



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

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

**Dydd Iau, 8 Mawrth 2012  
Thursday, 8 March 2012**

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

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

|                 |                                                           |
|-----------------|-----------------------------------------------------------|
| Mick Antoniw    | Llafur<br>Labour                                          |
| Mark Drakeford  | Llafur (Cadeirydd y Pwyllgor)<br>Labour (Committee Chair) |
| Rebecca Evans   | Llafur<br>Labour                                          |
| Vaughan Gething | Llafur<br>Labour                                          |
| William Graham  | Ceidwadwyr Cymreig<br>Welsh Conservatives                 |
| Darren Millar   | Ceidwadwyr Cymreig<br>Welsh Conservatives                 |
| Lindsay Whittle | Plaid Cymru<br>The Party of Wales                         |
| Kirsty Williams | Democratiaid Rhyddfrydol Cymru<br>Welsh Liberal Democrats |

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

|                |                                                                                                                                                      |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| Keith Bowen    | Rheolwr, Cyswllt Teulu Cymru<br>Manager, Contact a Family Wales                                                                                      |
| Joseph Carter  | Cadeirydd, Cyngor Niwrolegol Cymru<br>Chair, Wales Neurological Alliance                                                                             |
| Jeff Collins   | Cyfarwyddwr, Cymru, Y Groes Goch Brydeinig<br>Director, Wales, British Red Cross                                                                     |
| Philippa Ford  | Swyddog polisi dros Gymru, Cymdeithas Siartredig<br>Ffisiotherapi Cymru<br>Policy Officer for Wales, Chartered Society of Physiotherapy<br>Wales     |
| Ruth Jones     | Cymdeithas Siartredig Ffisiotherapi Cymru<br>Chartered Society of Physiotherapy Wales                                                                |
| Sandra Morgan  | Coleg y Therapyddion Galwedigaethol Cymru<br>College of Occupational Therapists Wales                                                                |
| Matt O'Grady   | Uwch Swyddog Polisi ac Ymgyrchu, Scope Cymru<br>Senior Campaign and Policy Officer, Scope Cymru                                                      |
| Ellis Peters   | Coleg y Therapyddion Galwedigaethol Cymru<br>College of Occupational Therapists Wales                                                                |
| Nicola Wannell | Rheolwr Datblygu Gwasanaethau (De-ddwyrain Cymru), Y<br>Groes Goch Brydeinig<br>Service Development Manager (South-east Wales), British Red<br>Cross |

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

|                |                                          |
|----------------|------------------------------------------|
| Victoria Paris | Y Gwasanaeth Ymchwil<br>Research Service |
| Llinos Dafydd  | Clerc<br>Clerk                           |

Catherine Hunt

Dirprwy Glerc  
Deputy Clerk

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

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

[1] **Mark Drakeford:** Bore da, a **Mark Drakeford:** Good morning, and chroeso i'r Pwyllgor Iechyd a Gofal welcome to the Health and Social Care Cymdeithasol. Committee.

9.30 a.m.

### **Ymchwiliad Undydd i Wasanaethau Cadeiriau Olwyn yng Nghymru— Tystiolaeth lafar One-day Inquiry on Wheelchair Services in Wales—Oral evidence**

[2] **Mark Drakeford:** Rydym yn **Mark Drakeford:** We begin this morning on dechrau'r bore yma ar ein hymchwiliad our one-day inquiry on wheelchair services in undydd i wasanaethau cadeiriau olwyn. Wales. I welcome Joseph Carter, the chair of Croeso i Joseph Carter, cadeirydd Cyngor the Wales Neurological Alliance; Keith Niwrolegol Cymru; Keith Bowen, Cyswllt Bowen, Contact a Family Wales; and Matt Teulu Cymru; a Matt O'Grady o Scope O'Grady from Scope Cymru. Cymru.

[3] Rwyf am ofyn i bob tyst ddechrau I will ask each witness to begin by going drwy fynd yn ôl at argymhellion y pwyllgor back to the recommendations of the last diwethaf. Gofynnaf i chi enwi tri pheth sydd committee. I ask you to name three things wedi gwella a thri maes lle mae gwaith i'w that have improved and three areas on which wneud. work remains.

[4] We normally open by asking people if they have any introductory remarks. Today, we are going to vary it very slightly by asking everyone we hear from whether they can begin by identifying three areas on which recommendations were made by the previous committee where they believe progress has been made, and three areas where they think ground still needs to be made up. Keith, you look like you might be about to start.

[5] **Mr Bowen:** Do you want to us to do that jointly, or take one area each?

[6] **Mark Drakeford:** Do you have a joint list?

[7] **Mr Bowen:** We will do one each, with three positives and three negatives in total.

[8] **Mark Drakeford:** You kick off then, Keith.

[9] **Mr Bowen:** Even though I start with the positives and the progress, waiting times are an area that will also show up in the negatives and the drawbacks, particularly for assessment and delivery. It must be acknowledged that the two centres on the ground have been putting a lot of effort into trying to address the issue of waiting times, despite some longstanding systemic problems. So, we must acknowledge that there have been some positive developments on waiting times, but this issue will also show up on the negative side of a balance sheet as well.

[10] **Mr Carter:** The key progress for us has been around satellite services, particularly in south Wales. One of our main criticisms last time around—and to an extent, it remains—was the dependence on two centres in Wrexham and Cardiff/Nantgarw. We have seen a move, particularly in the south Wales artificial limb and appliance centre, towards satellite services in west Wales, particularly around assessment. That has meant that, in the last six months, we have started to see some reductions in the time it takes for community occupational therapists to make an assessment, while, in the past, people had to travel to Cardiff to be assessed or, more often than not, wait for a specialised occupational therapist to come to see them in their home town or village. This service allows them to reduce travel times and make that far more efficient. It has made a real difference more recently.

[11] **Mr O’Grady:** I think that I will go down the same route as Keith and highlight an area where there has been positives and negatives, and that relates to recommendation 20 on maintenance. I want to make sure that you are aware that my comments are based on discussions with a very small number of our service users, but we think that they are very important, because these are the experiences of people with whom we work on the ground.

[12] We received positive and negative representations from our service users about repair services. The positive comments were mainly on the services that we run, with users saying that they had quite strong arrangements with them. For example, Craig-y-Parc School runs a regular repair clinic where someone will come to fix any problems that the students are having with their chairs, without any need for them to pre-book the service. Our skills development centre in Cwmbran did not have a regular reoccurring appointment in the same way that Craig-y-Parc School did, but gave praise to the individual that it works with, who is always happy to assist other service users with any problems that they are having. This also has a particularly useful function, because they are able to make referrals far more quickly than an occupational therapist could if they had to go through that route.

[13] However, those we spoke to who are not physically based in one of our services seem to have a more negative experience. For example, an individual we spoke to in Maesteg had to wait up to a week for repairs due to his location, meaning that he was unable to attend his day service. Essentially, he was confined to his house. Another individual we spoke to in Torfaen had a similar experience. She was unable to get a loan chair and was then unable to go to her voluntary placement. It is worth noting that having to wait for repairs can have a significant impact on someone’s independence, preventing them from being able to leave their home without assistance. It is concerning that we found that this was happening in the community, which is ultimately where we and, I think, the Welsh Government want more services to be based. We want to see people in their communities, enjoying themselves and participating in community life. Ultimately, we want to see that happen wherever possible, and it is concerning that repairs could end up being a barrier to that.

[14] **Mark Drakeford:** Keith, do you want to say a bit more on the ground still to be gained in relation to waiting times and where the problems still exist?

[15] **Mr Bowen:** One last little positive that should be mentioned and acknowledged, and, hopefully, we will find out more information about throughout the day, is that, in the interim period, there has been an allocation of £2.2 million of additional funding. This is to be noted and welcomed. That has definitely been a positive. There is a lack of clarity on the recommendation calling for an assessment of the long-term resources needed. That seems a little less clear, but it must be acknowledged that the additional funding has been put in and, hopefully, we will hear throughout the rest of the day how that has been spent.

[16] On the negative aspect, Joseph might say a bit more on the waiting times angle, although I am happy to speak later about that, but there has been less progress in the areas of

leadership and strategic planning. The momentum does not seem to have been kept up, despite a lot of work on the ground, at a more strategic level. For instance, we might find out about this later on, but we are not aware of progress on recommendation 1 on the national service specification, or on the strategic plan. Phase 2 is the ministerial review, but we are not sure what its status is. Is that the strategic working plan, and if it is, where can you find it? How accessible, public and open to scrutiny is it? On leadership and the chain of command running from the Welsh Government level through the Welsh Health Specialised Services Committee down to the centres, how much proactive leadership has there been to keep the momentum going? Our concerns over the last 12 months, after some initial progress, have been that that momentum seems to have eased off. So, hopefully, we will find out a bit more later today.

[17] **Mark Drakeford:** Thank you, that is useful.

[18] **Mr Carter:** Clearly, we will talk about targets and waiting lists as we go on throughout this session, but what I would throw into the ring at this stage is communication. Recommendations 8 and 9 were very specific about the need for communication plans and communication with stakeholders. One of the reasons we are here today, apart from a lack of progress on the ground, is a deep uncertainty as to what is going on, because of communication. Much of the information you have received in written form from the service providers, which you will hear this afternoon, is information that we as organisations had never seen before, because of that poor communication. One lesson for us is that if communication had been better earlier, perhaps we would not be here today and perhaps more progress could have been made sooner.

[19] **Mark Drakeford:** That is a helpful mapping out of some of the territory that we will look at throughout the day, so thank you for that. We will now go into questions from Members. I see that Lindsay wishes to speak first, and then Darren.

[20] **Lindsay Whittle:** Good morning, gentlemen. I am interested in the opinion of service users, mainly the younger service users, and the design of wheelchairs. I made the point in the debate last week that wheelchairs should be fun to get into, and not be a vehicle to be made fun of. Is there any evidence from any of your service users that they are not happy with the design? The previous committee took evidence from one student and, I cannot remember his exact words, but he said something along the lines of 'I'm not getting into that piece of junk—it doesn't reflect me as a person'. That is pretty crucial in my opinion. Do you have any evidence on that?

