



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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Motion under Standing Order No. 17.42(vi) to Resolve to Exclude the Public from the Meeting

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

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

Eraill yn bresennol
Others in attendance

Dr Maire Doran	Cyfarwyddwr Clinigol, Gwasanaeth Ystum Corff a Symudedd, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Clinical Director, Posture and Mobility Service, Betsi Cadwaladr University Local Health Board
Gareth Evans	Cyfarwyddwr Clinigol Perfformiad a Gwella, Grŵp Rhaglen Clinigol Therapiau a Chymorth Clinigol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Clinical Director of Performance and Improvement, Therapies and Clinical Support Clinical Programme Group, Betsi Cadwaladr University Local Health Board
Helen Hortop	Pennaeth y Gwasanaeth Aelodau Artiffisial a Chyfarpar, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Head of Artificial Limb and Appliances Service, Cardiff and Vale University Local Health Board
Fiona Jenkins	Cyfarwyddwr Gweithredol y Gwyddorau Therapiau ac Iechyd, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Executive Director for Therapies and Health Sciences, Cardiff and Vale University Local Health Board
Andrew Lloyd	Pennaeth Ansawdd a Thechnoleg Gwybodaeth, y Gwasanaeth Aelodau Artiffisial a Chyfarpar, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Head of Quality and Information Technology, Artificial Limb and Appliances Service, Cardiff and Vale University Local Health Board
Daniel Phillips	Cadeirydd, Bwrdd Partneriaeth Gwasanaeth Symudedd ac Ystum Corff Cymru Gyfan Chair, All Wales Posture and Mobility Service Partnership Board
Dr Cerilan Rogers	Cyfarwyddwr Gwasanaethau Arbenigol a Thrydyddol, Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru Director of Specialised and Tertiary Services, Welsh Health Specialised Services Committee

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

Victoria Paris	Y Gwasanaeth Ymchwil Research Service
Llinos Dafydd	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 1.31 p.m.
The meeting began at 1.31 p.m.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

- [1] **Mark Drakeford:** Croeso i bawb i'r **Mark Drakeford:** I welcome everyone to the
 Pwyllgor Iechyd a Gofal Cymdeithasol. Health and Social Care Committee.

Ymchwiliad Undydd i Wasanaethau Cadeiriau Olwyn yng Nghymru—
Tystiolaeth Lafar
One-day Inquiry on Wheelchair Services in Wales—Oral Evidence

- [2] **Mark Drakeford:** Rydym wedi bod yn trafod y mater drwy'r bore. Croeso i Helen Hortop, Fiona Jenkins ac Andrew Lloyd o Fwrdd Iechyd Prifysgol Caerdydd a'r Fro ac i Maire Doran a Gareth Evans o ogledd Cymru. **Mark Drakeford:** We have been discussing the matter all morning. Welcome to Helen Hortop, Fiona Jenkins and Andrew Lloyd from the Cardiff and Vale University Health Board and to Maire Doran and Gareth Evans from north Wales.

[3] Welcome to you all and thank you for taking the time to be with us. We are pressing ahead with our inquiry on wheelchair services in Wales. I will start, as we have done with everybody, by asking you to cast your minds back to the recommendations made by our predecessor committee in its inquiry on the provision of wheelchair services and asking whether you would be able to identify up to three areas where you think progress has been made since then and up to three areas where you think that there is still further progress to be made. Given that there are five of you, we will probably not be able to ask everybody to respond on everything in the time that we have. Helen, are you going to lead?

- [4] **Ms Hortop:** No, Fiona will.

[5] **Ms Jenkins:** We have prepared between us. We will each take separate items and run you through them. I will start off for the north and south Wales service collectively; the first thing that we are really proud of is the partnership working that has taken place since last time. There is partnership at many levels: with service users, staff, the third sector, and with the National Leadership and Innovation Agency for Healthcare, the Delivery and Support Unit, the Red Cross, and the Welsh Health Specialised Services Committee in particular. There has been a lot of partnership working between both services, as well as the rehab engineering services across Wales. On the partnership with service users, the Kafka Brigade has just been contracted to arrange user engagement. Communication with our users has improved significantly on many levels. There are meetings between paediatric and adult therapists, physiotherapists, occupational therapists and district nurses at all levels. That is the first area we would highlight to you.

[6] **Mr Lloyd:** The second area is our patient management system, which I am responsible for. We have taken a brand-new approach to this. We have moved from a component management system, which was a reactive system, to a proactive system under referral-to-treatment rules. Over the last 12 months, I was tasked to look at that system and move it forward. One of the main features that we have developed is referral screening. The process is now streamlined. When a referral comes in, it is screened and put on a waiting list for the appropriate pathway within 24 hours. We are also taking an approach of managing episodes of care, rather than individual components. Therefore, we look at the complete experience, from the referral to the delivery of an intended solution. Throughout the episode of care, we have built in proactive reports and early warning systems so that, if we are expecting something to happen, we are proactive about it. Before we get to that point, we are saying to our staff—both clinical and technical staff—that we need to do something about it now, before it becomes a breach. By taking this approach of lean management, we have been able to tighten up the complete episode of care, which has been a contributing factor to the shorter waiting times that we are now reporting.

[7] On the referral-to-treatment rules, without getting too technical, BEST is our patient management system. It stands for 'bringing equipment services together'. The RTT rules are embedded in that so they are applied automatically, which means there is a consistent approach to the management of RTT and more accurate reporting.

[8] Turning to other developments, auto-purchasing with INVEST means that things that used to take weeks now take minutes, because the system takes care of it. We have automatic links from BEST into the ORACLE procurement system. In addition, there is validation on top of this. Since September 2011, we looked at about 15,000 to 20,000 cases to ensure that what we are reporting are actual waiting times and to get a clearer picture of our current position.

[9] **Ms Hortop:** On waiting times, I will start and Maire will give the details for north Wales. In Cardiff, the current waiting times have dropped dramatically since February 2011. At that time, adults were waiting 35 weeks for assessment and children 32 weeks. Now, the figures have dropped to 17 weeks for adults and six weeks for children. At the highest point last summer, adults were waiting 50 weeks to start the assessment process and children 42 weeks. So, the lean implementation has benefited both services, although the main thrust of our investment and attention was on children and young adults, as we were guided. Standard deliveries stand at 96.5% delivered within 21 days, and most of those are delivered within five days. Compliance with the referral-to-treatment rules is at 91% across adults and children for the overall target. There is 84% compliance with referral-to-assessment rules for children, which will be 100% by 1 April. There is 97% compliance with delivery targets. As you know, implementation of RTT is from 1 April, so we are in the run-up stage now.

