



# **Cynulliad Cenedlaethol Cymru** **The National Assembly for Wales**

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

**Dydd Mercher, 6 Hydref 2011**  
**Wednesday, 6 October 2011**

### **Cynnwys** **Contents**

Cyflwyniad, Ymddiheuriadau a Dirprwyon  
Introduction, Apologies and Substitutions

Ymchwiliad i Leihau'r Risg o Strôc—Tystiolaeth gan Gynrychiolwyr y GIG  
Inquiry into Stroke Risk Reduction—Evidence from NHS Representatives

Ymchwiliad i Leihau'r Risg o Strôc—Tystiolaeth gan BMA Cymru a Chymdeithas Ffisigwyr Strôc  
Inquiry into Stroke Risk Reduction—Evidence from BMA Cymru Wales and the Association of Stroke Physicians

Ymchwiliad i Leihau'r Risg o Strôc—Tystiolaeth gan y Coleg Nyrsio Brenhinol  
Inquiry into Stroke Risk Reduction—Evidence from the Royal College of Nursing

Papurau i'w Nodi  
Papers to Note

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynnddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee.  
In addition, an English translation of Welsh speeches is included.

**Aelodau'r pwyllgor yn bresennol****Committee members in attendance**

Mick Antoni	Llafur Labour
Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour
Vaughan Gething	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Lynne Neagle	Llafur Labour
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

**Eraill yn bresennol****Others in attendance**

Dr Julie Bishop	Cyfarwyddwr Gwella Iechyd Dros Dro, Canolbarth a Gorllewin Cymru / Ymgynghorydd Iechyd Cyhoeddus, Iechyd Cyhoeddus Cymru Acting Director of Health Improvement, Mid and West Wales / Consultant in Public Health, Public Health Wales
Nicola Davis-Job	Cynghorydd Gofal Acíwt, y Coleg Nyrsio Brenhinol Acute Care Adviser, Royal College of Nursing
Dr Anne Freeman	Gynghrair Strôc Cymru Welsh Stroke Alliance
Dr Charlotte Jones	Is-gadeirydd, Pwyllgor Ymarfer Meddygol Cymru, Cymdeithas Feddygol Prydain Cymru Ysgrifennydd Cymru, Cymdeithas Feddygol Prydain Cymru
Professor Pradeep Khanna	Cymdeithas Ffisigwyr Srôc Prydain British Association of Stroke Physicians
Dr Richard Lewis	Cymdeithas Feddygol Prydain Cymru British Medical Association Wales
Denise Llewellyn	Cyfarwyddwr Nyrsio Gweithredol, Bwrdd Iechyd Aneurin Bevan Executive Nurse Director, Aneurin Bevan Local Health Board
Lisa Turnbull	Cynghorydd Polisi a Materion Cyhoeddus, y Coleg Nyrsio Brenhinol Policy and Public Affairs Adviser, Royal College of Nursing

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

Catherine Hunt	Dirprwy Glerc Deputy Clerk
Victoria Paris	Y Gwasanaeth Ymchwil Research Service
Naomi Stocks	Clerc Clerk

*Dechreuodd y cyfarfod am 9.30 a.m.  
The meeting began at 9.30 a.m.*

### **Cyflwyniad, Ymddiheuriadau a Dirprwyon Introduction, Apologies and Substitutions**

[1] **Mark Drakeford:** Bore da a chroeso i bawb i'r cyfarfod. Yr ydym yn dychwelyd heddiw i siarad am leihau'r risg o gael strôc. Fel y gwyddoch, yr ydym yn gweithredu'n gwbl ddwyieithog. Mae'r microffonau ymlaen yn awr; nid oes raid ichi eu cyffwrdd. Nid ydym wedi derbyn unrhyw ymddiheuriadau, ond mae Darren Millar yn mynd i fod ychydig yn hwyr.

**Mark Drakeford:** Good morning and welcome all to the meeting. We return today to discuss reducing the risk of stroke. As you know, this is a bilingual meeting. The microphones are on; you do not have to touch them. We have not received any apologies, but Darren Millar will be a little late.

9.31 a.m.

### **Ymchwiliad i Leihau'r Risg o Strôc—Tystiolaeth gan Gynrychiolwyr y GIG Inquiry into Stroke Risk Reduction—Evidence from NHS Representatives**

[2] **Mark Drakeford:** Ar gyfer y sesiwn gyntaf, croesawn Denise Llewellyn, cyfarwyddwr nyrsio gweithredol Bwrdd Iechyd Lleol Aneurin Bevan, a Dr Julie Bishop, cyfarwyddwr rhanbarthol dros dro canolbarth a gorllewin Cymru ac ymgynghorydd iechyd cyhoeddus i Iechyd Cyhoeddus Cymru.

**Mark Drakeford:** For the first session, I welcome Denise Llewellyn, executive nurse director at Aneurin Bevan Local Health Board, and Dr Julie Bishop, mid and west Wales acting regional director and consultant in public health for Public Health Wales.

[3] Good morning and welcome to you both to this second of our main sessions on our inquiry into stroke reduction issues. I remind Members of that from the beginning. In our first session, we naturally took a scene-setting approach to the inquiry, and we ranged fairly far and wide over stroke issues. However, today we want to concentrate as much as we can on the specific focus of this inquiry, which is not stroke services, but stroke reduction issues and what things we need to have in place to reduce the risk of stroke. We will offer you a few minutes at the start, in case there is anything that you want to ensure that we know before we get going, and then there will be questions from Members. Before we end this session, at approximately 10.15 a.m., I will try to ensure that you have a few minutes to round things up, to re-emphasise any points, or to ensure that, if there are things that we have not asked or points that you think we should hear, there is a chance for you to highlight those for us. Who is going first?

[4] **Dr Bishop:** From a Public Health Wales point of view, it is very welcome to see the committee looking at a subject like stroke risk reduction. While there has been, quite rightly, a very significant focus on treatment and services for stroke within Wales, and how we compare with the rest of the United Kingdom, very often, as with many other issues, the primary prevention—how we stop people from becoming ill in the first place—does not always get the same level of scrutiny. So, from our point of view, we were very encouraged to be involved in developing the risk reduction plan, and it is encouraging to see that the committee is looking at that very closely.

[5] **Ms Llewellyn:** Chair, I appreciate that the committee is today looking at prevention.

Ultimately, across stroke services, it is very important, from an Aneurin Bevan Local Health Board point of view, that we see risk reduction going across the whole pathway of stroke. I may touch slightly today on some of the transient ischemic attack elements of the bundles.

[6] **William Graham:** Thank you for your paper. Looking towards the end of it, at item 38, can you enlarge on how you ensure that general practitioners, in particular, have gone through these courses, that their awareness is as perfect as you can make it, and that they can communicate with their patients, both those at risk and those who might get into that category, to ensure that there is a good awareness of stroke?

[7] **Ms Llewellyn:** Across the whole of the health board, we are looking to ensure that people are trained to correctly assess issues around stroke and stroke prevention. It is particularly important to equip primary and community healthcare teams so that they are able to identify this. I guess that the predisposing factors to stroke need to start very early on in life, which is why we look to our school nurses, midwives, health visitors and GPs to put elements in place, through health prevention, to ensure that we are identifying this extremely early.

[8] **William Graham:** My question particularly was whether you were confident that GPs are equally aware? That is where much of it will start, is it not?

[9] **Ms Llewellyn:** Yes. We work that through the quality and outcome framework system. The over-50s health checks that Wales is doing gives us an excellent opportunity to look at vascular assessments for all, so that we pick up risk very quickly. To be able to know a person's 10-year risk of a cardiovascular event—including stress—can direct referrals, so that interventions around blood pressure or lifestyle can be put in place very quickly.

[10] **William Graham:** My second question is slightly oblique, but is to do with reduction in the future. I speak from personal experience, having had a member of the family suffer from a stroke. After the stroke, the next problem was communication—finding out in the hospital what was going to happen, how the treatment was going to progress and so on. That was incredibly difficult, even for me, who had no qualms about ringing whoever I knew to make sure that I got information. For an ordinary member of the public, who is probably elderly, with a partner who has just suffered a stroke, communication is appalling. Getting to the second stage, and preventing a second stroke, is down to communication. How can you improve that?

[11] **Ms Llewellyn:** I think that we improve that by asking our communities and patients, which is something that we do through patient satisfaction surveys. We now have the rehabilitation bundle, which we did not have in the past. We are able to look at clear interventions, which include communication with the patient and with carers. We need to make sure that that happens across the board. We can always do communication better, but I agree that that is an area that we need to look at.

[12] **Rebecca Evans:** What areas of particular concern do you have in terms of the implementation and delivery of the stroke risk reduction plan?

[13] **Dr Bishop:** I am not sure that 'concern' would be the right phrase from our point of view. Inevitably, the issues that are contained in this plan are common to a whole range of health conditions. They are fundamental to most of the major causes of disease, disability and death in Wales, particularly premature disease, disability and death. It is an extremely large programme of work, which is probably the greatest challenge that faces the services in Wales. If what is contained within this plan was delivered comprehensively and effectively across Wales, it would be a substantial body of work. Maintaining focus on all of those issues and keeping it going is one of our biggest challenges. That will always be the case when you are

trying to bring about significant change—keeping the momentum of change going.

[14] **Ms Llewellyn:** I think that it is about the spread across the local health boards, which are very large. There is an excellent opportunity because they are cross-primary and involve secondary care and work with voluntary services. We have to ensure equity and consistency across the organisation. One of the areas that we can look at is developing a prevention bundle. The bundles that we use in the acute stroke service give us some consistency and, talking to our public health colleagues, that is potentially something that we can put in place to ensure that that happens in a timely fashion. It is aspirational, but, two or three years ago, work on acute stroke was aspirational, and great strides have been made on that.

[15] **Dr Bishop:** One of the successes of the acute stroke work is the approach taken through the 1000 Lives programme. Denise has talked about the bundle approach and clearly identifying the interventions that need to be delivered. Fundamental to that approach is measuring that it has happened. Where we have seen great success is in our ability not just to describe what needs to happen, but to show that it happens in practice. We are keen to see a similar approach being taken in the preventative aspects of the plans.

[16] One of the earlier questions was on how we know whether training has been effective. It is partly about measuring that things have happened. One of the approaches that Public Health Wales has been looking at closely is how we look at audit systems in routine primary care databases, for example. We can run relatively straightforward software programmes that interrogate general practitioners' computer systems and tell us how many people have had a risk reduction evaluation, for example, or how many people have had their pulse checked. It is an effective population-based way of seeing whether the things that we write in plans happen in practice. We are already doing that, but we would like to build on this work in implementing the programmes.

[17] **Rebecca Evans:** We have heard from other witnesses that a lack of ownership over the reduction plans is a particular problem. What are your views on how the local health boards have taken ownership of the plan? Which parts of the NHS do you think are particularly lacking in taking that ownership?

[18] **Dr Bishop:** I am not sure that there is a lack of ownership. If you look at the number of different plans that are in place for all the different aspects of healthcare, they will all have different levels of prominence at various points in time in terms of the attention that they are given; that is inevitable in any health organisation. There is always a challenge—the old adage is that prevention is everybody's business, and we cannot state that often enough. Sometimes, there is a challenge with preventative plans, where they are put in a box that says that they belong to public health or another part of an organisation. Our changing healthcare system means that we have public health at the heart of health boards, which means that these kinds of plans have an ownership and prominence that they may not have had in the past.

[19] **Ms Llewellyn:** I agree; we are public health organisations as well as health organisations. At Aneurin Bevan Local Health Board, we have a director of public health who is taking the majority of this work forward. The organisation has a public health and partnership committee, which links back to our stroke board. There is clear ownership, as there has to be if we are going to make things happen.

