Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
The Health, Wellbeing and Local Government Committee

Dydd Mercher, 23 Medi 2009
Wednesday, 23 September 2009

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservatives
Ann Jones	Llafur Labour
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Kylie Crook	Cynghrair Nyrsys Strôc Cymru Welsh Stroke Nurses Alliance
Lynne Dacey	Coleg Brenhinol y Nyrsys Cymru Royal College of Nursing Wales
Dr Anne Freeman	Cadeirydd, Cynghrair Strôc Cymru Chair, Wales Stroke Alliance
Michelle Graham	Cynghrair Nyrsys Strôc Cymru Welsh Stroke Nurses Alliance
Dr Tom Hughes	Cynghrair Strôc Cymru Wales Stroke Alliance
Dr Trevor Pickersgill	Cymdeithas Feddygol Prydain Cymru British Medical Association Wales
Lisa Turnbull	Coleg Brenhinol y Nyrsys Cymru Royal College of Nursing Wales
Dr Mushtaq Wani	Cynghrair Strôc Cymru Wales Stroke Alliance

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

Carolyn Eason	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Steve George	Clerc Clerk
Abigail Phillips	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.16 a.m.
The meeting began at 9.16 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** We will make a start. I hope everyone enjoyed a lovely summer recess. I would like to welcome any members of the public that may be joining us in the gallery and I remind them that headsets for both simultaneous translation and sound amplification are available in the gallery. If anyone has any problems using them then the ushers will be able to help. Committee members and members of the public may wish to note the simultaneous translation feed is available on channel 1, while channel 0 gives the language being spoken. I would be grateful if everyone, both Members and members of the public, could ensure that all mobile phones, Blackberrys and pagers are switched off so that they do not interfere with the broadcasting and other equipment.

[2] If it is necessary to evacuate the room or the public gallery in the event of an emergency, then everyone should follow the instructions of the ushers, who will be able to guide you to the appropriate exit.

[3] Finally, I remind Members and witnesses that the microphones are operated remotely and it should not be necessary to press any buttons to activate them.

[4] Before we start the meeting proper, I welcome Abi Phillips to her first meeting as deputy clerk of the committee and also to Karl Gomila who provides assistance to the committee behind the scenes. Some of you will already know Abi and Karl, of course, because of their previous committee commitments on the Audit Committee and Finance Committee in particular. I place on record the thanks of this committee to Catherine Hunt for her work as the deputy clerk since the committee's inception in 2007, and to Ryan Bishop as well, of course, for his work supporting the committee over the last year. It is also great to see Val back with us after her absence before the summer. Welcome back, Val.

[5] **Val Lloyd:** I would just like to say 'thanks' to the good old NHS.

[6] **Darren Millar:** Of course. We have been notified of some apologies this morning. Irene James and Helen Mary Jones have indicated that they will not be able to attend. I believe that Peter and Lorraine will be joining us at some point soon.

[7] I invite Members to make any declarations of interest under Standing Order No. 31.6. I see that there are none.

9.19 a.m.

Ymchwiliad i Wasanaethau Strôc—Tystiolaeth gan Gynghrair Strôc Cymru
Inquiry into Stroke Services—Evidence from the Wales Stroke Alliance

[8] **Darren Millar:** I am very pleased to be able to welcome today Dr Anne Freeman, chair of the alliance, Dr Tom Hughes, a consultant neurologist, and Dr Mushtaq Wani, a consultant in the care of the elderly with a particular interest in stroke services. You have very kindly provided us with a paper, which has been circulated to Members, so thank you very much for that. I think that we indicated that we would go straight into questions, if that is okay.

[9] In your paper you concur with earlier witnesses by calling for an all-Welsh stroke strategy and implementation project. How do you think that would differ from the national service framework for older people in the Welsh Government stroke improvement programme? Do you think that it would be consistent with that or do we really need another programme?

[10] **Dr Freeman:** I would just like to take us back a couple of years, and state that the national service framework for older people was published in 2006, and standard 5 of that NSF is devoted to stroke. That NSF standard lays out most of the requirements needed for a comprehensive stroke service. As you will know, the Royal College of Physicians has been conducting audits biannually since 1998. It was really the audit of 2006, published in early 2007, that highlighted that stroke care in Wales was not only worse than in other countries of the United Kingdom but falling behind, and that the gap between Wales and the other countries was getting greater.

9.20 a.m.

[11] You will be aware of the Welsh health circulars of 2007, Nos. 58 and 82. In particular, circular No. 82 requested that a partnership should be set up between the National Public Health Service for Wales, the Wales Centre for Health, and the National Leadership and Innovation Agency for Healthcare to take forward a programme of work which had been signed off by the Minister in the autumn of 2007. The stroke services improvement programme was set up as this partnership, including also some clinicians, therapists and the Stroke Association. That partnership had a number of objectives, which we have outlined in our submission. Basically, those objectives were looking at pathway development, gap analysis, developing action plans, developing a workforce planning tool, symptom awareness, vascular risk reduction and the main collaborative improvement programme based around NLIAH.

[12] We found that the SSIP brought a lot of professionals together. There was a sense of corporate awareness and a sense of ownership, especially with the NLIAH collaborative project. It involved professionals at all levels and rallied the troops to be more aware of what the deficiencies are in stroke services and what we should be doing about it. However, I have to say that both the NSF and the SSIP have more or less just made a declaration of intent about how stroke services should look. The SSIP was always intended to be a short-term project and there was never any implementation attached to it. We now feel that there is a wealth of knowledge that we have created that needs to be translated into practice and we know that the SSIP is going to finish at the end of this year. It is working through the autumn looking at the local development plans and action plans for stroke for our new health boards and when that work is finished, following our visits to all the health boards in Wales in October, we feel very strongly that the Wales Stroke Alliance should probably become the body that takes forward the strategic implementation of stroke services. We need a longer term project and we need a good strategy to support the work of that group.

[13] **Darren Millar:** So, are you saying that it would complement the other stuff?

[14] **Dr Freeman:** Yes. It would complement; it would build on it.

[15] **Darren Millar:** So, it would complement rather than being a competitive document that could distract from some of the other areas.

[16] **Dr Freeman:** Yes. I think that we have done a lot of the basic infrastructure work so far and now we need to take that forward on the basis of a longer term plan.

[17] **Ann Jones:** You refer in your paper to your view—in fact, it is one of your summary recommendations—that the current regional stroke networks should be developed along the lines of those that have been successfully established for the cardiac, renal and cancer services. How are the networks working at the moment and how do you think they should be developed?

[18] **Dr Freeman:** Currently, we have three stroke clinical networks in north Wales, south-east Wales and mid and west Wales. We ensured that these were coterminous with the cardiac networks, because we appreciate there is a lot of cross-working between cardiac and stroke sectors; there are a lot of common interests there.

[19] Each of these networks comprises representatives from each of the member health communities or new health boards within the regions. Members include clinicians, nurses, therapists, ambulance staff, a general practitioner, managers—both pathway development managers and managers from the planning departments—and the representative from the regional office. We are discussing the ongoing development of stroke services; we are discussing the work of the SSIP and the NLIAH collaborative project. We also discuss regional planning for services such as thrombolysis and the local plans for each of the new health boards, with their LDPs and their action plans, but these networks do not have any commissioning power and no budget attached to them. Networks are looking at the long timeline of the complete patient pathway, and we feel that some of the big tests in the future for our networks will be, for example, looking at the provision of out-of-hours services for thrombolysis and the provision of complex neuro and neuro-psychological rehab for stroke. These are going to be some of the big tests for the integrity of our networks.

[20] It is important to state what is happening in terms of stroke networks in our other countries. Following the introduction of the stroke strategy in 2002, Scotland was divided into several managed clinical networks, which have been hugely successful. England, following the launch of the English national strategy in December 2007, has set up through its stroke improvement programme 28 networks, each covering a population of about 0.5 million to 2 million. It has a variety of networks. A few of them are stand-alone stroke networks, but the majority of them are combined cardiac and stroke networks. The important thing about the English networks is that they have commissioning power, they have a budget and they are well supported with time for clinicians and well supported with administration and management. They do seem to be working quite well.

[21] **Ann Jones:** Is that the way you want to see them develop, then—along the same lines as Cardiff?

[22] **Dr Freeman:** Certainly, we have to look at the future of networks, and I understand a paper has been written by Hugh Ross and submitted to the Assembly that looks at the future of networks in Wales—not just stroke, but cardiac, cancer and renal networks. It is fair to say that there are possibly three options: we can have stand-alone stroke networks; we can work more closely with cardiac networks; and we can also be cognisant of the neurosciences implementation and consider whether we should also work in line with our neurosciences networks, which will be established following the Steers review. I do not know whether my colleagues have any other comments to make on that.

[23] **Peter Black:** You recommend in your paper that changes in service provision and infrastructure for stroke should take into account likely changes in Welsh neurosciences and neurosurgery in south Wales. You also state this is particularly relevant in relation to neuroradiology, which you say will define the future practice of stroke medicine. Could you explain how the changes and neuroradiology will apply to the practice of stroke medicine?

[24] **Dr Freeman:** I will just recap a little bit about the Steers and the neurosciences review and implementation. There are now five main work streams as part of the neurosciences implementation board, of which stroke is one. The other work streams, as you will be aware, are acute neurology, neurosurgery, neuro rehab, spinal and neuroradiology. Traditionally, stroke has always sat within the care of the elderly, but I think that we have to look more at how stroke and neurology interact. I think that we have to see stroke as part of the bigger picture of neurosciences and work together for the better good.

[25] In terms of neuroradiology, that is absolutely essential for diagnosis and support for stroke. It is absolutely essential to make the diagnosis of stroke, and imaging with both CT and MR scanning is absolutely essential. It is important for thrombolysis, because we cannot give thrombolysis without scanning in those early hours. If we are aiming to change neuro-imaging services, it is more cost-effective—because we need a 24/7 neuro-imaging service, but so does the rest of acute neurology and neurosurgeons—if we look at developing a neuro-imaging service that covers more than just stroke, but includes more of the acute neurology.