[10] It is worth noting that the staff commitment to the service has been exceptional. Although the additional funding did not come into the system until June last year, the staff began seven-day working patterns to ensure that we started the process as soon as we could rather than waiting for recruitment. Recruitment has included occupational therapists, physiotherapists, rehabilitation engineers, technicians, administrators and delivery drivers. Some of those people are based in west Wales to ensure that we react appropriately to services and service users in west Wales. We have included new ways of working, such as one-stop shops at the depot and offsite locations. That means that, if we can identify from the referral the type of equipment a patient or client needs, we can invite them to come in to have their assessment and their equipment on the spot and go away with it. At one of those clinics at the depot last year, 16 people came in and 14 were able to go away with the equipment on the day.

[11] We also have a rapid response service so that anyone with palliative needs—people

with conditions such as motor neurone disease, multiple sclerosis and so on—will be seen within five to 10 days. We keep a stock identified in the depot so that we can fast-track those clients. We are now implementing paediatric reviews so that children are invited to come back for a review every year if they have not been seen. With regard to our consignment stock at the depot, we have more than 350 lines, including belts, parts and cushions. We also have additional clinic sites. We now have seven for adults and six for children.

[12] Andrew has described the BEST developments, all of which have contributed to that. The other work stream was capacity and demand work. Our clinicians have identified how they spent their day. Through that, we found that 13% of their time was spent on non-clinical duties, which we have been able to allocate to administrative staff. By appointing administrative staff to do these tasks, we have freed up time, which means that each clinician can see 4.5 extra clients a week. I will pass over to Maire now.

[13] **Dr Doran:** Reporting on waiting times, from the north Wales perspective, I have been in post since October 2011 and I have seen a rapid pace of improvement in north Wales since the implementation of the IT systems. I would like to acknowledge the commitment and energy that the staff have employed in relation to these improvements. We can report that any child referred to the service now will be seen within six weeks of referral. We have reduced the waiting time for children from 13 months a year ago to fewer than six weeks today. The waiting time for adults has also reduced—as it has in south Wales—as there has been a knock-on effect from the efficiencies and the process changes that we have made. So, a year ago, adults in north Wales were waiting 23 months for assessment, but now they are waiting 12 months. Those are the three areas in which we have made the most progress.

[14] **Mark Drakeford:** I am still keen to hear where you think progress needs to be made. I am also a bit anxious about the time. So, we will go straight into the questions and I hope that they will bring to the surface some areas where improvement is still needed, but we might need to come back to that at the end. Everyone will have a chance to contribute. Darren has the first one.

[15] **Darren Millar:** Thank you for the evidence that you have provided and welcome to the committee. I was interested to read in your paper and to hear in your opening remarks about the improvements in the south Wales service; there is no doubt that there has been a significant improvement there. However, in the written evidence that you submitted, while you provided the number of individuals who are waiting for paediatric services above the six-week referral-to-assessment time, you did not provide the same figure for adults. Therefore, how many people are currently waiting for assessment over the 18-week timescale?

[16] **Ms Hortop:** The longest wait for adults for assessment is currently 17 weeks.

[17] **Darren Millar:** So, that is the longest wait, is it?

[18] **Ms Hortop:** Yes, that is the longest wait for adults.

[19] **Darren Millar:** So, there has been a definite improvement on that. Why is the situation so much worse in north Wales?

[20] **Dr Doran:** From my understanding, the waiting times in north Wales have historically been a lot longer. However, with the changes that were made following the recommendations, there has been a similar reduction in waiting times. So, a year ago, adults were waiting 23 months for assessment, but are now waiting 12 months. So, the reduction is at a similar level.

[21] **Darren Millar:** People are waiting 52 weeks in north Wales for an assessment

compared with 17 weeks in south Wales. What is the problem? Is it a capacity issue?

[22] **Dr Doran:** There has been a historical difference between north and south Wales, but, yes, there is a gap between the funding level and what we can provide.

[23] **Darren Millar:** Was the extra cash appropriately divided between the centres in north and south Wales to enable you to cope with the demand and to help you to clear the historical backlog?

[24] **Dr Doran:** The funding given was clearly to meet the targets in relation to children. We have achieved those targets, which is what we focused—

[25] **Darren Millar:** That funding was not just given to meet the targets for children. When the Minister provided that funding, she made it clear that she wanted the maximum waiting time between referral and delivery to be 18 weeks for adults as well. While there was an emphasis on waiting times for children, given the tragic cases that came to the attention of Assembly Members and the public, adults, by your own admission, are still waiting 52 weeks or longer. Indeed, you mention 15 months in your written evidence.

[26] **Dr Doran:** That is now down to 12 months. We said that it would reach 12 months before the end of the year, and we have reached that.

[27] **Darren Millar:** How many individuals have been waiting over the 18-week time frame?

[28] **Mr Evans:** We do not have the figures for the 18-week time frame, but 63 individuals have been waiting for over 26 weeks.

[29] **Darren Millar:** That is a huge number of people who are waiting for appropriate equipment and whose quality of life, in the meantime, is severely undermined. I have concerns about the repair services, which I am sure that we will come on to during our questions. So, what do we need to address that problem? If it is a capacity issue in which you need investment, is it a short-term or longer term capacity issue? We have already heard that, in south Wales, people are now being invited back for reassessments in a proactive way, but I know that that tends not to happen for most people in north Wales, certainly not adults. What are you doing to address that?

[30] **Mr Evans:** To recap slightly, you are correct in saying that the funding allocated for this year was to reduce waiting times in general, but the emphasis was very much on the paediatric—

[31] **Darren Millar:** But it was not only on the paediatric—

[32] **Mr Evans:** No, but I think that ‘predominantly’ was the word that was used in the allocation letter. So, that is what we focused on. The money that we received, which was £700,000, reflected the bid that we put in to deliver paediatric services. The bid that we put forward to deliver adult services was, effectively, not funded.

1.45 p.m.

[33] Our position this year on adults, although improved, is improved mainly because of improvements in system redesign and the BEST IT system you have heard about. We have made significant progress on the total number of people on the adult waiting list, but not as much progress as we would like with regard to those people who are waiting longest, although the numbers are down, as is the average wait for adults. As a consequence, this year,

we focused on paediatrics in particular, given the resource, but we have been working through our planning cycles to try to understand what would be required to get to 26 weeks for referral to delivery for adults, which is the target that we believe we have been set. I do not understand why you are quoting 18 weeks; my understanding is that the target is 26 weeks.