[20] **Vaughan Gething:** Returning to the comments on transient ischaemic attack that you made in your opening statement, it might be helpful for you to explain what that is and how it links to stroke risk reduction for further strokes. My father had four strokes before he died, so I know that a first stroke episode means that you are at a greater risk. How does this relate to the stroke risk reduction plan as it is?

[21] **Dr Bishop:** We know that people will often experience a TIA, which is sometimes described as a mini-stroke, and they will experience symptoms that are sometimes quite mild but identifiable. One of the care bundles that Denise talked about, which has been implemented as part of the stroke programme work that has been happening over the last couple of years, is about treating those kinds of early warning signs as requiring urgent and serious care. I am sure that Denise will be able to talk about the way that health boards have done that. The plan is predominantly about what I would describe as primary prevention. When you start talking about prevention, one of the difficulties is that what you might encompass depends on the perspective you are looking at it from. I am a public-health professional, so my focus is on trying to keep the whole population as healthy as possible. A risk reduction plan such as this, which has been written from a public health point of view, will inevitably focus on how, long before you get to the point of a TIA—which in itself is an illness—we can reduce the risk of it ever happening. That is what this plan focuses on. The TIA work has been part of the mainstream care delivery processes, but it is clearly part of stroke prevention.

9.45 a.m.

[22] **Ms Llewellyn:** The symptoms may be weakness in the hands, arms, legs or face, as well as slurred speech. The Stroke Act FAST campaign identifies some of those things. They are transient symptoms: the patient or sufferer may have them, but they may go. It is really important that they are followed up. As part of the TIA bundle, we are looking at having rapid access to clinics. We are hoping that this will be available seven days a week; at present, it is only available five days a week. Under this system, patients will be seen by a clinician and assessed for risk of further symptoms. These steps are extremely important, in terms of prevention. About 30 per cent of patients who have a TIA go on to have a stroke. If we could prevent that, it would be fantastic for people and communities.

[23] **Vaughan Gething:** I wish to return to the issue of testing or screening. You have both said that you would not be in favour of systemic screening. To be fair, I do not think that anyone has so far said that they would. However, I am interested in how you plan for consistency in opportunistic screening and who will carry it out. Will it be GPs, nurses or pharmacists? If it is a range of people doing it, we come back to the point of the ownership in relation to screening and stroke risk reduction, and of communication between the different health professionals. In previous evidence, it appears that some people are trying to say that someone else is a problem, not them, as they are doing all they can. Therefore, there is still an element of confusion as to whether there really is ownership and effective leadership, and whether that is joined up between different branches of the health professions.

[24] **Dr Bishop:** In terms of cardiovascular risk and atrial fibrillation, which is the issue specifically highlighted in this inquiry, the national screening committee—the body that provides professional advice to all of the UK Governments on which screening programmes should be implemented at which population level—has looked at both issues and concluded that the current evidence does not support the use of a screening programme for identifying either. However, it has said that both issues are amenable to effective opportunistic, systematic risk assessment, which I believe is what you are talking about.

[25] Professor Julian Halcox undertook a review of vascular risk in Wales. Public Health Wales was asked, on behalf of the Government, to look at ways in which we could improve systematic risk assessment in relation to cardiovascular risk assessment. That work has recently been submitted. So, some of the things that we have identified within that work, and the recommendations that may come from it—it is at an early stage at the moment—will specifically address the issues that you have raised. You are quite right: what needs to happen is clearly understood. This is about making sure that it happens systematically, and that everyone understands that it has taken place. The mechanisms that I talked about earlier, such

as using audit tools for primary care software, are probably instrumental in our being able to monitor that.

[26] **Vaughan Gething:** What sort of timescale do you envisage before we get there?

[27] **Dr Bishop:** It depends on the recommendations and proposals. We have only done the first phase of the work at the moment, and the second phase is being done now. The commitment to introducing health checks also needs to be looked at in that context, as there is potential for duplicating the same type of assessment. Quite a lot of the work being done at the moment is to do with how we would bring all of these different strands together. We can make progress on some aspects of this relatively quickly. Denise has already mentioned the QOF, which is the mechanism used to monitor primary care activity under the GP contract. There are no specific requirements in the QOF relating to those particular elements. So, if we wanted to strengthen it, that issue might need to be looked at. Those elements are currently under review, so there may be an opportunity there. There are one or two things that would help in terms of moving the process forward.

[28] **Vaughan Gething:** I still do not understand what the timescale is. 'Relatively quickly' means different things to different people. I used to be a lawyer, so I am very aware that what is reasonable can mean different things to different people.

[29] **Dr Bishop:** Realistically, when you talk about bringing about major change across a wide system, particularly when you are talking about primary care and every GP practice doing something systematically, there is a long timescale frame for implementation. We can begin to start that journey relatively quickly, but realistically, that kind of change process is something that happens over years, not months.

[30] **Mark Drakeford:** We will have Lindsay's question now, otherwise we will run out of time.

[31] **Lindsay Whittle:** I will be brief. What recommendations could this committee make in order to reach the hard-to-reach groups, considering the social and economic problems that we have in Wales? A stroke is tragic for anyone, but I have met two young people who have had a stroke; how do you suggest we reach out to those people who feel invincible in their 20s, when some of them obviously are not? The younger you have a stroke, the more it will cost—and regardless of the money, we do not want them to have a stroke. So, how do we reach those hard-to-reach groups, and how do we get the message home to younger people?

[32] **Dr Bishop:** That is a big question, in the sense that it encompasses how we encourage people to take responsibility for their own health and to make choices about the way they live their lives to reduce the risk of further ill health. It is also about how we tackle the differences of health expectancy in the population and some of the underlying socioeconomic factors that influence people. In the first set of questions, there is a clear recognition that there are inequalities in the health experience in Wales, and we understand that some of that is closely linked to people's economic, employment and educational circumstances. Making sure that we tackle those fundamental issues is important to improving health, because they directly influence people's ability to make healthy choices.

[33] There are effective interventions that we can employ to help people to change their behaviours and to promote healthy behaviours, but those need to be delivered in an effective way. They are probably inconsistently delivered at the moment. They need to be given the same kind of prominence and importance that we attach to treatment and care interventions. Inevitably, our focus will be on putting things right when they go wrong. That is where the priority will be, because you have to deal with the immediate thing facing you. However,

reorienting our approach would allow the focus to shift to a public health focus. The health boards in Wales are starting to grapple with this issue, and looking at all of the opportunities that we have to change that focus to a preventative one is a significant challenge. However, the reality of the situation is that young people will always have that feeling of invincibility; it is part of feeling young is it not? We will never reach a stage where we will prevent some people from adopting health behaviours that are unlikely to promote their health. So, we will always need to have mechanisms in place to support and motivate those people to change.

[34] It is about having a multi-strand approach to the fundamental determinants of health and giving everyone equal choices. It is about good preventative programmes. We have a programme called ASSIST in Wales, and that has been shown to be effective in preventing young people from starting to smoke. It has shown that it is particularly effective, interestingly, in some of the areas of greatest need and deprivation. That is an encouraging strand. So, we need those kinds of universal programmes, but we also need targeted programmes that support people at every stage of the process, such as schemes to help people to stop smoking, as it is never too late. Even if someone has had their first stroke and they are still a smoker, it is still worth supporting them in trying to stop.

[35] **Lindsay Whittle:** I have a quick supplementary question, which you do not have to answer, really. The advert with the burning brain always shows an older person. Do you think that we should show a young person?

[36] **Dr Bishop:** I would have to look at the figures in terms of knowing what proportion of strokes affect younger people. The evidence would probably show that, while it is devastating when it happens, it is a relatively rare event. So, probably, in doing widespread public awareness programmes, it is best to focus our efforts on the population group that is most likely to experience a stroke, and that is people over the age of 50.

[37] **Lindsay Whittle:** I accept your opinion, obviously.

[38] **Kirsty Williams:** Apologies for not being here at the beginning. You are quite clear about the difference between a systematic screening programme and opportunistic testing. You have mentioned a number of times this morning the over-50s health check. I am wondering what evidence there is that 50 is the optimum age to be doing these checks, as opposed to 45, 55 or 60. Also, in terms of your desire to see opportunistic testing, would GPs only test people arriving at their surgery who are over the age of 50, or should they test everybody coming to their surgery? What does an opportunistic testing programme look like?

[39] **Dr Bishop:** There are two things, really. In response to the first set of questions, with any kind of programme, whether it is a screening programme or an opportunistic programme, we need to clearly identify who is most likely to benefit, and we need to use systematic tools. Those need to be clearly identified. In terms of the health check, I do not think that we have enough information at the moment; it is at its early stages of development. Whether or not that is the right time to do it will depend on what it includes, to some extent. That is quite a difficult question to answer.

[40] Fundamentally, we would expect a limited target group, so it is highly unlikely that something like vascular risk assessment would be done on a population basis. You would probably target people aged 45 to 50 and upwards, because that is the group that you are most likely to identify risk within. There are also different ways of looking at identifying that risk. One thing that could be explored—we have been looking at this as part of our work—is using some of the information that we already hold on people to initially look at their risk. That would help us to identify which people we need to bring in. For example, you would want to see people who have never had their blood pressure measured and who are in their 50s. It would make good clinical sense to do that. You could use some of the records that you



already have to identify those people, which would help us target our resources more effectively.

[41] **Kirsty Williams:** So, if this committee was to recommend something around opportunistic testing, it would not be as blunt as saying ‘everybody over this age’; that is not the appropriate way to use resources. It is about looking at individual risk factors for patients, and calling them in. So a 35-year-old could be called in because they are obese and drink and smoke too much, but a 65-year-old might not get a call, because they had good blood pressure the last time they were in the surgery.

[42] **Dr Bishop:** Absolutely.

[43] **Kirsty Williams:** We should not take a blunt approach; it has to be much more focused.

[44] **Dr Bishop:** Very much more focused, to use resources effectively.

[45] **Mark Drakeford:** That is interesting.

[46] **Lynne Neagle:** I wanted to return to the question of ownership, which was a strong theme in our first evidence session. The voluntary organisations that we heard from were very critical of the ownership of the plan and how it was being driven forward. Denise, you talked about the structures that exist in Aneurin Bevan LHB to take this forward. You may not be able to answer this, because other LHBs may be different, but I wondered whether all LHBs have that kind of structure to take these plans forward. I wondered whether you had any comment on ownership of this at a Government level, and the kind of strategic emphasis that was being put on this at that level.

[47] I also wanted to ask about the QOFs. We have heard fairly consistent evidence that doctors are not doing this opportunistic screening, because there is no QOF to encourage them to do it, which is a bit depressing. Are you saying that, unless it is in the QOFs, it is not going to happen? Are there examples of good practice, where GPs are doing this routinely when they take someone’s blood pressure, because it takes only 15 seconds to take their pulse?

10.00 a.m.

[48] **Dr Bishop:** I will take the second part of the question first, as I focused most on that. No, what we are saying is that there is very good practice and very good evidence that many GPs, as part of their clinical role in caring for their patients, undertake these sort of risk assessments. It is a matter of a process that comes down to individual clinical judgment and, if you like, the practice of the individual clinician versus a more systematic approach where we could be confident that everybody who needed it was getting it. We are certainly not suggesting for a moment that GPs in Wales are not doing that or that they are not providing good clinical care to their patients. However, GP appointments are relatively short. What a GP picks up and takes forward in that session will depend on what the person in front of them has presented with. That is going to vary. Inherent in the system is variation. We are talking about trying to reduce that variation as much as possible.

[49] **Lynne Neagle:** Would you favour it going into the QOFs?

[50] **Dr Bishop:** It has been shown to be a way of our being able to monitor that that happens, but there are other methods.