[26] **Andrew R.T. Davies:** You have touched in your paper on various monitoring tables that are currently done at the moment: the Royal College of Physicians sentinel stroke monitoring and also the annual operating framework, but you talk specifically about the stroke service improvement collaborative programme and the intelligent targets. Now, given that we have other monitoring going on at the moment, how do you see the intelligent targets that you refer to in your paper complementing the information that we glean from the monitoring of services that is currently available?

[27] **Dr Freeman:** We need to go back a step here and talk about the collaborative project, because the intelligent targets stem from that. You will know that the intelligent targets have been set up to look at four areas, of which stroke is one—the other three being cardiac, mental health and unscheduled care.

9.30 a.m.

[28] If we go back a step to work stream B of the stroke services improvement project, which has been led by NLIAH, it has been using the improving healthcare model from the Institute of Healthcare Improvement, using the bundle methodology, which has become very popular in America and used in other parts of the UK. You may remember a critical care initiative some years ago that used the bundle methodology and demonstrated significant improvements in some aspects of critical care, particularly ventilated pneumonia, line infections and so on.

[29] So, as part of the collaborative approach for stroke care, we have in the first year of that project got together all the sites in Wales to agree to collect data around initially the acute stroke care phase. We have developed four targets for acute care based around the first three hours of care, the first day, the first three days and the first week. Within each bundle we have between three and five core elements. We feel all those elements need to be achieved in order to make change. It has been proved through the Plan, Do, Study, Act cycles that if you introduce small elements of change together they improve the bigger picture. The first year of that work has been extremely successful. It has brought together the multidisciplinary teams in all the hospitals across Wales. They have met at three learning sets; there has been a huge amount of buzz and enthusiasm about this approach to improving care. It really is quite innovative and imaginative, as was the intention of intelligent targets to be imaginative and innovative.

[30] The second year of this project is going to move on to transient ischemic attack assessment and rehabilitation. Now, when we started to get involved with intelligent targets we put this scheme forward at the steering group and the concept was liked and we were asked to take this forward. So, all the work that we have done in year 1 of our collaboration, together with the work that we will be doing in year 2, extending it to taking on board TIA and rehabilitation, is going to form the basis of our intelligent targets. There will be four in the acute phase, as we have had in year 1, four for TIA assessment and two for rehabilitation. Those 10 targets are going to be informing the intelligent targets for stroke and that is, hopefully, going to be in place by the end of March so we can go live from 1 April next year. That is then going to inform the annual operating framework target for 2010-11.

[31] **Andrew R.T. Davies:** Just listening to what you said, these were targets that have been embraced, if you like. Often we hear of targets; why do we need targets? You are giving the impression that these intelligent targets certainly are complementing what is already there and they are creating incremental change in the service rather than being a great a big revolution, because the revolution very often never comes, does it? It is just that the target always sits there.

[32] **Dr Freeman:** That is right, and we found that by introducing a collection of small changes the improvement in the bigger picture is very significant. The other important thing about our project, and what we hope will follow through with the intelligent targets, is that it is very much embraced by the workforce. It has really brought together the multidisciplinary teams. They have really gelled and that really does help to improve clinical outcomes. We are very optimistic about a good outcome to this project.

[33] **Ann Jones:** We understand that you have been carrying out a Welsh audit of stroke services this year. How is that progressing and are there any emerging themes coming from it? How do you think it is going to help?

[34] **Dr Freeman:** I think that you are referring to the profession-specific audit of the Royal College of Physicians. Traditionally, the Royal College of Physicians has performed audits biannually, which have been divided into organisation of care and the process of care. We have normally audited about 60 sets of notes in the process of care. It has been mainly medical and nursing, with some questions relating to the therapies, but the Royal College of Physicians has quite rightly decided that the other professions involved in stroke care needed closer scrutiny through an audit. So, it devised an audit that covers tools for nursing, occupational therapy, physiotherapy, speech and language and dietetics. This tool was first piloted a few years ago in a handful of trusts. Powys took part in the first audit and the royal college then decided that, following on from the first pilot, it had obviously improved the tools that were being used and it was necessary to repilot that tool. Wales offered to pilot the tool for the Royal College of Physicians and the audit was done in autumn 2008.

[35] First, the tools had to be reviewed and that is where the rehabilitation subgroup of the Wales Stroke Alliance came in. It reviewed the tools that had been sent to us by the royal college, amended them as we felt appropriate, and we also agreed to write a new tool for clinical psychology. Twenty sets of notes were then audited by all of these professions. Each of these professions had its own pro-forma to complete, and this was done in the autumn of last year. The majority of the work done to support this was through the NPHS and the stroke services improvement project. A large number of recommendations have been made regarding improvements to the tools and those recommendations will be going back to the Royal College of Physicians once the report has been reviewed by the Assembly. The report has been sent to the Assembly but we have not had a response yet.

[36] I think that it is very important to state at this time that the purpose of this audit was to validate the tool to be used by the royal college in future audits. It was not to use any of the data collected by the professions about the service in Wales.

[37] **Ann Jones:** So there is no emerging theme, then, that you can pull out of it?

[38] **Dr Freeman:** There is no emerging theme; there is nothing that we can report at the moment. There will obviously be some data that we can use locally, but that was not the point of the audit. This audit may, in the future, be incorporated into the RCP biannual process.

[39] **Darren Millar:** I think that what we were looking for was whether that might be valuable in terms of evidence for the committee, but you are suggesting that because you have

made recommendations in terms of the scope of the data or changing the sort of data that is collected it might not be useful. Okay, thanks. Val?

[40] **Val Lloyd:** I would like to touch on service provision. How do you feel that NHS Wales can ensure that there is a 24-hour, seven-days-a-week assessment for TIAs and for thrombolysis?

[41] **Dr Freeman:** I will start and then hand over to my colleagues. The first thing that we have to clarify is its division into two. So, we will start with TIA. TIA is an important condition and should be treated as a medical emergency. If a TIA is not assessed and managed appropriately in the very early stages, and within 24 hours of onset of symptoms, then there is a much higher risk that that patient will have a stroke in the subsequent few days or weeks. So, that is important. The importance of the 24 hours here is that the patients are seen and assessed within 24 hours of symptom onset.

[42] Thrombolysis, on the other hand, is a treatment for acute disabling stroke and there must be a 24-hour service for thrombolysis that all patients in Wales should be able to access. Obviously, thrombolysis has to be given within three hours of the stroke. I will now hand over to Tom Hughes.

[43] **Dr Hughes:** Thank you very much. I think that it is important to make a clear distinction, as Anne has done, because the two issues appear to have become conflated in the report. So, TIA is a sort of dress rehearsal of stroke. The clot blocks the vessel but is then cleared and the problem manifests and then resolves, but in many cases it is heralding the real thing. About a third of people who have had a stroke will have had a TIA before. Now, we know that if we see those people within 24 hours we can reduce the incidence of further TIA or stroke by 80 per cent. If we initiate current proven treatments from the British National Formulary and if they are managed quickly we can reduce the incidence dramatically. So, TIA is an emergency but it is an emergency within 24 hours. Patients need to be seen the next working day.

9.40 a.m.

[44] If we then go to those who have been unfortunate enough to have a completed stroke, whose deficits are not lasting 20 or 30 minutes, like in a TIA, but are there two, three, and four hours later, they need to be seen quickly because, in the same way that heart attacks can be treated with clot busters, we are now confident that if clot busters are given within three hours of the onset of symptoms the number of people left dead or disabled is reduced. Therefore, we need to be able to see people with acute neurological deficits quickly to select out those that might have had a stroke. Unfortunately, we do not have an electrocardiography or a blood test of the brain that tells us what has happened. They all have to have a CT scan, which, if you like, is quite a crude way of excluding people who have bled into their brain, who have a tumour, an abscess or some other condition that might be mimicking stroke. If we can see them, scan them, distil the information and come to the conclusion that the brain is not working because a blood vessel has become blocked with a clot, then they need to have clot-buster treatment. All that needs to happen within three hours.

[45] **Val Lloyd:** So, if it has to be done within three hours, you need a focused service.

[46] **Dr Hughes:** You need a focused service that is up and running. It needs to be able to hit the ground running 24/7. As a model, the work done in London—the healthcare for London programme—has set the standard, in that every patient within Greater London should be within 30 minutes by ambulance of a place that can do what I have just said. The place doing it must then be able to get the clinical opinion, the scan and come to a conclusion about the clinical and radiological aspects within 30 minutes.

[47] **Val Lloyd:** Following on from this, how many places in Wales can provide that?

[48] **Dr Hughes:** At the moment, there are three hospitals providing a nine-to-five service. It was started off by local enthusiologists, not due to any dictat. Theoretically, if you have a clinician and a scan you can do it anywhere. In London they have decided, because of the need to concentrate expertise and to develop experience, that there will only be around 10 places in the whole of Greater London. I think that we need to do something along those lines to designate—certainly out of hours in the evenings and weekends—certain centres that will offer that sort of immediate assessment. On a nine-to-five, Monday-to-Friday basis, it may be that that can be done more locally, but, out of hours, the manpower issues and the need to have a scanner that is on, manned by a radiographer and then, absolutely crucially, interpreted by a neuroradiologist, mean that getting all of that on every street corner is out of the question. On the M4 corridor, we have the option of transporting people by ambulance just for this brief assessment and treatment to one central hospital from quite a distance.

[49] **Darren Millar:** Just following up on this, in terms of the TIA assessment, which has to happen roughly within a 24-hour period, can that be done nine-to-five?

[50] **Dr Hughes:** Yes, the next day, the next morning.

[51] **Darren Millar:** That is because there is no emergency situation, necessarily?

[52] **Dr Hughes:** Next morning is fine, yes.

[53] **Darren Millar:** The other service, the thrombolysis treatment if it is appropriate, does there have to be an assessment within three hours?

[54] **Dr Hughes:** Three hours, yes.