[21] **Mr Bowen:** At Contact a Family, we support families with disabled children across Wales, and yes, there is an issue with choice, especially for young people. Their identity is very important to them, and the chair that they use is a vital part of their personality. We have had feedback, though not as much as in previous years, on all the issues; that might be construed as reflecting positive developments, or it could be consultation fatigue, I am not sure. Generally speaking, I would say that the issues around choice, control and flexibility of the equipment are probably one of the areas where we had the weakest feedback from families. There were a number of examples where people said that they had an appropriate chair that reflected their personality and their needs, and it made a huge difference to them with regards to their development and independence. It was primarily the parents reporting to us, by the way, rather than the young people. However, we also had a lot of examples of people saying that there still was not much choice being offered, or not the range of choice that they were hoping for. So, there were some positive examples where young people had chairs that reflected their personality and were suitable for all the different activities that they wanted to get involved in, beyond the basic getting from A to B. However, there was also a slightly larger number of families who reported that there were still restrictions in choice. Maybe there were not as many positive developments on this as there were with some of the

waiting times issues, on which there was more positive feedback.

[22] **Mark Drakeford:** Does anybody else have a point to make on this?

[23] **Mr Carter:** The choice and the range of chairs available on the NHS were raised by a number of our parents. One parent, for example, said that she went to the roadshows and saw a large number of chairs that she thought would be particularly suitable for her daughter, but they were not available on the NHS in Wales. While some parents raised with us the potential for a voucher scheme, we have looked at how that scheme is running in England and there are some concerns, so I will not come out wholesale in favour of that, but certainly there needs to be a view as to how the NHS can increase the range of chairs that are available to parents in Wales.

[24] **Darren Millar:** Thank you for your written evidence. It has been useful to read that. Essentially, it seems that you are pointing to three particular problems. One is with access to assessments, another is access to repairs and the wait for repairs, and then there are the monitoring issues in terms of driving forward change. Could you make this clear to me: if some people are getting their assessments in a more timely manner, but obviously people with changing needs or degenerative conditions often need to be reassessed fairly regularly as well—particularly children, if they are growing and the size of the chair is not adequate—to what extent has there been an improvement on those fronts? Your evidence seems to suggest that reassessments are the area where there is a really acute problem and that people are not getting reassessed as and when they ought to. Do you want to comment on that?

[25] **Mr Carter:** There are a few reasons for that. There is geography, first of all. We know that the closer people live to the centres in Cardiff and Wrexham, the better their chances of having their assessment speedily. That is a factor. People living further away have longer waits, although as I said, the satellite service in west Wales has helped with that. The other factor is the issue of time—people who are being assessed now for the first time are seeing much shorter waiting lists, and I think that that is reflected in the written evidence put forward by the service providers who are coming in to this committee later this afternoon.

9.45 a.m.

[26] However, what we are seeing is that those people who perhaps were first assessed 18 months or two years ago are still on the system and are still facing these bottlenecks. So, the preference seems to have been to get the new entrants to the system, as it were, cleared quickest. That is one factor. It also varies for different conditions. We have seen evidence that there has been some prioritisation of those with certain conditions. Within the neurological sector, we know that the waiting lists for those with motor neurone disease, for example, have come down considerably. I know that the services are very proud of that, because that is a very quick and aggressive condition. In most cases, its effects are felt far quicker than those of conditions such as multiple sclerosis and most other neurological conditions. So, that is perfectly right. However, that has left a core group of people who, because they entered the system over 12 months ago, before some of these improvements came on line, are still having to wait for a very long time.

[27] We know of one individual, for example, in Brecon and Radnorshire, who was first assessed for his chair in July 2010. It finally arrived in December last year. By the time the occupational therapist arrived to measure it—because it is not like taking delivery of a television; you need someone to come to set it up for you and ensure that it is right for you—the packaging was undone and it was all set up, it was January, and the OT found that it was unsuitable, because it was the wrong size. So, it had to go back. A new chair arrived at the end of last month and the individual in question is still waiting for an occupational therapist to come to see him. It is fast approaching 20 months now and, before too long, if the new chair

does not work out, it will be two years. So, there is still a cohort of people who, for whatever reason, be it rurality or whatever, when they entered the system, or their condition, are still waiting for a long time, while others, particularly those who are entering the system now, are being seen far more quickly.

[28] **Darren Millar:** So, there is a definite problem and where you live determines how quickly you get your wheelchair. The date that you were referred also seems to be an issue. So, you are saying that the people last into the system are getting seen more quickly than the people who have been in the system for a while.

[29] **Mr Carter:** That is the perception of our members. Obviously, we can speak only from the perspective of the evidence that we have collected from our members. Some might argue that these are personal stories and not empirical evidence. We are certainly all keen to see what the service providers have to say about that this afternoon. However, that is certainly our perception, from what we have been told.

[30] **Darren Millar:** I can certainly challenge them with some of the evidence from my constituents. Keith, your evidence seems to point to reassessment being more of an issue.

[31] **Mr Bowen:** Yes. Two years ago, we would have had almost consistently negative feedback on all aspects of waiting times for assessment, delivery and review and maintenance. Two years later, we have had a lower level of response. That could indicate some positive developments, but it could also indicate consultation fatigue. With regard to review and maintenance in particular—although this is also true for the other areas—there are now three main groupings. People have seen a noticeable improvement, which is positive. The issue there, as Matt has mentioned, seems to be access to Craig-y-Parc School. A clinic is held there, so the children who access that can be seen more readily. So, some mechanisms have certainly been put in place, such as outreach clinics, among other things, which has speeded things up, which is good.

[32] If, for example, a child goes to a special school, it might be easier for them to access review and maintenance services than for a child who goes to a mainstream school. So, that might warrant further investigation. Some people have reported some positive developments, but others have not and are still waiting quite a long time for review and maintenance and have had difficulty in getting repairs. Having said that, there was one very positive report about the out-of-hours repair service, and then one negative report about that service. So, there has definitely been a general improvement in the co-ordination of review and maintenance, but issues remain because there are still negative stories.

[33] **Darren Millar:** I would like to follow up that point. You have referred to the situation in south Wales, but what is it like in the north? There was a contractual change, was there not, and the service was taken in-house in the south? To what extent has that improved the situation or been a significant driver in improving access to repairs? Is the situation in the north worse, about the same, or what?

[34] **Mr Bowen:** I must acknowledge that this time around, although not the last time around, the majority of our feedback has come from the south. We have a small amount from the north. I think that the timescales may have had something to do with that. There was positive feedback that taking the contract off Serco and bringing it back in was beneficial.

[35] **Mark Drakeford:** Kirsty, do you have a point on these answers?

[36] **Kirsty Williams:** I can wait.

[37] **Mark Drakeford:** Fine.

[38] I want to make sure that we have understood the answer to the very first question that Darren asked. In a way, he was pointing to the issue of young people whose needs are changing rapidly, so that their assessment at one point needs to be updated and so on. You isolated different factors, such as rurality, when someone went on a waiting list and the nature of their condition. Can I clarify whether, if the system is faced with someone whose needs are developmental and changing, it is your view that the system now responds in a more timely way? If that sort of person was living in a rural area, would rurality mean that they would not get a timely response?

[39] **Mr Carter:** The evidence that I was pointing to was from the adult population rather than from children. Most of our members in the Wales Neurological Alliance are adult-focused charities. Certainly, our impression is that someone living with a very complex neurological condition that progresses very quickly would have a far better service than they would perhaps have done two years ago, while someone with a condition that progresses more slowly would not.

[40] **Mark Drakeford:** Thank you. I was just trying to make sure that I had understood that. Vaughan is next, and then William.

[41] **Vaughan Gething:** I am interested in what has been said about direct payments and joint funding with regard to the potential to improve the supply and the time taken—it is recommendation 15—and I know that you have a range of comments on that in your evidence. I am especially interested in what was said in terms of the initial response about seeing partnership working between the NHS and local authorities, but I note that you are also clearly talking about joint funding between the individual and part of the state, regardless of where that is. How do you see that working in practice? If you could design what you think joint funding could and should be, what would it look like, and how quickly do you think it could happen? Also, what do you think would be the impact of that?

[42] **Mr Carter:** That is a very good question. While the recommendations of the previous committee were quite open on this issue and could be read in very different ways, most of the work being commissioned by the Government has been more towards looking at how different agencies within the Government would work together on this. I know that with regard to community equipment, excluding wheelchairs, a lot of work has been done by local authorities, health boards and education providers working together to provide community equipment, certainly for children, but, as I say, that excludes wheelchairs. So, we have seen some progress there.

[43] Coming back to the first question, our concern is that we have a system where you can centralise and improve procurement all you want, but it will naturally reach a stage, with the market as diversified it is and with so many different chairs on the market, where there are only so many chairs that can be kept at the central storage unit to try to meet everyone's needs. Our view—which we put in to try to challenge the status quo—was that if we explored using some sort of direct payment, it could allow people to bypass what was then a prolonged wait of over six months for a chair, after they had the assessment. Assuming that you have had your assessment, and that you know what your needs were, you could take that information to a private provider and buy the chair yourself. That would also have fed into the concerns about getting a chair that fits your very specific personal needs, such as a certain style for your child and so on. That was our feeling on the matter.

[44] **Vaughan Gething:** I am interested in how you would see that working with repair and maintenance obligations, if you part fund it yourself. The point was made that they still want ownership to remain with a Government agency, so that the obligation for repair and maintenance is clear and does not fall on the individual. How would a joint funding model



work, and what impact could or should that have?

[45] **Mr Carter:** There are two elements to that. We would envisage there being an obligation on the provider, first and foremost, at the initial stage, in terms of a guarantee as with any device that you would purchase. In the long term, there would need to be some sort of partnership with the wheelchair service so that these chairs could be maintained and monitored. There would have to be some sort of registration so that your purchase could be registered and become part of the system, to be tracked if there were any problems. Crucially, as with any direct payment scheme in social care, you would want to work with a group of registered providers deemed suitable, rather than giving someone a cash payment that they could give to Joe Bloggs. There would need to be some criteria, as there are at the moment within the current social care system.

[46] **Kirsty Williams:** The evidence seems to suggest that people have been working hard and that there have been some improvements, but it has not been universal. Not everybody is getting the service that we would all aspire to for them. It seems that the more complex your case, or the more rural your area, the more difficulties you face. Do you think that a system of direct payments, whereby a family or individual would be given a direct payment to allow them to carry out the transaction themselves, would address some of these ongoing issues of long waits or lack of choice in the equipment available?

[47] **Mr Carter:** The view of the Wales Neurological Alliance would be that it would help to an extent. We think that it would improve choice, and it would have the potential of reducing the waiting times between assessment and delivery of the machine. Clearly, that would not tackle issues around the time between referral and assessment. Challenges would remain in that area, although the evidence this afternoon will show that there have been improvements there. It would not be a panacea for all the ills, but we think that it would offer more choice and, hopefully, alleviate some of the pressure on the service.