[34] We have also looked at what we would require to put planned reviews in for adults as well. We have also been doing some work to look at how we can improve repair and modifications, through our approved repairers. That work is ongoing. It is part of our planning cycle. The final piece of that work is the capacity and demand work we want to do in north Wales, which the south Wales service referred to earlier.

[35] **Darren Millar:** Are you able to clarify—

[36] **Mark Drakeford:** We need to move on—

[37] **Darren Millar:** I appreciate that, but this is very important. You said that you made a bid for the £700,000 to address paediatric waiting times. You have managed to be very successful in that, and I congratulate you on your work on that because it was a serious issue and a serious cause for concern to the previous committee. Did you submit a bid to the Welsh Government to address adult waiting times? If you did, what resource did you request?

[38] **Mr Evans:** Yes, we did. It was a bid to get adult waiting times for assessment down to 26 weeks. Since that point, we are clearer about what the target really is: it is 26 weeks from referral to delivery. So, our planning assumptions for this next year are different because we are planning on that. We are also looking at what we require to do reviews and some improvements and modifications. So, the bid that we put in 12 to 18 months ago was not given. We are now looking at a slightly different scenario because we now understand exactly what we need to do to improve adult services.

[39] **Darren Millar:** Do you have a figure for the bid that you previously submitted?

[40] **Mr Evans:** Yes, I think that it was about £405,000.

[41] **Darren Millar:** Did the Welsh Government indicate why it was not giving the money in accordance with your request?

[42] **Mr Evans:** No. We were bidding against the £2.2 million that was allocated about 18 months ago. I assume that, by the time the bids for paediatrics for the north and south had come together, along with some of the other funding streams—some went to the Red Cross, some to palliative care and communication work—there was very limited or no money left. My understanding is that the Welsh Government prioritised paediatric services for the year that we are in now.

[43] **Mark Drakeford:** If it is available, it would be useful for the committee to see the allocation letter so that we can see the terms on which money was provided, how much you had and so on. If there is time at the end, it might be useful to go back to ask you, given the direction of travel in adult services that you have achieved over the last period, what ground you hope you might gain over the next 12 months. We will do that if we have time at the end.

[44] **William Graham:** Thank you for your evidence. I want to ask you about communication. You will recall that the previous committee recommended that an all-service communication strategy should be developed as a matter of urgency. We heard in evidence this morning that many service users believe that communication remains poor.

[45] **Ms Jenkins:** I will start on this, but I am sure that others will chip in. We have a

partnership board. I know that you will be having a discussion with Dan Phillips from the Welsh Health Specialised Services Committee, who chairs that partnership board, after this. One of the partnership board's work streams is on service-user engagement. It is chaired by one of our users. In fact, one of our users said at the meeting last week that we should shout the success from the rooftops because of what has been achieved in quite a short time since the allocation of funds. There is work going on.

[46] Certainly, the work we have commissioned with the Kafka Brigade to develop broader user engagement is something we welcome. Some of this is work in progress. We have been developing our communication strategy for some time in collaboration with users. Our partnership forum is a key area where we do that, but there are work streams on that outside our joint committee meetings that are being led by service users. As a result of one of the submissions that you had, I have put service users in communication with the Wales Neurological Alliance, and the chair of the group wanted to communicate with it, from the perspective of the more strategic user group that is going on, that there have been great successes. However, we recognise that communication is not a one-off event, but an ongoing process. We recognise that it needs to be better, but also that it is much better than it was. However, we take on board that we need to keep a strong focus on it.

[47] **Mark Drakeford:** Does anyone want to pick that up? It was a strong theme in our evidence this morning that, even when people knew that good things had happened, it was difficult to find out about them.

[48] **Ms Hortop:** I know that the work that has been started by NLIAH, as Fiona said, is not complete. One of the proposals is that we start working more closely with community therapists or, at least, develop what we are already doing. We already meet with the all-Wales professional groups, particularly paediatrics, to update them on what we are doing and also to listen to them about what they want us to develop. We will also meet with those groups under NLIAH's lead so that we can update them properly. It needs to be recognised that the funding came into the services in about June last year, so a lot of what we have been doing is only about six months old. There is probably a lot of work to do to let people know what we have done and how far we have gone forward. We know that that is a work in progress.

[49] **Rebecca Evans:** I wanted to pick up on that and see whether you had some concrete examples as to how you are working in partnership with charities in particular. I think that it was mentioned in recommendation 12 that the Artificial Limb and Appliance Service should explore further opportunities for joint working. Do you have examples of working with charities in the children's sector as well as those in the adult sector, and with organisations that represent specific user groups, such as war veterans or people with progressive conditions? That was for anyone on the panel.

[50] **Dr Doran:** In the time that I have been in post, I have been in contact with Whizz-Kidz, and I know that we are planning some training for children with other charities. We are in contact with the MS users forum and Disability Sport Wales. We are getting out there, starting to make these communications and involving these groups in our planning.

[51] **Ms Hortop:** They are also represented on the partnership board, as are a variety of groups, including the education authority, the local authority and charitable groups.

[52] **Ms Jenkins:** With regard to veterans, a Welsh Government group is looking at veterans who are amputees and the prosthetic requirements that have come out of the Murrison report. Helen and I are both members of that group. We meet next week for what is, I think, our third meeting, and one of the things that we have worked on with the veterans associations is to identify war veterans with amputations, so that we can do some modelling around the prosthetic needs of veterans in Wales. So, this dialogue is going on within our all-

Wales strategic group that is looking at veterans' needs.

[53] **Rebecca Evans:** I will ask one last question on this, if I may, and come in with something else later. There is a service user engagement strategy on the way. When can we expect that to be completed?

[54] **Ms Hortop:** The work that we have been doing with the Kafka Brigade is part of that ongoing work. In a meeting earlier this week, the Kafka Brigade described to us how it would do that on a variety of different levels, taking into account that our service users cannot necessarily access us, so we need to be creative about the way that we engage with them. It is organising group and one-to-one meetings across Wales. Telephone interviews will be run by trained staff—two of the people that they mentioned are social work lecturers at Cardiff University, people who have a lot of experience in talking through delicate issues with disabled people. That is part of it, as is training the staff, so that this is not just a one-off, but something that will carry on into the future. I hope that I have answered your question.

