation are the three key areas that we really need to focus on to reduce the burden of stroke. If we focus on those three areas, we are covering a major chunk, as nearly 90% of strokes are related to one of these risk factors. This is where we should be prioritising.

[78] In answer to your previous question about where we should be focusing our efforts, I do not think that we can focus on one area in stroke, because it is a continuum. We need to be able to recognise the problem in terms of patients and GPs recognising the problem and then having access to the specialist service, and when patients are discharged from hospital, they and their carers should have support to deal with this catastrophic illness, which has a tremendous social and psychological impact.

[79] Therefore, it is a continuum. We need to be looking at the whole pathway rather than concentrating on one area. The biggest thing from my point of view is education. Still, the biggest problem is that patients ignore that they have a TIA. Forty-three per cent of patients will have had a TIA two weeks before a stroke. They will have gone to the GP who will have missed it; they would have come to the emergency department, who would have missed it. So, there is a big problem—

[80] **Leighton Andrews:** You have just taken me straight into my next question: why are GPs missing it?

[81] **Dr Shetty:** It is because, as I said, stroke and TIAs have great mimics. It is difficult to diagnose these conditions, because, unlike with acute coronary syndrome when patients have severe chest pain and feel as though they are going to die and they rush to hospital, with TIA, they might have a slight tingling of the upper limb, which resolves in 10 minutes and they would think nothing of it. They would usually associate it with something that they are doing at that time and they do not take action. When they go to the GP, there is nothing to find. So, we need to educate everybody. These are the things that we need to be taking action on.

[82] For example, one of my colleagues in Swansea told me that the son of a patient saw his father developing a stroke and tucked him into bed, so that he could take him to hospital the next day. This is what is happening now. There has been a tremendous amount of campaigning about thrombolysis—the FAST regime—and what we really need to be doing is a campaign about TIAs. Prevention has much more benefit than dealing with the after-effects of stroke. So, I want the Government to take this very seriously.

[83] **Leighton Andrews:** That is helpful, because that indicates an area of priority, but are you confident that GPs have sufficient training to identify the challenges?

[84] **Dr Shetty:** All doctors are trained to diagnose stroke. Having said that, they have so many other things happening in a busy surgery, so I would not like to criticise anybody for missing the diagnosis. I deal with only strokes and TIAs, so I can pick up the diagnosis immediately. It is not easy, because GPs deal with a lot of other things. So, for a non-specialist to pick up the diagnosis is not easy. However, if we had an ongoing training programme for everybody who is dealing with stroke and TIA patients, certainly, that would lessen the likelihood of missing the diagnosis. That is what we should be doing. It should be part of their regular ongoing CPD programmes.

[85] **Mr Underwood:** I have a brief comment. You are exactly right. Obviously, GPs are fully aware of their registered population and are incentivised to manage the co-morbidities of their registered populations. The challenge is members of the population who do not attend their GPs and are walking around with high blood pressure, irregular pulses and AF risks. It is more about the public health campaign, going back to what Lowri said, for individuals who are too afraid or have never traditionally gone to their GPs, who are the stroke patients of tomorrow. So, I would say that GPs do manage their risks extremely well, because, obviously, they are incentivised and it is in their best interests to do so. However, it is for those individuals who are not part of a registered population or do not attend their GPs on a regular basis, because, regardless of the fact that they might be over 50, or not, they are, potentially, for me, more at risk than those who do attend and are monitored.

10:15

[86] We have services such as vascular risk reduction and stroke and health improvement services. Hywel Dda Local Health Board would be an area where that is provided, but, again, it is not equitable. We have a standardised service in both Ceredigion and Carmarthenshire but, due to funds it is not in Pembrokeshire. So, if you look to us to do certain elements of that pathway or support, we can only do what we are funded to do. Our issue is that we want to provide that, but it needs to be equitably funded at an appropriate level. Hywel Dda Local Health Board would be a great example of where we do that and do it well.

[87] **David Rees:** We will now move on to Kirsty to talk about the seven-day TIA.

[88] **Kirsty Williams:** Recommendation 3 of the report, which was published almost two years ago, stated that, by April 2012—and the Government accepted this—people would have access to seven-day-a-week TIA clinics. I appreciate that the wording could be misleading, so I am just wondering whether you could tell us whether you feel that there is access seven days a week to a TIA service, and could you confirm that clinical guidance in relation to carotid surgery is now being adhered to in the way that it was not when the report was written?

[89] **Dr Freeman:** First of all, on the TIA service, we asked all of the health boards at the end of March 2012 whether they had access to TIA, for the high-priority TIA patients, within 24 hours. The majority of the health boards, except Betsi Cadwaladr University Local Health Board—and obviously Powys Teaching Local Health Board sends its patients out of Powys for TIA—had a service in the form of clinics from Monday to Friday, and, at weekends, the majority of these health boards were utilising the medical assessment unit so that a patient would access the hospital, be assessed by a medical registrar, go through the protocol, and be either admitted or discharged home with appropriate follow-up arrangements for the appropriate imaging and follow-up. Betsi Cadwaladr University Local Health Board is the only health board at the moment that cannot adhere to this requirement. We have just undergone a review of the whole stroke service for the first seven days in Betsi Cadwaladr, including access to TIA service, and there will be recommendations regarding improving the access 24 hours.

[90] **Kirsty Williams:** That is in relation to high-risk TIA within 24 hours.

[91] **Dr Freeman:** That is high-risk TIA.

[92] **Kirsty Williams:** However, the committee also made recommendations about low-risk TIA being seen within a week. Is that happening?

[93] **Dr Freeman:** Yes. There are weekly clinics in all health boards, including Betsi Cadwaladr, for the low-risk TIA.

[94] **Kirsty Williams:** Yes, but there is a difference between a clinic and everyone that is of high or low risk being seen in clinic.

[95] **Dr Freeman:** Yes.

[96] **Kirsty Williams:** Is everyone who needs to be seen being seen within 24 hours if they are high risk, and within seven days if they are low risk?

[97] **Dr Freeman:** We have no way of monitoring this at the moment.

[98] **Kirsty Williams:** Okay. So, we do not know.

[99] **Dr Freeman:** There are the TIA bundles, which were developed through the 1000 Lives campaign, but they did not go through for performance management. They were for the health boards to monitor their own performance and to look for continuous improvement. The SSNAP audit does not yet include TIA review, but the royal college is expecting, next year, to run spotlight audits for TIA services. So, that will be another way for us to be able to monitor our TIA service.

[100] **Kirsty Williams:** There was also the question on access to carotid surgery, which was really scary when we looked at it two years ago.

[101] **Dr Freeman:** As you know, there is the carotid endarterectomy audit. Around five are being published formally next month. There are still delays in getting access to timely carotid intervention—there are delays between symptom onset and referral to surgeons, and from referral to surgery.

[102] **Kirsty Williams:** What kind of delays are we talking about in relation to what clinical guidance states should happen to those patients?

[103] **Dr Shetty:** Ideally, they should be operated within two weeks. If you operate within two weeks you are preventing 180 strokes per 1,000 patients treated.

[104] **Kirsty Williams:** How many patients are being operated upon within two weeks, and how many are not?

[105] **Dr Shetty:** We do not know at the moment. I can tell you about Cardiff. Once they come into our system they are operated upon fairly quickly, with very few exceptions. In fact, most patients are operated upon within a couple of days. We have problems—

[106] **Kirsty Williams:** We are not all with you in Cardiff, Dr Shetty, are we? I wish that we all had you. [*Laughter.*] We would then be doing all right.

[107] **David Rees:** I am getting conscious of the time. Are you okay, Kirsty?

[108] **Kirsty Williams:** Yes, that is—

[109] **Dr Freeman:** The audit does demonstrate significant delays.

[110] **Kirsty Williams:** Okay. Thank you. So, two years down the line, we do not know.

[111] **Elin Jones:** The results will be published—

[112] **Dr Freeman:** We have had sight of the draft audit, which will be published next month. We are already halfway through round 6 of the audit. There are issues with inclusion of all vascular surgeons in the audit as well. So, not all patients are being reported to the audit process.

[113] **David Rees:** The last question is from William.

[114] **William Graham:** From the point of view of the patient, I have a constituent who sadly suffered a TIA and complained that, once that had happened, they did not have sufficient information. Clearly, they are entirely in tune with the recommendations of the committee to prevent further stroke action, but they are not quite sure how to take it. They have difficulty in receiving proper information, both from clinicians they have seen in hospital, perhaps, and also from their GP. How can that be improved? It must be a priority, and would probably be pretty simple.

[115] **Ms Palazon:** In the Stroke Association, all of our work is always in partnership with others within the stroke community. Every year, we dedicate a full month, the month of May, to stroke. We call it Action on Stroke Month. We are planning 2014 now, as we speak, dedicating the month to raising awareness about TIA. So, we would not want that to be 'That is it, May is over—no more'. We would like to see that as the genesis of something that can support the implementation of all of these recommendations and try to really maintain it in the public domain. If we go back to the FAST campaign, that is one of the most successful health campaigns ever in the history of the UK, yet we do not maintain that presence constantly. There are, for example, road safety campaigns that are maintained throughout the year, but FAST is not maintained. FAST and TIA should be prominent in the public domain and across the age spectrums, in education, schools, universities et cetera—they all have a role to play in this. It is not just the NHS.