[48] **Mr Bowen:** There is a lot of potential there, and I think that your summary was fair with regard to progress and developments but, as you say, we are not quite where we would want to be. With regard to direct payments and Vaughan's question, there is potential there. However, as with direct payments for any other aspect of social care, the infrastructure to support that is vital. If the benefits of that more individualised model are going to be achieved, the infrastructure has to be there to support it.

[49] Whizz-Kidz provides an excellent service to disabled children and young people. I spoke to the charity briefly before today, and I know that there is some evidence of joint working between Whizz-Kidz and both centres in Wales. We would want to look at those sorts of partnerships between third sector organisations, which could support direct payments. Cutting ties too radically and setting people off on their own individual way without back-up, infrastructure and partnerships between the service and other providers, would be a little concerning. There is a lot of potential there to look into that.

[50] **Kirsty Williams:** In setting up that system, you would need to support the individual and ensure that the family or individual had the capacity to work through the system. That, potentially, would take up resources and would take time. However, would the benefit invested in that be reflected in significant changes to the waiting times? You might say that, if all the investment in the bureaucracy around direct payments would only result in an improvement of approximately two weeks, that is not where you would want to go. Could you give us an idea of how much difference a system of direct payments could make to someone's long wait? Alternatively, is the assessment the problem?

10.00 a.m.

[51] **Mr Carter:** That is a very good question. I do not have the figures to hand to try to predict what level of improvement that would make, but you are right: there is certainly a trade-off that you would have to consider. The experience with social care is that the bureaucracy costs are not astronomical, but there would clearly be a cost involved. We know of other services in south Wales that have been brought back in-house. There is a history of partnership arrangements with outside providers, and this is happening within the wheelchair service in north Wales and has happened in the past in south Wales. So, this is not unique. However, I do not have those figures to hand, I am afraid.

[52] **Kirsty Williams:** What I am trying to get at, Mark, is whether there is a significant improvement in performance if we go down that path. That is what I am trying to gauge.

[53] **Mark Drakeford:** That is a very good question, and a few people want to pursue it, but I will just throw something in at this point. Some of the issues around direct payments are not to do with speed; they are about quality. It is not just that you have a quicker result, but that, because it is in your own hands, you have a solution that is right for you. That is a different sort of gain. Before I go back to the panel, I would like to ensure that Mick and Darren ask their questions, and we will then come back to the witnesses.

[54] **Mick Antoniw:** I used to deal with a lot of wheelchair issues in relation to people with spinal and acquired brain injuries. One area that has always concerned me is to do with the wheelchair industry and wheelchair technology, which is continually changing. I am not quite sure how we get to grips with this. You would not give someone a computer that was three or four years old; even though it might have been fantastic four years ago, everything has changed so much. Wheelchairs are a bit like that, in terms of technology. How do we accommodate all of the things that you are talking about, in terms of choice and the fact that maintenance, repair and service contracts are continually changing? Are we talking about concentrating on a base system with adaptations, or are we saying that the system that we have at the moment is not capable of keeping up with that change, choice and demand, and that we might need to look at a different model?

[55] **Mark Drakeford:** I think that I can see the connection between that question and direct payments. However, just in case Darren's is slightly more direct, I will check what it is.

[56] **Darren Millar:** My question refers to one of the committee debates that we had in the last Assembly, which was about the clear difference between meeting a clinical, health-related need and a social need. It was a discussion about the fact that the NHS was there to provide a wheelchair that met a clinical health need, but that people often aspired to have a wheelchair that met their social needs as well, so that they could get out and about and take part in all sorts of activities that were a matter of choice for them. That is where the issue of direct payments came in, and that was the subject of our discussion. It appeared to me that there was no problem if Invacare, or another provider, received a request to provide a chair and could turn it around, no matter how complex it was, within a period of up to six weeks. The issue was more about broadening the choice so that people's social needs could be met. That is where direct payments might be useful. Whizz-Kidz was, at that time, being told that it could not top up anything that was being provided by the NHS because there was a blanket approach in Wales that was a case of: 'We cannot let you provide a different chair that is not on our list'. So, I think that we really need to tease out this issue of social need versus clinical need, and examine to what extent the direct-payments solution helps to address people's choice in terms of social need.

[57] **Kirsty Williams:** I would say that the question there is: how do you make a distinction between where social need begins and healthcare ends? If someone's social needs are not being met, it has an impact on their health.

[58] **Vaughan Gething:** I agree with Kirsty. This is not a matter of social need versus clinical need, but about matching up the two. I want to ask the occupational therapists about how they match them up, because I would have thought that both elements are part of the assessment of what is appropriate for users. I was interested in what was said about assessment and acquisition. Then, there is the next stage—ensuring that, once it is acquired, it is appropriate and meets the assessments that have already been done. Those assessments would be the whole assessments, and not just assessments for clinical need.

[59] **Darren Millar:** The previous committee wanted to address everybody's holistic needs, to treat individuals as individuals and give them what they required in order to live as full a life as possible. However, there was resistance from the NHS that it was only there to provide for people's health needs and that it would fulfil that obligation with a bog-standard piece of kit.

[60] **Mark Drakeford:** The answer could be that the NHS would provide a chair that covered a certain amount of people's need, but after that, if there were additional things that people would like, they could get them through direct payment—linking in to Vaughan's question about topping up. Is that something that you would advocate? People would be able to go beyond what the NHS is able to provide by putting in money themselves. Is that a good idea?

[61] **Mr Bowen:** Broadly speaking, yes. We would like to see things go in that direction. However, there are many issues to iron out first. One of my concerns with the issue that we are looking at now is that the current NHS specifications and strategic plan for wheelchair services are not clear, so it is not possible to try to work out the relevant issues. We are forging ahead a little too quickly on the direct payments issue. That might be a leap too far until we have sorted out some of the strategic and managerial issues. So, generally, the answer is 'yes', but a lot of work needs to be done on strategic planning and leadership before we move on to that complex issue. In principle, greater use of direct payments would be excellent, but there would need to be infrastructure and relevant mechanisms in place to sort out repairs and maintenance, which is a key area. The issue is not so much getting the chair in the first place; it is who repairs and maintains it. My concern would be that we are rushing things with regard to today's proceedings. We are rushing a little too far ahead without looking at what we need to sort out first.

[62] **Mark Drakeford:** Thank you; that was very useful. Matt, I promised to come back to you.

[63] **Mr O'Grady:** With regard to the direct payment scheme, I spoke to some of my colleagues in England about how the direct payment/voucher scheme operates in England. They said that, where the Government can create a framework or procurement agreement, it works well and is able to drive down costs. It works well for manual wheelchairs, which are simpler. However, when you try to buy something a bit more specialist, there is no standardised cost. A lot of the equipment needs to be modified for the individual and it becomes hard to create a standardised cost and drive it down. Usually, an individual has very little choice, because only a small amount of equipment meets their needs. It is hard to create a consumer-based approach when you cannot operate in that way. You would end up replicating the current system, which is not joined up and is underfunded. You could possibly say that funding is not as much of an issue now that the Welsh Government has put extra money into wheelchair services, but it still has to be looked at.

[64] We have no theoretical problems with a voucher system, and that was raised by several of the people that we spoke to. It would have to be done, as Keith kept saying, in partnership in a way that creates savings for the individual and for the Government and leads to the individual getting the equipment that they want. On health versus social need, social

need is not just about what an individual wants, but what an individual needs to really participate in their community. For employment, they need to ensure that they have equipment that will allow them to hold down a job and meet their needs in that way as well.

[65] **Lindsay Whittle:** There are advantages to the voucher system. However, there are disadvantages too and if I were a disabled person, it would make me feel like a second-class citizen. It is like saying, 'You are disabled. We, as the national health service, will provide you with a basic standard wheelchair and if you want a better one, you may have your voucher and pay extra for a better one'. I would feel like a second-class citizen because you would be treating me differently. Why should I have a basic standard? Why can I not have the very best? I think that there would be some resentment among service users.

[66] **Vaughan Gething:** [*Inaudible.*—basic standard chair in the first place, you are starting off from a point of undermining the value of the wheelchair product anyway.

[67] **Lindsay Whittle:** I do not think so, with respect, Vaughan. Let us be honest about what it means to have a basic standard wheelchair. We have already heard about the social impact on young people going out. I have seen some pretty good wheelchairs for young people. They are fun to get into and that is the point we made at the very start. If it is of a basic standard, young people may not feel confident about going out and then they will be confined to their homes. For every single disabled person in a wheelchair, the chair they need is going to change throughout their entire life.

[68] **Mark Drakeford:** I am going to put Lindsay's point of view in a slightly different way, and then I want to move on to another topic. What if I were to say to you that some of the things you have sort of advocated—such as a direct payments system that you could top up—would give people who are well-informed, well-resourced and able to do that sort of thing a quicker and better service, but leave people who are not in that position, people who are unable to make a contribution or navigate the system themselves, relying on a residual system that has had resources taken out of it, which would result in a two-tier system? Is that where direct payments end up, in your view?

[69] **Mr Carter:** You need to set up any direct payments system on the grounds that it is not for a basic service—the voucher or payment needs to be for a realistic amount that can actually purchase that service. We have seen similar issues with social care in certain local authorities. The amount that the voucher or payment is set at needs to be correct. However, I would say that I do not think we would suggest that there is such a thing as a basic wheelchair or cast aspersions on the quality of the stock of wheelchairs at Nantgarw, for example. I have been there myself in Mick's constituency and seen it. They have a massive array of chairs, some very complex and some far more basic. However, there is a very good range.

[70] We are advocating that, with the diversification of the wheelchair market, with so many different complex machines being developed and with technology changing all the time, in the long run, it may not be possible for one centre to hold every type of machine. There may be a portfolio of machines that could be made available from Nantgarw or Wrexham, but, for some machines, it might be better to look around and perhaps order it in from across the border. There are only so many machines you can physically store in one location.

[71] **Mick Antoniw:** Chair, I have just one point to make on that—

[72] **Mark Drakeford:** Be very brief.

[73] **Mick Antoniw:** Is a direct payment system capable of providing that? That is my concern, given those continual changes.

[74] **Mark Drakeford:** That is a problem because, even with direct payments, you end up with a very small choice of what you can actually spend your voucher on.

[75] **Mr Carter:** Yes, that is a problem when you are looking at bespoke chairs in that way.

[76] **Mark Drakeford:** I call Keith to answer and then William Graham will ask his question—I am determined on that.