[55] **Darren Millar:** Okay. Are you saying that there needs to be a 24/7 service rather than the nine-to-five service offered on the three sites in Wales?

[56] **Dr Hughes:** Correct.

[57] **Darren Millar:** Okay, so you are consistent with the other evidence. Val?

[58] **Val Lloyd:** I was going to ask you about common networks linking cardiac assessment as well, but I think that you have covered it quite fully in response to my colleague, Ann, early on.

[59] **Dr Hughes:** May I just go back to the neuroradiology? At the moment, a CT scan of the head is an excludagram: it tells us that they do not have a tumour or an abscess, or that they do not have a chronic bleed in their head—all the things that would be high risk in terms of giving clot busters. They are mimics that are high risk. We have to exclude those confidently. The scan does not really tell us what the extent of the stroke is. The scan can be normal if we do it quickly enough, so it is an excludagram. In the very near future, neuroradiology will be more advanced using CT perfusion and MRI scans, and those will tell us which bit of brain does not have its blood supply and which bit of brain is dead. That will define stroke medicine. The radiology will define stroke medicine. We will not be going on clinical ground; we will be going on radiology.

[60] **Val Lloyd:** How long will it be before that is operational?

[61] **Dr Hughes:** CT perfusion scans are available in Cardiff. It is a sort of tag on to a

normal CT scan. It needs slightly more advanced radiographic skills and radiology skills, but those are around. It needs to become the norm, as it will dictate who should have treatment. At the moment the scanning excludes those who definitely should not, but soon the scanning will tell us those who should. The radiology is the absolute quintessence of this.

[62] **Darren Millar:** Okay, thank you for that. We have heard a lot of evidence over the course of the inquiry about the need for training, education and research on stroke. How do you think the Welsh Government can ensure that there is a proper programme of accredited stroke training for specialist workers in all clinical professions and how do you think that can be delivered across Wales? Do you think that there is any way we can have a sort of core curriculum for these things?

[63] **Dr Freeman:** I think that, traditionally, over the years most units have offered their own individual education, at both ward and department level. Since 2002, we have run a very successful Welsh stroke conference, which has been held annually in Newport and attracted a faculty from North America, Australia, Europe and the UK. About 450 delegates, who are medical multidisciplinary, have attended from across Wales and, in fact, from parts of England, and this has been hugely successful. The Stroke Association set up a big annual conference about three years ago called the UK Stroke Forum Conference and, from that, a group of people decided that we should be looking at developing a core curriculum for stroke education across the whole of the UK.

[64] At that time, they looked at the English national strategy, which comprises 20 quality markers, and Professor Caroline Watkins and her team at the University of Central Lancashire devised what we now call a stroke services educational framework, which has compiled a core curriculum around the essential 20 quality markers in the English strategy. This went out to consultation to all four countries, so this is not just England. In fact, we have had representatives on the steering committee of this group and the four sub-groups, so Wales is very much involved.

[65] I think that the final document regarding this educational framework has either recently been published or is about to be published. We have a sub-group on education and training in Wales through the Wales Stroke Alliance, and we are going to be looking at how we implement that core curriculum in Wales. We are ahead of the game in Wales because we have the open college network, which has been accrediting healthcare education for several years. England does not have that so we are ahead here. We have a very enthusiastic education sub-group, which is already starting to look at some of the good educational opportunities already available in Wales, particularly a two-day training course run by the Royal Glamorgan Hospital and Cwm Taf NHS Trust. It is looking at putting this online, thereby creating the education opportunities that can be picked up by any multidisciplinary team member, and offering that education in local scenarios. We are trying to look at all the online lecture-theatre style and bedside education opportunities that there are and ensure that we have a comprehensive core curriculum to offer.

[66] **Darren Millar:** It is important that this is an accredited scheme, though, is it not, to ensure that the quality is there and the information is being received?

[67] **Dr Freeman:** It is very important. Every educational activity that is developed in Wales must be accredited through the open college network, because these credits are going to be incredibly important for our workforce in gaining higher qualifications.

9.50 a.m.

[68] **Darren Millar:** Okay. In terms of research, we heard from one witness that there should be a research unit in Wales. Do you think that that would be a good thing given that

there is good academic research already taking place elsewhere in the UK? Should we not just feed data and information into that or do we need our own, and how could we deliver it?

[69] **Dr Freeman:** Certainly, the other three countries have academic departments, and there are several professorial departments in England and Scotland, and at least one in Northern Ireland. It is not absolutely essential, but it is desirable and would be nice to have an academic department in Wales with senior lecturers and a research team. Currently, we have a stroke research network in Wales. It sits within OPAN, which is the Older People and Ageing Research and Development Network based at Swansea University, and we have built up a network of research nurses around Wales, at least one in each of the three networks. We also appointed last year a research portfolio development officer, again based within OPAN in Swansea. We have many ongoing national and international trials taking place in many of our district general hospitals. We are already contributing to trials on clots and the efficacy of nitric oxide in stroke, the third international stroke trial or IST-3, and the stroke study at King's College Hospital, and we collaborate with our academic colleagues in the UK. We are starting now to present posters at national and international meetings.

[70] So, our work is coming through, but there is a long way to go. We need to expand our research portfolio. We know for a fact that if you can get each patient who comes into a stroke unit assigned to a research trial, the clinical outcomes for those patients are better. Tom, I think that you want to add some more about academia.

[71] **Darren Millar:** Dr Wani, I think that you want to come in on this as well.

[72] **Dr Wani:** Okay. When we say that there is research already there so we can implement it, we also have to remember that Wales is geographically very different. It is probably maybe akin to Canada, or some other place. To go back to thrombolysis, it may be possible to implement it in bigger places, such as Swansea, Newport and Cardiff, but when we say within three hours it means that the treatment has to be delivered within three hours, which means the patients should be there in an hour, or a maximum of two hours. How do we do that in west Wales? How do we do that in north Wales? That is the challenge. Other local research might actually help us on how to do that. That is just an example. The same applies as regards neuroradiology.

[73] On the research itself, to have an academic department in Wales is desirable, but it might also provide answers to the local problem of service provision. For example, telemedicine may be one of the ways of doing it. Again, I do not think that the research out there can always help us to solve the local problems. We have had participation at a local level, but having an academic department in stroke research will be useful.

[74] **Darren Millar:** Given the peculiarities in Wales. Lorraine, did you want to come in here?

[75] **Lorraine Barrett:** Yes. My question on research has more or less been covered. You have just mentioned telemedicine, Dr Wani. How practical could that be given the distances? How could it work?

[76] **Dr Wani:** Telemedicine has been used and is still being used in Wales, for example, for dermatology, burns and plastics. It may be a bit difficult for strokes because assessment is important. It is not a case of saying, 'We will do that and have a look', but still it would help. It may help in the case of centres that someone could reach within an hour. However, not even the helicopters could help us at night time. Therefore it would help to have some telemedicine, where the peripheral hospitals could be linked to a centre.

[77] **Lorraine Barrett:** On that point, could it be used if a scan was done in one place and

where a specialist radiographer could look at the results on a computer somewhere else, in another department?

[78] **Dr Wani:** Given that we do not have a neuroradiologist, we could suggest that there could be a 24-hour service. So, you do not have to have a radiologist locally, but there could be an on-call system. There are already some neuroradiologists, so we could have an on-call service just to provide the reporting service on wherever the patient is. So, there are some solutions.

[79] **Dr Freeman:** We have a good example of that in east Kent where they offer an on-call thrombolysis service 24/7 between three district general hospitals. Not every DGH provides thrombolysis, but they are using telemedicine to link up to the centre that is on call at any one time. So, we do have examples of good practice with telemedicine that we can learn from. Certainly, it is under debate at the moment.

[80] **Dr Hughes:** I was just going to pick up on an earlier point about the difference between incremental change and a revolution to services. Most of the trials in stroke medicine are international, but you can enter them in any DGH. The randomisation process is computer-based, they are pragmatic, and they are designed to enrol people from the general medical take. So, if we want incremental change, every clinician in Wales has the opportunity to enter large pragmatic international trials, and that ensures that their practice is plugged in to a research mentality, and it gives them the benefit of mixing with the research group at the annual review of the research. It is a way of innovation by diffusion—slowly starting at the grass roots and building up rather than waiting for some huge revolution.

[81] **Darren Millar:** What do you think the barriers are to achieving that, Dr Hughes?

[82] **Dr Hughes:** I think that one important barrier, and it is underestimated, is the amount of time it takes for a clinician to get his department enrolled in a trial, to get the ethics approval, to sort the paperwork out, and to get the help he or she needs to run the trial properly. I think that one important thing would be to ensure that all clinicians have time within their job plans to ensure that they are plugged in to large international trials.

[83] **Darren Millar:** I appreciate that. I think that brings us to the end of the questions we wanted to ask. Are there any other points that any of you would like to make before we bring this part of the evidence session to a close?

[84] **Dr Freeman:** I have a point that I need to perhaps pick up with the clerk afterwards. I need to amend one of the sentences in the submissions to improve clarity, but I will ring tomorrow and make that amendment if that is okay.

[85] **Darren Millar:** Thank you for that. If members have no further questions I will conclude this item. I thank Dr Freeman, Dr Hughes and Dr Wani for attending committee today. Thank you.

9.58 a.m.

Ymchwiliad i Wasanaethau Strôc—Tystiolaeth gan Gymdeithas Feddygol Prydain Cymru
Inquiry into Stroke Services—Evidence from the British Medical Association Wales

[86] **Darren Millar:** We move on to item 3 on the agenda. We will continue with our inquiry by taking evidence from the British Medical Association. We are pleased to welcome

to the table Dr Trevor Pickersgill, who is a consultant neurologist at the University Hospital of Wales and a member of the BMA central consultants and specialists committee and of the Welsh council of the BMA.

[87] Members have received and had time to read the evidence paper. I think that we have indicated to you, Dr Pickersgill, that we will go straight into questions, if that is okay.

[88] I will kick off. To what extent does the BMA feel that the Welsh Government's neurology review, and the changes that are envisaged in that review, will improve the supply of neurologists in Wales and the services that can be provided to stroke patients?