[116] **Dr Freeman:** The Royal College of Physicians audit does enquire of health boards whether they provide adequate information on stroke and TIA on the wards and in the clinics, and all health boards responded positively to that. That is responding positively to having the information. We have no way of assessing whether all patients receive that information. The other development that has occurred recently is that you will be aware that ambulance personnel are often called to patients who appear to have had stroke-like symptoms that have resolved. If a patient is not transported to hospital, then the ambulance service has developed an information leaflet to give to the patient, with their blood pressure, their blood sugar, and other information. That leaflet they are to take to their general practitioner, and it explains about TIA. That is a recent development that has yet to be rolled out, but the information leaflet has already been developed. That is one of the latest developments.

[117] **David Rees:** I will give the final word to Paul.

[118] **Mr Underwood:** Just to say that we are working with Anne and her team and with the Welsh ambulance service to look at considerations for signage that would be able to reference key messages like FAST, and maybe Ask First TIA, or AFTIA, messages. That will hopefully be on the side of ambulances. That is something that the ambulance service has seen to be a very positive move, and we would definitely support that. I know that that has

been cascaded down from Anne and the delivery unit of the NHS as well—that partnership approach and signage would be a very good move for the general public.

[119] **David Rees:** I thank you all for attending today's session. Again, I apologise for the confusion that we had at the start. May I also thank you for agreeing to come together? However, given the time constraints that we have experienced, if there is any additional information that you would like to submit to the committee, please do so in writing. We can then consider whether we need another oral session as a consequence of that. Thank you very much for attending.

[120] I suggest that we have a five minute break before we go on to the next group.

Gohiriwyd y cyfarfod rhwng 10:24 a 10:33.
The meeting adjourned between 10:24 and 10:33.

Lleihau'r Risg o Strôc—Ymchwiliad Dilynol: Panel 3—Byrddau Iechyd Lleol a Iechyd Cyhoeddus Cymru
Stroke Risk Reduction—Follow-up Inquiry: Panel 3—Local Health Boards and Public Health Wales

[121] **David Rees:** Welcome back to this morning's session of the Health and Social Care Committee. I welcome the witnesses. We have Janet Smith and Dr Yaqoob Bhat from Aneurin Bevan Local Health Board; Hugo van Woerden and Nigel Monaghan from Public Health Wales; and Amanda Smith, who is representing the Powys Teaching Local Health Board. Thank you very much for attending, and I thank you for your written evidence for today's inquiry. Given the limited time, I would like to go straight into questions, if that is okay. We will start with Kirsty Williams.

[122] **Kirsty Williams:** Thank you, and good morning. The committee—in recommendation three of its report two years ago, which was accepted by the Government at the time—recommended that, by April 2012, everybody in Wales would have access to seven-day-a-week TIA services and that we would be meeting carotid surgery targets across Wales. From your perspective, as people who deliver services on the ground, could you confirm whether that is the case in health boards across Wales?

[123] **Dr Bhat:** I can talk about how we in ABLHB provide the TIA service. Two years before, we had a five-day TIA service. When we audited that, we were not seeing the patients within the time. We took action by educating the GPs and we also made some more changes by providing for the hot-slot spots within the health board. We have seen a significant improvement, and I can say that we now see almost 90% of our high-score TIAs within 24 hours, and almost all of the low-score patients within seven days. If we are not able to see 100% of our high-score patients, it is because we cannot get hold of them. When we receive the referral, we should have a telephone number for the patient.

[124] Regarding the five-day or seven-day service, we have a five-day specialist service, but we also have a seven-day service in place. It means that, over the weekend, for patients with high scores, GPs can admit a patient straight to the medical admission unit, where they are assessed by the medical registrar, who has been trained in how to deal with TIAs. They can take appropriate action, take scans and take appropriate measures such as administering medication, doing electrocardiogram tests, and then that patient will be booked straight away for the hot-slot clinics on the Monday morning to be assessed by the specialist.

[125] As for the question of whether we have a 24/7 carotid and vascular imaging service, for five days per week, a same-day vascular imaging service is available. We have discussed

whether we need to do it over the weekend as well, but we felt that there was no need to do vascular imaging over the weekend, as we would not take action over the weekend because we do not have the facility at the moment to do surgery over the weekend. The number is very small. We do around 60 carotid endarterectomies in a year. So, it was not regarded as being high-emergency surgery that needed to be done over the weekend.

[126] **Kirsty Williams:** Patients should be seen within two weeks, should they not? If they need surgery, they should have that surgery within two weeks. Are you able to meet that target?

[127] **Dr Bhat:** We were not able to meet the targets three months ago. The health board was quite a way off it. However, we have now appointed a new vascular surgeon, who has become a member of the stroke board and is a member of the stroke team. We have taken the combined majors together. We have set the targets. For the last month, our carotid endarterectomy rate has gone up and we now have a plan that, within six months, we will achieve 80% of the targets for carotid endarterectomy.

[128] **Kirsty Williams:** It is reassuring to hear that from Aneurin Bevan health board, given that a lot of my constituents come down to Aneurin Bevan for their treatment, I am very grateful to see that services are improving. However, I wonder what happens in the rest of Wales. Does anyone have a view?

[129] **David Rees:** Dr van Woerden, do you have a view as to what happens across Wales?

[130] **Dr van Woerden:** Your previous speaker, Anne Freeman, provided some information regarding her view of the big picture in Wales. The big picture is that it is improving but that there is some way to go.

[131] **Mr Monaghan:** Certainly, the one thing that I would say is that I have recently commented on a draft report that had data that suggested that around 96% across Wales of those eligible for thrombolysis were getting it. That is, they were getting access to the clinics. There is some way to go to get as many of those as possible getting that treatment within an hour. Within an hour is not the target, but we know that, the earlier you get it, the more likely it is to give you really positive benefits.

[132] **Kirsty Williams:** That is thrombolysis, but what about access to TIA surgery?

[133] **Mr Monaghan:** I do not have any data on that.

[134] **David Rees:** Amanda, you wanted to make a comment.

[135] **Ms A. Smith:** Yes, with regard to access to TIA treatment from Powys, we are accessing it all over Wales and also in England. It is a five-day service in terms of the clinics. At the weekend, it is as was described earlier. I just wanted to add that we are working with the commissioners in Herefordshire and Worcestershire to look at a combined service between the teams across Herefordshire and Worcestershire to ensure that there is a weekend service for TIA.

[136] **David Rees:** Before you go on, may I apologise for the echo that you are hearing. We are checking the technology. We have been told that, technically, it is okay outside, it is just a problem in here.

[137] **Dr Bhat:** We have stroke meetings taking place every Wednesday afternoon, at which we discuss our stroke patients. The feeling that I get from there is that the health board is aware of the issues and is trying to work on them. I know that Cwm Taf Local Health

Board has better results, but I cannot answer for the rest of Wales.

[138] **David Rees:** I understand that. Kirsty, do you want to respond to that?

[139] **Kirsty Williams:** No, that is fine, thank you.

[140] **David Rees:** I call on Lindsay.

[141] **Lindsay Whittle:** Good morning. We heard from previous witnesses that there is a shortage of consultants and trainees. Do you have any comments on what could be done to make sure that that does not exist? We also heard that there is a huge need for greater co-ordination of resources, perhaps by working with social services and aftercare, and also realignment of finances into the preventative services. They did not ask for any extra money, to be fair—they just asked for better realignment of the moneys available.

[142] **David Rees:** I will ask Public Health Wales to respond first on preventative work in particular.

[143] **Mr Monaghan:** The comment that I would make on the resources for prevention is that it is worth bearing in mind that there is some good news out there in terms of stroke incidence and stroke mortality. Over the past few years, the effort that has gone into prescribing statins and blood pressure drugs, et cetera, seems to be having an impact, and that is true across Wales and beyond. We are seeing a reduction in the incidence of stroke, even though we have an ageing population, and mortality rates are improving. That does not mean that there are not things that we might want to do. There was something in the media last week reporting on the stroke register for south-east England based in King's College London. We do not have a stroke register, but its data showed continuing decrease in stroke incidence, although it is not seeing a decrease in incidence for younger people with strokes, or for people from an Afro-Caribbean background, in particular. We do not have a handle on that yet—we do not have the data in Wales, as we do not have a register. However, in terms of thinking about prevention of stroke, that is the sort of thinking that I have been trying to push into our system so that we can get more of a handle on diagnoses or ethnic minority backgrounds that are at greater risk of stroke, and think about focusing more effort in those areas.

[144] **Dr Bhat:** What I can say is that we had the audit, which clearly indicated that there was a shortage of staff in hospitals in Wales compared with the rest of the UK. From the Aneurin Bevan Local Health Board's point of view, we understood that there was no additional money. We looked at the service in the bigger picture, and we are looking to make a few service changes; we have already had five workshops. Jan will add some further comments on how we are going to centralise the service in order to fill the gaps that were identified through the audit programme.

[145] **Ms J. Smith:** The audit programme has identified deficits in Aneurin Bevan and other health boards across Wales. The action that we are taking at Aneurin Bevan level is our stroke improvement plan, which has a very ambitious reconfiguration section to it. It will look to reduce the number of hyper-acute admitting areas, which will allow us to focus our medical staffing and non-medical staffing—the nursing staff and therapy staff—into fewer centres, and therefore concentrate their efforts on patients coming in through those centres. I know that it is not the subject of today's discussions, but it is quite important, in terms of the pathway, that we are looking at the rehabilitation component. That is still part of the staffing resource that you alluded to as to how we use it most efficiently; currently, we are not using our staffing resource efficiently, because we are delivering for small numbers of patients on too many sites. So, that work is under way at the moment. In fact, there is a meeting tomorrow that will look at the staffing, the costings and the models. We are down to three potential models that we will consult on. That may or may not—we do not know the answers

yet—release resources to reinvest in other parts of the pathway.