[77] **Mr Bowen:** Thinking back to the committee two years ago, the situation described at the time was that quite large numbers of families were having to opt out of the existing system and fund their own chairs or equipment, either through their own funds or from charitable funds, because the system was working so poorly. I picked up that that was not necessarily the way they wanted it to be. I picked up that, in many ways, they would have preferred to have a better organised and better resourced service and system. Going down the individual route completely could be problematic. Forging ahead too rapidly with the direct payments route from the current system might be a step too far. The services on the ground, as mentioned, have been putting a lot of effort into trying to address the pretty major problems that were there two years ago.

10.15 a.m.

[78] However, as mentioned, I do not think that their structures, such as their managerial structures, and the strategies that they have help them in that regard. So, that would need to be addressed first, before looking at developing that too much further into direct payments. That would be an awful lot to ask. The services would be overjoyed that you are thinking about direct payments, but it needs to be in the long run, not immediately. We are not there yet.

[79] **Mark Drakeford:** Thank you very much; that is helpful. William?

[80] **William Graham:** Thank you, Chair. I have two slightly different questions now. The first is about structure and strategic direction, and the second is about accountability. On the partnership board, and I appreciate that it is fairly early days, but what are your experiences of it?

[81] **Mr Bowen:** Following the previous committee's recommendations and the two-phase ministerial review, and, indeed, the funding put in about 12 months ago, we got to a good point. We thought, 'Great, the momentum is there and we've got a way forward.' Then, increasingly over the past 12 months, there was a lack of clarity on the development of that work. We heard a little initially, as Contact a Family, but we do not know much about what has been happening. We might find out later what has been happening, but I do not know what has been happening with that. So, the process has not been very transparent. The information is not available to the public—it is not up on the Government's website, the service's website or, as far as I am aware, on the Welsh Health Specialised Services Committee's website. I do not really know much about what has been happening there. I am a bit concerned, because we have not been able to find out about it and it has not been that clear, transparent or well communicated. The worry was that the momentum would disappear and that things would not be happening regularly. So, that was one of our concerns. However, I do not know enough to answer that question.

[82] **Mr Carter:** I echo those comments. We have been talking about this subject for a long time; it is almost four years since Edwina Hart was Minister and her review started in 2008. That review did not seem to press that far, and, in 2009, the previous committee took it upon itself to look at this issue and published its findings in 2010. When the Government's

internal review was going on in 2010-11, there was a sense that it was open to suggestions, and many of our organisations were invited to participate at various stages, and we gave our evidence. As Keith mentioned, we seemed to be happy with the result. The Government seemed to be addressing the issue and taking forward the previous committee's recommendations, and was trying to put forward ideas on how to move this issue forward. One of the key things that the committee recommended was to try to tackle the issue of targets, which were recommendations 1, 5, 6 and 7, by establishing 18 quality indicators, which were drafted. We were very happy at that point, but we have since entered this period of hiatus.

[83] Our perception—and it is only our perception; you can ask about this later on—was that there was a feeling that because WHSSC had set up this partnership board and had brought in service users to sit on it, there was no longer a need to consult more widely with charities, because it already had the people there. A key challenge at the start was around communication, and, as Keith said, we feel that we have had very little communication from WHSSC. Thankfully, documents and paperwork are published whenever WHSSC has a meeting, which is every two months, and there is often an update on the partnership board and its papers are published. It is only by sheer chance and luck, in some cases, that we discovered that much of this paperwork is online. So, while some progress is being made, seemingly in the background, we have heard very little about it and we have not really been involved. As far as this institution is concerned, it was only in preparation for the January meeting of the cross-party group on neurological conditions, which Darren attended, as did Mick, Rebecca and Kirsty—in fact, most of the committee attended, so thank you very much for that—that WHSSC kindly gave us a short briefing paper, but that was the first time that we had received anything concrete from it, so there is something missing there. Much appears to have been done, but we are not being involved in that process.

[84] **Mr Bowen:** More to the point, children, young people and their families and adults who use wheelchairs would not necessarily be aware of all that. If we cannot find that stuff, how will they find it out there?

[85] **Mr O'Grady:** For example, I looked for information on the ALAS websites. While the north Wales website had information on waiting times, it seemed to be very out of date, and there was nothing on the Cardiff ALAC website to communicate that kind of information to anyone who was using the service.

[86] **William Graham:** So, to paraphrase what you have said, there has been some movement, but you require much more, and certainly information is necessary. I go back to the previous committee's finding that there was a complexity and a lack of accountability. It made specific recommendations that clear responsibilities and lines of accountability for service delivery were needed. So, your evidence would be that those have not yet been implemented.

[87] **Mr Bowen:** Yes, we are not aware of how far things have gone with that. Hopefully, we might find out a little later in the day and we might be positively surprised. Interestingly, I am not quite sure, even with regard to today, whether it was that easy for the committee to find out who is in charge or who takes the lead on wheelchair services at the civil service level, which was another issue that cropped up two years ago. Again, I would not be able to answer that question and I am not sure whether it was found out that readily for today's proceedings. So, we are still concerned that those lines of accountability and responsibility, and the chain of command, I suppose, particularly at a senior strategic level, do not seem to be that clear and are certainly not transparent, open and public. It seems that if there is to be a clear plan of action, it should be open, transparent and public. The status of phase 2 recommendations needs to be clear, and how that process is working needs to be communicated to all concerned.

[88] **Darren Millar:** I want to come in on the recommendations on performance monitoring that you referred to, Joseph, in your answer to William. You mentioned the expert group's decision in October 2010 and the creation of these 18 quality indicators, but said that, effectively, nothing appeared to have happened since then on the decision as to whether they would be accepted as the indicators going forward. Are you any clearer on that in terms of why there was such a period of non-progress?

[89] **Mr Carter:** We are not particularly clear on that. Again, as Keith said, we hope to find out this afternoon where we are on this one. As far as I understand from the initial paperwork from the partnership board, it has been working towards these 18 quality indicators, so they are being used, but I know that there was a promise in that to reach a maximum of an 18-week target for wheelchairs. That has not been achieved across the board. There was also a promise to consult on those 18 indicators, but that consultation has seemingly not happened. The indicators are being taken forward by the partnership board, and I am sure that we will hear more about where it is with that, but in terms of making it official and something that it is bound by, at the moment, I do not think that that is the case. The promised communication and consultation on those indicators have not been done.

[90] **Mark Drakeford:** There is an important theme emerging, which is that, sometimes, we are not sure whether progress has been made, and even when it has, it is not clear enough to the people who need to know about it. So, there is a communications issue around all that, which is what you started with, Joseph.

[91] **Rebecca Evans:** Good morning, everyone. I was interested to read your evidence about the different experiences that people have with training to use their wheelchairs. Some quite mixed evidence was presented. Does it normally fall to the voluntary sector to provide that training, or is it integrated into the wheelchair service pathways?

[92] **Mr Bowen:** We have had some very positive feedback about training from families across Wales, particularly regarding the training provided by Whizz-Kidz. I am namechecking them quite a lot today. The training provided by Whizz-Kidz was highlighted by most of the families who got back in touch with us. Back in June or July, it was indicated to us that of the £2.2 million of funds allocated in total, £0.2 million was allocated this year for training. I do not know whether the Whizz-Kidz training is covered by that—I think that it is being funded by Whizz-Kidz itself. I do not think that that £0.2 million for training has been spent. We have had comments from families that some of the centre staff have been involved in some of the activities, so something seems to be happening, but I am not quite sure whether the funding has come from Government. Certainly, the value of training has come across very strongly in the feedback we have had with regards to building independence and confidence, which is so vital to the development of children and young people. The value of training comes across very clearly, but I am not sure quite how that is being funded.

[93] **Rebecca Evans:** What is access to training like for adults who suddenly find that they need a wheelchair?

[94] **Mr Carter:** As far as we are aware—and the feedback that we have had on this has not been as extensive as for the children's sector—none of our organisations have been actively providing funding for the voluntary sector for this. We know that training is provided at ALACs when someone gets a chair, but we have not ascertained the extent to which that is appropriate, or whether it is enough. As Keith highlighted, there are issues around training, particularly for young children, where training is more difficult and problematic than with adults. Certainly, most of our members receive very limited training, but that has been sufficient. While training can be done relatively straightforwardly, the greatest challenge has been making sure that the chair is adjusted into the right position and is safe for them. That

has been more problematic in some cases.

[95] **Rebecca Evans:** Finally, going back to the point that Darren Millar made about a holistic approach, what support is available to people to come to terms with the fact that they now need a wheelchair? At what point is that support given?

[96] **Mr Bowen:** That is a very good question, Rebecca. It is not an issue that has cropped up that clearly in terms of wheelchair services. I suppose that everybody gets quite focused on the nuts and bolts, and it is quite perceptive of you to ask about the more personal, emotional side of it. I am not sure how far the two are brought together. We spend a lot of time talking about the pieces of equipment that are provided, and the suppliers and the processes, and actually not so much about the personal side of it. I am not sure how that is addressed. To come back to your initial point about the training, I think that our experience—we have previously run wheelchair training and other events for families—is that one of the benefits is that, as well as getting good quality training on how to use your wheelchair, you also get the opportunity for the children and young people to meet others in the same situation, and the parents meet other parents in the same situation, which is actually an opportunity to address some of the issues you are talking about. That happens almost as a by-product of the training rather than a specific part of the agenda.

[97] **Mark Drakeford:** Diolch yn fawr iawn i chi i gyd. Thank you all very much. It has been a lively and wide-ranging hour. I am especially grateful to you for the balanced account that you have provided. It gives us a very good start to the day in being able to trace with other witnesses where your respondents have told you that things have improved over the last couple of years, and where it is clear that there are still issues that need to be pursued.

10.30 a.m.

[98] **Mr Bowen:** We have had a few bits of extra feedback, so I will send those in.

[99] **Mark Drakeford:** I was going to say to you that when you look back over the transcript of the session, if you think that there are some things that did not come out strongly enough during the hour, or there are points that we did not manage to cover, or if extra information is still coming in, we would be very grateful indeed if you were able to write in and let us have that as well. Diolch yn fawr.

[100] **Mr Bowen:** Thank you. We will be with you for the rest of the day. We shall be watching you from the gallery.

10.31 a.m.

**Ymchwiliad Undydd i Wasanaethau Cadeiriau Olwyn yng Nghymru—  
Tystiolaeth Lafar: Safbwynt yr Ymarferydd  
One-day Inquiry on Wheelchair Services in Wales—Oral Evidence: The  
Practitioner's Perspective**

[101] **Mark Drakeford:** Croesawaf y tystion nesaf i'r Pwyllgor Iechyd a Gofal Cymdeithasol. Croeso y bore yma i Philippa Ford a Ruth Jones o Gymdeithas Siartredig Ffisiotherapi Cymru. Croeso hefyd i Sandra Morgan ac Ellis Peters o Goleg y Therapyddion Galwedigaethol Cymru.