[89] **Dr Pickersgill:** By 'Welsh Government's neurology review' I take it that you are referring to the neuroscience review and the Steers report and review, which is ongoing.

[90] **Darren Millar:** Yes.

[91] **Dr Pickersgill:** If we ever get to implementation phase, which of course we all hope we will, I think that appropriate neurology services for appropriate population bases will hopefully be implemented. One of the issues at the moment is that, as we have laid down in the paper and as I believe you have heard in evidence previously, acute stroke care and, indeed, if you like, post-stroke care rehabilitation, is not delivered by neurologists. There are approximately 22 neurologists in Wales who have very little involvement in acute stroke cases, partly because we are spending a lot of our time in our job plans in the clinics dealing with patients with headache and with the worried well and anxious, rather than seeing acute patients.

10.00 a.m.

[92] Many of us want to do that but do not have the time within our working week. So, stroke care at the moment is often delivered or mostly delivered by general physicians, sometimes general physicians with an interest in stroke. I understand that you have just had evidence from Dr Freeman and Dr Wani, who are two such experts, undoubtedly. However, neurologists are experts in stroke as well and we have little involvement. I would hope that acute neurologists—the experts in neurological conditions—will be more involved in the case of patients with acute fresh emergency neurological problems, rather than seeing them days or weeks later. So, I would hope that that would be part of the solution.

[93] **Darren Millar:** Okay. Is this one of the strands that has been feeding into the ongoing review?

[94] **Dr Pickersgill:** It is indeed, yes.

[95] **Darren Millar:** Okay. Andrew R.T. Davies?

[96] **Andrew R.T. Davies:** Thank you for your paper. In it, you say that,

[97] 'The new local health boards should dramatically increase the number of whole time equivalent medical hours allocated to stroke treatment and management in each hospital within their areas'.

[98] We are all aware of the constraints, particularly financial, that all the public sector will be facing as we go forward. In your paper, you touch on how it is only two sessions in Wales but really it should be two whole-time equivalent sessions per district. In Wales, it falls woefully short of the prescribed levels. Given the constraints that we understand will be placed upon us in the next 12 to 18 months, or two years, how do you see the new local health

boards being able to meet your aspiration as an organisation to meet the more desirable targets that have been met elsewhere?

[99] **Dr Pickersgill:** That is certainly an interesting question and I am sure that many other specialties and services are asking themselves the same question. When I look at the jobs being advertised for neurologists and stroke specialists, I see that the vast majority—I would say 80 per cent, certainly at the moment—of new or replacement consultant posts, in England at least, are specifically for stroke. We do not have a stroke neurologist in Wales as such. Dr Hughes, whom you have just taken evidence from, takes the lead on stroke services in Cardiff, but that was not his job in the beginning. He has grown into it—and many people do grow in their careers.

[100] The evidence that we gave is that, on average, there are two sessions of stroke care in most district general hospitals and, in the majority of cases, those are delivered by consultant physicians with an interest in stroke. Within current manpower, I think that increasing the amount of stroke care being delivered acutely without impacting on other services would be impossible. That is the issue. You are looking at an already stretched service, and if you want a bunch of people—whether they are neurologists, stroke physicians, geriatricians or physicians—to take a lead on acute stroke at the front door, as it were, they will have to do less of something else. It is really as plain as that, unfortunately.

[101] That means that out-patient waiting list targets may not be met for routine patients. It may mean that waiting lists for endoscopies or for whatever else the physicians might be doing may have to go up. Those are purely the consequences of people becoming more involved in acute and emergency, rather than routine, care. At the moment, and certainly over the past 10 years, we are moving more towards a consultant-based service at the front door in general medicine. I am not a general physician, but I see it happening. When I was a junior doctor, nearly 20 years ago now, acute general medicine was delivered by people two or three years out of medical school and that was it, really, perhaps with a consultant ward round twice a week. Now, consultants are at the front door doing ward rounds two or three times a day in the medical admissions units. Their jobs have changed over the years and, if you want to develop that into acute neurology and acute stroke care, those experts' jobs will have to change as well.

[102] **Andrew R.T. Davies:** So, really, it is not necessarily additional resource that is required but a reprioritisation or reconfiguration of the service from how it has evolved to date. From your understanding, is the ability there to do what you request in your paper, but it is just a matter of reconfiguring it in a different model rather than providing additional resource?

[103] **Dr Pickersgill:** If you were to put additional resource on the table, I would not say 'no'.

[104] **Andrew R.T. Davies:** Yes, but in reality, that will be very unlikely.

[105] **Dr Pickersgill:** I accept that, but I think that reconfiguration of what people currently do is one facet of this Rubik's Cube, if you like. You know, you have to try to get all sides of the Rubik's Cube correct rather than just look at one side.

[106] **Lorraine Barrett:** In your paper, you mention that stroke medicine is regarded as a sub-specialty. Would it be feasible for stroke to be upgraded to a speciality in its own right? What difference do you think that that would make to stroke services?

[107] **Dr Pickersgill:** One of my roles is as the Welsh medical member of the PMETB, which is the Postgraduate Medical Education and Training Board, which is the regulatory

authority and competent authority for UK medical training. Stroke medicine is not just regarded as a sub-specialty, it is actually labelled as such. When we train specialists in the UK, the trainees go through training programmes and come out at the end with their ticket, which is their certificate of completion of training, and that could be in surgery, medicine, neurology, or all sorts of things. Specialties and sub-specialties have built up really by nothing more than luck or bad luck, or serendipity. The important thing is the skills that people have.

[108] Stroke medicine has become a recognised—certificated, if you like—sub-specialty over the past three or four years, recognised in legislation. I personally do not think it would be feasible for it to become a headline speciality because that would imply a doctor training in nothing but stroke. At the moment, we have neurologists, cardiologists, pharmaceutical medicine doctors or care of the elderly doctors who develop and take an interest in stroke and want to learn more, so they go off onto a stroke sub-specialty training programme, either before or after they get their main qualification. To develop a new specialty requires sponsorship from the Department of Health and evidence to be submitted along those lines. Therefore, the current system of sub-specialty medicine in stroke is actually growing and developing quite well, and it is probably a little premature to change that.

[109] **David Lloyd:** I suppose that if we, as a committee, are cross-examining the British Medical Association, I had better note my own membership of it. From your paper and for the committee record, Dr Pickersgill, can you confirm how acute brain units would differ from stroke units, and what would be the advantage over stroke units?

[110] **Dr Pickersgill:** I would like to compare this idea to that of what are commonly called coronary care units, or CCUs. They are present in the vast majority of, if not every single, acute admitting hospital in Wales and the UK and probably the world, but they do not just deal with people who have got a blockage in a coronary artery causing chest pain and angina or heart attack; they deal with people who have heart failure, who are short of breath from an unknown cause, who have heart valve problems, structural heart problems, congenital heart problems, and who have become acutely ill. So, in fact, they are not named correctly. They are heart units, not coronary care units. I think that stroke units could easily develop or become brain units.

10.10 a.m.

[111] As we have mentioned in our paper, stroke has many mimics and many things mimic stroke. At the front door, when somebody is presenting with a neurological problem, it is sometimes difficult, or impossible, clinically, to know exactly what is wrong with them. That might develop over time, as signs and symptoms may mature over hours or days, but the patients' problems are the same. They may have fits. They may be unwell with sepsis, they may have low blood pressure, or they may have weakness, bladder problems, or bowel problems. The nursing, early rehabilitation, and potential treatments of those are similar across a range of conditions. Over the years, the acute medical take has become more specialist-led but, very often, those specialists are not trained in neurology or have very little experience. Twenty years ago, the vast majority of consultant physicians who were taking patients from accident and emergency departments and from general practitioners had done a neurology registrar job; now, that is almost unheard of, even at a more junior level than that.

[112] So, I think that it is worth exploring the idea of developing a unit specialising in a range of conditions where the nursing, physiotherapy, bed management and medical expertise can be concentrated but also developed with experience. Patients who have acute neurological problems should be dealt with by an acute neurological team, if you like, not just neurologists. I am not blowing my own trumpet here, but stroke units would be a place where that could start to mature.

[113] **Darren Millar:** So, is that the next stage after developing stroke units in Wales?

[114] **Dr Pickersgill:** At the moment, stroke units are often developed with local enthusiasm, as it were, rather than a pre-planned new building that we will call a stroke unit. So, in effect, it is a corner of a previous medical ward with a new sign, maybe with new staff, and maybe with better training, but, with the concentration of that disease there, experience of how to manage and look after those patients better would quickly build up. That could be said across—

[115] **Darren Millar:** What I am trying to get at is that many previous witnesses said that we need dedicated stroke units across Wales. Are you suggesting that the starting point should be the establishment of stroke units and that they could evolve into acute brain units? Is that what you are suggesting, or that we leapfrog straight to brain units in our district general hospitals?

[116] **Dr Pickersgill:** That would be a step too far for the majority of places. If we thought about this sensibly and interdigitated with Steers and the implementation groups, we might find that neurologists could be involved in the four neurology centres that the implementation groups are talking about but they could be doing more than just stroke. They could run the whole gamut of emergency neurology as a model for the future.

[117] **Darren Millar:** You are next, Val.

[118] **Val Lloyd:** Sorry, I was just thinking about what Dr Pickersgill has said. I have some questions about training. In your view, how do you think the Welsh Government should make sure that there is a hospital training programme that will retain and keep doctors in Wales who wish to specialise in stroke?

[119] **Dr Pickersgill:** We have a very well established and well regarded training programme in neurology in Wales. It is an all-Wales training programme but, in effect, it is just south Wales because that is where the neurology centres are. I do not believe that there are currently any training posts in stroke medicine per se. To have training posts, you need accredited trainers, of course, namely doctors wishing to become trainers who are already experts and who wish to pass on their knowledge and train people up. That requires funding for the training posts, for the junior doctors' salaries, and for the proportion of the trainers' time that it takes to train as opposed to deliver their service and do their day job. So, in reality, it is a question of time and resources for those currently dealing with stroke and giving those consultants and those teams the ability to take on more staff to train.