[51] **Ms Llewellyn:** With regard to other LHBs, there is an expectation that everyone will have gone through this plan and identified this plan by March 2012. I do not have the detail

for that, Lynne, but we can certainly send that to the committee if it is required.

[52] **Mark Drakeford:** Thank you. I think that that would be useful.

[53] **Mick Antoniw:** We seem to have a sort of scattergun approach to health. When we look at a particular issue, we decide whether it is a good idea to come up with a new plan or a variation on the plan. However, with regard to focusing resources and actually achieving results, does it not really all boil down to ensuring that we have a high take-up and a high-quality level of annual check-ups for individuals over a particular age—the most vulnerable age group? If we did that, we would pick up on so many other areas as well. Does it not all come down to the quality and consistency and then the evaluation of annual checks, rather than trying to reinvent a series of different wheels?

[54] **Dr Bishop:** Although I understand what you are saying, and it is an interesting question, at the moment, we do not have the experience, evidence or research to say one way or another. We know that good opportunistic work can happen and can make a difference. Regular check-ups are still a relatively new concept, so we do not yet have the evidence to say whether bringing someone in for a health check would offer a greater benefit than doing these things opportunistically. Given where we are at the moment, more work would need to be done before we could give you an answer to that question.

[55] **Mick Antoniw:** I wonder why that is. We know that people with certain conditions are in much higher vulnerability categories. We also know that some of those issues, such as obesity, smoking and so on, affect fairly significant sections of the population. We could diversify too far, whether we are looking at screening processes or whatever. Is it not really just the case that everyone over a certain age should have an annual check? Why certain people are not having those checks should be followed up, those checks should be more consistently designed to identify the various morbidity factors, and then those checks should be followed up. Is there not a danger of having too many people with too many fingers in the pie, whether it be community pharmacies, social services or whoever? That scattergun approach does not work very effectively.

[56] **Dr Bishop:** I do not think that that is the case with the current position. The reality is that primary responsibility for the sort of issues that we are talking about rests with the general medical practitioner. We have a universal primary care system in this country. Primary care practitioners see the majority of their patients relatively regularly, and those people who are likely to be most at risk are likely to be regularly seen. So, we have a good system that enables this to happen. Instinctively, we tend to think that screening programmes or health checks—whatever you refer to them as—are a good thing, because looking for something and finding it early and then providing treatment has to be a good thing.

[57] However, one thing that we know from implementing screening programmes is that there is an associated risk—you are taking healthy people, looking for something that they might not know was wrong with them, and, as a result, there could be quite some significant consequences. To take the example of vascular risk assessment, if your GP assesses your risk of a heart attack and finds that your risk of having a heart attack or a stroke in the next 10 years is quite high, that might have a psychological impact on your wellbeing. It might be a motivator for change, which is the rationale that we use. However, it can impact on individuals. It is likely to affect your ability to access travel insurance at a reasonable cost, and it could have an impact on other forms of insurance. So, there are negative consequences to bringing people in and telling them that there might be something wrong with them when they might not have identified that themselves, versus actually concentrating on the people who are most likely to be at risk, where the cost-benefit equation is different. Those are probably the sorts of issues that are important in deciding between those two approaches.

[58] **Mick Antoniw:** Are there not great advantages in getting people in and telling them, ‘You’ve had a good MOT—you’re reasonably okay, so just carry on’, which means that you have identified the people who are at risk? I do not quite understand the logic of what you said about the sort of results that you get from it. It seems to me that the identification of various risk factors automatically arises out of a health check and that the scattergun approach misses many people.

[59] **Dr Bishop:** I understand what you are saying, but, at the moment, we do not have good evidence that doing that has a greater benefit than doing it the opportunistic way. If you look, for example, at the issue of screening for atrial fibrillation, you will see that a research study was done, looking at primary care practices, comparing opportunistic risk assessment, targeted screening and inviting everyone in. So, there were three different approaches. The opportunistic risk assessment identified more people at risk of atrial fibrillation than the other two options.

[60] **Mick Antoniw:** Yes, but it would, would it not? That is bound to happen, because opportunistic checking identifies people who are likely to be in a high-risk category automatically. Is that right?

[61] **Dr Bishop:** Not necessarily. If you consider that the purpose is to identify people who, in this case, have atrial fibrillation, the most effective strategy is the one that identifies the most people who have that condition. I appreciate that it is a complex issue and that it can sometimes appear counterintuitive, but that is not always the case.

[62] **Elin Jones:** In your earlier response to Lynne Neagle, you said that your preferred approach to reducing the variation on opportunistic testing between GP practices was to introduce it through the QOF. You also said that there were other methods of reducing that variation, but I do not think that you mentioned what those would be. You mostly mention the role of GPs in opportunistic testing; you have not mentioned the role of nurses within GP practices. At the same time as doing this inquiry, we are also doing an inquiry on community pharmacy, so I was wondering whether you have a view on the role of community pharmacy in screening for stroke and opportunistic testing in this context.

[63] **Dr Bishop:** The quality and outcomes framework is the mechanism that we have in place, so it is the most appropriate way at the moment of understanding what people are doing and monitoring activity in primary care. There are other mechanisms for doing this, such as using the audit programmes, which I mentioned. So, it is a case of working within the framework for primary care practice that we have at the moment. I do not know whether it is necessarily our preferred approach, but it would be a way of using our existing tools.

[64] With regard to primary care—I am sure that Denise would say the same thing—in practice, most of the work is undertaken by nurses within primary care, and they are fundamental to this kind of work. There is clearly a potential for other bodies, such as community pharmacies, to play a role; they have the skills and the opportunity. One challenge in involving those groups is avoiding duplication—how do you avoid the scattergun approach? Some people could go to have their risk assessed in half a dozen different places; they may have done it at work by the occupational health nurse, they may go to a pharmacist and they may have done it at their GP surgery. That is clearly not a particularly good use of resources. At the moment, the only people who hold the comprehensive record on our health is our GPs. If there are ways in which pharmacists can work in partnership with general practitioners, and a way of the information being transferred between the two, then clearly that offers potential. However, without that, we risk not having a systematic approach.

[65] **Ms Llewellyn:** Nurses, certainly, are vital with regard to the opportunistic testing. We already do that in some areas. We work with the Stroke Association in local

supermarkets, for example, and then advise patients to go to their GP. On No Smoking Day, people come to get their blood pressure taken by nurses. We have also looked at our district nurses who take blood pressure readings during flu clinics for the elderly. They are all areas where we could implement this type of testing.

[66] **Mark Drakeford:** I am keen to give you a minute towards the end to sum up, but I want to ask one question, which is probably for you, Julie. How do we count things that do not happen? One thing that we will be thinking about is the extra investment that we are often urged to recommend for particular purposes. That is one of the themes of this; if you can prevent strokes from happening, you save a lot of money, so you need to try to lose some money upstream to match. Although it is easy to count strokes, because they happen, how can we count things that do not happen? If you have prevented a stroke, it has not happened. So, how good are we at finding ways of capturing that sort of information, which then allows you to make that financial argument more robustly?

[67] **Dr Bishop:** That is one of the perpetual challenges of public health: how do you show that you have prevented something from happening? You could look at that in a number of different ways. One way is that you would hope to have an impact on the number of strokes that are happening. However, that in itself is complex because we have an ageing population, which means that we would expect the number of strokes to increase just as a result of demography.

[68] One question that we do not know the answer to, at the moment, is the extent to which we can prevent stroke completely or whether what we are doing is delaying the age at which people have a stroke. Obviously, that is a very important goal, because we want people to be healthy as much as possible. Most of us have probably recognised that, at one time, we were aware of people in their 50s and 60s having a lot of strokes, whereas when you look at the age profile of people having strokes now, typically they are in their 70s and 80s. It is a complicated question, but that is one way that we could look at it.

[69] We have a very good understanding about what contributes to stroke risk, and we can measure that. Theoretically, we could look at our success in managing the blood pressure of the population, we could look at our reduction in smoking rates and the impact that we may have on the levels of obesity in the population. All of those things are indicators of what we might be avoiding, without our ability to put a number on it.

[70] **Mark Drakeford:** Thank you. In case there is anything that you want to ensure that we take away from this session, or anything that we have not asked you that you think we ought to have done, do you have any final thoughts?

[71] **Ms Llewellyn:** I feel that it is important that the committee knows how seriously we take this, and that there is ownership in the services.

10.15 a.m.

[72] We have done a lot of work, as evidenced by the action plan that we sent in from Aneurin Bevan health board, but we also realise that we have a lot more work to do. Working with public health, we will continue to strive to improve health in the communities within Aneurin Bevan health board's boundaries.

[73] **Dr Bishop:** Everything has been covered from my point of view; thanks.

[74] **Kirsty Williams:** [*Inaudible.*] I have had the opportunity to visit, with Denise, the acute ward at Nevill Hall Hospital, which does thrombolysis and is literally saving people's lives. I recommend it to other health committee members, if Denise does not mind, as an

exemplar of how you provide really good quality in-patient stroke care, should someone have a stroke. It is very good.

[75] **Ms Llewellyn:** Nevill Hall and Royal Gwent were the two top Welsh hospitals in the latest audit.

[76] **Mark Drakeford:** Thank you both for what has been an interesting and useful session for us. You will receive a transcript of the evidence that we have gone through today. If there are any factual errors that need to be corrected, we will be glad to hear from you.

[77] **Diolch yn fawr i chi'ch dwy. Yr wyf** Thank you both very much. I adjourn the yn gohirio'r cyfarfod o dan Reol Sefydlog meeting under Standing Order No. 17.47. Rhif 17.47.

*Gohiriwyd y cyfarfod rhwng 10.16 a.m. a 10.23 a.m.  
The meeting adjourned between 10.16 a.m. and 10.23 a.m.*

**Ymchwiliad i Leihau'r Risg o Strôc—Tystiolaeth gan BMA Cymru a  
Chymdeithas Ffisigwyr Strôc  
Inquiry into Stroke Risk Reduction—Evidence from BMA Cymru Wales and  
the Association of Stroke Physicians**

[78] **Mark Drakeford:** Diolch i bawb am ddychwelyd ar amser. Yr ydym wedi cyrraedd y drydedd eitem ar yr agenda. Yr wyf yn croesawu'r pedwar tyst sy'n ymuno â ni ar gyfer y sesiwn hon: Dr Charlotte Jones, is-gadeirydd Pwyllgor Ymarfer Meddygol Cymru; Dr Richard Lewis, ysgrifennydd Cymdeithas Feddygol Prydain Cymru, sy'n gyfarwydd i ni i gyd; yr Athro Pradeep Khanna, o Gymdeithas Ffisigwyr Strôc Prydain; a Dr Anne Freeman o Gyngghrair Strôc Cymru.

**Mark Drakeford:** I thank everyone for coming back on time. We have reached the third item on our agenda. I welcome the four witnesses who will join us for this session: Dr Charlotte Jones, the deputy chair of the General Practice Committee Wales; Dr Richard Lewis, secretary of the British Medical Association Wales, who is familiar to us all; Professor Pradeep Khanna, from the British Association of Stroke Physicians; and Dr Anne Freeman from the Welsh Stroke Alliance

[79] I welcome you all. Thank you very much for coming here this morning. This is our second set of evidence sessions in relation to the inquiry that we are conducting into reducing the risk of stroke. Would you like to make any brief opening remarks to point us in the right direction for the questions that will follow? We have all had a chance to read the evidence that you submitted in advance. There will be a chance for Members to ask questions and, right at the end, I hope to come back with another chance to speak to round up anything that we have not asked you, or to see what we need to take away from the session. As there are four of you and, from experience, I know that every Member will want to ask a question, please do not feel that everyone has to answer every question. If you feel that the point has been made by one of your colleagues, then we will move on. Does anyone want to start with opening remarks?