**Mark Drakeford:** I welcome the next set of witnesses to the Health and Social Care Committee. Welcome this morning to Philippa Ford and Ruth Jones from the Chartered Society of Physiotherapy Wales. Welcome also to Sandra Morgan and Ellis Peters from the College of Occupational Therapists Wales.



[102] Thank you very much for being here. We have a half-hour dash, with a lot of material to cover in that time. We are asking everybody we see today if they can begin very briefly by identifying three places where, against the background of the recommendations made by our predecessor committee, they think there has been progress in the intervening period, and three places where they think progress still needs to be made. After that, we will go straight into questions from Members. Philippa, are you happy to kick off?

[103] **Ms Ford:** From the referring therapists, we see progress on work to improve the experience of service users. For example, clinics are held in different places to cut down on travel, and there are things such as drop-in clinics for maintenance and repair. We also see some improvement in communication, and there is some perceived improvement from service users and referrers. For example, there is the development of a welcome pack for service users in north Wales, and there have been meetings between the ALAS managers and some of our top-level paediatric physiotherapy managers. There has also been more joint assessment with referring therapists. So, there is improvement there.

[104] There has also been work to improve the referral process. A DVD has been developed to help referring therapists, and work has been done on an all-Wales referral to get more commonality. There is also the use of photographs, for example, so that things can come in to assist the referral process. So, those are some of the progress areas.

[105] **Ms Morgan:** Feedback from occupational therapists indicates that there has been significant improvement in waiting times, and that is a huge piece of work that has been done. Delivery times have improved, as well, particularly for standard chairs and for children. There are also the beginnings of a more flexible approach to assessment and provision.

[106] Routine reviews of children's wheelchairs are beginning to be implemented, so that is good news. Also, a significant amount of level 1 training—the basic training—has been undertaken in Wales already, with 1,000 therapists and nurses having completed their training.

[107] **Mark Drakeford:** Are there any areas where progress has not been so good, or where progress still needs to be made?

[108] **Ms Morgan:** I will pick up on that to start off with. Communication is still an issue. Practitioners are still hearing about change to the service in an ad hoc way. So, there is not a formal cascade of information to prescribers. On transparency of process, such as that of joint funding, when there are opportunities for joint funding, again people hear about it in an ad hoc way. The integration of lifestyle assessment into the assessment of postural management is an issue that needs to be looked at. Service specifications and priorities need to be shared.

[109] **Ms Ford:** For the referring physiotherapists, there are issues like training for service users in the use and maintenance of their wheelchairs. In south Wales, ALAS reports that it has started to do this. There is a tender for future work, but that is an area in which there needs to be progress. Progression to the electronic referral has been looked at in the work streams that ALAS has been undertaking, but it must not be lost as it will free up time. There need to be regular reviews, repairs and maintenance for all. Once again, this has been started in ALAS in south Wales, but progress is needed. There has been a focus on children, but that has to be sustained, and we then need to see an improvement in adult services as well. That is our starter for six.

[110] **Mark Drakeford:** That is lovely; thank you very much. That was very useful. Given that there are four of you and many Members want to ask questions, we will probably have the chance for only one person to take the lead in answering any question. I will go to

Vaughan first, because I know that he had a question that he mentioned in the last session.

[111] **Vaughan Gething:** A point was raised in the previous session about the extent to which the assessment is clinically led and/or takes account of the social need of the wheelchair user—whether they are a young person or an adult—and the way in which that is balanced in the assessments done by your members. What is your view?

[112] **Ms Morgan:** The focus still appears to be on postural management, and practitioners are looking at other solutions if a wheelchair does not fully meet someone's lifestyle needs. There are opportunities to look at a more joined-up approach. Progress is being made in children's services, with joint working between the ALAS assessors and the local practitioners. However, that is in the early stages. This does not seem to be happening at a significant level within adult services. We are looking at modifying homes because the wheelchair does not quite fit. People have to modify their lifestyle to fit in with their chair rather than the chair fitting in with someone's lifestyle. So, a lot of work still needs to be done there.

[113] **Vaughan Gething:** Is that work that needs to be done with local government, or does it need to be driven by the Welsh Government, in terms of it setting out what it expects of people in the NHS and local authorities? In the earlier session, we discussed the role of the third sector. What role do you see being played by each of those to deliver the improvements?

[114] **Ms Morgan:** It will be a combination. NHS services are performance driven, so if you look at the way in which services are being targeted, you can see that it is in relation to achieving performance targets. So, if the performance targets do not indicate that there is a need to consider lifestyle and look at outcomes relating to lifestyle, then they will not be a key feature of the service. Social care has not been hugely engaged in the provision of wheelchairs either, because it has been seen as being a part of the health remit. So, I would say that it is a shared process. It is interesting that you talked about the third sector, where user views are probably the most powerful in looking at the way in which we need to redefine wheelchair services.

[115] **Lindsay Whittle:** Good morning, all. I notice in your evidence that, in north Wales, it seems that the review is a little ad hoc—and please tell me if I am wrong. In south Wales, it appears that adults are reviewed once a year and children are reviewed twice a year. While there are issues relating to the delivery of wheelchairs and repair and maintenance, it is the suitability of the wheelchair that I feel to be the most vital. Could occupational therapists and physiotherapists cope with more reviews than that? In your opinion, is it enough to review adults once a year and children twice a year? What is happening in north Wales? Why is that different? Does anyone know the reason for that?

[116] **Ms Jones:** Certainly, in the experience of therapists, the review once a year for adults and twice a year for children is not happening. I appreciate that ALAS is starting to roll out the reviews for children, but, as paediatric physiotherapists, we have not seen any real evidence of it going across the board yet. As for adults, a review once a year would be ideal, but I have had nothing from anybody across Wales, north or south, about adults being reviewed annually like that—

[117] **Mr Peters:** I think that those figures are for the medical engineering provision.

[118] **Ms Jones:** Ah, the rehabilitation engineering service.

[119] **Mr Peters:** The rehabilitation engineering service offers reviews; it has done so for many years. However, it is now part of ALAS and ALAS's standard provision does not meet those targets.

[120] **Ms Jones:** Rehabilitation engineering is a specific, specialised area of ALAS, which looks at children and adults with extremely complex needs: moulded seating and complete postural needs. It is a very specific area. As therapists, we work with it, but reviews are not yet happening for adults who use standard wheelchairs with adaptations and children with adapted wheelchairs. We appreciate that they will be rolling out, we are looking forward to that and we will be happy to work with them when that happens.

[121] **Lindsay Whittle:** I have a quick follow-on question. I am aware from a previous career that occupational therapists are a little like solid gold, and I am sure that physiotherapists are as well. Would they be able to cope with the demand if this review was carried out strictly? How could we, as a committee, start to roll out these reviews, Chair? I mentioned in the earlier part of this meeting that people's needs in relation to wheelchairs will vary throughout their lives. Children grow taller and, I am afraid, us adults grow wider. That is critical.

[122] **Mark Drakeford:** Speak for yourself. *[Laughter.]*

[123] **Lindsay Whittle:** I asked for that.

[124] **Ms Morgan:** I would like to make a comment about the extent of the assessment, in that the scope of the assessment is key to its being effective. The degree of wheelchair use significantly affects the need for review. Some people still use wheelchairs for transit only, so they have very limited use, and they do not have the same level of need for reassessment as those people with complex needs. So, to have a standard process for reassessment is quite challenging, because that does not always reflect client need. The feedback that I have had from practitioners is that there is a concern that, if a complex chair is provided, it may need to be reviewed after three months or six weeks to confirm its suitability rather than us having a six-month standard review.

[125] **Ms Ford:** Very quickly, we know that there has been an investment in the services, so there has been an increase in the therapists who are part of the ALAS provision. So, that should help in terms of being able to deliver some of this, but the question is whether the improvements can be sustained and whether what you are looking for in terms of reviews can also be built in. North Wales ALAS and south Wales ALAS have been doing capacity reviews. They will have to look at them and then at whether they can also build in this amount of reviews. So, that is a question for them.

[126] **Mark Drakeford:** Can you answer Lindsay's point about north and south Wales slightly more broadly? The previous committee received a lot of concerning evidence that performance was very different. Eighteen months on, is that better or different?

[127] **Darren Millar:** May I come in on that? We will be taking evidence later from the services, and they have reported to us that, while there have been improvements, there is still a huge disparity, particularly for adults, in the waiting times between referral and assessment in north Wales—60-odd weeks is the longest that someone is having to wait at present—compared with less than half that time in south Wales, which seems to be an appalling situation. We know that extra money was given, which was very welcome, by the former Minister for health in order to improve the service, but it was given on, as I understand it, quite an unscientific basis. It was not based on the need being greater in north Wales than it was in south Wales in terms of improvement and the catch-up that needed to take place. Do you feel that sufficient focus and emphasis have been given in north Wales to addressing that service's lack of capacity to meet demand compared with the situation in south Wales? I know that you say that extra therapists have been taken on, but it seems to me that it is still disjointed and, for whatever reason, the service did not get a proper allocation of resources.

10.45 a.m.

[128] **Ms Ford:** They have started from different positions. We understand that north Wales put on a lot of extra clinics to clear the backlog. North Wales has had to work on the massive waiting lists that it had, while ALAS in south Wales has had different priorities. I do not know whether there is anything that you want to add to that, Ellis.

[129] **Mr Peters:** No.

[130] **Darren Millar:** According to its paper, the maximum wait in north Wales now for an adult from referral to assessment is 15 months. We accept that there have been improvements, because the previous committee's inquiry found that 22 months was the longest wait from referral to assessment. The point that I am trying to make is whether the capacity is now there on a permanent basis—not just through extra clinics as a one-off to clear a bit of backlog—to continue to bring that down and, bringing on board Lindsay's point, to then have more regular reassessments. Are the mechanisms and the capacity right within the system now, or do you still think that it is under capacity?

[131] **Ms Morgan:** Regarding local therapists, all specialist assessments are currently done by ALAS staff. We have talked about the viability of tier 3 training of local therapists, particularly if they are working in specialist services. That currently has not been actively pursued, but it is an opportunity to look at capacity release for initial provision from ALAS. Currently, if somebody needs lateral supports, say, the request has to go back to ALAS, and an ALAS practitioner has to do the assessment for just that add-on item.

[132] **Darren Millar:** So, that is one way of increasing capacity across the board.

[133] **Ms Morgan:** Absolutely.