[55] **Mick Antoniwi:** You have dealt with some of the issues with regard to the repairs and maintenance service in your written evidence. What particular problems are you facing with that in terms of waiting time targets and delays?

[56] **Ms Hortop:** To speak from a Cardiff perspective, we brought our repair service in-house a little over two years ago. We have found that we have much more flexibility in the delivery of that service now; we can respond very quickly to user needs. We have a 365-day response to emergencies. Sometimes, the delays are in getting the equipment that we need, because manufacturers do not always have something on the shelf, but as I said before, we carry 350 lines of commonly used equipment in the depot, and we have also kitted out the vans used for delivery and fitting to carry commonly needed parts. We try to get accurate information from the service users when they ring in, so that we can take the right part out to make it a one-visit fix. If we cannot fix it, we try our utmost to temporarily replace the chair, but as so many of our users have quite complex needs, it is not that easy to have an off-the-shelf solution. However, we do that if we can, because we recognise that, if you are a wheelchair user, your life might come to a stop if you do not have the chair that you need. We are very aware of that fact, and we try, whenever we can, to be responsive.

[57] **Mick Antoniwi:** What are the average waiting times now for someone reporting a problem or a defect?

[58] **Ms Hortop:** We would respond within 24 hours. If an emergency takes place out of normal office hours but is between 7 a.m. and 9 p.m., we would go out and see that person. Normally, we do repairs within three days—that is our target, and we do our utmost to achieve that, but if we do not, as I say, it is often because we cannot get the part.

[59] **Mick Antoniwi:** What are the longest delays that you are experiencing?

[60] **Ms Hortop:** It could be some time. I can remember, recently, a time when Invacare, our largest supplier, could not source the little front wheels on a wheelchair—the castors—anywhere in the world for us. After something like that, we try to source them from other suppliers. It is usually with issues like that, when the supplier cannot supply us, that we see the major delays.

[61] There have been difficulties in the past with not always being aware of the issues, but there are the things that Andrew described in the BEST system now—there are triggers that alert us to deadlines that we hope will help us largely to overcome the difficulties, so that people are not lost in the system, as they have been at some times in the past.

[62] **Mick Antoniw:** Where there is an exceptional delay arising from, say, a part not being readily available, what do you have by way of contingency plans, and how effective are they?

[63] **Ms Hortop:** It depends on the needs of the user. If the chair is very complex—some of our users have custom-made seating—it would be very difficult to provide another chair. If it is a standard power chair, however, we would do our utmost to lend another power chair. It is the same with active users: we recognise that that person has a high level of dependency on the chair, so we do it wherever we can.

[64] **Mick Antoniw:** This is a south Wales position. Is it the same throughout Wales? Is the position consistent throughout Wales, or are different problems experienced in different areas?

[65] **Dr Doran:** It is very similar. I would say that, with the issues that Helen has alluded to, if there is a problem with a long wait, it tends to be that there is a supplier issue. In north Wales, we have an approved repairer on contract, and we also have some performance indicators, the most recent of which show that 100% of emergency repairs are being done within 24 hours. The non-urgent ones have to be done in three days, and we have an average of 97% response on that—it was 99% in January. Collection on time is another target, and that is 99%.

[66] On the issue of loan chairs, we say that we will provide a loan chair if the broken chair cannot be fixed immediately. However, we have been doing a lot of work in the past year with the approved repairers to try to get a higher rate of ‘first fixes’. So, we have more collaboration with our technical officers and the approved repairers, in that they meet weekly to look at the issues so that we can drive through and there are no prolonged delays.

[67] We recently looked at some statistics on our loan chairs, and we have seen that the number of chairs that we have loaned has come down, which is an indication that first fixes are increasing. So, in the quarter between August and October, we were making an average of 25 loans per month, and that came down to 12 loans per month, and it is continuing to come down, so it is working—first fixes are being done much more quickly.

2.00 p.m.

[68] Also, in north Wales, the approved repairer is very committed to improving the service, and has just appointed an IT expert to help develop the best system to work more closely with us, and to train its staff. It is also improving the communication with clients, because one of the criticisms is that, when there is any sort of a delay, there is not enough communication with the client to let them know what is happening. We are working on that as well.

[69] We are going out to tender at the moment for a new contract for an approved repairer, we have used all the lessons that we have been learning from reports from people, and we are putting that into the contract tender to enhance the service that we will get from the new contract.

[70] **Darren Millar:** I have a question about information in north Wales. Who provides the information to you in terms of the speed of the repairs? Is it the repairer?

[71] **Dr Doran:** Yes, we work with them and we get reports monthly. We do quarterly reviews with them as well.

[72] **Darren Millar:** Do you audit those data?

[73] **Dr Doran:** I do not think that we audit the data.

[74] **Darren Millar:** So the repairer can report whatever they want, can they not?

[75] **Dr Doran:** Yes, exactly. We are working closely with the repairer, and we have people on site dealing with the issues and problems. On the audit side, when we have developed the BEST system, which is happening over the next few months, we will be able to get much clearer data.

[76] **Darren Millar:** It is critical that the data are audited, because otherwise people come screaming to me and other Assembly Members. You know very well that there are cases in my constituency where people have been waiting 20 months for their wheelchairs to be repaired, and I have had to correspond with the chief executive of the health board.

[77] **Dr Doran:** That is not my understanding. There are differences between repairs, which is what we are talking about, where a technical part of the wheelchair needs to be repaired. That can sometimes become blurred with other repairs to complex seating and modifications to armrests, footplates and postural seating. We might have to go out several times to make those modifications and repairs. Sometimes they take a long time, not because they are waiting for something, but just because the general adaptations are complex.

[78] **Darren Millar:** However, to wait 20 months for an adequate piece of equipment is unacceptable, is it not?

[79] **Dr Doran:** I would agree—that would be unacceptable. I would be happy to look into any cases—

[80] **Darren Millar:** I do not want to raise specific cases with you. However, in terms of the new contract, will you be able to audit the quality of the data that you are being provided with in terms of the speed at which repairs are undertaken, so that you can monitor that?

[81] **Dr Doran:** I do not know the detail on that, but that is definitely something that we should put into—

[82] **Darren Millar:** May I ask one final question? It is an in-house service in south Wales, so why have you decided to maintain a service that is out there in the wider world, rather than bringing it in-house?

[83] **Dr Doran:** That was looked at before I came into post. Gareth Evans should be able to tell you about that.