[80] **Professor Khanna:** Chairman, I represent the British Association of Stroke Physicians, which has a strong membership across the UK, with 500 consultants and associated specialists. I speak on their behalf, specifically regarding Wales, about the issues that are important to us. Much has been done over the past 18 to 24 months, and we welcome the fact that the Minister for Health and Social Services has given a very high priority to stroke and transient ischaemic attacks in Wales. However, the main issue for us remains that there is not an integrated and co-ordinated approach to the prevention of strokes and TIAs between primary care, secondary care and public health. In particular, we are concerned that

there remain huge inequalities between urban and rural areas, and we are concerned about health and socio-economic issues, especially in the Valleys. Those need to be addressed, as it is a specialised group of people whom we provide a very good service for. Unfortunately, we do not provide a similar service for everyone, and there can be variability in provision between urban areas and rural areas and areas with socio-economic problems. I will stop there for now.

[81] **Dr Jones:** I concur that there is not much joined-up thinking between public health, primary and secondary care, and with our health and social care partners. Stroke is a devastating condition for patients and for their families. There needs to be an integrated strategy in place across preventive and public health from a young age. It needs to be about work with those in care homes, being able to detect a pulse, having a healthy lifestyle and exercise. It needs to extend into primary care, across general practitioners, practice nurses and pharmacy colleagues. When patients have a stroke, they should have access to secondary care services in a timely fashion, and access to the full range of services, including surgical intervention if that is necessary, and then have rehabilitation to get them back into the community. Patients should have the right social care, given in a timely fashion, so that they can return home and be rehabilitated and supported as quickly as possible. Although stroke risk reduction has addressed some of those issues, from what I can see, there is no overall ownership, and we need to focus on a whole package of care and not on only one particular area.

[82] **Dr Freeman:** You will be aware of improvements in stroke care across the acute part of the pathway through the intelligent targets. The intelligent targets for transient ischaemic attacks and early rehabilitation have now been developed and implemented. We are now starting on the performance management of that area of stroke care. We are hoping to see similar improvements in the management of TIAs and early rehabilitation as we have seen with acute strokes. It is our job as the clinical lead on stroke, along with colleagues in the delivery and support unit and performance management, to start to address the other areas of the stroke pathway—prevention and life after stroke. We know that stroke is treatable and preventable. This must be addressed. To finish, you may be aware of the delivery plans being developed within the Welsh Government; Andrew Jones and I have just completed the first draft of the stroke delivery plan, which takes stroke services from 2011 to 2015. Prevention plays a huge part; there is a whole section in the delivery plan relating to prevention. That is all I will say for the moment.

[83] **Mark Drakeford:** Thank you, all. Much of what you have said echoes things that we have already heard this morning, although not necessarily in the same way. So that has been very helpful for us. We will have to be very disciplined if we are to make best use of the time that we have. William Graham is first, and Kirsty is next.

[84] **Williams Graham:** There are common themes throughout your paper, which we are most grateful for. May I ask you to amplify a bit about rapid access units? Some of the figures released yesterday by the British Medical Association were alarming, although I now gather that we have 24/5 if not 24/7. So, that is a bit better. This is a chance for you to tell us why these rapid access units are so important to prevent further attacks.

10.30 a.m.

[85] **Dr Freeman:** Across Wales, we now have 15 sites with acute stroke units with beds. The only aspect of the acute intelligent targets that we have not yet reached 95 per cent compliance on is the one on direct access to a stroke unit bed. That has been the hardest challenge to date. It is well documented in the evidence that direct admission to a stroke unit bed is probably the intervention that has the greatest benefit for patient clinical outcomes. That is a challenge that we are still working on. That really improves the acute management

of stroke patients, minimises complications, and will minimise mortality and morbidity. The actual prevention of stroke obviously needs to happen before admission to a stroke unit. Once one has had a stroke, then secondary prevention is important, picking up atrial fibrillation, carotid stenosis, and so on, because at that stage you are trying to minimise the risk of a further stroke.

[86] **William Graham:** At the moment it is 24/5, so should we not be moving towards 24/7?

[87] **Dr Freeman:** Stroke units work seven days a week. Are you referring to thrombolysis?

[88] **William Graham:** Yes—that is obviously a key element.

[89] **Dr Freeman:** Up until about 18 months ago, there was very little thrombolysis in Wales, but we now have 24/7 thrombolysis in four of the local health boards: Cardiff and Vale, Aneurin Bevan, Abertawe Bro Morgannwg, and Hywel Dda. The only two remaining are Betsi Cadwaladr and Cwm Taf. Those two local health boards are offering thrombolysis 9 a.m. to 5 p.m. We have now had the funding for the telemedicine equipment, which has been delivered to four health boards at the moment, and the carts are ready for the other health boards, and, through telemedicine, we hope that by March of next year we will have 24/7 provision in all health boards. There has been a huge improvement and change over the last 18 months.

[90] **Professor Khanna:** I will make a brief comment, if I may. Direct admission to stroke units remains a real problem, because the demand on secondary care is not going down. We need to look at strategies in a different setting to do that.

[91] The second issue is resources. If you look at stroke and TIA services per 250,000 of population in England compared to that in Wales, we do not have financial resources or manpower on the same level. We are therefore trying to be imaginative and joining up with other local health boards, and so on, and bringing in telemedicine. We will get there, but the feeling is that it will take time. We have to work imaginatively and in a different way. Whereas, in England, they have just been given a lot of resources.

[92] **Dr Freeman:** The other thing is that we will be looking at how we can reduce the number of acute stroke units in order to centralise expertise in fewer locations, particularly looking at the concept of the HASU, or hyper acute stroke unit, such as one sees in London and some of the other major centres in England. We have been asked by the Deputy Chief Medical Officer for Wales to look at realigning acute stroke services to concentrate the hyper acute in a smaller number of centres. However, there are obviously issues about rurality and travel times, and how we can access patients in a timely way in order for them to get the correct treatment.

[93] **Dr Jones:** I would echo what was said about rurality. It is all well and good having stroke units or hyper acute stroke units, but you need to be able to access them, and that is a particular issue, from time to time, for GPs—both during hours and out of hours—and paramedics. We may well have these units, but we need to be absolutely certain that they are working properly and that they can be accessed to deliver the best outcomes for patients.

[94] **Dr Freeman:** Yes, because with thrombolysis there is a critical time period.

[95] **Kirsty Williams:** Professor Khanna, you said in your opening comments that there was a lack of integration and co-ordination with regard to stroke prevention. I am wondering whether you could give us an idea of how we could address that. What would need to happen

to achieve your goal of an integrated and co-ordinated approach? Then, if I could turn to the BMA, we have had some quite startling presentations from people who have been—I think this is the only way to describe it—critical of the current role of GPs in looking at AF and identifying it, and subsequently managing it correctly. I am sure that you have seen the presentations that others have made to the committee. Do you recognise that? What is happening within general practice to address those perceived failings?

[96] **Professor Khanna:** To answer the first question, we have given some suggestions on that at the end of page 1 of our written evidence. We are very thankful that Anne has taken over the role of co-ordinating services for Wales, but I still do not think that the emphasis is as strong as it is in England, where there is a joint cardiac and stroke network. That network includes people from primary and secondary care, public health and multi-disciplinary professions such as nurses, physiotherapists and occupational therapists. Those networks have clinical directors who report directly to the improvement plan—it would be to the Assembly, in our case. These directors have a clear remit as to what needs to be achieved across the sector. I am talking about elements such as public awareness in primary and secondary care, rather than just in one area. The third aspect is ring-fenced budgeting, because the budget is still not very clear. It is quite limited and it is in small pockets, rather than it being across Wales. For instance, rural areas do not get the same amount of resources as some other places do. So, we need a very co-ordinated approach with a clear network, clear clinical leadership and a ring-fenced budget.

[97] **Kirsty Williams:** Thank you, that is very clear.

[98] **Dr Jones:** We are aware that there is criticism out there of the role of GPs in the identification and management of atrial fibrillation. We are generalists, and a number of studies have demonstrated a marked improvement in the identification of atrial fibrillation over the years from 1999 onwards, and there is further evidence of this since atrial fibrillation became part of the quality and outcomes framework of the GP contract.

[99] Atrial fibrillation is not always easy to detect; it is not always symptomatic and it does not always manifest in an irregular pulse—it sometimes does and it sometimes does not. We are not the only group of professionals to try to pick this up; there are many other opportunities out there that we should be working with.

[100] Management has changed; I have only been a partner in a practice for 11 years, and when I first came into practice it was all about rate control with a medication called digoxin. Nowadays, GPs know that warfarin is the gold standard. It is all well and good to say that everyone with atrial fibrillation should be on warfarin, but the reality is that patients do not always want it—they will not accept it, no matter how much you discuss it with them. We need to be more aware of using other risk assessment scores and to be educating patients all the time, and coming back to the issue each time we see them by asking, ‘You didn’t want warfarin before, would you accept it now?’ I have two 70-year-old gents as patients who play contact rugby, and they will not take warfarin for that reason. I would like to have dabigatran available, but the Welsh Government has decided that it is not available. So, there are therapeutic options out there that we could be using that we are not able to use.

[101] I am not being critical of the decision not to use dabigatran—I completely understand it—but we have to put this into context. Warfarin is not always right for patients—warfarin can be very dangerous for patients, and we have to make the right choice for the patient. GPs are generalists, as I said—we are all very aware of atrial fibrillation, because it is in our quality and outcomes framework, so we are on top of that and there is no practice of which I am aware in Wales that does not deliver on that or does not get involved in working on that. However, there are always updates, and we have LHB-provided education and an appraisal system across Wales.



[102] On the whole, GPs are aware of the areas that they need to develop and work on, and they do that, but we cannot know everything about everything. Sometimes, you can do more harm than good by leaping on a bandwagon and doing something for a patient. I am thinking here of some of the medications used in the past that have subsequently been shown to be very dangerous, such as thalidomide. However, we can work harder and the proposed changes to the QOF, if accepted, will introduce more scoring to general practice, which means using additional tools within the consultation for us to assess an individual's risk. That can work and it can be quite a powerful message to patients, so that we can then say, 'Okay, you don't want to take warfarin, but here's your score—you're really at risk of having a stroke or a mini-stroke, and you really don't want that, do you?' That will help us much of the time.

[103] We can work more in partnership with other agencies to highlight patients who have irregular pulses—I am thinking of community pharmacy colleagues and people who work in care homes, for example; everybody out there involved with patients. Everyone trained in basic life support should be able to feel a pulse, but that is not always the case. We can also look at some of the newer areas of the quality and outcomes framework, such as the quality and productivity pathway area. You wanted end-of-life care provided across Wales in a proper, consistent way across general practice; that is being delivered. You may want to suggest to health boards that they put atrial fibrillation in there. You may want to have that delivered at an all-Wales level rather than leave it up to individual health boards or networks. That would be a very helpful way of proceeding on this, to get more atrial fibrillation identified and managed.

[104] **Rebecca Evans:** Following on from that, some witnesses have suggested that GPs need greater stroke awareness training. What is your view on that?

[105] **Dr Jones:** As I said, GPs are generalists. To be perfectly honest, GPs are only too aware of strokes and atrial fibrillation and many other risk factors. They are all very common across the disease areas, from blood pressure to cardiac disease to diabetes—the risk factors are very similar. GPs and GP teams work very hard in managing these risk factors as much as they can, but we cannot do it all in isolation.

[106] With respect to your question about training, most health boards put on protected learning-time sessions and GPs have an appraisal that they have to engage in contractually every year, which includes identifying learning needs and becoming up to date. Obviously, medical management changes year on year, and it is very hard to keep on top of it. However, we do have mechanisms and we work in teams, and there are opportunities, as I have said before, to highlight awareness, but not to be overly critical of the work that GPs do. GPs and the practice teams do an awful lot of very good work and it is very easy to criticise them.