[134] **Ms Jones:** Local therapists are more than willing to take on that role. They are actively seeking this additional training. I understand ALAS's reluctance in that they do not want everyone out there prescribing whatever. We understand that, but we have experienced therapists who are extremely skilled in their areas. They also see the child, young person or adult in social settings—they see them in school, on the sports field and in the home, and so they are sometimes best placed to give an idea of exactly what is needed.

[135] **Mark Drakeford:** Just one last go at this: given that our key purpose today is to reflect on the position as it was previously and how it is now, the last committee was—rightly it seemed to me—concerned about the evidence that it had about the different levels of services in north and south Wales. Is it your impression that things have got better, got worse or stayed the same?

[136] **Ms Ford:** My impression is that services are starting to get better. I understand that money and investment have only just come into the service. An awful lot of work has gone on in developing strategy, performance indicators and all that kind of stuff. We are starting to see improvements now. North and south are in different situations, but there have been improvements in both parts of Wales.

[137] **Mick Antoniw:** I am interested in what you say about the increase in numbers, but I have difficulty understanding precisely the scale of it. More important than that are the comments that you make on training. One of the suggestions is that, with the continual changes that are ongoing, training is becoming a real issue, and that either you are being overloaded or the incorrect type of information is coming through. What is happening on training and on numbers at the moment, and to what extent are you satisfied that there is a

consistent process of ongoing training to keep up with changes and developments?

[138] **Ms Ford:** ALAS has an all-Wales trainer, who has trained over 1,000 people to level 1, but there are issues around training people to level 3. In the main, it has taken the approach of keeping their level 3 trainers within the ALAS services, although north Wales has what it calls gatekeeper or trusted assessors. South Wales has developed some approved assessors—people who have either previously worked in ALAS or who have much more knowledge about wheelchairs and deal with wheelchairs as an everyday activity. If these people refer in, there is a lot more ability for ALAS to deal with the prescriptions that it has made. There is more to be done on training, and I think that there is a wider multi-disciplinary issue around training as well. But ALAS has reasons for keeping its level 3 trainers within the ALAS environment. There are clinical governance issues, there are issues around maintaining a knowledge base of the prescriptions that are coming in, and there are issues around control of the budget for wheelchairs.

[139] **Mick Antoniwi:** If you were to make any changes to the training programme and the way in which it is being operated, what would they be?

[140] **Ms Jones:** We would be looking to get local therapists trained to level 3. Also things like improving e-mail communication would help an awful lot in terms of streamlining referrals in. It would help if queries could be sorted via e-mail instead of having to wait three or four weeks for someone to come out, go back and all the rest of it. That is the sort of thing that we would welcome. The therapists on the ground would welcome the chance to work with ALAS, and they do work very closely with ALAS whenever they can. They attend joint appointments when they know about them. Certainly, the individuals within ALAS work well with therapy services. It is an individual thing; personalities matter here. People at a local level are making a difference. However, we would welcome increased training. The therapists are up for it.

[141] **Kirsty Williams:** Recommendation 3 in the previous committee's report was quite clear about the need for better integration between those people working within the community and a centralised service. What are the barriers that have stopped that very clear recommendation from being implemented, and what is your best guess as to the impact that having level 3-trained people in the community would have on waiting times for assessment, overall waiting times and the quality of service that an individual would have? It is impossible to quantify these things, I am sure, but what is your best guess regarding the impact that having level 3 people in the community would have in terms of improving the service?

[142] **Ms Morgan:** One of the issues here is to look at the scope of assessment, and what can happen if people have a local assessment. From an occupational therapy point of view, we are looking at integrated services, so practitioners are increasingly broadening their scope of practice to look at the health and social care components. Currently, the wheelchair assessment, when it is a specialist wheelchair, is outside of that. So, somebody can do an assessment for a disabled facilities grant, they can have a major adaptation done, they can have minor pieces of equipment and they can deliver a therapy programme—but they cannot prescribe the wheelchair. We have an opportunity to look at redesigning the scope of practice, and practitioners are accepting and quite excited at the idea of delivering more holistic services. One issue that I doubt has been explored is, in cases where an assessment is right and meets someone's needs, how many queries would not go back into the service. Certainly, from a demand perspective, local practitioners are doing problem-solving when a chair does not meet someone's needs. So, they have to do other areas of work to compensate. It is quite difficult to untangle all of that. If you look at quality and efficiency, you will see that there would be gains from local practitioners being more involved.

[143] **Kirsty Williams:** To sum up, there is scope for a better service for the individual

because the lead occupational therapist is looking at the entire person's needs, rather than having a very narrow focus. Potentially, this could also save money because you would be getting it right and you would not be having communication battles, and also because you would not be doing major DFG grants if you could get the wheelchair aspect of that person's lifestyle correct. Would that have an impact on waiting times as well?

[144] **Ms Morgan:** It would, because those practitioners currently generate a proportion of the referrals.

[145] **Kirsty Williams:** So, they could just get on and do it, rather than waiting for someone else to come and do it.

[146] **Ms Morgan:** There is nothing to stop ALAS from developing a role in looking at second opinions and expert advice. In rural areas, we are looking at telehealth, and so there is the capacity to look at videoing an assessment or a social context, with the expert sitting in at ALAS, providing advice to a specialist practitioner.

[147] **Ms Ford:** The proviso that I would make is that there would be a training element and a need to keep up to date with equipment and the various aspects of wheelchair services, if you are at level 3.

[148] **Kirsty Williams:** Those staff are subject to continuous professional development to maintain their skills anyhow, so this would be an additional element of continuing professional development, would it not?

[149] **Ms Ford:** Yes, they are doing it anyhow.

[150] **Darren Millar:** What proportion of the current number of referrals to the service come from community therapists, which you effectively deal with when you are doing your other stuff?

[151] **Ms Ford:** I cannot answer that, I am sorry. ALAS will probably be able to give you that answer with all its statistics.

[152] **Darren Millar:** It would be useful to get a steer on it. It could immediately chop a significant proportion of the work.

[153] **Mr Peters:** I can only answer from my perspective, but I would say 'definitely'. However, the more complex the need, the more likely it is that the referral would come from the community therapist. In my case, for children, almost all the referrals to ALAS come from the children's occupational therapists.

[154] **Mark Drakeford:** I will go back to the issue of communication, which you raised at the beginning and we heard a lot about in the first hour this morning. It has been mentioned this morning that people felt that they did not always know the state of play in relation to policy development and practice changes. Sometimes, even when good things had happened, it was hard to find out about them. Does that reflect your experience of the way in which things have developed over the last couple of years?

[155] **Ms Ford:** I would say 'yes' to that. When we asked our members if they had any knowledge of the strategic direction, the performance indicators or the communication strategy, most of them said 'no'.

[156] **Ms Jones:** If you are going to be measuring something, it is useful to know what you are measuring against. I sit on the all-Wales paediatric physiotherapy service managers

committee and we have not seen any of the communication strategies or anything like that. We would like to, as it would be very useful to us.

[157] **Ms Morgan:** I have talked to practitioners about the variation between services in the east and the west. I work in west Wales, and when information is only passed by word of mouth it can take a long time for us to become aware of changes in service and of new flexibilities in how seating can be accessed. I just wanted to raise that as a local variation as well.

[158] **Mark Drakeford:** Rebecca, is your question on this point or a different one?

[159] **Rebecca Evans:** You could call it communication.

[160] **Mark Drakeford:** Okay. Darren also has a question on communication.

[161] **Darren Millar:** My question goes back to the discussion on training, if that is okay, Chair. It is a clear question and I hope that you will have an answer. What would be the cost of bringing sufficient numbers of therapists up to level 3?

[162] **Ms Ford:** I do not have that answer for you, Darren. However, it would be useful to look at the cost. Some £2.2 million or so has been invested in wheelchair services. A lot of that has gone on training people to level 3—13 members of staff in the Betsi Cadwaladr ALAS and 11 in the south Wales ALAS. That would account for some of the investment, but I am sure that there has also been investment in other areas—there has, supposedly, been some training for service users.

[163] **Rebecca Evans:** Ruth Jones, you said that your professionals work well with ALAS, but it often relies on personalities. How could we encourage joint working and integration in a more formal way that does not rely on personalities for their delivery?

[164] **Ms Jones:** The drop-in clinics in north Wales have already been mentioned. It is about developing relationships with the local therapists so that we know who the individual ALAS assessors are and we can organise clinics and sessions for them to come to in our local areas. If it works well in the north, it should work in the south, in Powys, and in the west. Also, electronic communication is a great way of developing links with people. To an extent, it is working now. Individuals who use an electronic form of communication find it helpful. They can find out where a wheelchair is and what has happened to the parts, and so on. That is really useful. It is about ensuring that everybody can have the same level of access to people in the centres.

[165] **Rebecca Evans:** Sandra Morgan referred earlier to the importance of listening to the voices of service users in developing services, but you also have a huge wealth of experience and expertise. Do you feel that your expertise is being sufficiently drawn upon in terms of the development of services?

11.00 a.m.

[166] **Ms Morgan:** There is less engagement with regard to adults' services than with children's services. I see clear indications of ALAS wishing to work in partnership with children's practitioners, but I am not seeing the same indication for adults' services, although there are more adults out there who need wheelchairs than children. So, I am concerned that there is not enough of an exchange going on.

[167] **Mark Drakeford:** So, there is a scope for more.

[168] **Ms Ford:** There has been some improvement, but we need to see more in all aspects of communication with service users and with referring therapists.

[169] **Mark Drakeford:** Diolch yn fawr **Mark Drakeford:** Thank you very much for iawn i chi am sesiwn mor gloi, ond such a quick, yet useful and interesting defnyddiol a diddorol. session.

[170] You will shortly receive a transcript of today's proceedings. If there are any points that we did not have a chance to draw out to the extent that you think that we should have, it would be useful for us if you could let us know. Some information was not immediately to hand during this session, so, looking back, if there anything that you could point us to, or that you are able to collect from your members, then that would be helpful. Thank you very much for your time this morning.

[171] Mae gennym egwyl fer yn awr. We now have a short break.

*Gohiriwyd y cyfarfod rhwng 11.01 a.m. ac 11.14 a.m.  
The meeting adjourned between 11.01 a.m. and 11.14 a.m.*

**Ymchwiliad Undydd i Wasanaethau Cadeiriau Olwyn yng Nghymru:  
Tystiolaeth Lafar—Safbwynt y Darparwr Elusennol  
One-day Inquiry on Wheelchair Services in Wales: Oral Evidence—  
The Charitable Provider's Perspective**

[172] **Mark Drakeford:** Croeso yn ôl i'r **Mark Drakeford:** Welcome back to the final sesiwn olaf yn ein hymchwiliad undydd i session of our one-day inquiry into wasanaethau cadeiriau olwyn. Croeso wheelchair services. A special welcome to arbennig i Jeff Collins, cyfarwyddwr Jeff Collins, director in Wales for the British Cymru'r Groes Goch Brydeinig, a chroeso Red Cross, and welcome also to Nicola hefyd i Nicola Wannell, rheolwr datblygu Wannell, service development manager for gwasanaethau de-ddwyrain Cymru gyda'r south-east Wales with the British Red Cross. Groes Goch Brydeinig.