[84] **Mr Evans:** I will give you some background on that. At the last committee meeting that we attended, a couple of years ago, we promised to look at and learn from the experiences of south Wales; we have done that, and seen lots of positive things. We undertook a fairly extensive option appraisal on this last year, looking at the various scenarios available to us, and the conclusion was that, within the financial envelope that we had available, the approved repairer and the contract was still the best option available to us. However, we recognise that, if the financial landscape changed, and if we could invest and put in the improvements that we would like to see, that is a scenario that we might revisit.

[85] **Darren Millar:** If I may make a statement rather than ask a question, it seems to me that the resourcing for north Wales is inadequate. If south Wales can afford an in-house service that is more expensive, it seems to indicate that there is an issue with the investment that is being given to the service in north Wales.

[86] **Ms Jenkins:** Could I make a point on that? Our service does not cost any more because it has been brought in-house. We have actually made efficiencies by bringing the service in-house. Compared with the system that we used to have, ours is now more cost-effective and cost-efficient, as well as more responsive in time.

[87] **Mark Drakeford:** Dr Doran, the figures that you provided were obviously very impressive, leaving aside the audit question for the moment. If there is a definition that you could provide us with as to what you mean by a repair, that would be useful—so long as it is easily provided, rather than being a lot of work. I might have been wrong in assuming that those figures covered a wider variety of circumstances than they do. For example, you have said that certain things are not considered to be repairs, but are defined as something else. I am interested to know what you are counting; that is, what the 97% figure means. There is no need to do that now, but we would like that information in order to understand better what is being delivered within those timescales.

[88] **Lindsay Whittle:** First, I would like to apologise to witnesses for my late arrival to the committee; I was in another meeting with the Presiding Officer that overran slightly. I also apologise to the committee.

[89] I am interested to hear about approved contractors and suppliers, and the fact that suppliers cannot get particular parts. Do you have more than one supplier? Instead of just sticking to one supplier, if one supplier cannot get it, do you go to another?

[90] **Ms Hortop:** We have just been through a comprehensive contracting process for the wheelchair service. We do it across Wales, so that the same type of equipment can be available in the north and south. It also gives us additional buying power and we get better prices. Given the ranges available, we tend to have more chairs from some suppliers than from others. There are around 148 chairs in the range. We go out via the contracting process, which is advertised in the European journals, and contractors and manufacturers are invited to bid. We then consider the suitability of those wheelchairs. There is no wheelchair provider in the UK that has a wider range than we have. The service users were involved in that process. They were at the depot when we undertook a review of the suitability of the chairs and looked at all of the features that were important to us, such as comfort and look, but also durability—because we are repairing chairs and we need them to be durable—and price. So, we screened against a range of factors. We were led by the procurement department. That is how we came to our decision. However, there is a very wide range of chairs.

[91] **Lindsay Whittle:** One of the first witnesses said that they could not get the small wheels for the front of a wheelchair from a supplier. There must be many suppliers and you do not have to go to that one supplier. That is the point that I was making. You can go to any supplier.

[92] **Ms Hortop:** Invacare is our largest supplier. If it is an Invacare chair and it cannot give us the front castors, that is obviously a problem for us. That was just an example of one of the issues where—

[93] **Lindsay Whittle:** Would you go to another supplier?

[94] **Ms Hortop:** If Invacare cannot get it, it is unlikely that another supplier can get a castor for that chair. If it is a specialist chair, it is likely to have an individual castor that might not be on others. We did our utmost to try to find castors.

[95] **Lindsay Whittle:** Is Invacare the supplier or the manufacturer?

[96] **Ms Hortop:** It is both. It manufactures and supplies us. It sources worldwide.

[97] **Mark Drakeford:** So that we are clear, I think that you said earlier, Helen, that in that particular example, when Invacare was unable to find it, you looked to see whether any other supplier might find it.

[98] **Ms Hortop:** We did, and so did Invacare.

[99] **Mark Drakeford:** That was Lindsay's question: did you look elsewhere? I think that you said that you did.

[100] **Rebecca Evans:** I would like to ask you about something that we heard this morning, namely that people are sometimes inappropriately referred to your service when they have only a short-term wheelchair need, which could be met elsewhere. To what extent is that a problem, and how does it affect the service that you can provide?

[101] **Ms Hortop:** We have done some work with the British Red Cross on that. That claim has been made, but we found that it accounted for less than 1%.

[102] **Mr Lloyd:** We had some data from the British Red Cross around two weeks ago. The referrals that the British Red Cross categorised as 'awaiting ALAS provision' equated to around 1% of our total referrals. So, what we previously thought was a common crossover was a lot less so. However, in answer to your question, you are talking about the other way around: when we receive the referral, what do we do with it then? We screen it and, if it is less than six months, we would advise the referrer to go to a short-term loan service, such as that provided by the British Red Cross.

[103] **Rebecca Evans:** What percentage of people is in that category?

[104] **Mr Lloyd:** I do not know the exact number, but it is a very small number. I would like to add something to that: part of the work streams in which I have been involved look at designing a new referral process for the service. That referral document clearly identifies the criteria.

[105] **Rebecca Evans:** So, what would the criteria for a short-term loan be? Would you be able to share that document with us?

[106] **Mr Lloyd:** The draft document is in the pack that we have here and that we were going to leave behind.

[107] **Rebecca Evans:** Okay, thank you.

[108] **Mr Lloyd:** That document is an ongoing project. We only have a draft document at the moment.

[109] **Mark Drakeford:** I will now put two points to the witnesses that arose in this morning's session, to see whether they recognise these issues, based on their experience. They are both to do with strategic leadership on wheelchair services.

[110] One point put to us was that, while there was a good deal of momentum on this about a year ago, some of the impetus behind improving these services has dissipated recently. Is that something that strikes a chord with you? Would you recognise that as a fair description of the current position?

[111] **Ms Jenkins:** I may be able to add something on that issue. I am the executive director

of therapies and health sciences. My role is around executive leadership, but I was asked to take on operational responsibility for the south Wales service. It is quite exceptional, really, to be operationally managing a service. It is something that I have been doing for 18 months, and I continue to give focus to this role. I can tell you, very broadly, the strategic elements of the ALAS service. I am also involved in the posture and mobility review group. I was asked to chair that group, but I felt that to do so would have represented a conflict for me, as part of the provider of a service. I can assure you that there has been no letting up of the impetus and focus on wheelchair services in those 18 months. Likewise, in north Wales, I know that there is leadership from the assistant director of therapies and health sciences there. We meet regularly and have dialogue. So, if you are asking us what our role is as service providers, we would say that this is a key part of what we deliver and is a key focus of our attention.