[120] On retention, you can retain doctors or specialists in Wales or GPs in Wales only if there are jobs for them to go into once they have finished their training. It is as simple as that, frankly.

[121] **Val Lloyd:** We have touched on prevention, but we have been talking mainly about secondary care. I wish to consider primary care for a moment. Is there any training available to GPs and other primary care staff in transient ischaemic attack or stroke recognition and management, immediate management, and care?

[122] **Dr Pickersgill:** I am not a GP but I have talked to my colleagues about this. Vascular medicine, stroke medicine, TIAs, and heart problems are bread and butter for a good GP, and so training in all these areas, in stroke and in TIAs and recognition of them, starts at medical school and carries on through GP training, the attachments that GP trainees and registrars have in the hospital side of their training programmes, within the practice itself where GPs are trained, then through hot reviews of cases, review of things that go wrong, half-day training

programmes, half-day release programmes each week, and regular meetings with the GP trainer. These are all used for postgraduate training in general practice.

[123] The system that GPs use to keep themselves up to date, namely continuing professional development, could be fine-tuned to major on those things that need developing, and stroke might be one of those. I was talking to a colleague yesterday who has recently completed an online *BMJ* learning module on neurology, including updates on stroke recognition, prevention and treatment. So, there is a variety of ways in which current GPs and the GPs of the future are trained and can be trained in this.

[124] Dr Hughes mentioned earlier the difference between TIAs and stroke and said how, in reality, they need to be managed somewhat differently, but many GPs are fully cognisant of that difference. In reality, one issue is what to do with a patient once you think that they are having a stroke or have had a TIA. It is about access to local services either in the community or the secondary care sector, where the expertise can be developed in treating those patients appropriately.

[125] **Darren Millar:** Dai, do you want to come in on the other GP-related questions?

[126] **David Lloyd:** Yes. Just on the back of that and on stroke services in the community—and granted this is the view from secondary care—what is your impression of how GPs are increasing the timeliness of diagnosis of TIAs and suspected strokes, and what improvements could be made? In my own experience of admitting people with suspected TIAs, I think that GPs—and I include myself in that—tend to admit people either too early or too late. So, how do you think things are improving?

[127] **Dr Pickersgill:** The recognition of TIAs is improving, and that is just my own view and experience, really. What patients need is a pathway to appropriate treatment, and it does not actually matter where that is. We are talking about TIAs now. So, that might be a daily TIA clinic in the local hospital, the regional hospital or wherever, or immediate appropriate drug treatment, whether blood pressure lowering with aspirin or an appropriate equivalent or cholesterol-lowering drugs. All have been shown to prevent stroke in those at high risk. They do not prevent every stroke and nothing ever will, but reducing the risk and the incidence on a population-wide basis is what government and public health is all about. As for increasing the recognition, it is really to do with GPs getting more training, to be honest.

10.20 a.m.

[128] **David Lloyd:** To follow on with the ongoing community support in primary care, after patients have been discharged with a diagnosis of stroke—in other words more long-term rehabilitatory efforts in the community—what is your view of the services provided now and how could things be improved? Moving away from the acute situation now, we are in the long-term rehabilitatory situation after discharge from hospital.

[129] **Dr Pickersgill:** Patients can be discharged early if they have recovered well but still have some deficits, perhaps a clumsy hand and a bit of speech disturbance but nothing else. They do not need to be in hospital taking up an acute bed where they could catch pneumonia or whatever, but they do need ongoing support and care, whether through speech therapy, physiotherapy or occupation therapy, to help them to cope in their environment with their new disabilities. That is where things start to break down.

[130] My own expertise and sub-specialty area is in multiple sclerosis where similar problems of chronic and progressive disability are seen in the community but access to community services is tricky. Community physiotherapy is very hard to access in many areas, both from the hospital side when referring patients into the community or the general practice

side, with primary care trying to get its own patients treated. There is also an issue with communication between the hospital and the primary care team. I am sure that Dai is fully aware of this. There have been long-running problems between hospitals and GPs with getting appropriate information out in a timely manner, and I think that that problem continues. A GP wants to know not just when a patient was discharged and what drugs they were on but who they have been referred to, when, why, and what the plan is, but that information may take weeks and weeks to come out, if at all—and you would probably agree, Dai. So, I think that communication is an issue.

[131] Therefore, there is the issue of the hospital, the stroke unit or the rehabilitation unit setting up services to enable patients to go home and linking in with what is happening in the primary care team. I think that that linkage is not great in many areas.

[132] **Darren Millar:** Talking of links and partnership working—

[133] **Andrew R.T. Davies:** May I just come in on that point?

[134] **Darren Millar:** Pardon me.

[135] **Andrew R.T. Davies:** I notice that, in your paper, when talking about community and links, you talked about designated social workers for stroke services. In Wales, only 53 per cent of stroke units have that coverage. In England, it is 73 per cent and, in Northern Ireland, it is 100 per cent. I would suggest that an obvious key aspect—and I am speaking as someone looking from the outside in—is that link between social services and the hospital and the unit. Do you see that as a big anomaly that needs to be addressed given that only 53 per cent of units in Wales have a dedicated social worker, and given that the link between social worker and hospital is often cited as a cause of problems further down the chain?

[136] **Dr Pickersgill:** I agree with that. I have worked in Rookwood Hospital, in the rehabilitation unit there, and undoubtedly the whole-team approach—of social services, occupational therapy, physiotherapy, speech and language therapy and all the allied health professions helping patients to recover and to fit back into their homes and community with their new problems and new disabilities—is the best. Social services and social workers do fit in with that. They have a big part to play in advising patients which benefits and alteration grants they can access, or helping them if they need wheelchair access or other equipment for their disability, and I think that that is an issue.

[137] **Andrew R.T. Davies:** Why are we so far behind Northern Ireland, for example? Northern Ireland has comprehensive coverage. Is it because they operate to a completely different model or do they put more resources in? We should all be aiming for 100 per cent coverage. You touched on wheelchair services there. That has been highlighted on numerous occasions and, when it comes to assessment, it is very often on the social service side that there is a breakdown in helping people to access wheelchairs, for example. Is it a relatively simple operation for us to overcome the deficit that we face in Wales?

[138] **Dr Pickersgill:** I do not know the answer to that, I am afraid. Part of the problem is the separation of health and social care budgets historically. If that changes in the future—and I hope it will—that should improve things.

[139] **Andrew R.T. Davies:** Did you say that you hope it will?

[140] **Dr Pickersgill:** Yes.

[141] **Ann Jones:** I will just stay on the partnership working for a moment, if I may. You have been highlighting the importance of a multidisciplinary team to assist a stroke person

coming home and the continuous care. Could this be done within existing partnerships and structures or does it need a specific partnership? Perhaps it needs a total reshake of where social services lie at the moment.

[142] **Dr Pickersgill:** That is quite a difficult question. It harks back to previous answers, really, in that partnership working in the community involves all those agencies that we have talked about. The theory of the partnerships is good but, in practice, many of my primary care colleagues find that it is going backwards rather than forwards. So, for instance, three or four years ago, when primary care teams would meet regularly to discuss different issues and problems with patients, there would be district nurses and community OTs and health visitors involved in that. Now they are not, because they are not based in practice. That is one issue that my GP colleagues have highlighted. District nurses, health visitors and midwives all have a part to play in stroke prevention, if we are dealing with stroke, but, in the wider sense of the healthcare community and the partnership, many of those individuals do not now attend primary care team meetings. Whether you wish to set up new partnerships just for stroke is debatable, but improvements in current working engagements would probably improve things.

[143] **Ann Jones:** Okay. I do not expect you to answer the other one. That is a policy decision for us to make, but I feel very strongly about it at the moment.

[144] May I take you further on to the professional forum and the stakeholders' reference group that you refer to? You say that they should be used as mechanisms to highlight stroke issues. How do you see that being done?

[145] **Dr Pickersgill:** My understanding of the new local health boards is that these boards, fora and the stakeholder reference groups will be really high-level strategic bodies with representation from various professions and, hopefully, patients in the community. They will be setting the direction of the new LHBs, but it will not be feasible for any of them to look in any great detail at any one area, whether it is cancer services, stroke services or renal services, and to make implementation plans for that locality. So, setting the strategic direction for the executive team and the appropriate structures within the new LHBs to implement those strategies will be the role of those bodies. I hope that they will not become disenfranchised talking shops.

[146] **Peter Black:** I want to look at prevention and to ask what is being done to reduce the levels of undiagnosed and untreated high blood pressure in Wales. What other measures have been taken to identify those at risk from stroke through other factors?

[147] **Dr Pickersgill:** When I see patients who may have had a stroke or other problems, we try to identify what risks they may have. We look at smoking, diabetes, a strong family history—none of us, of course, can do much about that apart from know about it—blood pressure and previous events. If you have vascular disease in your legs or heart you have it in your brain as well, that is almost certain, and the risk factors and the treatments are much the same.

[148] In terms of identifying those at risk, or primary prevention, I would hope that the new quality and outcomes framework, the new contractual arrangements for funding and contracting in general practice, have helped. Previously, screening for blood pressure, for instance, would be done on an ad hoc basis: if mum brought little Johnny in with a sore throat, she might get her blood pressure checked, if there was time in the consultation. It was ad hoc in that way.

10.30 a.m.

[149] Now, with QOF, practices are funded to pull patients in who would not otherwise be screened for risks like this. So, if QOF is working, and to stick with the wider population screening and treatment of blood pressure, we would hope that the incidence of stroke and heart disease will come down. The incidence of heart disease is coming down, due to various socioeconomic and industrial changes—reduction in smoking, among others—but the quality and outcomes framework was designed to improve screening and public health and we hope that that is what it is doing.

[150] **Peter Black:** Have you seen any evidence of that?

[151] **Dr Pickersgill:** Personally I have not, but there is a lot of data-mining going on in QOF and I am sure that there is something in there.