[146] **Lindsay Whittle:** I am told that we need 18 stroke consultants in Wales. Do we know how many we have?

[147] **Dr Bhat:** The stroke service in Wales is provided by the geriatricians, most of whom have other commitments such as geriatric medicine and acute medicine. So, there are only two specific stroke specialist consultants in Wales. I do not have a figure for how many are needed in total to fill the gaps, but I am aware that there has not been much hunger for stroke trainees to work in Wales. We sent a few trainees to England to be trained, but they did not come back. We now have a trainees programme in Wales at last; we have three registrars getting trained here. We are hopeful that we may be able to recruit them, because, although we understand that there is a staffing issue, at the same time we understand that the post has been vacant for some time and there has not been much enthusiasm to come here.

10:45

[148] **William Graham:** When we took evidence at the earlier stage in committee, before issuing our recommendations, we were concerned about access to stroke prevention for vulnerable groups and other hard-to-reach groups, particularly those with mental health issues. Has that improved at all?

[149] **Dr van Woerden:** I am aware that Wales was one of the first places to introduce annual health checks for people with learning disabilities or difficulties, and I think that has been a phenomenally successful programme. That includes pulse checks and other things that would identify individuals at greater risk—cholesterol testing and other things as well. So, there is something for that group that is well embedded in the system, but I am not aware of specific initiatives at a national level for other groups.

[150] **Ms J. Smith:** There is some work being undertaken on inverse care law, looking at deprived populations. So, that is not necessarily specific condition-based populations, but deprived populations generally. A paper is going to our board in November with a proposal to pilot targeting for cardiovascular risk in a ward in Blaenau Gwent. We are looking at Blaenau Gwent West as a potential site for a pilot scheme and there will also be a second site, in Cwm Taf, where we will be piloting that approach. So, it will pick up some of the deprived communities, but is not condition-specific.

[151] **Mr Monaghan:** My point links to that. When work is done on trying to improve the health and wellbeing of people with, say, mental disorders, a lot of it is cross-cutting, such as healthy eating et cetera. There are also stroke-specific risks with certain groups, which you could then say are the most vulnerable groups, and an example is amphetamine use. That is a risk for stroke. That is not widely known; I only got that from Anne Freeman as a new piece of knowledge a couple of weeks ago. However, it is an example of an area that, having highlighted it, we are now able to start thinking about what are we doing in that area and what we could do. It has implications for all sorts of these things, such as stroke awareness. If we are doing work with substance misusers, do we raise awareness among substance misusers of the risk of stroke associated with amphetamines, not just for themselves but for the people they associate with?

[152] **David Rees:** Amanda, do you want to comment?

[153] **Ms A. Smith:** I want to emphasise the need to understand our population. On targeting prevention activities, people with mental health problems and others within our population who have particular needs and who are vulnerable, we are currently engaging in the health, social care and wellbeing agenda with the local service board with our partner

organisations, undertaking a population needs assessment. We are also piloting a neighbourhood management scheme looking at needs in the round and the responsibilities of all partners in the local service board. However, I would like to add that what we know about our population is that we have a rural area and we have an ageing population. We also know that emergency admissions mortality and lifestyle risks for stroke are lower in Powys than elsewhere, but heart failure and hypertension are higher. That correlates very much with the age of our population. So, our vulnerable groups are our older population who have a range of other difficulties. We know, for example, that exercise on prescription for them is directly linked to geography and access to travel. So, we need to be thinking creatively about how we make services and support accessible to them.

[154] **William Graham:** To follow that up, on the next stage, those folk who have had a TIA or stroke, perhaps with vascular dementia, are a difficult group to rehabilitate in any way. Have any studies been done on that?

[155] **Dr van Woerden:** There is the Caerphilly cohort study, which is a huge study that has been going on for many years. It is on cardiovascular risk, with a large focus on vascular dementia. So, there is a large cohort study in place.

[156] **William Graham:** Could we see a copy of that, do you think, Chair?

[157] **Dr van Woerden:** I can get you details.

[158] **William Graham:** Thank you very much—please send it to the clerk.

[159] **Rebecca Evans:** I have three questions for Public Health Wales on the evaluation of the stroke risk reduction action plan. The Minister told us in response to our last report that you would be undertaking an evaluation of the plan. I understand that it was completed by April 2012 but was not put in the public domain until September of this year, and I was wondering why that was the case.

[160] The Stroke Association told us that, within that evaluation, there was no co-ordinated approach to evaluate the original 40 recommendations and that, as a result, the stroke delivery plan that followed it is, basically, mark 2 of the risk reduction plan and does not really move us any further forward. Finally, how did you go about the evaluation process and whose expertise did you draw on? Again, the Stroke Association told us that it was not consulted on that piece of work.

[161] **David Rees:** Which one of you wants to answer that question? Dr van Woerden?

[162] **Dr van Woerden:** I think that Public Health Wales had a role. It is not a performance-monitoring or management organisation; it is a facilitative organisation with responsibility to work across systems to try to improve health. Its role in undertaking the evaluation was, if you like, to be the neutral facilitator in the context of that evaluation. As you know, the evaluation was led by Siân Price and Julie Caffel, who, interestingly, had a very strong inequalities and vulnerable groups-type background. So, I think they were well placed in terms of their skill set to do that. The idea was to invite anybody and everybody who would want to take part in the evaluation to contribute and submit views. If there were any groups that were inadvertently missed out in that, then I apologise for that. I think that the exercise was useful, however; it did gather views from a significant number of stakeholders and provided the opportunity for those stakeholders to reflect on what had happened. The role of Public Health Wales in that was to sum up and re-present to the system what the stakeholders were saying as a neutral third party in the situation. That was then presented back to the Welsh Government. There is recognition that that is part of a journey that is ongoing and that needs to be tied together. Anne Freeman has called for a particular approach

to that. There are different views as to how all that is brought together across Wales, and I think that that is part of what this committee needs to consider and make recommendations on.

[163] **Rebecca Evans:** Are the data available, do you think, for robust analysis to be undertaken anyway? Our previous witnesses suggested that data are not available for all the different aspects of stroke prevention.

[164] **Dr van Woerden:** Across a lot of health topics in Wales, we have challenges around the quality of data that we have and collect in the system. The delivery support unit has been looking primarily at data in recent times. Some of the other colleagues from health boards can maybe speak better towards that. There have been care bundles and the 1,000 Lives Plus team has been very involved in supporting that approach. However, the 1,000 Lives Plus approach is very much one of developmental support, rather than performance monitoring. It is about creating tools such as the stroke passport, and other things, such as care bundles, that local teams can use to assess themselves. Then you have the Royal College of Physicians, which undertakes this large audit as well. So, there are levers in there. Nigel alluded earlier to the collation of that in a larger form in terms of a register. There are gaps in that way in terms of data. Other colleagues may have reflections on data.

[165] **David Rees:** Jan, do you want to reflect on the data collection and data analysis that may be taking place in your health board and other health boards?

[166] **Ms J. Smith:** I will comment on the bundle approach first, if I may. The 1,000 Lives Plus care bundle approach has been immensely valuable in improving and driving improvement in service delivery. The bundles are built on evidence and that evidence is reflected in the RCP audit, so there are a number of triangulations that happen in terms of what should be clinically delivered and at what point. The bundles have been used at health board level across Wales to drive up care. They have succeeded in doing so over recent years—over the last three, four, probably five years—to improve the hyperacute and acute phase in particular, but also the TIA management. I would emphasise, however, that bundles are there as a tool for improvement and not really a tool for performance, even though we clearly measure performance against the bundles. So, those data are held at health board level and are available. Some of those data are submitted into the delivery and support unit, but not all. Currently, we submit into the DSU the bundle data on the hyperacute and acute phase of a stroke patient. We do not submit the TIA data, but those are held locally. Yaqoob may be able to expand on that a little more.

[167] **Dr Bhat:** We are not sending the TIA data because it is not considered a tier 1 priority, as the acute stroke bundle has been. However, we do monitor them locally within the health board and we are consistent in terms of performance and the 1000 Lives Plus targets. I am quite happy with the way that we are dealing with the TIA service at the moment, although, we have challenges, particularly for the carotid endarterectomy, which we are hopeful that we will address.

[168] **Ms A. Smith:** We have not mentioned the quality and outcomes framework data that we look at, and, relevant to this, we know that 95% of people with atrial fibrillation are treated in Powys with anti-coagulant and anti-platelet therapy, which is equal to the rest of Wales. We have increased slightly the number of people with hypertension who are given lifestyle advice, and we are now at 84%. So, we do look closely at the QOF figures.

[169] **Elin Jones:** I have two questions. One is on atrial fibrillation and whether you have any evidence that there has been an improvement in the last two years on the diagnosis of atrial fibrillation, especially at a GP level, and whether, in any of the health boards or across Wales, there is any kind of progress on putting a system in place to co-ordinate the diagnosis

of atrial fibrillation.

[170] My other question is on leadership on stroke services in Wales. We had a discussion in our previous session with witnesses on the important role that a clinically managed network could provide in providing that leadership for stroke services improvement, ensuring that there is learning of good practice across Wales from particular parts of Wales and how it would aid, possibly, the recruitment and retention of staff in stroke services. So, from a local health board and Public Health Wales point of view, I wonder whether there are benefits to be had from having a clinically managed network for stroke services in Wales.