[112] **Mark Drakeford:** Okay. I will move on to my second question. It was also put to us this morning that you would be hard pressed to name the person who is in charge of this within the Welsh Government. I do not want you to name anyone. However, if I was to ask you who is in charge of this in the Welsh Government, would you be able to tell me?

[113] **Ms Hortop:** Yes.

[114] **Mark Drakeford:** Good. I am interested to know that. I now bring in Darren Millar.

[115] **Darren Millar:** This morning, we heard evidence on community therapists and the role that they might play in helping to reduce the number of referrals or assessments that need to be undertaken within your services. To what extent do you think that some level 3 training and assessments could be done in the community? Many OTs are assessing cases that involve significant sums of money, in the form of disabled facilities grants, for example, which might be invested in someone's property. However, they cannot, for whatever reason, conduct an assessment for someone who may need a wheelchair. Would this take a lot of pressure off your services, and what proportion of the assessments referred to you come from community therapists?

[116] **Ms Hortop:** I will lead on this and will explain one of our concerns about the proposal. As I have already said, there are 148 chairs in the range, and our staff members take at least six months to become familiar with them. Then, there are hundreds of different components that are added to those chairs. We have to ensure that the client is safe in the chair. Peer support would not be there for community staff, and I think that they would be hard-pressed to obtain the necessary level of knowledge about the chairs, along with doing their day jobs. So, I think that we would be compromising safety. We work closely with community therapists, and there are community therapists—perhaps those who work in a neurological setting—who have a fairly high level of knowledge relating to a specific range of chairs. If they give us the detail of what they want, we can prescribe it. I really do not think that level 3 training is necessary, certainly for the south, and I would have safety doubts. However, as I said, there are people in neurological and paediatric settings, in some instances, who have a sort of trusted assessor role. The range of chairs has just been changed, and we will be giving our staff in-depth training in all of the models. It would be difficult for someone else to keep up to date with that range of chairs.

[117] **Darren Millar:** What about north Wales?

2.15 p.m.

[118] **Dr Doran:** I would say the same thing. I think that community therapists would be perfectly capable of assessing someone's needs. However, it is the knowledge and the prescribing of the equipment that would be the problem. We have taken on those recommendations and have started training—we now have a number of people trained at level

3—but we have changed its focus so that we are training people to give good referrals in the first place. So, we are training the referrer, rather than providing training on giving more detailed assessments. That is what we have focused our efforts on.

[119] **Darren Millar:** So, is it the complexity of the equipment that presents a barrier?

[120] **Ms Hortop:** Yes.

[121] **Darren Millar:** Could you have a threshold of certain types of assessments that could be undertaken by community therapists, such as those in respect of the more standard equipment?

[122] **Ms Hortop:** Yes, and that also links into the referral form. If we get good information, then we can prescribe straight from the referral form. That is in our best interest, because it speeds people through the system, which is our aim.

[123] **Kirsty Williams:** You said that you have worked on a system of trusted assessors. How many trusted assessors do you have?

[124] **Ms Hortop:** I cannot give you a number, but in neuro settings, particularly in relation to people who have been through the ALAS service, we have rotational posts for a year at a time. So, those people move back into their setting—often into paediatrics or stroke units—and we get very good assessments from them, which means that we can then prescribe the chair. They are dotted around Wales; I know that there are some in mid Wales, there are some in paediatrics in the Swansea area, and Awel-y-Môr in the Swansea area is a neuro unit. However, this must be done in a setting where we can give a lot of support. This would be part of their core duty, and there would be a specific range of chairs that they would commonly use.

[125] **Kirsty Williams:** On your concerns with regard to peer support and expert guidance, would there not be a case for your organisation providing that peer support and expert guidance to community-based therapists who, certainly from the evidence that we heard this morning, are anxious to take on greater responsibility? They felt confident that, in taking on more training and greater responsibility within the community, they could offer a more holistic view of someone's needs and could perhaps speed up the process by which the appropriate piece of equipment got to the person in a timely fashion. They could also, perhaps, save other departments money by not having to have such significant adaptations made to people's homes.

[126] **Ms Jenkins:** Part of my role is director of therapies. I am a therapist by profession and have responsibility for the therapy staff within our health board. There is a mix between what you do frequently and what you do infrequently. As a community therapist, you will dip in and out of wheelchair cases, but it will not be the core focus of your daily job, whereas if you are a therapist within the ALAS service, this is what you do—it is your bread-and-butter, your daily job. If we did not have our waiting times down to the level that they are now, there may be some scope. Two years ago there was scope for looking at what more community therapies could do. However, we have given them instant access to level 1 training—we provide that training on demand, so there is a regular relationship with the therapy teams to get them to level 1 training—and we believe that the level 3 training is for the experts who do this regularly.

[127] I read in the Chartered Society of Physiotherapy Wales's submission that some therapists thought that the range was bewildering. It is bewildering if you do not do it on a daily basis. So, there is something in ensuring that we use the best skills of the therapist within the community to do the level 1 stuff, but to have instant, quick access to the service

for those who do this daily, who know the range and the changing range of equipment that we have. If we are doing that in a timely manner, then I do not see that there is a huge need to change the system that we have set up within the past year.

[128] **Mark Drakeford:** Thank you very much. Diolch yn fawr iawn. We have run over time slightly, therefore I am afraid that we are unable to come back to one or two of the points that we wanted to pick up. I am sorry that we did not have a chance to ask you to identify where you thought the next challenges were and where more progress is needed. I invite you to write to us with any thoughts along those lines. Dr Doran and Mr Evans, we heard where you have got to so far in relation to services in north Wales, but it would be interesting for us to hear about the trajectory of services and where you expect to be in six months or 12 months' time. If there are any questions we did not get to, or any points you consider important for us to be aware of and not lose sight of in our inquiry, then we would be grateful if you might let us have those in writing, but, for today, thank you all very much. I see there is—

[129] **Ms Hortop:** This is one that we prepared earlier.

[130] **Mark Drakeford:** Indeed. Thank you very much. Diolch yn fawr iawn.

[131] Thank you for that session, and this is where we move to the planning level.