[152] **Peter Black:** It just occurs to me that we are putting a lot of extra responsibilities on to primary care but the number of GPs being sampled has not increased in the last 10 years. Are they able to cope with all these additional responsibilities, despite the new contracts?

[153] **Dr Pickersgill:** It is not just GPs who take blood pressure or ask someone whether they smoke; it is every health professional. I am thinking about diabetes clinics, for instance, whether in primary care, in the secondary care sector or in the back of the lorry that goes around the Valleys. If the chiropodist or the podiatrist who is dealing with the diabetic foot talks about smoking, that is a health intervention. It is not just the GP. Over the last 10 to 15 years, the ingrained behaviour of all health professionals has been changing and we are looking at opportunities to address vascular risks like this. I talk about smoking in my clinics. If someone comes in with a headache I will check someone's blood pressure, for instance. I might not have done that 20 years ago.

[154] **Peter Black:** Finally, on the contributions that allied health professionals in the community are making to prevention, how might their roles be enhanced?

[155] **Dr Pickersgill:** One of the big risk factors is smoking. Smoking cessation and smoking advice is paramount, and I appreciate the Assembly's involvement in that and the work that it has put in. Health education does not just come through publicity but it also comes through individual contact. So, district nurses, community nurses, practice nurses taking bloods to be checked for cholesterol in those at risk, or in those who have had a stroke to check their lipids, checking on smoking, reinforcing the public health messages, is probably one of the most important things. That is certainly something that the whole primary care team and not just the GP in the consultation could be doing.

[156] **Andrew R.T. Davies:** On the training and retention of doctors, of specialists—touching also on social workers—your paper alludes to the fact that Dr Tony Rudd gave us evidence last term on the importance of training people in Wales; if we train them in Wales they will, hopefully, spend the rest of their careers in Wales. The BMA has a role obviously to play in promoting Wales as an attractive place to practise one's profession. What role do you see for you, as a professional body, complementing other Welsh Assembly Government work in promoting Wales as a place to come to to practise one's specialty? I am thinking about the field of social work as well, although I appreciate that that is not your dedicated discipline, but, as a partner organisation, one thing that is highlighted is the ability to attract social workers as well. So, it is the whole team approach and everyone working together to say that there is a positive agenda and that this is where you should be coming to practise your profession and hopefully improve the services.

[157] **Dr Pickersgill:** The BMA has worked in partnership with the Welsh Assembly Government, I think, and the postgraduate deanery over the last two or three years to try to improve the attractiveness of Welsh training programmes for specialty doctors and for doctors

who wish to train in the different areas of medicine in Wales. That has had some partial success, but I think that the evidence from last year's specialty training application round is still that Wales is not a popular choice, unfortunately. I do not have a magic wand as to how we can improve that, but the BMA is happy to work with many agencies to try to improve the attractiveness of Wales for health professionals.

[158] **Andrew R.T. Davies:** Can you tell me why it is not an attractive place? We get very mixed messages and some rather ludicrous suggestions as to why people do not look at Wales as being an attractive place, but why do you think that Wales is not an attractive place to come to practise?

[159] **Dr Pickersgill:** If I speak to colleagues in England, they look at a different NHS, which they see as not working as well. They see the differences; maybe that is because those are the differences that are promulgated in England. They see lower standards. We do not see that, from this side of Offa's Dyke, but I think that that is one of the issues: it is the perception of how NHS Wales is performing in terms of quality and patient care. In terms of quality, I think that we are right up there, undoubtedly, and that is one of the messages.

[160] **Darren Millar:** Is that an accurate reflection in terms of substance?

[161] **Dr Pickersgill:** Based on the evidence that you have heard today and through the sentinel stroke audits, that is accurate. I do not know whether you could say that about other services. As I say, my sub-specialty area is MS and our unit is being built up and is one of the better ones in the UK—that is according to the MS Society, not us. So, there are quality aspects in our care at which we are very good, but stroke does not seem to be one of them.

[162] **Andrew R.T. Davies:** How proactive is BMA Wales in dispelling that myth of it being a poorer service, or a backward service? You did not identify stroke services in particular—you spoke of the perception of NHS Wales.

[163] **Dr Pickersgill:** That is the perception that I—

[164] **Andrew R.T. Davies:** I agree that that is the perception, so the perception has to be, if you like, burst. You, as a professional organisation, interlink with your colleagues in England, Scotland and so on, so how are you, as an organisation, working to dispel that myth? By not dispelling that myth, you are giving credence to it.

[165] **Dr Pickersgill:** BMA Wales is part of what is not, strictly speaking, a federation but works as a federation of bodies within a UK umbrella. In the UK BMA council, UK representatives meet and many of us point out the positive differences, the things that we do better, and not just the things that NHS England says it does better.

[166] **Darren Millar:** That brings us to the end of this particular part of our meeting. If members have no further questions to Dr Pickersgill, I will say 'thank you' for joining us. We appreciated your evidence today.

[167] **Dr Pickersgill:** It was a pleasure.

[168] **Darren Millar:** Thank you for the paper that you circulated, too.

10.38 a.m.

Ymchwiliad i Wasanaethau Strôc—Tystiolaeth gan Goleg Brenhinol y Nyrsys Cymru a Chynghrair Nyrsys Strôc Cymru

Inquiry into Stroke Services—Evidence from the Royal College of Nursing Wales and the Welsh Stroke Nurses Alliance

[169] **Darren Millar:** I am pleased to welcome Lisa Turnbull, policy adviser, and Lynne Dacey, clinical nurse specialist for stroke, from the Royal College of Nursing Wales, and, from the Welsh Stroke Nurses Alliance, Michelle Graham, who is a clinical nurse specialist for stroke and the current acting chair, and Kylie Crook, clinical nurse specialist for stroke.

[170] We have had some evidence papers from both sets of witnesses, which have been circulated to committee members—papers 3 and 4—and we have indicated that there will not be a requirement for an opening presentation. Therefore, we will move straight into questioning.

[171] Can you clarify whether the Welsh Stroke Nurses Alliance is part of the Wales Stroke Alliance chaired by Dr Anne Freeman? I suppose that that is a question to either Michelle or Kylie.

10.40 a.m.

[172] **Ms Graham:** I suppose that I should answer that. We feed into the Wales Stroke Alliance, which is made up of professions allied to medicine as well as medics themselves. We feed in and have representation on the alliance.

[173] **Darren Millar:** Thank you for that. We appreciate it.

[174] **Lorraine Barrett:** In its paper, the Welsh Stroke Nurses Alliance says that, in stroke literature, nursing care is given little importance other than in the field of rehabilitation. How can this lack of recognition be addressed in Wales?

[175] **Ms Graham:** We need more commitment to training across Wales and recognition of the specialist role of nurses. We do a lot more than just participate in rehabilitation. One of the biggest drives at the moment is that everyone is talking about thrombolysis, the need for it to be available 24/7 and that it has to be given within three hours, but, unfortunately, once it has been given, there is then great emphasis on the aftercare of that patient, especially the first 24 hours. It requires close physiological monitoring and assessment and the ability to be able to react promptly and quickly with these patients if they show any sign of deterioration whatsoever. This role will fall upon the nursing staff within these units. We are already quite stretched in terms of the skill mix that we have and bodies on the ground available to provide this service. So, we need to start focusing on continuing professional development for nurses and expanding the specialist skills of the nursing staff that we have, to be able to facilitate the thrombolysis that will be occurring as of 1 April.

[176] **Lorraine Barrett:** Does the RCN have a view on how the role of nurses can be recognised or given more prominence?

[177] **Ms Turnbull:** Yes. The point that I would add to this is that if you can monitor the activity that is taking place—for example, one of the things that we are calling for is some nationally consistent guidelines on appropriate staffing levels and, indeed, on the uptake of CPD—you are establishing the evidence for how it is affecting the outcome. Within the last five years, certainly, we have seen the evidence for nursing interventions increase quite dramatically, in the US and the UK. There are some references in the paper that my colleagues have provided and there are also references in terms of general nursing. Not only does it make a very distinct and important difference to the outcome for the patient, which is the most important thing, it also has a beneficial impact for the service itself. The faster that people recover and the more well they are, the less financial impact they will have on the

NHS.

[178] So, I think that it is important to see that sort of systems perspective as well. Investment in specialist nursing skills and in the right numbers of staff on the ward will make a difference: you will end up spending less money on the service as a whole. We can begin to quantify that now.

[179] **Darren Millar:** You say that you can begin to quantify that. What sort of staffing ratios are you talking about?

[180] **Ms Turnbull:** If we are talking about specific staffing ratios in stroke, I think that I would be better off handing over to my colleagues who would be more able to answer that.

[181] **Ms Graham:** We have recommendations for staffing levels in stroke, and you will find that the Royal College of Physicians' recommendations are contained within the document. We also added work that we did with specific units; we looked at staffing levels across all the units in Wales, so you can see how far away we are from what we would like.

[182] **Lorraine Barrett:** What role does or should a specialist stroke nurse play in the community?

[183] **Ms Graham:** We have a great role to play. I should say that I am a clinical nurse specialist in the community, and I bridge the gap between acute and primary care services. It is the same role as we have in the hospitals, in that there is leadership, communication, advocacy, education—not just for staff—and linking in with practice nurses, district nurses and our colleagues in chronic disease management, but also in working with the patients and the carers themselves.

[184] I am responsible for the Open College Network programme, Living with Stroke—we started this process in the borough where I work. We need to concentrate more on our role in the longer term management of these patients, whether that be through clinics or more of a co-ordination-type role. We are needed to provide the information just as much as we are needed in the acute provision and also to disseminate that knowledge to our general nursing colleagues in the community, especially as we move more and more towards a community model of nursing and of care across Wales.

[185] We need to be able to disseminate these skills to our colleagues because more and more of the care is going to fall on them, especially with programmes such as early supported discharge, where you will have patients who are not very long post-stroke and their care will be expected to be in the community. You need some form of specialist intervention, which is only going to be advisory, when you look at the number of specialist nurses as opposed to the number of patients suffering stroke.