11.15 a.m.

[173] Welcome to you both this morning. Thank you very much for coming to help us with our inquiry. We have asked each group of witnesses today to start by thinking back to the recommendations made by our predecessor committee on this area, briefly giving up to three places where progress has been made and up to three where progress is still needed.

[174] **Mr Collins:** Certainly. Good morning to you all and thank you for inviting Nicky and me. If the questions get too difficult, I will ask Nicky to answer them. [*Laughter.*] Nicky knows the sharp end of the business very much better than I do.

[175] On progress, following on from the work of your predecessor committee, the posture and mobility group was formed inside the Welsh Government with the NHS and, for the very first time in my 10 years associated with this subject, focus was given to this issue. As a result of that work, we have a structure, which is now tackling the problems that exist. As I said, in the 10 years that I have been associated with this work, this is the first time that this has happened. Out of that, last year, the Welsh Government recognised that we needed assistance with funding, and £100,000 per annum was negotiated with the Red Cross. That brought immediate financial relief, because the spending of charitable funding had been growing like Topsy, the demand had been growing like Topsy, and I had forewarned that 2011 was the year when I just simply could not take any more charitable funding and throw it into a



wheelchair service. That relief was real progress and very welcome.

[176] The second area of progress that I would identify is our work with the Artificial Limb and Appliance Service, which is very positive. Its history goes back an awful long way. There have been historical difficulties, but I have to tell you—I am so pleased about this—that we now meet fairly regularly, we engage in training together, we collect each other's equipment to save money on transport and we share data. We still have a long way to go—there are no two ways about it—but that is real progress.

[177] The third area of progress that I would like to identify is that we are now getting much better at collecting data, looking at data and sharing data. Prior to your predecessor committee's work, we were hopeless at it. By 'we', I mean everybody associated with wheelchair services. We were simply bad at collecting data. We are now collecting those data.

[178] Moving on to where we need further progress, we need to understand those data. We are collecting data and, in my submission, I demonstrated the fact that the numbers for 2010-11 had grown by 20%. However, we do not really understand why. That cannot all be down to an ageing population. It cannot all be down to improvements in delayed transfers of care. We need to understand it. There are real anomalies in Wales. The demand for wheelchairs in Powys is huge compared with the demand in other parts of Wales. We do not really understand why. That is where we need more progress.

[179] We have established pilot schemes with Aneurin Bevan, Hywel Dda and Betsi Cadwaladr health boards, but, frankly, they are too pedestrian. We need to put some energy behind those pilot schemes and we need to move on. In particular, with the LHBs and, indeed, the local authorities, we need to link this work up with the increasing amount of health and social care care-in-the-home packages that we deliver right across Wales. Those pilot schemes must now move on so that we can develop a service that is fit for purpose and fit for the client base in those particular localities, because they vary.

[180] The final area where progress is needed relates to the fact that there are still too many red figures on the Red Cross books concerning this subject. The sum of £100,000 is very welcome, but that still leaves a big hole, which we have to close in some way or another.

[181] In overview, as I said in our submission to you, this has been a difficult problem for as long as I have been around, and I think that there were more ups than downs in the progress made last year. I thank this committee, because, after all is said and done, it provided the impetus for all that work to happen.

[182] **William Graham:** Thank you for your evidence today. May I say how impressed I was when I visited your premises in Newport with the modern facilities and the degree of expertise that your staff have on this issue? You have put forward various ideas for co-operation. In your opinion, how realistic would the proposals be for things such as common stock purchase or the sharing of training? Are they really possible?

[183] **Mr Collins:** The sharing of training has already happened, so that is undoubtedly possible, and we intend to move forward on that. The common purchasing of stock, to save money, will be difficult, but I intend to pursue it. The main area of co-operation with ALAS is what I call 'getting rid of the four-journey effect'. There are still many instances of a patient being referred to the Artificial Limb and Appliance Centre for a permanent wheelchair—I am not being critical of ALAS—but there is a gap between the referral finding its way to ALAC and its supplying the chair. So, what happens is that the patients come to us for a loan wheelchair for the first three, four, five or however many weeks it is. That means two journeys and one wheelchair for us. The ALAC wheelchair arrives, and that is another two journeys for us, and another two journeys for the patients. My dream solution, which we are

slowly edging towards, is that, if a potential ALAC client has a Red Cross wheelchair and we share data properly, they keep our chair and ALAS simply reimburses us for it. That way, we will have saved four journeys and only dealt with one wheelchair. What is more, the client will have been dealt with urgently and on time. We are moving towards that, and I am hopeful that, in the next year or so, systems will allow us to do that.

[184] **Darren Millar:** Thank you for your paper. I also thank you personally, because I experienced British Red Cross wheelchair provision last year, and it was an excellent service. I self-referred, because no-one told me to refer myself to the Red Cross. I live in the Betsi Cadwaladr health board area, where I note that you have a pilot scheme; I would like to know a little more about that, if possible. However, the process seemed to me to be as a result of the fact that I was an intelligent customer who knew of your services, made a call and, within 24 hours, the wheelchair was delivered by the Red Cross, which suggested a donation, but it was not obligatory. The suggested donation was made, and I could keep that wheelchair as long as I wanted and then return it to you. To what extent does that sort of arrangement mean that it is difficult for you to keep track of the loans that you make?

[185] You say that demand is much higher in Powys than in north Wales. Is that because it is essentially a word-of-mouth-type operation for people to be aware of your services? When people think of the Red Cross, they think of international situations, of battlefields and difficult parts of the world, and of the relief work that you do, but not necessarily of the fact that you have a local centre down the road with all sorts of aids and supports that people might need from time to time. Is it just that the general level is higher in Powys than in other parts of the country? How is this pilot scheme operating, specifically in north Wales, given that I certainly was not aware of it when I self-referred to the service?

[186] **Mr Collins:** There are three questions there. First, how good are we at tracking stock? Our staff and volunteers own each wheelchair themselves, so we are actually jolly good at it. Is that right, Nicky?

[187] **Ms Wannell:** Yes. I will explain what happens in south-east Wales. Our loan period is up to a maximum of 12 weeks—if somebody needs it for longer than that, we would not take it off them, but that is the guideline. What we generally say is, ‘We are going to loan it to you for a month, but if you need it for longer than a month, give us a ring, and we will extend it’. We are always in contact, because if they have not given us a ring, we will ring them, just to find out what the situation is. We do not lose contact with that person. That is how we can constantly track the stock and where that person is in terms of their need for the wheelchair.

[188] **Darren Millar:** How do those people become aware of your service? Are they referred by ALAC, or is it just chance?

[189] **Ms Wannell:** It happens in a variety of ways. A lot of people will get to know about our service because they know somebody who has used the service before, or a relative or friend, and then you get into what we call the health-related referrals, where we are being phoned by nurses, doctors, social workers and community nurses on behalf of their clients.

[190] **Darren Millar:** Is the approach from ALAC consistent in referring people to you when there is going to be a gap in—

[191] **Mr Collins:** ALAC does not refer to us. It is the community occupational therapist who tells the patient to get hold of us, or the general practitioner, hospital or whatever. They normally inform the patient, ‘Look, the form has been filled in, a process is under way to get you an ALAC wheelchair, but in the interim, so that you can be released from hospital, give the Red Cross a ring, and get a wheelchair at home until the ALAS process is complete’.

[192] **Darren Millar:** But that is not consistent, is it?

[193] **Mr Collins:** No. It is becoming more consistent, and I think that it is one of the reasons why we are seeing such an exponential growth in usage.

[194] **Darren Millar:** I think that you are right.

[195] **Mr Collins:** On the pilot schemes, particularly the Betsi Cadwaladr pilot scheme, we are saying, 'We have this facility, and we have a little bit of Welsh Government funding; how can we tailor what we do for your local health board?' How can we bring consistency to, for example, hospital referrals? Some hospitals use one methodology, and others do not use us at all. How can we bring consistency to that so that we can really tackle delayed transfers of care? How can we have a conversation with the OTs on how they would wish the referral to be made? Can we collect data? Do they want a service that costs £x, for which we deliver the wheelchair, or a service that costs £y, for which the family or somebody else comes to collect it? There are variations that we need to consider. The data, the demands and the methodologies are entirely different in south-west Wales compared with north Wales. It is all to do with history and the way that this service has grown. I was saying to Nicky that, from my research, if you go back 30 years, every hospital, GP surgery, school and OT would have had a collection of wheelchairs in all sorts of different places. If somebody wanted a short-term wheelchair, the OT, or the GP or whoever would find them one.

[196] I think that one of the reasons for the exponential growth in demand is health and safety. People's standards for cleaning and inspecting wheelchairs have improved, so gradually, over the years, all those stocks have dwindled—and so they should. That is one reason. As Nicola said, it is custom and practice.

11.30 a.m.

[197] **Darren Millar:** I think that this is one of the success stories in terms of the way in which the Welsh Government has engaged positively and has responded to some of the recommendations. People do not have to wait long periods for a loan chair. You have mentioned the fact that there are pilot projects taking place. However, your charity is still funding this to the tune of around £200,000 per year. Is that sustainable for you?

[198] **Mr Collins:** No, it is not. As my masters remind me frequently, it is not sustainable. We hope that when we tailor this service specifically in those pilot areas, they will be able to provide some funding for particular service level agreements or contracts with those particular local health boards.

[199] **Darren Millar:** This will not require NHS funding; it will just mean that they are saving money and giving some to you in order to provide the service.

[200] **Mr Collins:** It does not work that way, does it, because of the accounting problems in health and so on? However, there are no two ways about it: if we get this right, there will undoubtedly be savings for the NHS, in the area of delayed transfers of care alone. People used to talk about £400 per bed day. We know of people who have waited 10 days in hospital to get a wheelchair.

[201] **Mick Antoniw:** My question follows on from that point. There may well be savings and the steps being taken are obviously very good, but you are facing a 20% or so increase per year. You provide an intensely valued and essential interim service, and you have a business plan until 2014, but any savings will be eaten up by the increased demand on the service. What will be the solution in three or four years' time when you find yourself possibly in the same sort of deficit situation? You described the service as being financially

unsustainable under those circumstances. What do you think should happen?