[107] **Dr Lewis:** It is important to note that, whatever direction you take, whether it is management of atrial fibrillation, stroke or anything else, there is always room for improvement. There is plenty of evidence to suggest that the management of stroke and the awareness of doctors with regard to the importance of atrial fibrillation, the risk factors and so on have been improving over a number of years. I was fortunate enough when I was a senior house officer in 1985, to be the SHO to start one of the first stroke units, in Sully Hospital with Dr Gladys Tinker. So, the importance of stroke units has been known for 20-odd years. However, we have heard from Ann already today that it is only within the last 18 months that Wales, both from a Government and, potentially, a health board perspective, has begun to focus on that issue. It is a great pity for Wales, but we unfortunately lag behind in this particular area. We have already heard from Pradeep about the need for increasing focused and consistent resources. We know what the evidence is; what we have to do in Wales is put our money and resources behind ensuring that the evidence is appropriately fulfilled to the benefit of Welsh patients.

[108] **Professor Khanna:** I will just add to that, because it is a very valid question—it is about awareness. We recently did an audit in our health board and there is a lack of awareness of mini strokes—the TIAs. That is important in preventing further strokes. The awareness is that people might have a facial droop—you might have seen the Stroke Act FAST campaign—which goes away within five minutes, and they do not take it very seriously. People need to become more aware that this is an emergency. Similarly, we saw that once a person went to a general practitioner, they were referred very quickly. Again, there is some lack of awareness, which is that people may be kept for a few days before they are referred or not treated as an emergency. We know that the first 10 days are absolutely crucial when there is a very high chance of having a stroke.

[109] Similarly, if the same people come to hospital and they are not seen by stroke physicians, which is 90 per cent of the time, and they see a general physician in a hospital, they may not take it as an emergency and, again, it may take a few days to refer to a specialist. It is a very valid question and a very important one, which needs to be addressed right across the board. The public, the family, the carers, primary and secondary care, and all professional pharmacists need to be aware of it and say, ‘Look, if you have a mini stroke, it may be very transient and you may lose your speech for a few minutes, but take it as if it was chest pain’. As it goes away, they just forget about it. If they mention it to one of their relatives, they might say ‘You must go to your doctor; have you not seen the campaign?’ and they might just turn up a month later. That is a valid point.

10.45 a.m.

[110] **Dr Jones:** One way that GPs are included in the quality and outcome framework is through work that we have been doing with audit plus, which is a joint general practitioners committee and Welsh Assembly Government toolkit, which measures performance within practices. It links in with work that we have been doing on the 1000 Lives campaign to improve health outcomes for patients. GPs across Wales are very engaged in it; there are very few practices that are not using it to enable us to drive up quality. We want to drive up quality and perform well; there is certainly no lack of want, or inertia on our part. However, we are generalists; we cannot do everything for every individual disease, but we will do our damndest to get there.

[111] **Rebecca Evans:** The theme of ownership has come up strongly in all of the evidence that we have taken so far. Given the competing pressures on GPs’ time and expertise, to what extent do you think are GPs taking ownership of the stroke risk reduction plan? Are they getting enough support, communication and direction from the Welsh Government to do so?

[112] **Dr Jones:** I do not think that the stroke risk reduction plan was written for GPs to take ownership. I read it as being for health boards to take ownership and deliver on it. GPs are certainly a very important part of it, but public health is an even bigger part, and secondary and tertiary care need to be sorted out. However, we are looking at a whole-system approach here. When GPs get a patient in front of them who has a high risk of stroke—whether they have atrial fibrillation or not—we manage those very well. However, there is also a whole group of people of whom we do not know and with whom we do not engage, but whom we need to target. We really need to get to those sorts of groups. At the other end, once they have had a stroke, we need to ensure that they have the treatment that they need. I might be wrong, but I did not take it that GPs should take ownership of this, but I do not see anyone taking ownership of it, if I am perfectly honest.

[113] **Dr Freeman:** The stroke risk reduction action plan was developed by public health, and it is for public health and the LHBs to drive this. As far as I am aware—I have enquired about this—there is no mechanism for the LHBs to report back regularly as to how the

implementation is taking place. A survey was done prior to this inquiry, and I believe that you have had a response from the Minister regarding the number of actions in the SRRAP that have already been achieved and those that should be completed by March next year. It is important to say that the stroke risk reduction action plan was produced before the Halcox report on vascular risk reduction and in the time of the old health authorities and trusts. Now that we are developing this stroke delivery plan, of which prevention will play a major part, it is time to look again at that stroke risk reduction action plan, to re-do it and to bring it up to date. There are some omissions: TIA assessments and carotid endarterectomy are not included in that plan, but are being dealt with outside of that by us.

[114] **Professor Khanna:** We need a co-ordinated approach—not just on policies, but on implementation. I chair the stroke board, which is under Aneurin Bevan health board; you met Denise earlier, who is an executive on it. We have now identified general practitioners who sit with us. We have set the direction under Chris Jones's strategy on primary care. We have set up our national neighbourhood clinical networks, which are led by GPs. We have appointed 10 of the GPs, one of whom is going to take the lead on primary care, stroke and TIAs. I am going to take the lead on secondary care, and we have a public health person as an executive director. As a group, we now have a clear remit and responsibilities from the executive to take this agenda forward right across primary and secondary care and public health issues. There are solutions available if there is clear leadership and direction.

[115] **Dr Freeman:** Every health board in Wales has an executive and clinical lead for stroke, and they now have regular stroke steering planning meetings. At the moment, they do not all include a GP and public health representative, which is something that needs to be addressed by us to ensure that they do.

[116] **Professor Khanna:** There are good examples. Recently, awards were given for the best direction and units in the whole of Aneurin Bevan health board. Our stroke team won it, which shows the direction and planning that we are doing to take things forward.

[117] **Mark Drakeford:** However, there is a feeling that some of these things are emerging rather than necessarily being in place already or being in place in the same way everywhere; that is a theme in everything that we have been hearing.

[118] **Mick Antoniw:** I am more confused now. In your comments at the beginning of this session, Dr Jones, you talked about there being no overall ownership and you said that we should concentrate on the whole package of care. If we are talking specifically about prevention and identifying those at risk—and the whole series of factors that help to identify them, including smoking, obesity and so on—one of my concerns is that we still have a scattergun approach, with a load of people who have their fingers in the pie but with no integration. Are we not trying to develop too much of a broad-based policy rather than saying that the key thing is that we should be focusing on the quality of the health checks that the most at-risk age group have and what emerges from them? Is that too simplistic?

[119] **Dr Jones:** Our opinion of the stroke risk reduction pathway is that it is woolly and broad. With respect to targeting certain populations, we can only manage those individuals who present to us or are picked up opportunistically when they come across our services. There are certainly huge swathes of the population who do not engage with any health service and could be picked up in other ways, and we need to explore that issue. There is always going to be a bit of a scattergun approach. I remember doing health checks for those over 75 years of age many years ago; I do not think that we picked up a huge number of conditions of which we were not already aware. We need to focus on children of school age upward to get their outlook on healthy living, exercising and linking in with the healthy lifestyle measures that everyone need, rather than targeting a group of people. However, we will still miss people. I have two colleagues who had strokes well outside any targeted population group.

They fell short of being able to access any therapies, which is appalling. We need to capture all of those who are at risk and do our best to ensure that vulnerable patients are seen and managed quickly. We also need to think about how we are going to target those groups that are probably more worrying to me, namely those who are not already accessing healthcare services.

[120] **Dr Lewis:** It may be helpful to consider the management of stroke. There are three clear components to this management. The stroke risk reduction plan Wales focuses on primary prevention strategies to ensure that people are healthier from school age onward, by exercising more often, having access to obesity services and through tobacco and alcohol control; all of these are extremely important. Part of the issue is access to exercise, which is the responsibility of local authorities in enabling access to cycling and walking paths. I understand that this has been built into legislation for highway authorities to make walking and cycling paths part of creating an active Wales. It is everyone's responsibility and there is a lot to do in that regard. The second component is identifying people who are at some risk and trying to prevent those risks. The QOF in general practice, which focuses not only on stroke but on cardiovascular risks in general, is active. The third component is the management of people who are, as other colleagues have mentioned, at risk of TIA and the management of patients who have had strokes in a timely fashion so that mortality rates are improved. Those are the three distinct components of stroke management that have to be implemented. If you do not think of the matter in that way, it may seem that there is a blunderbuss approach to it all, but by separating the issue into these distinct areas you get a degree of clarity about the work that has to be undertaken to improve stroke outcomes.

[121] **Mick Antoniw:** The paper that was presented referred to a study of a piece of equipment that was used to detect atrial fibrillation. Do we need equipment to do that?

[122] **Dr Jones:** It is used to enhance the feeling of a pulse. I am sure that you are all aware that when you feel a pulse, atrial fibrillation is not always easily detectable and the other issue is that it can come and go. Feeling the pulse does not always pick up other irregularities, which may be in the pulse form behind it. They may not be of a sufficient volume to show up wherever it is you are feeling the pulse. So, this is a piece of equipment that attaches to the finger tip—I am sure you have all had your oxygen levels measured at some time—and it links to a software patch on the computer. That can pick up odd patterns, which you will not feel at the pulse because they are of too low a volume or are not happening frequently enough to be normally detected. So, it can help. It is a very small piece of equipment that could be held in pharmacies, supermarkets where they have defibrillators and so on, and it would enhance our pick-up rates. It has been shown to be equivalent to an ECG. If you were to look at an ECG for everyone who walked through the door, it would be time consuming and labour-intensive. Furthermore, ECGs just tell you what the heart rate is doing at that moment in time. This looks at the heart rate over a slightly longer period. So, it would enable us to pick up more patients. We should always look at new technologies and ask whether they can enhance what we are already delivering.

[123] **Mick Antoniw:** Chair, perhaps we could have a copy of that paper.

[124] **Dr Jones:** It is from *The British Journal of General Practice*. We will send you a copy; I think I have a copy, and you are very welcome to have it.

[125] **Mark Drakeford:** One of the effects of the inquiry is to make Members sit here feeling their pulse for most of the morning.

[126] **Mick Antoniw:** I can't find mine. [*Laughter.*]

[127] **Dr Jones:** Actually, I have to say that that is not uncommon. It is really difficult. I

think we need to get the information out there on how to measure your own pulse. I do this with my kids. They are really proud that they can feel it, and I would hope that they could, given that I am a doctor. When I am in the out-of-hours centre, people ring up and say, ‘I can’t feel my pulse’. You know full well that they have got one, because they are talking to you on the phone, but, all jokes aside, we need to get the information on how to feel a pulse out there. The number of care home staff who do not know how to do that is very worrying.

[128] **Mick Antoniw:** Chair, can I sit closer to the doctor?

[129] **Mark Drakeford:** You will be moved closer to the door. [*Laughter.*]

[130] **Dr Jones:** I will feel your pulse. I am more than happy to do that.

[131] **Professor Khanna:** We know that if you have atrial fibrillation or an irregular heart rate at 40, you are not at such a high risk of having a stroke as you would be over the age of 75. So, yes, screening for a certain age group clearly needs to be done. However, again, it comes back to awareness. As Charlotte rightly says, we are seeing just a few people who approach us. So, the public needs to be made more aware. I have been hammering on the door of Terry Matthews and Celtic Manor saying, ‘Please let us do a campaign on knowing your numbers’. He said, ‘What do you mean?’ I said that if people knew that their cholesterol level should be less than 4 and that their blood pressure needs to be 140/80, we could reduce heart attacks and strokes by 50 per cent in Wales. How many of you know your numbers? Similarly, there is a third campaign, the Know your Pulse campaign. People should know whether it is sometimes irregular. These simple messages need to get across to the public and to the professionals. People should know that these things are important.