[186] **Ann Jones:** Despite the evidence that stroke unit care is highly effective when compared with care on a general medical ward, you say that the favoured model is still for patients to go through the general admissions unit. Why is that?

[187] **Ms Graham:** I could not tell you why. Kylie, would you like to answer that?

[188] **Ms Crook:** It is basically due to the lack of availability of stroke beds. Any blockage that occurs in transferring patients from the acute stage into rehabilitation beds is the major hiccup.

[189] **Ann Jones:** Would you like to see a model whereby someone who is displaying all the symptoms of a possible stroke goes straight to a specified stroke unit?

[190] **Ms Crook:** Yes, most certainly. That is a philosophy of care that should be implemented. The alliance and many stroke specialist nurses and stroke co-ordinators are trying to bridge the gap by being the first point of contact for patients as they arrive into hospital from accident and emergency departments and medical assessment units. They are there to provide professional nursing advice and support to generalist nurses caring for patients within this acute stage and, obviously, to ensure the implementation of the national clinical guidelines.

[191] **Ms Turnbull:** Part of the issue about trying to move to planning and increasing the number of stroke beds is around making sure that you have nurses who can provide that care. One thing that needs to be monitored is the number of education places in pre-registration and post-registration education who are actually commissioned as well as the uptake of those places. As we know, the Government can put money into commissioning places, but unless they are taken up then obviously that is—

[192] **Ms Crook:** Could I just add to that? One of the expanding roles of the clinical nurse specialist is to implement this kind of training programme in-house and at ward level, because of the lack of formal programmes available for people to attend. With patients being cared for in the acute stage within general medical areas, the clinical nurse specialist is not only trying to support specialist skills for patients working with stroke, but also supporting the training of generalist nurses.

[193] **Darren Millar:** We will come on to the education and training issues a little later.

[194] **Ann Jones:** In your paper you mention annual operating framework targets. What is the AOF target for co-located beds? Can you explain what that means? What is an appropriate patient for one of those beds?

[195] **Ms Graham:** What is an appropriate patient? I will start from the other end. The target was that, by March of this year, all units across Wales would either have acute stroke units or co-located beds for stroke patients. By having co-located beds, and all the stroke patients in the same place, you start to be able to implement some of the skills and the black box effect of a stroke unit. Although we know that stroke units work very well and we have an idea of why that is, it is still a bit of a black box effect, in that it is the whole programme being concentrated on that patient that improves the outcome. You cannot pick out particular interventions, although we have gone a way towards doing that with the care-bundle approach that we are currently using in the 14 units across Wales.

10.50 a.m.

[196] I seem to have forgotten the other part of your question.

[197] **Ann Jones:** It was about the annual operating framework target. What is that target?

[198] **Ms Graham:** It was to have the stroke unit, which has been achieved now across Wales. Actually, we are unable to quantify how well this is working and whether the appropriate patients are getting there, because, as the medics who were here earlier were explaining, it is very difficult to rapidly assess and decide whether someone has definitely had a stroke. It is helping that we are giving patients CT scans more quickly, but an awful lot of patients are referred who may be confused or have infections or because this care has always been linked with care of the elderly—if it is an older person who is confused or has an infection, or sometimes for social reasons, they tend to be defined as stroke patients and are moved to a stroke unit. Patients who require immediate care and constant physiological monitoring are not receiving that because they are being sent to outlying wards, as there are

no stroke beds available for them.

[199] What helps with that is the role of the clinical nurse specialists, where they go down to the accident and emergency department to carry out an assessment, working with bed managers to get patients in the appropriate beds. It is not a case of a good stroke or a bad stroke and cherry picking the good ones; it is just a case of trying to get the stroke patients to the stroke units as quickly as possible. The more that we push for following a coronary care unit model and going for direct access, the better it will be. However, it is also about recognition with our colleagues of the emergency care aspect of stroke and the fact that time is brain—the quicker we act, the more chance we have of improving the outcome.

[200] **Peter Black:** You identify a role for nurses to play in the acute sector, where specialist units exist, so can you explain more about how you manage that so that expectations of patients and carers are not unduly raised?

[201] **Ms Graham:** I do not think that they are unduly raised. We work closely with the patients and relatives and inform them of what they should be having and what is available. This gives them more of a voice so that if they are not receiving the care that they should be receiving they are able to articulate that—they seem to have a lot more influence over the powers that be than the people that are working in these units.

[202] **Darren Millar:** On partnership working, what sort of structures are in place both in the hospital setting and the community setting to ensure that there is this multidisciplinary approach to working between nurses, doctors, therapists and, of course, social services in the wider community and the voluntary sector? Can you give us some examples of the advantages to patients of working in this way, and where you think it is working well in Wales and where you think it is working particularly badly, perhaps? Who wants to take that question?

[203] **Ms Graham:** Working as part of the multidisciplinary team, whether it is in the acute unit or in the rehabilitation unit, and having regular goal-setting meetings which include the patient themselves, is the most important factor. It is not just about the professionals being part of that team; the patient needs to be part of the team. Units that have been proven to work well are those where the patients themselves are involved in the goal setting, where the treatments work around the patient's aspirational goals rather than just the professional goals for getting this patient better, safely planning their discharge and getting them home.

[204] It starts to not work as well in the community because of the difficulty of being able to draw all those specialists together in a multidisciplinary team to allow them to meet and discuss the patients, but that is an area where telemedicine may again help us as you do not all have to be in the same room to be able to discuss the patients and their care and take matters forward.

[205] It is also very difficult with stroke patients due to the complex nature of many of their care needs post-discharge. We need to work closely with our social service colleagues, which we do, but information sharing becomes difficult. Although we now have unified assessment documentation, we are still a long way from collaborative information sharing, which would help the patient and speed things up.

[206] In some areas they are looking at having co-ordinators of care in the community as a central point of contact and a virtual stroke rehabilitation team working in the community. You pull in the aspects of the care that the patient needs and have one central point of co-ordination where anyone can go to find out exactly what care that patient is receiving.

[207] **Darren Millar:** You mentioned data sharing. What sort of problems are there?

[208] **Ms Graham:** There are problems with confidentiality and with information that is on the separate databases for health and for social services. These are problems that we have come across in the past. Unified assessment is working towards resolving those problems, but I feel that we are still a long way away from that. With stroke, working with social services—partnership working—is vital for these patients. They do not want to tell their story a million times; what they want in the community is to know that they are getting the right care at the right time and in the right place, which is their home.

[209] **Darren Millar:** Is the barrier from the NHS passing information to social services or—

[210] **Ms Graham:** No, it is both—it works both ways.

[211] **Darren Millar:** All you need, though, is the consent of the patient.

[212] **Ms Graham:** It is not just the consent of the patient.

[213] **Darren Millar:** It is their data, is it not?

[214] **Ms Graham:** Yes, it is and you would think that that would be the case, but the problems we have are the logistics of sharing that information and even the fact that organisations work on different computer systems—it is about accessing that information. It is not that we do not want to work together; it is just difficult sometimes.

[215] **Andrew R.T. Davies:** I am going to ask you to give your opinions. In the previous evidence session we touched on social workers and the need for social workers, as part of the team, to build that community support. To use a figure that the BMA provided to us, in Wales there is 53 per cent coverage for a dedicated social worker in a stroke unit. In Northern Ireland, for example, it is 100 per cent coverage, and in England it is 72 per cent coverage.

[216] Would you suggest that far better coverage of dedicated social workers working in that team environment would facilitate better sharing and better access? Have you seen that situation getting worse or better over the last couple of years? Is there less contact or more contact?

[217] **Ms Graham:** It depends on the area in which you work. I work in Gwent, which has five boroughs. In the hospitals we have hospital-based social workers and on the stroke unit we have borough-based social workers. The difficulty we have is when patients are cared for in a stroke unit out of the borough—because each borough does not have its own stroke unit—you do not have a dedicated social worker. They may be working with a team out of the borough. Say, for example, you have a patient in Torfaen who goes to Newport for their stroke care because there is a bed on the stroke unit and because there is no availability in Torfaen, planning their care becomes very difficult because you need the social worker from the borough that they are from to sort this out. We see problems like this time and again.

[218] I have also worked on a stroke unit in England where we had a dedicated stroke social worker and it worked well, but the issue is the inter-borough relations. Although we are going to have seven health boards now in Wales, we are still going to have all the separate social service boroughs and we are still going to have to find a way of working across those boroughs.

[219] **Andrew R.T. Davies:** As you see it, is there not a route map to break that barrier down at the moment?

[220] **Ms Graham:** I cannot see that. I do not know whether my colleagues have anything to add to that. That is just my personal perspective.

[221] **Ms Turnbull:** On a general point, we have expressed concern about the barriers between health and social care before. What is key for us is the need for specific joint budgets; people need to be measured against the same targets. That is crucial in encouraging joint co-operation to ensure that nothing is standing in the way. The IT question is also very important. I do not want to take this too far, but unified assessment needs to be reformed. It should be an electronic system. Unfortunately, because it has not been properly integrated into IT, it is manual and it is becoming more of a burden than the problem it was intended to solve. So, those are the key areas.

11.00 a.m.

[222] **Andrew R.T. Davies:** Is the issue turf warfare—this is my system and you cannot access it? That is the impression that I am getting.

[223] **Ms Turnbull:** The point that I am making is that there needs to be direction from the centre. The Welsh Assembly Government needs to take control of this issue because the unified assessment system was brought in nationally but it has not been as successful as it should have been in conception. One of the reasons for that is the IT issue. Those are the sorts of areas where we have broadly expressed concern about the lack of direction on getting health and social care to work together.

[224] **Andrew R.T. Davies:** Okay, thank you for that. You provide evidence in your paper about the need for additional specialist nurses and you touch on how hyper-acute and acute stroke care has tended to get the funding for nurse positions. According to the evidence that has been given today, the pathway that needs to be constructed in order to provide a whole package of care will require an expansion in the number of nurses available.