[171] **Dr Bhat:** Regarding the AF diagnosis and management, from Aneurin Bevan health board's point of view, from 2012-13, it has become mandatory, as part of the QOF, that patients who have been diagnosed with AF have a chart score done and will be reviewed after every year. We have seen, consistently, SASD-wide, in the figures that primary healthcare has sent to our health board that there is a big question about those who are not diagnosed with AF and are in the community. There is already a programme running in relation to 1000 Lives Plus and the primary care quality service, which has helped to produce the software, as to whether it can identify people post-65 as opportunistic patients to have the pulse check to diagnose AF.

[172] I mentioned to the board that Aneurin Bevan LHB will be the first health board to use that software, and nine primary health centres have signed up for it. The 1000 Lives Plus will collect the data in the next six months and, by March 2014, we should be able to use that data and see whether they can be shared with other practices. We can then get information from it about whether it will need to be done at a national level, or whether there are any costs behind it. So, we have already started that programme in the nine primary health centres in Aneurin Bevan LHB.

[173] **Elin Jones:** Is there any evidence that the preventative diagnosis of AF at primary level is happening in other parts of Wales?

[174] **Mr Monaghan:** The complication here is the fact that while we have NICE guidance recommending opportunistic screening, we have the national screening committee, which is due to report next month on whether the screening should go on at all. It is a strange position to be in, because we have a body of experts who are looking at evidence making one recommendation, and another group of people who are experts on screening who have yet to report. So, it is very hard to make formal recommendations and not be aware that we could have egg on our faces within just a couple of weeks.

11:00

[175] So, the views on this have been fairly clear, looking back over the last few years, and it would be a good idea if pulses were checked manually. That is what the NICE guidance says; it is manual checking, because not all of the machines are capable of picking up an irregular pulse. I speak as somebody who has one at the moment, and I saw my GP yesterday for an ECG. It really is an issue where I would not want to be pushing hard. I would like to see what the national screening committee says, and then, as soon as the committee has spoken, and if it is recommending the same thing, I think that we really should be pushing hard on it because we then have the body of experts in screening saying it too. At the moment, I do not know what it will say. I have not had any noise back on that, but I am aware that that process has been going on for over a year. We are still waiting for the national screening committee to report. I do not know whether that helps, but that is the position that we are in. We have a group here, based on a previous report, which is recommending that we follow a piece of NICE guidance that is, in itself, something that is not being reviewed by NICE. However, that same subject is being reviewed by the experts in screening.

[176] **Dr Bhat:** They are probably quite useful—[*Inaudible.*]—1000 Lives programme about the opportunistic screening or the pulse checks. That might then help us with our pulse checks in terms of the quality and outcomes framework, which is not happening at the moment. So, we will see how things will come up next year.

[177] **Elin Jones:** What about the clinically managed network—the national network in Wales?

[178] **Ms J. Smith:** I think that it would be worth noting the amount of leadership that does exist in NHS Wales currently. The high profile that stroke has, both at Government level and at health board level, and the exceptional leadership that we have seen occur predominantly in a voluntary way where people are placed in a position to actually take that leadership forward. I would particularly refer to Anne's position, as the national stroke leader, and the drive and support that she has been able to provide to health boards through her role in the delivery unit. There is also the national stroke delivery group, which, until recently, has been chaired by central Government, initially by performance and more recently by a deputy chief medical officer, but that is actually in the process now of being revised and reconsidered. There are also regional stroke networks, which I think were alluded to by previous colleagues, which network on a regular basis. That is clinically driven currently. There is a Wednesday afternoon use of technology to enable clinical colleagues to discuss cases and processes. We are looking at how we can use that to rekindle regional discussions perhaps around thrombolysis and so on. So, against that backdrop, there is a significant amount already in place, but it is not as well co-ordinated as it perhaps could be, hence the argument for a national clinical network along the lines of the cardiac network and the cancer network, which are resourced. Currently, the stroke network is very much delivered on the goodwill of the people who are very committed to improving stroke services in Wales.

[179] **Mr Monaghan:** I would add that such a network could be very good at co-ordinating our efforts and helping us to develop a national infrastructure for some of the things that do not necessarily need a lot of money but which could assist us. If we are talking about public awareness campaigns, it would be great to integrate and co-ordinate things, so that anything going on nationally is supported locally and vice versa and so that you get the momentum there. I know that you were discussing earlier issues about GPs' role in this, and, wearing a different hat in a different area, I have made the argument that a managed clinical network can act as an umbrella under which you can develop care pathways and develop a combination of resources, training materials et cetera to help the likes of GPs to develop enhanced skills in an area. I think that there is a potential role for a network, which has that professional input et cetera, in helping us to develop that infrastructure across Wales.

[180] **David Rees:** We will now have the final question, from Kirsty.

[181] **Kirsty Williams:** I am just curious about whether anyone will have an idea of the costs associated with delivering a network in cancer and cardiac services. How much does the network cost? Does anyone have any ballpark figures?

[182] **Mr Monaghan:** My personal view has been to not come at the problem from that direction. The direction that I have come at it from has been that, to a degree, you can regard stroke as a cardiovascular event and, therefore, as part of cardiac disease. Therefore, the cardiac network should be supporting the stroke network out of the existing resource alongside it. The rest of us seem to have to do more with less. Asking the cardiac network to support the stroke network would be one way of addressing this.

[183] **Kirsty Williams:** Does anyone have an idea of the costs associated with managing the network?

[184] **Dr van Woerden:** There are two managers who are employed. The chair is a chief executive of a health board. The additional resource is the time of people attending meetings and coming together.

[185] **Kirsty Williams:** So, do you have ballpark figures on the two people whom we would have to employ?

[186] **Dr van Woerden:** It would be possible for one of us to go away and ask the cardiac network, for example.

[187] **David Rees:** It would be very helpful if you could provide us with that type of information.

[188] **Dr Bhat:** It is easy to get that information [*Inaudible.*]

[189] **Kirsty Williams:** It just strikes me as slightly odd, if we are spending 4% of the national health service's budget on a particular condition, that we do not see fit to employ two people to make sure that the money we are spending is right.

[190] **David Rees:** If you could come back to us with something on that, it would be very helpful. Thank you very much for your time. Unfortunately, time has caught up with us. Thank you very much for attending this morning. You will receive a copy of the transcript for factual corrections. If you find that you have any further information from the discussions this morning, please feel free to write to the committee and we will be able to take it into consideration.

11:07

Lleihau'r Risg o Strôc—Ymchwiliad Dilynol: Panel 4—Cyrff Proffesiynol
Stroke Risk Reduction—Follow-up Inquiry: Panel 4—Professional Bodies

[191] **David Rees:** Good morning, and thank you for coming this morning. I apologise for the slight delay; we have experienced some technical problems this morning, so we are overrunning slightly. I welcome Dr Jafar and Dr White from the BMA, and Nicola Davis-Job and Carole Saunders from the Royal College of Nursing. Thank you for coming this morning. I thank both associations for the written evidence you have provided to us. We are tight on time this morning, so I hope it is okay that we go straight into questions into relation to the stroke inquiry that we are undertaking.

[192] One of the issues clearly identified has been leadership and the clinical networks that might be in existence. Do you wish to comment on the position you see as leadership at the moment in relation to national clinical networks operating in stroke?

[193] **Dr Jafar:** Leadership in the NHS is very important. What I mean by 'leadership' is we need, when we put a plan in place, to identify who is responsible for implementing the plan—who is doing what and which department is responsible for which business in the plan? For example—I always give stories to back up my evidence—I met a lady patient who was a nurse in Cardiff, in the prison, and she had had a CT scan of the brain in 2000. She was referred to me a few months ago, and this lady was complaining of numbness on the left side and a slight weakness. I noticed that there was a previous CT scan of the brain, so I went, as always, to the clinical workstation in our department, and in front of me is a computer. When you see a doctor doing this without a computer nowadays, this is a management leadership problem. There is always a computer, there is always a check of the previous radiological and

biochemical investigations and results of the patient. I saw that the previous CT scan of the brain showed meningioma, and she did not know about it. The GP did not tell her about it. This lack of communication between primary and secondary care is part of the leadership problem in Wales. I know that we now have seven local health boards, which is better than 22 trusts, but we still have communication problems. We still do not have an IT system that could work, and we are still not saving money in this part of the plan. In these recommendations, Mr Rees, I found that there was a lack of leadership, if you read through how to implement them. That is what I meant, really, by leadership.

[194] **Ms Davis-Job:** I would just like to add to that and agree with it. I think that leadership is everybody's issue, and we should be encouraging healthcare support workers and the whole of the nursing workforce to look at leadership and their role in that, and in advocating patient's wishes. I would be interested to see how many hand-offs there were, or how many people that lady must have seen before Dr Jafar who maybe could have had a chat with her about the issue. It is not one profession; we should look at the workforce as a whole, really.

[195] **Lindsay Whittle:** Good morning—is it morning? I cannot see the clock, and it is dark in here.

[196] We have heard from previous witnesses, from the Stroke Association and the Welsh Stroke Alliance, about the shortage of stroke consultants in Wales. My guess is that there is a shortage of specialist nursing staff trained in stroke work as well. What action do you think is needed to ensure that we have adequate numbers of appropriately trained staff? Also, is anybody able to tell me how many specialist stroke consultants there are in Wales? We were told that we need 18, but nobody knows how many we actually have.

[197] **David Rees:** Let us hear from the specialist nurses first.

[198] **Ms Davis-Job:** I would like to say that we have no consultant nurse for stroke. I would like to draw your attention to the workforce in general and maybe look at the roles and responsibilities, and specialist nurses have a huge part to play in their role. They can do many of the same things that medical colleagues can do. Also, I would like Carole to tell you about the sentinel audit research that is being proposed, specifically looking at specialist nurses.