[202] **Mr Collins:** I believe that the pilot projects must now move at a pace. It is only if those pilots really move on that we will scientifically be able to understand the data. We need to collect these data and understand the reason for the increase—based on more than Jeff’s understanding of why it has happened—and have scientific analysis of these data to understand what is going on. It cannot go on in the same way. This is not a precise figure, but I would say that, for the last three to four years, we have seen a 20% growth every year. Why is that?

[203] **Mick Antoniw:** Whatever the reason, that seems to be the trend, unless it suddenly stops. This means that, whatever way you save, you are still left with a similar sort of deficit or an increasing deficit. So, there is a real challenge for us regarding the position you might be in with regard to this service in three or four years’ time. Is that fair?

[204] **Mr Collins:** I cannot predict that, until we analyse the data. As I have said, there needs to be encouragement to make these pilot projects move more quickly in order to stop your prediction from happening. That is why I have put it down as an area in which we need more progress. The LHBs need to be encouraged to expedite these pilot projects so that we can collect the data and so that we can stop your prediction from happening.

[205] **Mark Drakeford:** Does anyone else have a question at this point?

[206] **Rebecca Evans:** Looking at your paper, you say that there are no standard eligibility criteria for receiving a short-term wheelchair loan. Would you suggest that criteria should be put in place? If so, what would they be?

[207] **Mr Collins:** It is a really tricky subject. We are working on it. We have produced some draft criteria with Aneurin Bevan Local Health Board and we have some draft criteria with Hywel Dda Local Health Board as well. I am nervous about this, I have to say. At the British Red Cross, we have fundamental principles, which are that, if someone needs help with mobility, we provide it and we do not ask too many questions. Anecdotally, I have heard of people who have complex housing, where perhaps they want a wheelchair on the first floor and another on the ground floor. I have heard of cases where people, having used some equipment, are not minded to return it. I have also heard of cases where equipment stays in the family and moves around. Those are very crude things, but we are moving towards some sort of criteria. Apart from anything else, this is about understanding what short-term and long-term needs are. The ALAS definition is six months, which is normally used by local health boards. Here is a question: do some referral agencies refer someone to ALAS to obtain a wheelchair when they only need one for a few weeks?

[208] **Rebecca Evans:** That was going to be my second question—how would you define a short-term loan?

[209] **Mr Collins:** Our eventual definition of a short-term wheelchair loan will be something that fits exactly into the cogs of ALAS. I do not know if it would be six months. We would have to wait and see. There are anecdotes about people being referred to ALAS when they only need a wheelchair for a few weeks and they could just borrow it from us. That is a huge expense to ALAS. These are the sorts of things that we would tackle within the criteria.

[210] **Mark Drakeford:** Thank you very much indeed, both for the written evidence and the oral information we have had this morning. There are a couple of minutes left before we need to finish the session. Jeff, are there any points that have not come out in the questions so far that you think that we definitely ought to be left with before you go? Or, have we

succeeded in drawing out the things that you think are most pertinent to the inquiry?

[211] **Mr Collins:** I would just like to reiterate a couple of things. The first thing is that the glass is half full. The last time I appeared before you, the glass was certainly half empty. It is now half full because there is recognition of the importance of this subject, there are now structures in place to address it and to move it on. I believe that the foot now needs to be put on the accelerator in pursuing these pilot projects with the LHBs. Of course, they are very busy organisations. They have an awful lot on their plates; I understand that. However, that is where the impetus and next stage of improvement is going to come from. I thank you for listening to us.

[212] **Mark Drakeford:** Diolch yn fawr i bawb am ddod yma y bore yma. Mae gennym gwpl o bethau i'w gwneud cyn dod â'r cyfarfod hwn i ben. **Mark Drakeford:** Thank you all for coming here this morning. We have a couple of things to do before drawing this meeting to a close.

11.39 a.m.

### **Ymchwiliad Undydd i Thrombo-emboldd Gwythiennol—Trafod y Cylch Gorchwyl** **One-day Inquiry into Venous Thromboembolism—Consideration of Terms of Reference**

[213] **Mark Drakeford:** The next item on the agenda is for us to consider the draft terms of reference for our next one-day inquiry, into venous thromboembolism prevention in hospitalised patients. It is important to emphasise, in case anyone out there is thinking about this, that it is the hospital-based aspect of this in which we are interested. You will have seen the terms of reference in paper 8. There are two focuses for us. The first is to look at the implementation of NICE and the 1000 Lives Plus risk assessment in relation to this. We will examine whether it does its job properly and how well it is being used in the field, and so on. The second thing we are going to concentrate on is whether the preventative measures that are available—there are pharmacological and mechanical things that can be done to help prevent this condition—are being utilised well in Wales. This is a chance for anyone to make comments on the draft terms of reference. If we are happy with them, confirming them today will mean that people in the field will have more time to provide evidence than people had for today's wheelchair inquiry, which had to be organised reasonably quickly.

[214] **William Graham:** On witnesses, Dr Noble from Lifeblood Wales, who has spoken to a number of members of the committee, has suggested two people that we might be able to approach. One is Dr Beverly Hunt and one is Dr Roopen Arya, both of whose addresses can be obtained from Lifeblood Wales.

[215] **Mark Drakeford:** Thank you; that is very helpful.

[216] **Kirsty Williams:** I think that it would be useful to hear from those clinicians. One of the significant differences between the approaches in dealing with this in Wales as opposed to England and Scotland is that risk-based analysis is mandatory in England and Scotland. Those two clinicians have been involved in implementing the new regulations in an English context, so it would be useful to hear from them whether making it mandatory has worked, whether it makes a difference to patient outcomes or whether it is just a tick-box paper exercise. It would also be useful to hear from them about whether a mandatory system would be useful for us, or whether there are lessons that we can learn from how they have implemented the system in England so that we would not fall into the traps that they have in England.

[217] **Mark Drakeford:** Excellent; thank you very much.

[218] **Mick Antoniw:** Chair, would it be possible to have copies of that guidance? It would be useful to see it before we start the inquiry.

[219] **Mark Drakeford:** Yes, we will make sure that we get it distributed in the lead-up to it.

[220] **Lindsay Whittle:** Would we be able to look at the publicity around this issue because, until I met Dr Simon Noble, I was unaware how much in the dark I was living. Do not comment further, you rotten lot. It was absolutely fascinating. We all know about travelling on an aeroplane, taking an aspirin and exercising, and so on. That is the popular one, but none of us think that we might develop this terrible illness in a hospital. It is the last place that you would think of it happening. We need to look at some publicity to raise awareness of it among the public.

[221] **Mick Antoniw:** Are we specifically keeping this apart from other incidences of deep-vein thrombosis?

[222] **Mark Drakeford:** Yes, this is an inquiry about hospital-related incidence.

[223] **Kirsty Williams:** It would be useful to have a briefing from the Research Service on what the pharmacological and mechanical prophylactics are and, in terms of witnesses and the list of professional bodies, it would be important to hear from the acute medicine side as opposed to the orthopods, who would have a different view to the physicians. They have a different view to the people who deal with thrombosis once it occurs.

[224] **Mick Antoniw:** They are also critical of each other.

[225] **Mark Drakeford:** It would be good to have that exposed in the evidence that we have. Thank you; that has all been helpful.

11.44 a.m.

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

[226] **Mark Drakeford:** We have a series of papers to note, as well as one other thing for me to mention to you.

[227] Papers 9 and 10 give follow-up information from the meeting we had on 25 January on European Union matters, so there is a paper on cross-border healthcare and a paper on professional qualifications. There are two other bits of information that we asked for that day which are still in the pipeline. We will have a paper on models of residential care across Europe, including not-for-profit models used elsewhere. Gregg Jones from the Assembly's Brussels office says that, as far as he has been able to find so far, there is no updated information on the revised EU health strategy, which we discussed briefly. We asked him whether anything further had happened in relation to it. He is keeping an eye open, but at the moment, the state of play appears to be as it was reported to us back in January.

11.45 a.m.

[228] Paper 11 includes some interesting information following our session with officials on the draft Food Hygiene Rating (Wales) Bill. It gives us some extra information on the extent to which the web pages are used and information relating to hospitals and food

hygiene. So, that is just stuff for us to note in advance of our second session with them when the consultation period is at an end. There are some interesting figures for Powys in there, Kirsty, in relation to food ratings.

[229] Finally, I just want to say that the Minister mentioned in the Business Committee on Tuesday that there are some doubts over business on the final Wednesday of term, because it is a potential day of industrial action. We do not know whether it will be a day of an industrial action, but if it is, I think that the Presiding Officer's view will be, as it has been, that there will be no business conducted formally inside the building on that day. We are therefore looking to see whether we could reschedule a bit of our business, so that we could use that Wednesday morning to go to do some visits relating to the strands that we have identified. We will reschedule our business so that we can catch up on things on another day. That may not be necessary, but I just want to alert you to the fact that we are looking into that. So, the clerk might come to Members with suggestions of potential visits that align with the strands that we are taking an interest in individually. There will be more information on that shortly.

[230] **Lindsay Whittle:** If we do that, Chair, where it is arranged is important, because I do not want to drive into this building and park here, even though I would only be parking, because that would mean crossing the picket line.

[231] **Mark Drakeford:** It will be designed so that people will not be put in that position, if they do not want to be in that position.

[232] **Darren Millar:** I will give you a lift, if you want.

[233] **Mark Drakeford:** I can see you with a blanket over your head in the back of Darren's car. *[Laughter.]* However, there will be no need for that. There will be a chance for people to carry out the committee's business, but, where people do not want to be in a position of crossing a picket line, they will not need to do that in order to be doing proper business. We will report back before that date, because that situation may not arise.

[234] **Darren Millar:** While we are talking about future meetings, I understand that one of our meetings clashes with a service of thanksgiving.

[235] **Mark Drakeford:** Yes, indeed. On that day, we are scheduled to hear from some third sector organisations that have alternative models of providing residential care services. My thought is that, instead of asking them to come here, we could consider visiting one of those alternative providers that morning. That would mean that the people who would like to go to the service would be able to do that, while Members who would like to go on the committee visit would be able to do that. We may need to slightly extend our afternoon session to squeeze in some stuff that we would otherwise have done in the morning. However, that would allow people to choose between the different duties that they could be undertaking that morning. We will pursue that as well and let you know.

[236] We will be back for our afternoon's meeting at 1.30 p.m.. Diolch yn fawr iawn.

*Daeth y cyfarfod i ben am 11.48 a.m.  
The meeting ended at 11.48 a.m.*