[132] **Darren Millar:** What we did not touch on a great deal was the finance. We did not ask what happens, for example, if someone moves in from England with a chair that they have bought with a direct payment, or if they have topped up their payment or bought privately. How do they address the maintenance issues? I think that is a pertinent question.

[133] **Mark Drakeford:** One of the things I am keen that we do afterwards, when we finish, in the last half hour that we have, is identify things that we need to follow up further. For example, it might emerge from the day that there is information we need to collect, and so on. We will come back to that, definitely.

2.21 p.m.

Ymchwiliad Undydd i Wasanaethau Cadeiriau Olwyn yng Nghymru— Tystiolaeth Lafar One-day Inquiry on Wheelchair Services in Wales—Oral Evidence

[134] **Mark Drakeford:** Croeso. Diolch yn fawr iawn i'r ddau ohonoch am ddod yma'r prynhawn yma. Rydym yn bwrw ymlaen â'n sesiwn olaf yn yr ymchwiliad undydd. Felly, estynnaf groeso mawr i Dr Cerilan Rogers, cyfarwyddwr gwasanaethau arbenigol a thrydyddol, Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru—mae'n deitl hir iawn yn Gymraeg. Croeso hefyd i Mr Daniel Phillips, Cadeirydd, Bwrdd Partneriaeth Gwasanaethau Ystum Corff a Symudedd Cymru Gyfan.

Mark Drakeford: Welcome. Thank you very much to both of you for attending this afternoon. We are going ahead with the final session in our one-day inquiry today. So, I extend a big welcome to Dr Cerilan Rogers, director of specialised and tertiary services, Welsh Health Specialised Services Committee—it is a very long title in Welsh. Welcome also to Mr Daniel Phillips, chair of the All Wales Posture and Mobility Service Partnership Board.

[135] Thank you both very much for being here this afternoon. This is our last session of this one-day inquiry. We started with the user experience and we have made our way right up to the planning, strategic level. We have asked all the people who have been helping us today

to begin by casting their minds back to the recommendations made in the report prepared by our predecessor committee, and trying to identify for us three areas where they think the most progress has been made and three areas where they think the most ground is still to be made up. So, we will start with that, and then there will be questions around the table for you. Cerilan, will you be going first?

[136] **Dr Rogers:** Thank you, Chair. I will start in a slightly different way, I am afraid, by saying why I am here, before I hand over to Dan to do most of the presentation and talking.

[137] **Mark Drakeford:** By all means.

[138] **Dr Rogers:** As you said, I am director of specialised and tertiary services for Wales, and, as a committee, we are responsible for planning and securing the services within our remit on behalf of the LHBs. That includes ALAS, of which the wheelchair service is part. I am accountable to the joint committee of WHSSC, and it receives regular updates on these services. This is for you to understand the accountability, in terms of the planning and securing of these services. We will, obviously, be looking forward to engaging with you on the issues, but I think that it is important for me to say that this has been a very positive development over the last year. It is recurrent investment, so we would expect to see further positive developments. It is important to say that from the outset.

[139] **Mark Drakeford:** Thank you for those points.

[140] **Mr Phillips:** Thank you very much for giving us the opportunity to be here. Obviously, I heard the evidence of colleagues who appeared before us and I have read the information that you have all received. We are not at all complacent about the quality of these services, but, like Cerilan, I think there is some very good news in these services in terms of the improvements that have been made in the last 12 or 18 months and which users have started to see during the last few months.

[141] I will just give a brief overview of the three areas where I think we have made the most progress as a partnership board, and then move on to the second issue, which is the challenges that we need to tackle. We had planned, at the end of March, to record where we were, present a report to the Minister and talk about our achievements during the last year. However, today gives us an opportunity to rehearse some of those issues before that. The three key things I think we have made most progress on are: service transformation and continuous improvement; waiting times, particularly for children; and service user engagement in the partnership board. Colleagues who came here before have given you lots of examples about the transformation in this service in almost every process that is going on—the administrative processes, the technology that is being used to record things, the assessment process that is being used, and the different staff grades that are being used. I have seen that evidence to you. It is tremendous work. There is joint working between north and south Wales in a way that there was not previously and a lot of support from NLIAH, the learning and improvement agency for the health sector. It is behind-the-scenes work, but users are starting to see the improvements coming from that.

[142] Waiting times are transformed. We had not expected that we would be in a position today to say that we had met the target for children. It was going to be a challenge, and I thought that it would be a very close-run thing as to whether we could achieve it by 31 March, but colleagues in the partnership board were able to assure me earlier in the week that it is being delivered now or will be delivered by 31 March. I think that that is great and the benefits from the modernisation and all the learning that has been done in focusing on children as a priority have also shown themselves in adult services. Helen and Maire gave you examples earlier. I will not go back through the numbers, but, while waiting times for adults are still long, they are significantly improved.

[143] We have also engaged more users through clear networks and stakeholders that represent them on the partnership board and have tried to bring a service-user focus into the partnership board. I have learned a lot from them, and we have also changed the way that we work as a partnership board, using teleconferencing and so on, to ensure that they can contribute effectively and that their input is valued and at the centre of what we are doing. I think that that is a big achievement. However, as I said, we are not complacent at all. We need to build on what I consider to be significant successes and move on. We clearly need to do more work on adult waiting times; they are not of the standard that we want them to be, so we have to do that.

[144] We have to work on communication. We have good news, but if there was a message that I received from reading the papers that you had, it was that it is not getting out. As one of the user representatives said to me last week at the end of the partnership board meeting, 'These improvement in waiting times and the good news that we have today need to be shouted from the rooftops'. I thought 'How true' and told him at the time that he might hear his words again, but I had not realised what the timing of the opportunity would be.

[145] We also need to plan for the next two years in the next few months, because one of the challenges this year has been that we started with a situation in which we did not have clarity about definitions about how long people were waiting, what they were waiting for and the components that Andrew was talking about earlier. One of the things that I was impressed by, hearing the evidence, was people's ability to tell you exactly how many people are waiting exactly how long. It would be fair to say that, if you went back two years, they could tell you what the longest wait was and how many people were waiting, but there is a transformation in terms of precision and clarity with regard to the work that is going on and the awareness that this patient is waiting too long for that component. Having that information will now allow us to plan much better going forward, because, before, the plans were very broad, and now they are very precise.

[146] **Mark Drakeford:** I will go to Kirsty first and then to Darren.

[147] **Kirsty Williams:** You have just said.

[148] 'We clearly need to do more work on adult waiting times'.

[149] Can you articulate what that work is and any timescales by which you would expect to see significant improvements?