[225] We all know how difficult the funding situation is going to be, but in making that wish list for more nurses, have you got a feel for how many would be needed to provide that complete coverage to facilitate a successful model of pathway care, and has that been costed? You might say, ‘It is not our role to cost it; it is for the trust to do that’, but could you give us your insight in putting that request on paper and including it in your evidence?

[226] **Ms Graham:** We have put that request on paper, and we have asked for a review of stroke specialist nursing across Wales because we only have a feel for the areas that we currently work in and we only know the numbers for those areas. We currently have 16 CNSs and one stroke nurse consultant across the whole of Wales. Due to the role of the clinical nurse specialist, we feel that more of them are needed especially, as we have said, to bridge that gap between inpatient and outpatient services and the community model that has been developed.

[227] We would welcome the government taking matters forward and getting a consensus on what is needed across Wales, looking at the numbers and auditing what we currently have and where the gaps are. I do not know whether the gaps would be identified locally and then fed into a national document, so I could not give you the cost implications. What I can tell you is that it would be cost effective because you would be disseminating information. You are not just providing specialist nurses to work within little silos; you are upskilling the rest of your workforce, which is important. We recognise that specialist nurses alone cannot save the world and cannot save stroke services, but we can go a long way in upskilling our colleagues so that we have a more comprehensive service for patients across Wales and across the community as well as across secondary services.

[228] **Andrew R.T. Davies:** You touched on the need for an audit to understand the requirement. Working in your own chosen field, you have an understanding that there is a need for more nurses, but your paper mentions a recruitment freeze and then it goes on to state,

[229] 'in other areas vacancies that are managed by in-house management processes are extending the length of time taken to fill a vacancy.'

[230] In other words, there is a cap on recruitment at the moment.

[231] **Ms Graham:** There is at the moment.

[232] **Andrew R.T. Davies:** Is that a long-term situation or is it something that has only recently come into play?

[233] **Ms Graham:** It has come into play more recently; over the last 12 months I would say. It has got worse over the last 12 months. We all recognise that resources are not infinite, but perhaps we could look at the way that we use resources and become a bit clever about that and think outside the box a little bit more than we currently do.

[234] **Ms Turnbull:** I will just add two points to that. The first one is about creating more nurses. I emphasise that we are not necessarily talking about creating nurses from scratch. What we need—and I think that perhaps my colleague can talk about this—is a succession plan to upskill nurses that we already have.

[235] On your point about being cost effective, it is possible to cost up the training and the backfill that you would need if someone was going out of the ward to train. It is possible to cost that, but one should also cost the effectiveness of the intervention when that person goes back to the ward and the impact on patient care. If you do not assess it like that, then you will get a false picture.

[236] The other point that I wanted to make is about education and your point about cascading education and training. We have talked about specialist nurses, but healthcare support workers are also an incredibly valuable part of the nursing team. I know that there are some excellent training programmes, for example, in Scotland that are working well in terms of cascading those nursing skills. Perhaps I could ask Lynne to come in and say something specifically about that point.

[237] **Ms Dacey:** Many areas have taken that on board, because of the financial problems that we currently face, looking at how they can be creative in providing education and learning for the healthcare support workers that work within their environment. They make up a huge proportion of our nursing workforce. There are a number of healthcare support workers that are already skilled, have NVQ qualifications, and are looking to build on those skills.

[238] We, as specialist nurses, can help those individuals develop the skills they already have and, perhaps, look at changing their roles to those of generic workers to provide seven-day-a-week therapy for stroke patients. They are not in our wards from Monday to Friday; they are there seven days a week. At the weekend, when the therapists are not there, in many units seven-day therapy is not provided.

[239] Therefore, upskilling some of our healthcare support workers to become generic workers would help to fill a little bit of that skill gap and, perhaps, provide speech and language therapy exercises that they could do with the patients over the weekend. They could also be involved in any training and development within the stroke development areas.

[240] Where I work, we recently completed a training needs analysis of all the staff that work within stroke areas to find out the skills gap among both registered nurses and healthcare support workers. You can then devise your in-house education programmes to cater for the skills that they do not have and to build on skills that they do have.

[241] **Darren Millar:** I am conscious of the time. I ask members to be brief in their questioning and witnesses to be sharp with their answers.

[242] **Ann Jones:** I think that you have talked about upskilling and training nurses in hospitals. What stroke training is available for community, district and GP practice nurses? Who should provide that training?

[243] **Ms Graham:** At the moment it is provided locally by CNSs that are in post. In the area in which I work, I am responsible for a training programme for district nurses and practice nurses.

[244] **Ann Jones:** Does that happen across Wales?

[245] **Ms Graham:** No, it does not. We need some form of policy to drive these programmes so that we have to meet specific standards, and to ensure that the programmes are provided pan-Wales rather than in pockets throughout Wales.

[246] **Ms Turnbull:** We would hope, with the new LHBs, that the role of the primary care framework would be to look at doing an audit of both community nursing skills and practice nursing skills to identify the deficits and put that kind of educational programme in place and, of course, to do the financial work that is necessary to go with that.

[247] **Val Lloyd:** Before I start my questions, I want to say that I support what Lynne has said about using the workers that you have on the ward on the weekend across an inter-disciplinary skills measure because that will benefit patients.

[248] Turning to education briefly, you say in your paper that pre and post-registration education to support nurses developing a career in stroke nursing are inadequate, and that it is difficult to achieve the standards outlined in the Department of Health's framework. You also say that it is difficult to safeguard protected time for study. How can the Welsh Government ensure that these elements of professional development are progressed?

[249] **Ms Graham:** We need a core standard across Wales that has to be achieved and, as I have said before, which is policy driven and has to happen.

11.10 a.m.

[250] We have reached the point where we need to take a stick approach instead of a carrot approach.

[251] **Val Lloyd:** You also outlined the living with stroke module in your paper. Could you outline very briefly what it encompasses and how it could be rolled out across Wales?

[252] **Ms Graham:** We are currently trying to roll it out across Wales through the specialist nurses, and a couple more areas have started to take on the programme this week. I designed the programme to enable patients and carers to learn the skills required for self-management of their condition, which is a long-term condition. It is a six-week programme that looks at medication, rehabilitation, what a stroke is, secondary prevention and lifestyle changes. We also include a section where we invite the voluntary sector to speak and we give benefits

advice as well. At the end of the six-week programme they have built a portfolio of information and, hopefully, skills and tools to enable them to carry on and live their lives in the way that they want.

[253] **Peter Black:** In your paper you mentioned that the Royal College of Physicians national sentinel audit refers to general nurse activity such as monitoring patients' weight and mood. Could you explain more about the specific tasks that are monitored by the sentinel audit that nurses undertake with stroke patients? Are there other tasks that would benefit from monitoring?

[254] **Ms Graham:** Those are the only two specific tasks that relate to nursing that are monitored currently in the Royal College of Physicians audit. Swallow screening is part of the audit, and across Wales many nurses are trained to do a screening assessment. It covers matters as simple as teaching nurses to give basic mouth care. If a patient's mouth is clean and they aspirate, they are less likely to develop aspiration pneumonia than if they have a dirty mouth full of bugs because they have not had simple, basic mouth care. A lot of what we are talking about is not rocket science; it is basic bedside care as per the fundamentals of care in nursing.

[255] **Lorraine Barrett:** What roles do nurses play in stroke prevention? What scope might there be to expand that work?

[256] **Ms Dacey:** I think that any opportunity would be good. If we go out of an evening, if the opportunity arises I grab it by the horns and go for it.

[257] **Ms Graham:** I think that we have all been there, taking blood pressures in Tesco in the middle of town.

[258] **Ms Turnbull:** Going back to my earlier point about the role of the new LHBs, what is interesting is being able to take a holistic look at the primary nursing care workforce and see the excellent work that is going on there and perhaps roll out best practice across the area. That could be a way of looking strategically at some of these opportunities to prevent strokes.

[259] **Lorraine Barrett:** Do you think that there is an opportunity in GP practices and in the resource centres to hold clinics or something for stroke prevention, among other things?

[260] **Ms Graham:** Yes. Even the practice nurses themselves holding clinics is vital. I am involved in the intelligent targets work because I am clinical adviser to the stroke collaborative—perhaps I should have mentioned that earlier. With the intelligent targets work that we have been doing with the TIA, both the beginning and the end of that pathway are in primary care in the GP surgeries. We are currently looking at a way of using the Audit Plus tool that is currently available in the GP surgeries and somehow piggybacking that on to the current QOF targets to enable the practice nurses to achieve the targets that we are setting.

[261] **Darren Millar:** I think that that brings us to the end of the questions. Thank you for your papers and for the interesting oral evidence. It will help us to draw our conclusions and make our recommendations in our report. I thank you all.

[262] We will now close the meeting. I have a few notices for members before you disappear. We have had about 40 responses to our stroke inquiry so far. Without listing them, it is important to note that we have had many responses from individual members of the public, patients and people caring for people with stroke. I have discussed with the clerk the opportunity for some members or a small delegation of the committee to meet with a local stroke association group or stroke club to try to gauge patient experiences at some point, in addition to another delegation going to one of the local stroke units down here.

[263] It is unlikely that we will be able to go to Sweden as part of the stroke inquiry, mainly due to time constraints and the inability of members' diaries to be co-ordinated. We will be taking evidence via video link from Sweden, particularly about the telemedicine issues in rural areas.

[264] We have the budget round coming up. As a committee we play an integral part in scrutinising the health, social services and local government budgets. It is very important that as many of us as possible attend the Finance Committee seminar on 29 September 2009, which will help you to gain an understanding of the current budget process. It is slightly longer than last time, but we will be able to do a better job if we are able to attend. That brings us to the end of the meeting. We will be discussing the sunbed inquiry at our next meeting on 30 September 2009.

[265] **Peter Black:** Will the details be circulated?

[266] **Darren Millar:** They have been circulated, as I understand. We will send a reminder.

Daeth y cyfarfod i ben am 11.15 a.m.
The meeting ended at 11.15 a.m.