[132] **Dr Jones:** This is important. When we had the swine flu epidemic, the number of patients who did not have a thermometer or access to one was quite staggering. These are simple things that patients and the public should know about.

[133] **Dr Freeman:** Are you aware of the work being done by the Primary Care Quality and Information Service on atrial fibrillation, working with the 1000 Lives Campaign and using the 1000 Lives methodology? They have already developed a how-to guide and a driver diagram on how to manage atrial fibrillation with stroke risk reduction. That work is being developed, led by Paul Myres. Geoff Tinkler, a GP, is very much involved in that. We are working alongside them to try to develop this as an extra tool in general practice. There is also the GRASP-AF tool, which is well used in England. It is a mechanism that can search GP registers to see whether patients recorded as being in atrial fibrillation are being correctly treated with anticoagulants. With regard to screening for atrial fibrillation, the issue of the difference between targeted and opportunistic screening is sitting with the UK National Screening Committee at the moment. That is the body that advises all health ministers—as you will be aware—regarding screening campaigns. It is considering the best way of taking atrial fibrillation forward. It should be reporting in March next year.

[134] **Mark Drakeford:** Thank you very much. All of those are interesting things for us to know about in understanding the landscape in which these things are taking place. We are going to run slightly over the allotted time for the session, but I am keen that we make the most of our chance to learn from you this morning. So, I will allow this to run until about 11.15 a.m., if that is all right with you. That means that we can now turn to Lynne.

11.00 a.m.

[135] **Lynne Neagle:** I just want to return to something that you said in response to Rebecca. Professor Khanna highlighted the structures in place in Gwent to take all of this work forward, but Dr Freeman then said that, in other parts of Wales, there is no GP or public

health representative on these groups. It just seems to be a complete no-brainer that a GP is needed on the group. Why is that not being delivered consistently throughout Wales?

[136] My second question relates to TIA. The BMA evidence states that it is an unfortunate omission that TIAs are not in the risk reduction plan. So, presumably, you would want us as a committee to recommend a change in that. You also highlighted the issue of patients having surgery on the neck arteries, and the crucial fact that guidance states that this should be done within 48 hours. Whose guidance is that, and to what extent is that happening throughout Wales? We know about the difficulties of access to the units, but are there any figures about how many people are getting this procedure in a timely way?

[137] **Dr Freeman:** Yes, TIAs were omitted from the stroke risk-reduction action plan and, as we said, with the stroke delivery plan being developed, it is now timely to revisit the stroke risk-reduction plan and make good those omissions. TIA is now being actively looked at in terms of the intelligent targets, which have only just been implemented and we are now starting to put them through performance management. However, with the work that we are doing at the delivery and support unit, we should be seeing improvements. We must now aim for a seven-day assessment of TIA patients, not just Monday to Friday; all stroke services must be available seven days a week. So, there will be improvements in TIA. We also have the royal college audit every two years, which audits our performance in all areas of stroke.

[138] Within the TIA bundles, there are interventions related to carotid Doppler scans and referral to the vascular surgeons for consideration for endarterectomy. You are all aware of the Royal College of Physicians audit, which comes around again in 2012, but, in addition, the royal college, in association with the Vascular Society of Great Britain and Ireland, also undertakes an audit on carotid endarterectomy. We have had the third round of audit, which is held by vascular surgeons. However, not all vascular surgeons in Wales are contributing to that audit and not all endarterectomy patients are being audited. This has come to our attention because of the link, and the deputy CMO has asked Andrew Jones and me to work with the vascular surgeons to improve their performance. The main delays have been in the time between referral by a stroke physician to a vascular surgeon to be assessed in the clinic or on the ward, and then between the assessment and the time to surgery. The Royal College of Physicians, in association with Vascular Society, has set the optimum time limit for surgery down to 48 hours. In Wales, we are certainly now trying to reduce the limit to two weeks in the first instance and to get it to 48 hours eventually—that is from symptom onset, while, at the present moment, we are looking at it from time of admission.

[139] So, we are doing a huge amount of work on this, but we anticipate that we will see improvements. Vascular surgeons are meeting in Aberystwyth today, and Andrew has gone to represent the pair of us there. We are certainly looking into this very seriously, because we must get those times down. Through our process of working with the vascular surgeons, we will be able to understand all of their barriers and challenges in order to improve the service. We also know that there is a need to concentrate the number of endarterectomies done in a small number of centres. There is no point in having lots of vascular surgeons doing small numbers in many centres; you must have a critical mass—a critical number of operations being done—to maintain expertise and good clinical outcomes. So, we must map out across Wales exactly where all surgeons are working to improve the service. That will happen.

[140] **Mark Drakeford:** Other members of the panel want to chip in, but, Lynne, I see that you want to follow up on that first.

[141] **Lynne Neagle:** Yes, because I am still not clear about something. Those figures are alarming: it is alarming that someone should have something within two days and then have to wait two weeks. However, I am still not clear as to how many patients this is affecting. That might be because you do not have the data, because of the things that you said are

ongoing, but I would like to get a sense of how big a problem this is.

[142] **Dr Freeman:** The obvious solution is that we set up a performance management system for the vascular surgeons through the DSU to record the details of every single person referred, all the information about the delays and whether they have surgery. Not all patients who have carotid stenosis are suitable for surgery, but whether someone is suitable or not is a decision for a vascular surgeon. We do not have the total number of patients having endarterectomy at the moment, because they are not all being reported through the audit, but they will be, through the mechanism for recording all surgical procedures in Wales. However, we are still in the early stages of accessing those data and using them to take the work forward.

[143] **Professor Khanna:** That was a crucial question. The stroke risk reduction action plan that we have now is too narrow. It is about primary prevention and does not touch on transient ischaemic attacks, carotid endarterectomies or atrial fibrillation, so it needs to become more comprehensive. There is no question about that.

[144] To come back to the direct question of how well we are doing, we are not doing well. The reason is that, because there are no national or regional plans, it is left to local implementation. So, in some patches, it is very good, and in some patches, it is not. I know that certain areas are good on vascular surgeons, especially Cardiff, but outside that, even in Aneurin Bevan LHB, I would not say that we are that good. We have done an audit and we found that only about 20 per cent were receiving it in the time they needed it. So, our meeting is on 14 October, next week, and I shall be chairing it, and we will bring in the vascular surgeons and share the detail of the audit. The point I am making to you, however, is that it is left to local implementation. There is no comprehensive regional policy or national plan on these issues.

[145] **Dr Freeman:** Hopefully, there will be once the stroke delivery plan has been completed. It is only in the early stages at the moment, as are all the other delivery plans.

[146] **Dr Jones:** There are pockets of good care out there, and that needs to be shared, and quickly, so that other health boards can look at it and model things according to their needs. All too often, good services are available between 9 a.m. and 5 p.m. or 9 a.m. and 4 p.m. for five days a week, and that is it. So, we need to work on that.

[147] To come back to endarterectomy and vascular surgery, most general surgeons have stopped doing vascular surgery, because it is a discrete specialism and you need to carry it out regularly to do it safely. So, the number of vascular surgeons across Wales is suboptimal by a considerable amount if they are to do this work in addition to all the other emergency work that they have to do. My concern is not just about delivering the service and the performance, but about having the right number of surgeons available to do this, because it cannot be done by any other surgeon. I would take slight issue with the number of critical procedures, only because I know that it happens to be their favourite operation in the entire world and they all try to do it regularly, because it is such a neat little operation that is quickly done under local anaesthetic, and they love it, because they get these lovely plaques out. They get very excited about it.

[148] However, there is a real issue about consultant gaps and consultant vacancies. As a committee, you need to look at where the gaps are, whether proper workforce plans are behind delivering this service and, if there are gaps, how those gaps are being advertised—I hear all too often from colleagues in the BMA that waiting lists are being driven up and that they cannot do this or that, because they do not have the numbers of doctors, consultants and nurses, and this is across the whole spectrum of the workforce. That needs to be in place before you can deliver an effective service.

[149] **Dr Freeman:** May I come back on this? First, we must also remember that we have to look not just at the surgeons and the surgical procedure, but at the resources for the sonography, the carotid Doppler scans or the carotid angiography, as well, namely the procedure required to detect the degree of stenosis. So, there is that issue as well. There is a lack of sonography in Wales at the moment, certainly in Hywel Dda LHB, and that is being addressed.

[150] On consultant numbers, I agree that there is a lack of vascular surgery sessions. There is also a lack of consultant stroke physician sessions in Wales, which is a serious lack when you compare the number of sessions in vascular surgery and stroke medicine with British Association of Stroke Physicians recommendations. BASP will produce a new report later this month that will outline the recommended number of consultant sessions per population. I have had sight of that document, and we are grossly under-numbered.

[151] You will know that the first meeting of the new cross-party group on stroke was held fairly recently, and the second meeting is at the end of November. At the next meeting, we plan to give a presentation on where we are with stroke across the board in Wales, and we will be highlighting the consultant staffing levels as well. We will also touch on the staffing levels of the other disciplines that we require to support stroke care in terms of therapy and psychologists in particular.

[152] **Mark Drakeford:** Thank you very much. Several of us were at that first meeting, and we look forward to the next one. The last set of questions for this session come from Vaughan.

[153] **Vaughan Gething:** There are some very important messages in what you have said about how we deal with TIAs and having a few centres of excellence, rather than centres everywhere across the country. However, I do not understand some of your evidence. I am not completely sure what you are trying to tell us in the table in the evidence of the British Association of Stroke Physicians. I do not understand everything that is in the table—I am not sure if they are percentage figures or absolute figures, because I cannot get them to make any sense. If this is important, I would like to understand it. I think I now understand what ‘carotid endarterectomy’ and ‘carotid stenosis’ are, but I did not until that last exchange. So, can you treat us as lay people and tell us what the table is trying to tell us? I think that you are trying to tell us about how we can lower the risk of stroke, but I do not understand what this table means in practice.

[154] **Professor Khanna:** I put the table in, so I should be answering the question. What we are saying is that we need to look at certain areas in order to reduce the chances of having a further stroke. If you look at aspirin and the last two tables, they say that the number of people that you need to treat over two years to prevent one stroke is 33. For example, if someone has a stroke and you put 33 people on aspirin for two years, you will prevent one stroke. There is a similar picture on blood pressure: it takes 25 people to prevent one stroke.

[155] **Vaughan Gething:** What does historic blood pressure lower by?

[156] **Professor Khanna:** By 9 mm.

[157] **Vaughan Gething:** So, you are saying that whatever the drugs are, you are lowering their blood pressure. Okay; I understand that.

[158] **Professor Khanna:** Yes, and if you treat it for two years, you will need 25 people to prevent one stroke. Similarly, if you reduce cholesterol, you need 25 people to prevent one stroke. You asked a very good question about surgery, which is very effective. If you do it at



the right time with the right people, you need only seven people to prevent one stroke. It is similar with warfarin, which is even more effective than atrial fibrillation, where you need only three to six people to prevent one stroke. So, it is a comparison.

[159] **Vaughan Gething:** That helps, because I did not understand and you have explained it.

[160] **Professor Khanna:** The last column is the most important as it shows the number of people that you need to treat to reduce stroke, and how many people you need to treat to prevent one stroke.

[161] **Vaughan Gething:** That has helped a lot, because I really did not understand.

[162] **Dr Freeman:** There are some areas of stroke risk reduction that will take a while to achieve, because changing people's lifestyle will not happen overnight, whereas treating atrial fibrillation with warfarin or performing endarterectomy is something that can prevent a stroke immediately. There are different timescales according to the different types of stroke risk intervention that we can perform.