[199] **Ms Saunders:** I do not know if you are aware of it, but every two years, we do a sentinel audit of the organisation, and when they crunched the numbers recently for the last round, they showed that the lack of nurses on a ward or in an area has a direct effect on the outcomes for the patients. So, we are going away now and they are going to do some proper research so that we can bring it back to areas like this and show you that it is actually the nurses who make the difference to patient outcomes. We always felt that we knew that, but we have not had any hard evidence. We are now going to be able to have that hard evidence.

[200] I would just like to say again with Nicola that we do not have any consultant nurses in Wales. I am a clinical nurse specialist by trade, but I do not feel that there is a strategic person I can go to. Given that my role is clinical, I deal with the patients, but I feel that I need somebody in a strategic position that I can go to to say what we need—'We need you to go to Welsh Government; we need you to ask for this, and we need for this and that to happen'. So, I feel quite strongly that we do need a clinical consultant nurse.

[201] **Lindsay Whittle:** I am sorry to lead you, but that possibly needs more money invested in training, which is important, as well as in recruitment.

[202] **Ms Saunders:** Absolutely.

[203] **Lindsay Whittle:** I am sure that if you advertised, people would apply, but is the training adequate as well?

[204] **Ms Saunders:** Unfortunately, in Wales, there are a couple of courses that we do, but they are both in south Wales and not in north Wales, and we have to go outside Wales to get any more training. So, if I want to go on to do anything more in stroke, I have to go to England, and therefore I have to ask my health board for money, and that is costly—and in this kind of climate, the chances of me getting any extra education will be limited, I fear.

[205] **Ms Davis-Job:** Could I just add one thing? We do need general nurses who have a basic training in stroke, and then we need the specialist nurses, consultant nurses, with further training. Consultant nurses in Wales in particular are not the same as those in England, where you can just advertise the job if you have the money. They have to go through strict scrutiny by the chief nursing officer's office, and they have to be educated to Masters and PhD level to be able to apply for the job. The scrutiny of the job is, I think, really important, because we have a much higher standard in Wales.

[206] **David Rees:** May I ask the question of the consultants?

11:15

[207] **Dr Jafar:** I think that we should agree first on the definition of 'stroke consultant'. All over the country, in England, Scotland, Wales and Northern Ireland, we have neurologists whose speciality is neurology, but they are doing stroke medicine, and we have geriatricians doing stroke medicine. In Wales, most of the practice of consultant jobs on stroke are run and done by geriatricians. Neurologists have a certain part to play in it, in that they are on the rota to thrombolyse stroke patients, but they are not actually doing stroke medicine. In Wales, you have only one doctor who has been trained to be a consultant stroke physician, and that is my colleague Dr Bhat, who was in front of you earlier. He trained in Scotland in stroke medicine.

[208] In postgraduate medical training through the royal colleges and the General Medical Council, they give numbers for doctors for their high-speciality training. I gather from Professor Tony Rudd, the clinical lead in the country, who is on the audit panel of the Royal College of Physicians in London, that there are only 30 places to be given to 30 postgraduate doctors for their training in stroke. How many do we have in Wales? Dr Hamsaraj Shetty spoke last year about one or two. So, we need more specialist registrars to be trained in stroke medicine. That is very important for Wales. I need to say that in front of this panel. We have a very good number of speciality and associated specialist doctors in geriatrics. Associated specialist doctors are very well trained; they are doctors with high degrees and qualifications. We need to use their skills in stroke medicine as well. So, that is the Welsh conclusion and our solution to the problem of having a low number of stroke physicians. I am personally an associated specialist, but I have a large number of patients in the stroke and TIA clinic in Wales. I have seen 3,000 TIA patients since 2006 in my TIA clinic in the Royal Gwent Hospital. So, this is a solution to the problem—an immediate solution, if you like.

[209] **Rebecca Evans:** I have a question for the RCN about the role of the specialist nurses. We are particularly interested on this committee in stroke-risk reduction and prevention. Do the specialist nurses play a role in prevention, or do you really come into play after somebody has had a stroke? Also, do you have any contact with patients who have had a TIA to try to prevent a major stroke following that?

[210] **Ms Davis-Job:** Yes, nurses run their own TIA clinics. More general nurses would see patients who might have diabetes; they might be district nurses and would see patients who are at risk and could give the prevention message before someone has a TIA. Certainly, after someone has had a TIA, we need to look at roles and, maybe, look at the workforce as a

whole.

[211] **Rebecca Evans:** Do you feel that you currently have sufficient training to deal with stroke-risk reduction? I understand from your comments that we might have to look again at workforce planning; do you have any ideas where we should start?

[212] **Ms Davis-Job:** When I used to chair the education sub-group of the Welsh Stroke Alliance, we started at a very low level, we got lots of information and we pinched the stroke training and awareness resources programme, which was already validated in Scotland. We then got a similar programme validated by Agored Cymru, which is our own Welsh Open University. That was at a very basic level, but it is a good place to start. We are a small nation. I did my Master's degree in England, because I could not do the course that I wanted to do in Wales. I was given the opportunity—although, with regard to funding, I paid for it myself—to go to England to do my Master's degree.

[213] **Dr White:** The majority of stroke prevention work is undertaken in primary care by practice nurses and GPs. This has been going on particularly since the new contract, but even before then, and I believe that, probably, a reduction in stroke comes from the primary care effort as much as anything else.

[214] **David Rees:** I think that we might come back to GPs a little bit later.

[215] **Kirsty Williams:** When the committee did its report two years ago, it made very specific recommendations about access to TIA services on a seven-days-a-week basis, and also access to carotid artery surgery within the clinical guidelines. Does the BMA feel that we are currently meeting the requirement for everyone with a high-risk TIA to be seen within 24 hours and low risk to be seen within the week? Are we meeting the two-week surgery guidance?

[216] **David Rees:** Before you answer, I apologise for the echo that we still seem to be experiencing.

[217] **Dr Jafar:** The plan from the beginning was to have a 7/7 TIA clinic, but what we have in certain parts of Wales—I think in four or five health boards—is a five-days-a-week TIA service. For the information of the panel, we have ABCDD scoring for patients—A for age, B for blood pressure, C for clinical presentation and D for duration. The other D is for diabetes. This is for the GP; we designed this as a pro forma, and this is an internationally validated scoring system for a suspected TIA patient. So, for patients who present with these symptoms to their GP, the GP should score the patient on this ABCDD tool and refer them immediately to the secondary care doctor. If the score is above four, for example, the patient needs to be seen within 24 hours. In Wales, we need a study or an audit of how many patients have been seen after their referral with an ABCDD score of four within 24 hours. I can tell you, from my practice and the Royal Gwent Hospital, that the figure is about 80%, with the help of a specialist stroke nurse, one of whom is available to us, and the daily clinic from Monday to Friday; of course, we are missing Saturday and Sunday.

[218] There are differences between a TIA assessment when patients in Newport or Cardiff, for example, present with signs and symptoms of TIA, with patients realising that, because of education campaigns and television programmes, it may be TIA or a mini stroke. They contact the helpline, and the helpline says 'Yes, go to the hospital', and the patients go to the hospital and get an assessment from the specialist registrar, not the consultant in stroke or a very well-trained specialist in TIA. That is part of the service throughout the weekend that is available to the people of Wales. However, is it going to be done within the time limit, for example? Do not forget the issue of thrombolysing stroke patients within three hours of presentation. So, the definition of TIA and acute stroke is difficult. The answer to your

question is that we are far away from 7/7 provision. As to how we can achieve it, as a BMA representative here—I told my colleagues in the BMA about this—there should be a group to supervise and study this problem based on numbers and figures. You need statistics to support your conclusion, then you attack the problem, and sort it out. That is what you need.

[219] **Kirsty Williams:** From a GP's perspective, the BMA paper says that GPs are not clear and are confused by the guidance on TIA. Why is that?

[220] **Dr White:** With the original TIA guidance, certainly in north Wales we are very confused, because we had a service in the Walton Centre that was within the week. With the repatriation of services, we now have a local stroke service that is just as good, but in between there has been no guidance as to exactly how quickly you need to refer people. We tend to refer a TIA patient immediately, having done some basic assessments—you would do an ECG to see if there is any fibrillation, you would listen for bruits, because, even before you do an ultrasound on the neck, you can sometimes hear it. If we found something like atrial fibrillation, which is one of the commonest causes, we would start treating them straight away—we would not wait for them to go to hospital. From the seven-day clinic point of view, the minority of strokes that are thrombotic, where there is a clot, are the ones that need to be seen very quickly, and that is where you need to concentrate on a rapid scan and treatment.

[221] There is general advertising all over the place telling you that, if you develop any of these symptoms, go to hospital straight away. This has increased the number of people who are apparently presenting at hospital with stroke, whereas we think that the presentation of the numbers of actual stroke is reducing year on year because of the increased input in controlling the risk factors, such as hypertension, and the work done by Welsh Government in concentrating on the bad things that people get up to, such as smoking and alcohol. That is where the message lies. We cannot do it on our own. We have to have a general work-out about strokes and general health.

[222] **William Graham:** It all sounds rather depressing. You have seen the recommendations made by our committee and you have seen the Welsh Government's response. Is there no evidence of stroke reduction in Wales, then?

[223] **Dr Jafar:** Stroke reduction?

[224] **William Graham:** Yes, that is the whole purpose of our inquiry today—how you put stroke reduction in place.

