Cross Party Group on Stroke held on 17 October 2013 at Ty Hywel

Present:

Guest Speaker: Prof Mark Drakeford, Minister for Health and Social Services.

Joyce Watson (JW), Chair of Cross Party Group
David Rees (DR), Chair of Health Committee Nigel Monaghan, PHW
Dr Anne Freeman MBE (AF), Clinical Lead for Stroke in Wales
Ana Palazon (AP), Director of Stroke Association in Wales
Richard Dewar (RD), Consultant Stroke Physician at Cwm Taf HB, Chair of Welsh Assoc of Stroke Physicians
Dr Alison Cooper (AC), Older People and Ageing Research Network, Swansea University
Janet Ivey (JI), College of Occupational Therapists
Phillipa Ford (PF), Chartered Society of Physiotherapy
Felicity Waters (FW), Action in Smoking and Health in Wales
Fay McCaffer (FM), Chair RCSLT Stroke Expert Group and Speech & Language Therapist Cardiff and Vale ULHB
Julie Wilcox (JWil), Consultant Clinical Psychologist, Cardiff and Vale
Lowri Griffiths (LG), Corporate Events Manager, Stroke Association
Gareth Davies (GD), Corporate Events Assistant, Stroke Association

In Attendance:

Jillian Haynes, Minute Secretary, Stroke Association

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The Chair welcomed members and advised that under the new orders, the Chair and Secretariat needed to be nominated and seconded. It was **AGREED** that JW would continue as Chair and the Stroke Association would continue to perform the Secretariat function.

The Chair introduced the guest speaker, Prof Mark Drakeford.

Prof Drakeford began by stating that the NHS in Wales was firmly in the age of austerity and decisions were shaped by balancing declining budgets alongside rising demands. PHW had performed an analysis of the pressures within the NHS over the winter period, looking at the effects of temperature, demography and increasing acuity but the most harming factor was poverty. He quoted the Rowntree report which stated that Wales had the highest number of households where the highest, or only, wage earner was a woman. As the NHS is a large employer of women, as a result, most staff had their own financial problems. The Minster felt privileged to have inherited a position which had improved in comparison with other conditions and with a sense of forward momentum.

The Stroke Delivery Plan of December 2012 had, at its core: prevention; detection; treatment; living with the condition; and addresses inequalities and the research culture in

Wales. In terms of prevention, a campaign with the community pharmacies had been implemented which had allowed a further 10,000 checks in Wales. With regard to research, he had spoken with AF on how to further the research effort. The local Health Board delivery plans (LDPs) determine local needs and the first annual report on the Stroke Delivery Plan would be available before the end of 2013.

PF asked how members could support the LDP. MD reported that there had been a debate on the floor the previous day regarding diabetes and he had reviewed a local quality plan. All HBs published their own individual detailed diabetes delivery plans. A useful role for the CPG would be to 'give it life'.

AP advised that the LDPs acknowledged the risks of not achieving their stated actions, but did not report how the risks could be avoided. If the correct reporting mechanisms were not constructed, failure would be inevitable. MD replied that agreeing the criteria against which to report was crucial, and that further down the line, knowledge gained would be useful in this regard. A barrier to progress was the lack of funding, but the answer is not to allocate more, but to use the resources available to their greatest effect.

LG asked the Minister if he had any thoughts on stroke network development which was a thread for risk reduction. MD was not against the idea per se, and stated that what was very clear, was the pattern of advisory machinery although it was difficult to understand each Committee's boundaries and the area of overlap. He wondered whether the voice of clinicians and their colleagues was inaudible. Chris Jones, Deputy Chief Medical Officer (DCMO), had been asked to review the structures in Wales. Authorities in New Zealand had redesigned their structures completely and implemented a very effective and powerful top tier committee. The DCMO had produced a document that Dr Ruth Hussey was progressing to clarify and streamline the system. RD agreed the structure was over-complicated as he belonged to ten different working groups.

NM suggested that the first step should be to map the systems in place and thence propose a solution to the DCMO. AP advised that any proposal should be holistic to be effective. MD stated that there were over 60,000 participants in the consultation. LHBs would meet in November 2013 to make decisions on the way forward. The south Wales plan would be agreed after Christmas 2013.

GD had determined the key issues from each of the LDPs for comparative purposes and reported that lack of resources was often quoted as the reason for not having targeted research. He advised that all elements of the plans needed to be implemented and that HBs should not be allowed to select areas of development.

ACTION: LG agreed to forward the key points summary to Prof Drakeford.

Members discussed possible meeting days/times and it was agreed to schedule future meetings at lunchtime on a Tuesday in a ground floor room, following the meeting of all political groups. Members of all political parties would be encouraged to attend.

AP suggested that the key challenge was working with LHBs. JW agreed and stated that the plans needed to be implemented with subsequent social service support so that survivors would not remain in hospital unnecessarily, with associated further costs and risk of infection. Unscheduled care was required at both ends of the service.

NM commented that, historically, the NHS was seen as a safety net if the Local Authority (LA) did not spend its budget on a particular condition. PF agreed that the Welsh Government could push for integration of health and social care for those with complex needs.

AP noted that a one week PHW campaign had previously brought about changes in public behaviour, and there were opportunities similarly for stroke prevention awareness. NM noted the relationship between late stage cardiovascular disease, diabetes and stroke. Public awareness of the relationship between the conditions would be beneficial; there was a need to pilot different approaches and measure risk factors, with the emphasis on mortality not morbidity. International indicators, he reported, looked at life length only. LG stated that the 50+ health checks aimed to partially cover this gap in public knowledge. Members agreed that stroke was a political priority. A discussion ensued regarding the costs/benefits of certain drugs for certain conditions and the 'rules of rescue'.

ACTION: LG would approach Marcus Longley for advice on economic analysis.

PF suggested approaching LHBs for ideas for cost savings and AF agreed that the Welsh Stroke Alliance could take this forward; NM advised that it would be difficult to earmark any cost savings for stroke, however. GD suggested determining trends in the LHB reports. NM stated that it would be useful to have knowledge of the problems that the LHB encounters, rather than its successes ie the barriers and facilitators. Given the shrinking and ringfencing of funds, what would be the alternative action to bridge the gap between supply and demand for services?

ACTION: LG to invite an executive from a Health Board to present the key elements of their delivery plan at the next meeting.

JWil warned that ESD could become a tick box exercise with minimal input if no definitions of a TIA service were implemented. She related the position in Cardiff; ESD had been implemented which absorbed patients from the acute service who were being discharged imminently but with no support service. A better quality service had been put in place which meant that the momentum of throughput had been lost. This had resulted in stroke survivors in receipt of rehabilitation were being discharged due to the patient blockage created.

NM suggested that it would be useful to follow the patient's story from beginning to end. AF reported that this was already being recorded and that it had been educational as 40% of acute patients could be processed via ESD. PF said that 1000+ Lives could also assist with that exercise.

LG summarised the actions listed above and agreed the role for this Group would be to scrutinise the delivery plans.

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