[163] **Mark Drakeford:** Thank you all very much. We have covered an enormous amount of ground in a short period of time and we are very grateful to you all for that. In case there are points that you think that we ought to have asked you about, or things that we have not had a chance to hear from you that you feel that we need to take away from this session, I will give you a minute to add something.

[164] **Dr Jones:** Can we make sure that there is an integrated approach that is directed from this committee? We need to strengthen and support all the individual groups that need to be involved in reducing the risk of strokes. You can assist us in this, with respect to legislation on healthy lifestyles, cycle paths, exercise availability, public education, getting people to understand how to reduce their risk of stroke and how to assess their own risk of having a stroke. We should also enable opportunistic screening in the community, and I am not just talking about GP surgeries; we need to think more broadly. It would also be very helpful if the committee gave a very strong message that the workforce plans need to be robust across public health, through to local authorities and primary and secondary care providers, in order to deliver an effective plan for patients. That is what we all want: to deliver the most effective patient care.

11.15 a.m.

[165] **Professor Khanna:** I would just like to say that manpower and financial resources are very limited. We have done very well in relation to the amount of money that we have received. If you make a direct comparison with England, what we have received is miniscule. We have done loads, and we could do a lot more. However, we do not have the tools: we do not have the neuroradiologists or the sophisticated CT scanners that do diffusion and perfusion studies. We need to move towards modern technology.

[166] **Mark Drakeford:** We will have the last word from Anne.

[167] **Dr Freeman:** To sum up, I know that Wales has been criticised heavily over the years for lagging behind the other three nations in the UK. However, the 2010 audit by the Royal College of Physicians showed that, although we were still not performing brilliantly, we had improved significantly. The royal college acknowledged that the pace of change in Wales had increased dramatically and that, in some areas of stroke care, our pace of change had overtaken that of England and had certainly overtaken that of Northern Ireland. We are all fairly hopeful that our pace of change from now on is going to increase at a greater rate,

and we hope that we will catch up with England. However, as Pradeep says, we need additional resources to help us to keep that momentum going. We are passionate about ensuring that patients in Wales get the best care possible. However, we need a bit of help to do that.

[168] **Mark Drakeford:** Diolch yn fawr i **Mark Drakeford:** Thank you all very much. chi gyd.

[169] You will receive a transcript of the evidence session. As you know, if there are factual matters that need to be corrected, we would be very glad to hear from you. Thank you all very much for your evidence this morning. It has been very helpful.  
11.17 a.m.

**Ymchwiliad i Leihau'r Risg o Strôc—Tystiolaeth gan y Coleg Nyrsio  
Brenhinol  
Inquiry into Stroke Risk Reduction—Evidence from the Royal College of  
Nursing**

[170] **Mark Drakeford:** Symudwn ymlaen yn awr at eitem 4, sef yr eitem olaf ar yr agenda, a'r tystion olaf a fydd yn rhoi tystiolaeth inni y bore yma, sef cynrychiolwyr o'r Coleg Nyrsio Brenhinol. Estynnaf groeso i Lisa Turnbull, cynghorydd polisi a materion cyhoeddus y sefydliad, a Nicola Davis-Job, cynghorydd gofal aciwt y Coleg Nyrsio Brenhinol.

**Mark Drakeford:** We move on now to item 4, which is the last item on the agenda, and the final witnesses who will give evidence this morning, namely representatives of the Royal College of Nursing. I welcome Lisa Turnbull, policy and public affairs adviser for the organisation, and Nicola Davis-Job, acute care adviser at the Royal College of Nursing.

[171] Thank you both for being here this morning. We have spent all morning looking at the topic of services that help to reduce the risk of stroke, and we are grateful to you for coming to help us out. We are still aiming to finish on time, in about half an hour or so. I would like to offer you a couple of minutes at the beginning to highlight anything in your written evidence that the committee should be particularly aware of. We will then rattle around the table, and I know that many people will want to ask you questions. Before we finish, I will try to come back to you, so that you have a chance to highlight any things that have arisen during the session that you believe are especially important. I refer, in particular, to things that we have not managed to ask you about, but that you think we should be aware of. Lisa, would you like to start?

[172] **Ms Turnbull:** Yes. In brief, the two areas that we would like to emphasise are: first, the need for consistent guidance for the practice team in primary care, in terms of stroke prevention; and, secondly, the role of the stroke specialist nurse. We are concerned, especially in these difficult times, that these kinds of posts, which are very important, will be vulnerable to cuts. It is also interesting that the majority of stroke specialist nurses in Wales are currently working in the acute sector. We would like to see more posts developed specifically for community and primary care. We would also like to draw attention to the fact that there is no longer a stroke consultant nurse in Wales. My colleague was formerly a stroke consultant nurse, so I am very pleased that she is here today. However, we are very concerned about this lack and it is something that needs to be addressed in terms of the work that can be done by people in these posts, and we are happy to elaborate on that later.

[173] **Mark Drakeford:** Nicola, would you like to add anything to that?

[174] **Ms Davis-Job:** I will just add that it might be good to look over the border for once

at how it has joined cardiac networks and stroke networks together because the primary prevention agenda for both cardiac and stroke is practically the same.

[175] **Mark Drakeford:** Thank you; that is a point that we have heard once or twice in the evidence that we have received. So, I am open to offers. Who would like to ask the first question?

[176] **William Graham:** I was going to ask about a particular point that you made about the lack of consultant nurses. Will you explain why that is so important in your opinion?

[177] **Ms Davis-Job:** Consultant nurses are at the top of the professional tree in terms of how they can strategically look at the agenda. That is the difference between consultant nurses and clinical nurses: consultant nurses can see things at a national level and at a local level. When I had the role, I was able to set up a national network of specialist nurses so that we could look at things that were specific across the stroke agenda. Consultant nurses probably have around 20 years' experience at a masters or doctoral level, are au fait with all aspects of the role, and they provide leadership for the teams. They also sit on some of the health boards; I think that it is very important to have a clinical nurse voice on the health boards.

[178] **William Graham:** That is very helpful, but may I ask you to go a little further? Is the difficulty a lack of resources or a lack of recognition for that type of post?

[179] **Ms Davis-Job:** I think that it is a little of both. It is not just the stroke nurse consultant role that has been lost recently, but a few others, particularly one looking at the cardiac agenda. There are currently 22 consultant nurses and consultant paramedics in Wales, compared to England, which has at least five consultant nurses just for stroke.

[180] **Lindsay Whittle:** To follow on from that, you say in your evidence that atrial fibrillation is not considered as a chronic condition by the chronic conditions team. Is that part of your evidence? If my oracles were beating at different times to my ventricles—forgive my ignorance—that sounds like an extremely chronic condition to me.

[181] **Ms Turnbull:** The point that we are trying to make concerns the inconsistency and the variation of approach. In some local health boards, there is a very clear pathway—which may, in fact, have been developed by either a nurse consultant or a nurse specialist—for referral once the diagnosis is made and for how that then proceeds. In other areas, perhaps it is a little unclear. I do not know whether you want to say anything more about that, Nicola.

[182] **Ms Davis-Job:** There is a specialist nurse in the Cwm Taf Local Health Board area who can direct and be a central point for patients in primary care and refer them to the stroke consultant or the cardiologist for treatment. It is a smooth pathway so that everyone is clear about where the referral needs to go.

[183] **Lindsay Whittle:** Is that a role for clinical champions?

[184] **Ms Davis-Job:** Yes, definitely.

[185] **Rebecca Evans:** You say in your evidence that a lack of ownership by the stroke teams and primary care is an important factor in the implementation and delivery of risk reduction actions. Will you expand on that and talk about a bit about the role that nurses could play in addressing that lack of ownership?

[186] **Ms Turnbull:** When we consulted our members on the evidence that we would put forward to this committee, we were quite surprised at the lack of awareness, even among

specialist teams, of the stroke risk reduction plan. That is clearly worrying. So, either that plan, or any future revised plan, needs to have a greater awareness and ownership among the people who will actually be delivering the actions. I think that Nicola wants to say something about the networks again.

[187] **Ms Davis-Job:** Yes, if you are thinking of the primary care teams, it might be that it is a healthcare support worker who is doing a manual pulse and who needs to refer that back to the GP, who can then refer the person to the appropriate place to prevent the patient being at risk of AF, to solve the AF, and to prevent the patient from being at risk of stroke.

[188] **Rebecca Evans:** What do you think of the guidance, support and communication from the Welsh Government to people in your profession in terms of the stroke risk reduction plan?

[189] **Ms Turnbull:** It was clear from conversations with our members that more awareness needs to be raised about this plan or any future direction. As Nicola has already mentioned, it is also important that, if you have these networks or boards set up in various places, you include clinical representatives on them and not just representatives from one particular profession, because it is important that everybody is on board with the actions that need to be delivered.

[190] **Rebecca Evans:** To what extent is that happening at the moment?

[191] **Ms Davis-Job:** I would say that it is patchy across Wales. It is really good in some areas, but in others it is non-existent.

[192] **Mick Antoniw:** As far as you are concerned, is the key issue the lack of resources or the lack of focused, additional resources? Is that the key thing that is preventing improvement in the work that you are doing?

[193] **Ms Turnbull:** I do not think so. One of the key points for us would be that there is consistent guidance for people in the practice team, in terms of how, once they have identified AF as an issue, it is taken forward. That, in itself, does not necessarily mean a huge amount of resource. There would be resource implications if we were talking about developing further specialist posts in the community, which is an area to which we have alluded. However, not all of these actions would involve a great amount of investment. Another area that has been discussed already this morning would be altering the QOF, so that the targets are more explicit around prevention. Similarly, the annual quality framework from the Welsh Government, in terms of the direction to the LHB, could be altered to emphasise prevention action. So, there are actions that could be taken that do not require large amounts of upfront investment.

[194] **Mick Antoniw:** Following on from that, there is quite an emphasis in your paper on training issues, and problems with releasing people for training. Is there a need for a more obligatory system of training and release in this particular area, or even for a qualification standard? It seems to me that what you are saying is that you are not getting enough specialist training, you have problems accessing it even where it exists, and that that adds to an inconsistent level of knowledge, which obviously impacts on delivery.

[195] **Ms Turnbull:** Yes, there are two areas: one is primary care. The vast majority of primary care is delivered in the independent contracted GP system. The people within practice teams—healthcare support workers, practice nurses and so on—are, essentially, employees of that business. Therefore, if we are looking to provide education, it is important for them to have the opportunity to undertake it. Obviously, there is an issue about their release and about ensuring that there is an incentive for the business to do that, so there is an

approach to that kind of issue. In secondary care, there is also a serious problem collectively—certainly for nurses—in terms of access to continuing professional development, because of the need to backfill the post when they are released. So, it is not about the cost of the training; the cost, essentially, is the cost of the backfill. That would be an area where investment would pay off and there would need to be a coherent approach to that.

[196] **Ms Davis-Job:** I was once the chair of the education sub-group of the stroke alliance. We developed a programme of training for staff, but we were not given any funding, and it was really difficult to roll that out. We were talking about training at a very basic level for family support workers and non-professional people. Nonetheless, these people are really important people working in the stroke units, where patients will be asking them for advice.

[197] **Mick Antoniw:** Do you think that these things should be incorporated into a stroke prevention plan?

[198] **Ms Davis-Job:** I think that they need to run alongside it.

11.30 a.m.

[199] **Mark Drakeford:** While other Members are thinking about the questions that they would like to ask, Lisa, I wonder whether you could help us with the following issue. We have heard from a series of witnesses that one issue that has to be faced in stroke prevention services is ensuring that there is a coherent pattern of services on the ground. We have heard that there are a lot of potential players, and that the services do not always cohere into something sensible at a patient level. How much of that is the result of professional turf wars? How much is it to do with there being the absence of a plan, but with professions being unwilling to give up activity that they think is part of their professional domain?