[225] **Mr Jafar:** With regard to stroke reduction, we are addressing the risk factors for TIA and strokes. We are focusing on hypertension. If you read any text book on TIA and strokes, the first and most common risk factor is hypertension. Atrial fibrillation comes second or third, but hypertension is the first. We are addressing that through primary care. There are organisational problems in every health board with providing TIA services. That is what I was telling Mrs Williams about having a 7/7 TIA service and what we are currently doing. In north Wales, we even have a problem providing a five-day-a-week TIA service. Sometimes, we do not have a TIA clinic in certain hospitals.

[226] **David Rees:** Nicola, do you want to comment?

[227] **Ms Davis-Job:** In terms of stroke improvement, I think we are a long way forward from where we were five years ago. That has largely been because we have looked at acute stroke and thrombolysis and made it a tier 1 priority. What we need to do is to make the other bits of the pathway—prevention and long and short-term rehab—maybe not tier 1, but a priority for the health boards. That way, we can see improvements and hold people to account for the improvements.

[228] **David Rees:** I have one question on that. Is there a problem with data collection to be able to provide that analysis?

[229] **Ms Saunders:** Data collection is a big issue at the moment. We are currently being asked, for acute stroke, to cover two databases. There is the old all-Wales stroke services improvement collaborative database, and we have now gone into the sentinel stroke national audit programme. We run a TIA clinic, very much like the gentleman here, five days a week. We use the AWSSIC database, so we have masses of data that we can show you, and I am sure that many of my other colleagues are doing that. However, it tends to be the clinical specialists who enter data into those databases. In the grand scheme of things, that is quite an expensive commodity for data collection, and it can be an issue across all health boards. The data are available but they need to be—

[230] **Dr Jafar:** On data collection, we need a stroke register in Wales. We do not have one. England has a very good and comprehensive one. Scotland has a very good and comprehensive one. We need a stroke register—a database or software to catch every single TIA and stroke patient in Wales. That is one thing. Also, we need a chair of stroke medicine or a senior lecturer to promote stroke research in Wales. We do not have a chair or professor of stroke medicine in Wales. Wales, unfortunately, so far is an unattractive place for professors and senior lecturers in stroke medicine to apply for. We need to energise stroke research activity. By appointing such a chair to lead on stroke research we will do very much better than now on stroke research activity.

[231] **David Rees:** Leighton, do you have a question on GPs?

[232] **Leighton Andrews:** Kirsty has asked it.

[233] **David Rees:** Okay. Elin is next.

[234] **Elin Jones:** On atrial fibrillation and progress with its diagnosis, I wondered whether you had any comments to make on progress over the last two years, and where you think it could be improved in early recognition of the diagnosis, and then improvement in stroke prevention.

[235] **Dr White:** The comments we put in from north Wales were about access to prolonged ECGs and Holter monitors. You can diagnose it there and then with an irregular pulse on an ECG if it is constant. If it comes and goes, it is more difficult to diagnose and you need these five-day Holter monitors, and the last time we tried to get one the wait was about three or four months, which is probably unacceptable. There needs to be concentration on getting an early diagnosis from the atrial fibrillation point of view.

11:30

[236] **Dr Jafar:** If I may comment on this, according to medical statistics, about 20% to 25% of people aged 80 and above have atrial fibrillation. The guidelines from the Royal College of Physicians are not just speaking about AF as persistent irregularities of the heart rhythm, but paroxysmal AF as well. You have paroxysmal AF and persistent AF and for both of them you need to be started on the same treatment and the same prevention strategy. Now in Wales—I am talking about south Wales—we are much better in asking for Holter monitors. As a patient, I could go to the GP to check my pulse and the GP would say 'No, there is no AF'. However, I might have paroxysmal AF, which can only be detected by a Holter monitor. That is not only for 24 hours, 48 hours or 72 hours, but one week. You send the patient home with the monitor for one week, for example, in order to rule out paroxysmal atrial fibrillation, because you are going to do much better if you start that patient on aspirin.

Are we doing this much more than we were two years ago? Yes, of course. I have data to support my conclusions. So, we are better in this sense, but, again, you need a TIA clinic that focuses on the request for this type of investigation. The general physician will never think about that.

[237] **Ms Davis-Job:** As well as the Holter monitors, we also need to take every opportunity we can, with practice nurses, healthcare support workers—and asking the patient, because sometimes they can feel that they might be in AF. Going back to the very beginning and the leadership question, we need a lead in the health board that people can refer back to.

[238] **David Rees:** Thank you very much for your time. I am very conscious of the time that we have left. The Minister is next and he has to leave just after 12 p.m.. We want to be able to question him as well. Thank you very much for coming today and answering the questions. You will receive a transcript for you to check and make factual corrections. If there is anything that you feel you still need to submit to the committee as evidence, please feel free to write to the committee with that additional information.

11:33

Lleihau'r Risg o Strôc—Ymchwiliad Dilynol: Panel 5—Llywodraeth Cymru
Stroke Risk Reduction—Follow-up Inquiry: Panel 5—Welsh Government

[239] **David Rees:** Good morning, Minister. Thank you for coming this morning to the committee's inquiry into the work done previously on stroke. I welcome Mark Drakeford, who is the Minister for Health and Social Services, and Chris Jones, the deputy chief medical officer. We have many questions and a very limited amount of time. We are aware that you have to leave before 12.05 p.m., so we will move straight into questions. Kirsty, do you want to start off?

[240] **Kirsty Williams:** Yes. Turning to recommendation 3 of the committee's report, that is, the Government's acceptance that everybody should be seen in a TIA clinic in line with clinical guidance and that everybody should have access to carotid surgery in line with the clinical guidance, the evidence that we have received this morning is that we simply do not know whether that is the case, but the suspicion is that that is not happening across Wales. What steps will the Government now take, two years after the acceptance of these principles, to make that happen?

[241] **The Minister for Health and Social Services (Mark Drakeford):** Thank you for the question, Kirsty. I think that we know a bit more than that. We know that, in terms of the two issues you identified, there is good progress in one and not good enough progress in the other. Access to a TIA service, on a five-day-a-week and a seven-day-a-week basis, is, I think, much improved in Wales. I think we have learned a lot about it over the last two years. There are things that we can go on improving. Members will have seen the submission from Cardiff and Vale University LHB that deals with the issue that the British Medical Association raised in its written evidence of this thing called TIA mimic, which is that about half the people who are referred to TIA services turn out not to have had a TIA at all, but have had symptoms that are very like it. It is sometimes difficult to distinguish between the one and the other.

[242] In Cardiff, they have done extra work with their GP community. As a result, their referrals into TIA have been very much reduced, and because of that, they are able to deal with the real TIA referrals much more quickly. So, on the TIA front, I think that a lot of progress has been made. We are reasonably confident that, across Wales, although not in every site, because we cannot possibly do it on that basis, but, in every LHB, there is a service

that allows the people who are the urgent end of TIA to be seen on a seven-day-a-week basis, and the low-risk people to be seen on a five-day-a-week basis.

[243] Where we have a less successful story to tell and where there is more we need to do is on the carotid surgery side of things. Again, things are better than they were, but we have been unhappy at both the level at which the service has responded to the most recent audit in this area and at some of the things that those figures are showing. The action on that will be led through Dr Jones from his position as the Deputy Chief Medical Officer for Wales.

[244] **Kirsty Williams:** Thank you for that. I note that Dr Jones wrote to all health boards in June 2011 on this issue of improvement of performance on carotid surgery. I note from the Minister's paper that you will now raise the issue with the health boards again. What difference is your intervention now going to lead to, when your letter in June 2011 has not led to the improvements that you would hope to have seen?

[245] **Dr Jones:** If I may, I would like to explain to the committee the national measures we are taking to try to enable the national clinical audit to be much more centre stage, but also the particular issue of carotid endarterectomy. Since the last inquiry, we have established a national clinical audit advisory group chaired by Professor Peter Barrett-Lee, who is medical director of Velindre NHS Trust. It is responsible for overseeing and ensuring participation and performance in the national clinical audit. It is undertaking a series of visits to health boards to ensure full engagement. Leads for each of the audits are being identified within the health boards. We are also planning to publish the results of national clinical audits on My Local Health Service. They are already in the public domain, but this is a much more explicit commitment to be very open about these audits and demonstrate areas for improvement.

[246] With regard to carotid endarterectomy, for which the latest audit is due to be published today, it is true that the published data to date suggests that there has not been a great deal of improvement and that participation rates in Wales are still too low. There has been a slight improvement in some of the timing, but still only a minority of patients are getting properly timed carotid surgery according to the audit. I think that that is an underestimate, because the largest vascular surgery unit, in Cardiff and Vale, was not contributing to this audit at the time, which was a problem, and its performance is excellent. I am pleased to report to the committee now that they are all online and engaged and uploading their data. So, the true situation is better, I can tell you in truth, than it appears in the publications to date.

[247] **Kirsty Williams:** I am interested, though, in understanding what will be different this time. We have had a two-year gap in which, by your own admission, we have not seen significant progress. I am not clear about what will happen this time that will mean that, in two years' time, the people who we know need access to surgery to prevent a stroke will have it. Minister, I am interested in your comments, because all the evidence we have had this morning suggests that a five-day service is not available in the Betsi Cadwaladr University LHB area. Given that it covers such a significant population in Wales, I am anxious to know why you think we have a five-day service in Betsi when nobody else we have heard from this morning thinks we have.

[248] **Mark Drakeford:** I accept the point about Betsi Cadwaladr that its recent service has not been where we would like it to have been. That was picked up by the delivery and support unit within my department and action is being taken to make sure that we bring it back into the position that we need it to be. In a way, that demonstrates that the system that we have works in the sense that it knew there was a problem—it spotted the problem through the routine monitoring that it undertakes, and then it is able to intervene with a local health board to provide it with some extra support to make sure that its services are put where they need to be. So, corrective action is already in place.

[249] I will turn to Kirsty's more general question as to what grounds for optimism we might have, and whether, on the surgery front, things will be better in two years than they are now. We rely on the things that we have talked about before in the committee and elsewhere, in that the best lever for performance is peer pressure and peer review, and that is why participation in and publication of audit is so important, so that organisations that are not doing as well as they need to can see themselves compared with their peers. That puts a driver into the system that I think will bring some improvement.

[250] **Lindsay Whittle:** Good morning. We have heard from witnesses this morning that there seems to be a lot of problems with data collection and co-ordination of all of the data. We do not have a national stroke register in Wales. Why not? They have got one in England and Scotland; I am not sure about Northern Ireland. That is my first question.

[251] My next questions are on recruitment and training. We have heard evidence that we need more consultants. Nobody knows how many stroke consultants we have in Wales. We are told that we may need 18. What are we doing about training for that, and what are we doing about specialist nurses in stroke? What are we doing about preventative work? Minister, 4% of your budget is spent on stroke victims, which is hundreds of millions of pounds, and there is no co-ordination to try to improve this service, as we have heard this morning.

[252] **Mark Drakeford:** To take the issue of workforce first, because I think that it is a particularly interesting area to think about in terms of this topic. Committee members will be aware of the Greenaway review of the shape of medical training and the medical workforce. The Greenaway report is due to be published very shortly, probably within weeks rather than anything else. I met Professor Greenaway earlier in the summer to hear from him what he thought his emerging findings might be. We will see what his report says—I have not seen the report itself—but I felt that one of the strong things that he was saying to me was that his committee will conclude that the NHS across the United Kingdom has been drawn too far down the road of specialism and sub-specialism, cutting the slice of work that any one individual is thought to be able to do ever more thinly. They will argue for a new generation of generalists. That is particularly important in terms of stroke.

[253] One of the reasons why I have lots of doubts about some of the figures that you will have heard about the number of this and the number of that that we need is because that is based on a model that may not be serving patients as well as it needs to. I heard a little of your proceedings earlier in the morning where a physician said to you that he leads a team of people who are more generalist in their approach—they are geriatricians by training, but they are able to turn their skills into work in the stroke area. So, I am slightly hesitant to commit myself to the idea that we know exactly how many special people of this sort and special people of that sort we need, when maybe what we need is a rather different approach to the whole way in which we provide services for a population in which we know that age is a very significant driver of the use of these sorts of services.

[254] I am also taken by some of the evidence that we provided to the committee in looking at some of the propositions that the committee made two years ago, namely that anywhere between 20% and 70% of work done by clinicians could be done by advanced practitioner nurses, provided that those people are properly trained and given the experience that they need to do that job. Ask a consultant/physician where they have enough consultants/physicians, and surprisingly enough they will tell you that they could do with more of them. Ask that question to almost anybody and that is what you will get as an answer. However, I think that there is a wider pattern of workforce reform that we may need in this area to deliver the service that we need to deliver.

11:45

[255] I will ask Chris to tell you about the stroke register issue.

[256] **Dr Jones:** The stroke delivery plan is a bold commitment to an ambitious programme of population-based health planning for stroke, and it was produced in extensive collaboration with our partners, from whom you have heard this morning; it was co-produced. As part of those conversations, the proposal for a stroke register did not particularly materialise and, therefore, is not in the delivery plan. It was not particularly raised as a major mechanism of improvement at that time. Having said that, the plan is now followed by the establishment of an implementation group, which has leadership from Adam Cairns, the chief executive of Cardiff and Vale University Local Health Board, who has agreed to chair this delivery group. That will be a multi-agency group with all the relevant individuals who will be able to decide what is right for stroke care in Wales. If the consensus emerges through that group that a stroke register will add value, then it can be driven forward by that group.

[257] **Lindsay Whittle:** May I say through you, Chair, that I accept what the Minister is saying about the number of specialists in Wales? In my meetings with the Aneurin Bevan health board, it is informing me of specialists in the upper gut and the lower gut, or the large bowel and the small bowel. It gets to the point of infinity; you can go on and on specialising, can you not? However, stroke is one of the three biggest killers in Wales with cancer and cardiovascular disease. Surely, we must be able to concentrate on those to save the majority of lives. We are probably not going to save everybody's life, and we all have to die eventually, but if we can prevent, to some degree, the three biggest killers, surely we have to put the resources into that.

[258] **Mark Drakeford:** I do not disagree with any of that, Lindsay. I think that where I slightly did not answer your question was in picking up prevention.

[259] **Lindsay Whittle:** Prevention, yes.

[260] **Mark Drakeford:** Of course, the prevention work is not done by consultants in specialist fields; it is done by GPs, practice nurses and people in community pharmacies. That is where the prevention side of things is. It is done by the third sector in many important ways, too. In the sense that the original report was about reducing the risk of stroke, I agree with you very much that the more that we can do to have a concerted, concentrated and co-ordinated approach to try to prevent strokes from happening in the first place, the better the effect that that will have throughout the whole system, rather than dealing with the results of stroke, awful as they can be, in the lives of individuals, after the event has taken place. A lot goes on—

[261] **Lindsay Whittle:** Is there too much going on, Minister?

[262] **Mark Drakeford:** I do not think that too much is going on. I take some of the points that I know that witnesses have raised with you about the need for it to be better co-ordinated and for us to be sure that with the things that we attempt in one place, the lessons from that are shared with others and that we do not reinvent things all the time. However, a lot of effort does get invested in this field.

[263] **David Rees:** Leighton, did you want to come in on this?

[264] **Leighton Andrews:** I just wanted to ask about prevention and, particularly, the role of GPs. What do you see as the role of pulse checks?

[265] **Mark Drakeford:** Pulse checks do have an important role to play, but they are not a

panacea. About half of the people who suffer from atrial fibrillation would not be picked up through a simple pulse check, because atrial fibrillation happens in two sorts of ways. Some people have it all the time, and a simple pulse check will pick that up very well, but some people have it on an infrequent basis, and their pulse can be fine when it is being checked and then, half an hour later, it is not fine, and I think that the BMA made this point in its evidence to the committee. Where we expect GPs to concentrate on pulse checking, and where they say, and I think that we believe, that they do a good job of it, is with those people where the risk of stroke is already known. So, for anybody going into a GP surgery with the telltale signs that put them in an at-risk group for stroke, pulse checking should be a routine matter. After that, our belief, and I think the committee's conclusion last time, is that you have to try to do it on an opportunistic basis. You have to take all the chances that there are in the system for this to happen, rather than to have a pulse-checking screening programme.

[266] **Leighton Andrews:** Do you consider that the information is there via the health boards as to what GPs are actually doing in this area, then?

[267] **Mark Drakeford:** Very often there is good news and less good news in this.

[268] **Elin Jones:** But never any bad news.

[269] **Mark Drakeford:** The good news is that we have this system called audit plus that runs in all GP surgeries—100% of them have had it available since 2007. The recent UK new screening programme in the area of kidney disease has looked at various options and concluded that the Welsh system is the one that they want to adopt on a national basis for that programme. However, the extent to which GPs are expected to put information into the audit plus tool on the stroke front is more limited than that. It is not one of the areas where it is compulsory for them to do it. They have a programme through 1000 Lives Plus that allows them to do it. It is an increasing number of GP surgeries that use that. If they use it they can extract the data at practice level and at LHB level very easily. We are not in a position to compel participation because money does not necessarily flow from it in the QOF system, but it is about encouragement and getting people to see that this is the way in which local practices can know what they are doing and improve their service. It is an improving picture.

[270] **Leighton Andrews:** In your evidence you made reference to the nationwide stroke awareness campaign that was carried out, co-ordinated by Public Health Wales. Do you expect Public Health Wales to assess that?

[271] **Mark Drakeford:** Public Health Wales has assessed that. It published its report on it in August of this year and it is available on its website. I have had a read of it and, yes, we certainly would expect, where we have these new campaigns—and I think it was one of the recommendations of this committee in another inquiry—that we should have a programmatic approach to these things. There are five of these campaigns annually conducted in community pharmacies in partnership with Public Health Wales, and what works well is that there is a strong third sector partner, and the Stroke Association was very heavily involved in that campaign earlier in the year. The figures showed that over 10,000 medicine-use reviews were carried out that week; not all of them would have been relevant to people with symptoms of early signs of risk of stroke, but a very large percentage were, and in an ordinary week about 7,500 MURs for people with a risk of stroke are carried out. So, there was a significant extra number of medicine-use reviews carried out in Welsh pharmacies in that week as a result, we believe, of the campaign.

[272] **Leighton Andrews:** Can you then extrapolate from that the benefits? Is there any kind of modelling that tells you that that public health campaign will result in a reduction in strokes? It is a question on the value of public health campaigns.

[273] **Mark Drakeford:** Indeed, it is a good question. I think that it would be a secondary analysis that you would make. We know from the analysis that an extra number of people had a medicine-use review in community pharmacies as a result of that campaign, but we would need a secondary piece of analysis to see whether medicine-use reviews themselves have an impact on the risk of stroke. I do not have that in my head, but it would be very easy to do because we collect absolutely routinely the number of medicine-use reviews that community pharmacies carry out, and we know the sort of patients who come forward for those reviews and we know the percentage of those reviews that lead to changes in medication. So, I am sure that we could trace it down the line to see the impact that it has, in the way that Leighton has asked.