[200] **Ms Turnbull:** I will try to think of a polite way to say this. This is not necessarily a conspiracy; it is usually the other thing. I do not think that people are unwilling to cooperate or to do what is important. Everyone has the benefit of the patient at heart. It is one thing to set out a clear direction in terms of preventing stroke, and that is what we would like you to do, but the key point then is probably the referral and what happens afterwards. I just want to ensure that I understand what you are saying. There are a number of professions and places that could assess people and discuss their stroke risk with them. However, once you have told someone that they are at increased risk, the question is what happens next. We are saying that that is the bit that needs to be consistent and clear to everyone. I am sorry if I have misunderstood the question.

[201] **Mark Drakeford:** That is helpful, but I will ask you something slightly more specific. With regard to AF, a number of different places and professional groups could take the lead in opportunistic screening. It could be done by GPs, who see people coming through their doors; it could be done by community pharmacists, who see people in their settings; it could be done by practice nurses as part of the work that they do, as we heard this morning; and it could be done by care workers at care homes. There are many different potential players here. Personally, however, I do not have in my mind a clear sense, from the people who have given us evidence on the professional side of services, of where they think that this would be best done.

[202] **Ms Turnbull:** Our position would be that it is important that it is done. Certainly, there are groups that do not access certain types of healthcare, for example, and which might prefer other types. A classic example of this is young men. In England, the evidence demonstrates that young men very much prefer the anonymity of the walk-in centre approach. So, the important thing is that healthcare is delivered to the population. There are difficulties with that, one of which has been alluded to earlier this morning, and that is the capturing of

that information. There is a policy question as to how important it is that we record interventions, and how important it is that we are monitoring what is being done. Are we doing it because it is part of the contract? In other words, we have asked a professional group to do something, and we want to make sure that it is doing it. Alternatively, is it part of trying to measure the benefits? How do we capture that information? There are things that need to be done—and things that are being done—to improve the health record and to ensure that health records for individuals in Wales are consistent, and those things might solve this problem. I do not know whether Nicola wants to add anything to that.

[203] **Ms Davis-Job:** Alongside recording information, there needs to be a clear escalation. So, staff at a care home would perhaps detect AF by taking a manual pulse, and they should know who is next in the chain of command, as it were, to take up the baton. There needs to be a smooth pathway. It should not be a case of everyone fighting their corner, but a case of everyone doing their bit and passing things on.

[204] **Mark Drakeford:** Thank you. That is a useful way of thinking about this.

[205] **Mick Antoniw:** Following on from that, in your paper, you refer to the Miller evidence of 2010 in respect of the workplace, and screening and information programmes and so on. Could you tell us a little more about that? We have not touched on the occupational arena very much. Do you have any ideas about how we might engage more with people in the workplace, perhaps through trade unions, in terms of educational programmes?

[206] **Ms Turnbull:** Yes, that would be an excellent opportunity, not just in terms of this agenda but the broader public health agenda. There are national occupational health networks in Wales. A lot of work was done in the last Assembly on establishing and developing those. It would seem to make sense, because, going back to the point about different groups accessing different types of healthcare, just as the school nurse is a useful way for the population of schoolchildren to have access, the occupational health nurse can be helpful for the working population to have access. There are others as well. Occupational health nurses, clearly, would only capture those who are in work, but it would be a good idea to bring those networks on board with the plan.

[207] **Ms Davis-Job:** I will tell you about an example in the Hywel Dda Local Health Board, where people in Trostre steelworks are being targeted for cardiovascular tests. I do not know much about it and I have not seen results, but I know that it is happening and that work is going on there, looking at cardiovascular risks.

[208] **Elin Jones:** It is good to hear of good work being done in west Wales, because it always seems to be happening somewhere else. So, thank you for that. Today, the Minister is giving some publicity to the annual seasonal flu jab. That is mainly delivered by nurses. Given that the people who will receive the flu jab are at risk, and the overlap of those risk categories with stroke risk categories, do you have a view on whether there is an opportunity to combine flu clinics and opportunities for screening and testing pulses?

[209] **Ms Davis-Job:** That would be an excellent idea. When that nurse takes the pulse, we then need the baton to be passed on so that the nurse tells the GP and the GP knows the specialist nurse or the consultant to refer the patient on to. For that group who are at risk it would be a good, easy and cheap way of finding out if they are at risk or if they have atrial fibrillation.

[210] **Lindsay Whittle:** We have heard earlier that the taking of the pulse is not the perfect way to detect AF, because it comes and goes, and that there is a machine—I forget the name of it, I am sorry—that is much better. Do you not think that if we were to just rely on the testing of pulses that we could miss someone?

[211] **Ms Davis-Job:** If I was taking your pulse I would ask you, ‘Have you had a fluttery feeling? Have you had a strange feeling on and off?’ You could gain that information by conversation as well as just through the manual pulse. That is why we need a little education to go along with taking a pulse. The cardiac networks have done a lot of work already on this, and I think that it is well worth joining forces with what they have done.

[212] **Lindsay Whittle:** The more the merrier—I guess that is what you are saying, really, is it not?

[213] **Ms Turnbull:** It is an important conceptual point: it is not just the task of doing it; it is the education and knowledge that the person doing that brings to their assessment. That is an important point because, quite often, if you just look at the task, and this is particularly true in nursing, it appears quite simplistic, but the point is that the person doing it has the ability to understand the context and the potential consequences.

[214] **Lindsay Whittle:** I have tested my pulse more often since I have sat on this committee than I have in my entire life. [*Laughter.*]

[215] **Mark Drakeford:** Yes, we are all doing that. I will ask one last question. It follows a question that Lindsay asked an earlier witness. In the experience of the Royal College of Nursing, are there any ways that you can suggest to us as to how we can be more effective in communicating some of the risks to do with stroke to younger people? Most of our campaigns, as you know, are targeted, sensibly enough, at the highest risk groups, but we know that strokes can happen at a much younger age and we are not quite as good in raising awareness among those groups. Are there any lessons from the work of the royal colleges on how we can be more effective in that field?

[216] **Ms Davis-Job:** We know that the FAST campaign and using the media has worked. When the FAST campaign uses an older woman in it, as you said earlier, that may lead to children watching it and raising the alarm if their grandmother were to suffer a stroke. It is good to have an older person there, although maybe a cartoon figure would be a bit better. The website hits for NHS Direct have gone up in response to the campaign. Having different ways of giving information is good.

[217] **Lindsay Whittle:** I met a man who was playing rugby one week, and then—not the next week, but some months later—he was in a situation where he would never play again. He had great difficulty in obtaining employment.

[218] **Ms Davis-Job:** On that, we must not forget the modifiable risks, such as smoking, drinking, being overweight, not doing exercise, and having high blood pressure. They are all combined. That message needs to go out, regardless of age.

[219] **Ms Turnbull:** It may be that young people have understood the risks linked to cancer, or even to a heart attack, but they have not thought of stroke. It may be a nuance of the public health education message.

[220] **Mark Drakeford:** Thank you for that; it has been very interesting. For these last minutes, if there is anything that you particularly want us to take away from the written evidence and what has been said this morning, or if there is anything that you feel we have not managed to cover in our questions but that you think that we ought not to forget, then we have a few minutes left if you need them.

[221] **Ms Turnbull:** I will reiterate the two points that I made at the outset. The first is that there needs to be a consistent approach to primary care and to the education of the whole

primary care team, including healthcare support workers and practice nurses. They need to have clear guidance on what to do. The second point, which I think is important, is the need to look at the distribution of stroke specialist nurses across Wales and the areas that they specialise in. The distribution is important, as is the fact that we need to ensure that these posts focus on prevention and the community as well as the acute sector.

[222] **Mark Drakeford:** Are there any last thoughts?

[223] **Ms Davis-Job:** Hoffwn atgyfnerthu yr hyn a ddywedodd Lisa. **Ms Davis-Job:** I would like to reiterate what Lisa has said.

[224] **Mark Drakeford:** Diolch yn fawr i chi am ddod yma y bore yma. Bydd trawsgrifiad o'r cyfarfod yn cael ei anfon atoch o fewn wythnos neu ddwy i chi wirio ei fod yn gywir. [225] **Mark Drakeford:** Thank you for coming along this morning. A transcript of the meeting will be sent to you in a week or two for you to check its accuracy.

11.43 a.m.

### **Papurau i'w Nodi Papers to Note**

[226] **Mark Drakeford:** Yr ydym wedi derbyn llythyr oddi wrth y Gweinidog Iechyd a Gwasanaethau Cymdeithasol ar y diweddraf o ran sut mae cynllun gweithredu Llywodraeth Cymru i leihau risg strôc yn cael ei weithredu. Cawn gyfle i gwrdd â'r Gweinidog i'w holi ynglŷn â'r manylion yr ydym wedi'u derbyn. Hefyd, derbyniwyd papur oddi wrth Darren Millar, Cadeirydd y Pwyllgor Cyfrifon Cyhoeddus. Mae ef wedi ysgrifennu atom yn dilyn y gwaith a wnaed gan Swyddfa Archwilio Cymru ar wasanaethau iechyd meddwl i oedolion. Mae'n gofyn i'r pwyllgor hwn edrych ar yr hyn y mae'r swyddfa archwilio wedi'i nodi yn yr ymchwil. **Mark Drakeford:** We have received a letter from the Minister for Health and Social Services about the latest on the implementation of the Welsh Government's stroke risk reduction action plan. We will have an opportunity to meet the Minister to ask her about the details that we have received. We have also received a paper from Darren Millar, Chair of the Public Accounts Committee. He has written to us following the work undertaken by the Wales Audit Office on mental health services for adults. He is asking us, as a committee, to look at what the audit office has noted in its research.

[227] There is a question for us in relation to that. Darren has written to us to draw our attention to a piece of work that his committee has seen to ascertain whether we want to respond to it in any way. It is up to the committee to decide what it would like to do with that. I would say that we need to be aware that, as a result of the Mental Health (Wales) Measure 2010, there is an implementation timetable in place that stretches over the next three years. I suspect that if we were to embark on something now, the answer from the Government to most of the matters that we would want to raise would be to point to the fact that it has an implementation plan for the next three years in which these things are being addressed.

11.45 a.m.

[228] I suggest, therefore, that we write to the Minister, asking for sight of the implementation plan, including milestones and dates. When we have got that, the committee may want to see whether there is a point that we would like to identify further down the track in our timetable, when it would be sensible to do that piece of work.



[229] **Kirsty Williams:** Also, the Government is working on its follow-up strategy to the mental health strategy, which was a 10-year strategy in 2001. That has now come to an end, so it is doing another one at the moment. It may be worth looking at that, once it has been published, in conjunction with the timetable.

[230] **Mark Drakeford:** That is a good point. We could ask the Minister for her timetable for that updated strategy work. Following up the work that the committee did in the previous Assembly in the mental health field is something that we ought to keep in mind; it was an important piece of work. Mental health needs to be kept on the front burner as much as possible. I feel that there is a timing issue here regarding when would be the best point to do it. If you are happy with that, we will write such a letter, and when we get a reply, we will have another chance to think about when we may want to do that.

[231] **Diolch i chi am y bore yma. Byddwn yn dychwelyd y prynhawn yma am 1.45 p.m. er mwyn i Aelodau gael chwarter awr i ystyried y cwestiynau yr hoffent eu gofyn i Gomisiynydd Pobl Hŷn Cymru. Diolch yn fawr.** Thank you all for this morning. We will be returning this afternoon for 1.45pm. Members will have quarter of an hour to consider the questions that they would like to ask to the Commissioner for Older People in Wales. Thank you.

*Daeth y cyfarfod i ben am 11.46 a.m.  
The meeting ended at 11.46 a.m.*