[274] **David Rees:** I have two questions now—Gwyn followed by Elin.

[275] **Gwyn R. Price:** Just touching on pharmacies and the campaign, what did you get out of it, and have you got anything in the future that you can build on to make the public aware of stroke?

[276] **Mark Drakeford:** What the campaigns are designed to do, primarily, is to raise awareness. I went to Carmarthen, to help launch this particular campaign, and, in the pharmacy there, it was not simply the fact that the pharmacist was more aware of medicine use reviews for stroke, but that there was good publicity available as soon as you walked in. That is where the Stroke Association was so important, because it supplied publicity material right across Wales to participating community pharmacies. The main thing it does is to say to people, 'Have you thought about the risk of stroke? Here are some very simple things that you yourself can do to ask yourself that question, and if you think that there is a risk for you, here is something that you can do immediately: you can ask the community pharmacist for advice, and if they are not able to advise you fully themselves, they can refer you to primary care'. So, for me, a lot of it was about consciousness raising and awareness raising—it had some good coverage in the media and so on during that week. It was of direct benefit to those 10,000 and more patients who came forward for an MUR during that week.

[277] I am awaiting advice about next year's campaigns. As I said, there are five of them in any one year. The latest one, which was just a week or two ago, was about flu and flu inoculation and so on. When I get the advice, I will look to see what more we can do in the stroke area.

[278] **Elin Jones:** Weinidog, os caf, hoffwn ofyn i chi am arweinyddiaeth glinigol genedlaethol. Rydym wedi cael tystiolaeth y bore yma ei bod yn bryd symud tuag at gyfundrefn yng Nghymru o rwydwaith clinigol a reolir ar gyfer gwasanaethau strôc, fel sydd eisoes ym maes canser a maes y galon. Yn eich papur chi, rydych yn dweud eich bod yn adolygu trefniadau arweinyddiaeth ar hyn o bryd. Felly, a gawsoch chi eich perswadio erbyn hyn fod angen datblygu model strwythuredig clinigol fel hyn i roi'r arweinyddiaeth glinigol honno yng Nghymru?

Elin Jones: Minister, if I may, I would like to ask you about national clinical leadership. We have received evidence this morning that it is time to move towards a system in Wales in which there would be a managed clinical network for stroke services, such as already exists for cancer and cardiac services. In your paper, you say that you are currently reviewing leadership arrangements. Therefore, have you been convinced yet that we need to develop a structured clinical model such as this to give that clinical leadership in Wales?

[279] **Mark Drakeford:** Diolch yn fawr am y cwestiwn. Cefais gyfle yr wythnos diwethaf, pan euthum i'r grŵp trawsbleidiol ar strôc fore Mercher, ac roedd aelodau'r

Mark Drakeford: Thank you very much for that question. I had an opportunity last week, when I went to the cross-party group on stroke on Wednesday morning, where the

grŵp am siarad am y rhwydwaith clinigol hwnnw. Yr hyn a ddywedais i yw y gallaf weld yr achos y maent wedi ei wneud. Mae'r prif weithredwyr sydd gennym yn yr awdurdodau lleol wedi dod at ei gilydd i roi cyngor i mi am y darlun mawr yng Nghymru o'r grwpiau sy'n rhoi cyngor i ni fel Llywodraeth ac sy'n gweithio gyda'i gilydd yn y maes clinigol. Ar hyn o bryd, gan edrych ar yr hyn sydd gennym, nid wyf yn hollol siŵr fod y gwaith sy'n mynd ymlaen yn hollol effeithiol, achos mae nifer fawr o'r grwpiau hyn. Maent yn cwrdd â'i gilydd mewn un grŵp, ac yn cwrdd â'i gilydd y bore wedyn—dyna beth yr oeddent yn ei ddweud wrthyf yr wythnos diwethaf.

members wanted to discuss that clinical network. What I said was that I can see the case that they have made. The chief executives that we have in local authorities have come together to give advice to me on the big picture in Wales of groups that advise us as a Government and engage in partnership working in the clinical field. At the moment, just looking at what we have, I am not entirely sure that the work that is ongoing is absolutely effective, because there are a great many of these groups. They meet each other in one group, and they see each other again the next day—that is what they told me last week.

[280] I understand the case for the clinical network, and I can see how it is persuasive, so I am certainly not saying that we are not going to do it, but if we do it, I want it to be done against a landscape where the advice and the way in which these networks work is clearer, simpler and therefore more effective than is sometimes the case, I believe, at the moment. The chief executives have been brought together to do exactly that; to map what is there and to give me advice about how we can, as I say, simplify the field so that the voice of clinicians is louder and clearer, rather than being a bit cloudy, as it sometimes is now, and lost in the plethora of different groups that exist, and in the plethora of advisory mechanisms and committees that are out there.

[281] **Elin Jones:** I ymateb i hynny, rwy'n credu taw'r hyn a glywsom ni'r bore yma oedd bod lot o waith yn digwydd a lot o gyfarfodydd—mae lot o ddiddordeb gwirfoddol bron gan bobl yn y maes hwn mewn creu strwythurau mewn rhywfaint o wagle. Felly, yr union beth yr ydych chi wedi ei ddisgrifio yw'r hyn y maent yn gofyn amdano fwy neu lai—maent yn ei ddisgrifio fel *clinically managed network*.

Elin Jones: To respond to that, I think that what we heard this morning was that there is a lot of work going on and there are a lot of meetings—there is a lot of almost voluntary interest from people in this field in the creation of structures in something of a vacuum. So, exactly what you have explained is almost what they are asking for—they describe it as a clinically managed network.

12:00

[282] Y gair pwysig, efallai, yw 'managed', oherwydd mae hynny'n rhoi'r strwythur penodol a'r dilyniant penodol, a chyfeiriad iddo, sy'n harneisio'r diddordeb gwirfoddol sydd ymysg pobl arbenigol ond sy'n rhoi'r cyfeiriad a'r rheolaeth iddo hefyd. Felly, rwy'n gobeithio y byddwch yn ystyried hynny ymhellach.

The important word, perhaps, is 'managed', because that gives the specific structure and the continuity, and direction, which harnesses the voluntary interest that there is among specialists, but also gives the direction and the management aspect to it as well. So, I hope that you will consider this further.

[283] **Mark Drakeford:** Ie; diolch.

Mark Drakeford: Yes; thank you.

[284] **Rebecca Evans:** A previous witness this morning said that, because stroke is a cardiovascular event, the cardiac-managed clinical network should be expanded to take in stroke work as well, rather than setting up a separate network for it. Is that something that you would consider?

[285] **Mark Drakeford:** I heard that witness give that evidence. It comes back very much to the points that Elin was making and my answer to her, that people involved in the field of stroke argue very strongly for a separate stroke clinical network, and they do make a strong case in that way. However, I do not want to agree to that if it ends up simply creating another overlapping mechanism that does not in an efficient way make sure that the objectives that the people who are keen on the network have, and which I share, are not pursued in the best possible way. So, we will look at that idea and we will make sure that the chief executives' group, which is looking at clinical networks more generally, hears it. There will be some resistance from some people in the stroke field specifically who very much want their own network. So, the case will have to be weighed up one against another. However, it is very much in the same general area that we have been talking about, in trying to have systems out there that make the best use of people's time and make sure that we do not have overlapping, time-consuming ways for people who are basically in the same field to go over it many different times from slightly different angles.

[286] **David Rees:** I am conscious of the time, Minister, so we will have the last question, which is from Kirsty.

[287] **Kirsty Williams:** Just to clarify, with regard to your issues around the establishment of a managed clinical network for stroke, are your concerns about stroke, or are you saying that you have wider concerns about the appropriateness of clinical networks? You will be aware from your time on this committee that a consistent theme that runs through reports is a lack of leadership from the centre to help to drive change. The centre itself cannot be responsible for it all, but that is a consistent theme. Are you saying that, at the moment, you are carrying out a review of how support from the centre helps to deliver change on the ground?

[288] **Mark Drakeford:** No, I am not quite saying that. What I am saying specifically is that the chief executives of local health boards have come together to look at the pattern that we have currently of networks and some other things that sometimes look like networks and act like networks but are not called networks, to try to make sure that we have a sound understanding of the way that the current pattern operates and of ways in which we could make that a more effective pattern in the future. I read a lot of the evidence that the committee had for today's proceedings, and there is some very interesting and very positive stuff that you will have heard. One of the themes that I found myself getting slightly depressed by as I read through it was the number of organisations, and sometimes even individuals, who are themselves in leadership positions in the Welsh NHS who then complain about a lack of leadership. I ended up asking myself at the end of one or two of them, 'So what are you doing about it?'

[289] **David Rees:** We will leave it there, at that point. I thank you for attending today, Minister, and I also thank Dr Chris Jones. You will receive a copy of the transcript to make any factual corrections. Thank you very much for your time; we appreciate it. Thank you also for your written evidence.

12:04

Papurau i'w Nodi
Papers to Note

[290] **David Rees:** We have received a letter from the Minister for Health and Social Services on the question we raised regarding the immunisation budget.

[291] We have also received a letter from the south Wales plan programme board relating

to the question as to whether the national clinical forum was making things public. It indicated at the meeting yesterday that the information that we had requested would be made public, so that should be on the website at some point.

12:05

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

[292] **David Rees:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

[293] I see that all Members are happy with that.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:05.
The public part of the meeting ended at 12:05.