2.30 p.m.

[150] **Mr Phillips:** We have seen significant improvements already, while we have been prioritising getting children's waiting times down. Given that the money that has been invested in the service is recurrent, we would expect to see similar improvements next year if we did nothing else. However, the other thing about the timing of the change is that a lot of it came in in the latter part of this year and that is why, I think, the Welsh Nursing Academy said, from its evidence, that it did not think that we would meet the national service framework targets for children. However, we are able to stand here today and say that we are confident that we are doing so. By the end of March, we will have clarity on how many adults are waiting, for how long they are waiting and what the trend will be if we do nothing else. Then, we will have to look at what else we need to do to achieve the targets. Will we naturally hit the 26-week target next year without doing anything else by continuing the improvement that we have made, or do we have to look at how we are deploying resources and move them around? I cannot give you the answers in precise figures, but I am quite confident that the improvement that we have seen this year means that by June or July we will have a clear plan

about what will be achieved next year for adults. We will then ensure that it is delivered in the same way as we ensured that the plan for children's services has been delivered.

[151] **Darren Millar:** What is the waiting time that the services are working towards for adults?

[152] **Mr Phillips:** We are working towards a 26-week target.

[153] **Darren Millar:** Why is it 26 weeks, when a recommendation was made in the phase 2 report of the all-Wales posture and mobility review that there should be a maximum waiting time of 18 weeks, not just from referral to assessment, but from referral to delivery?

[154] **Mr Phillips:** I cannot answer that here today, but 26 weeks is what we are working to—

[155] **Darren Millar:** Is that 26 weeks from referral to assessment?

[156] **Mr Phillips:** No, from referral to delivery.

[157] **Darren Millar:** Why is the wait for adults that require wheelchairs in north Wales much worse than it is in south Wales?

[158] **Mr Phillips:** It is because north Wales started from a lower base. I think that Maire touched on the issues earlier. It was clear that they were starting from a more difficult position with regard to both adults and children. The improvements in the service for children in north Wales have been greater than in south Wales, because north Wales started from a worse position. There has been a big improvement. However, as you have highlighted, waiting a year for a wheelchair is not acceptable. We will get that time down, but it started from a lower base.

[159] **Darren Millar:** Waiting 15 months for an assessment, which is what was stated in its paper, is completely unacceptable and is a long way off 26 weeks from referral to delivery of equipment. Given that north Wales had further to go to catch up, why was it not given extra resources, over and above the resources given to south Wales, to be able to meet its backlog?

[160] **Mr Phillips:** The allocation was given by the Welsh Government; I am not sighted on the details of how that was done.

[161] **Darren Millar:** The partnership board would have been involved in trying to make a case for that, would it not?

[162] **Mr Phillips:** No. It pre-dated this.

[163] **Darren Millar:** I see. Do you have an assessment of whether the capacity in north Wales is sufficient, not just to clear the backlog—I am sorry to focus on north Wales, but there is a bigger issue in north Wales—but to introduce a regular programme of reassessments for the individuals who need them? We heard this morning that reassessments—people being invited back—are becoming a regular feature in south Wales, for young people in particular. However, what about the adults with degenerative problems whose situation may get worse from year to year?

[164] **Mr Phillips:** Clearly, that is where we want to go. However, I cannot give you that assurance now, for the reasons that I mentioned earlier. Until around Christmas time, we did not have any solid data to plan services. The service has done tremendously well with the information it had. It has put firm foundations down. We are now really starting to understand

what is going on in the service. The service has been modernised and re-engineered. We will get a clear plan in place by June or July on what we can deliver. We will then communicate that to the Minister. So, we will be clear as to what can be done. I cannot give you an assurance now, either way.

[165] **Darren Millar:** Do you have a steer on the sort of investment that may be required?

[166] **Mr Phillips:** No. To be candid, people did not believe that they could deliver the improvement that they have delivered with the £2 million allocated. They have delivered more than we expected and more rapidly. It was very difficult to estimate what was going to be delivered. They have transformed the service and that has changed things. All those stories about administrative staff taking over work from therapists so that additional therapists are not needed as much are all part of a real transformation of the service—I think that it is absolutely commendable, and it is a real success story.

[167] **Darren Millar:** You have certainly been shouting it from the rooftops this morning. I have one final question. I do not think that you would be shouting it from the rooftops if these figures were reported publicly on a regular basis, because, clearly, it is completely unacceptable that people should have to wait 65 weeks simply to get an assessment. That is still the case in north Wales, and I think that is appalling, so we do not need to be too self-congratulatory. Is that information going to be publicly available on the internet or elsewhere so that people can hold the service to account and hold the Welsh Government to account in the future on these particular targets?

[168] **Mr Phillips:** It needs to be.

[169] **Darren Millar:** So, at the moment, it is not.

[170] **Mr Phillips:** No, it is not.

[171] **Darren Millar:** It is something that you would like to see, though, is it?

[172] **Mr Phillips:** Yes.

[173] **Mark Drakeford:** I have one brief follow-up question on that. I read in one of the papers that we had for today that, while money is very important—I am not for one minute suggesting that investment is not crucial—from a planners' point of view, as well as extra money, you have to have capacity. You have to be able to recruit the people that you need, and reorganise the service so that things are done in a different way. So, money is one crucial component, but it is not the only thing that makes a difference.

[174] **Mr Phillips:** Absolutely, and I think that this is one of the better examples that I have seen in my career of that being the case, in the redeployment of the resource that the service had.

[175] **Mick Antoniw:** I am interested in trends and your forward planning in respect of future demands and so on, and the implications that has for the capacity to achieve targets. What sort of forward planning do you have? What sort of trends are you detecting in the demands on the service?

[176] **Mr Phillips:** We do not have detailed information on that. To be honest, we have been concentrating on sorting out what were embedded problems. Once we have a steady-state situation then we can assess changes in demand. We all know that, if you reduce waiting times generally, you flush demand out of the system, so we will have to look at that, but we do not have details on future demand.

[177] **Mick Antoniwi:** You are not noticing any particular trend at the moment in terms of the numbers coming in, then, are you?

[178] **Mr Phillips:** No.

[179] **Mick Antoniwi:** Do you plan to undertake that sort of process?

[180] **Mr Phillips:** Yes.

[181] **Lindsay Whittle:** How do you involve the service users in provision? Do you also work closely with occupational therapists and physiotherapists and the voluntary sector, which plays a major part in helping to ensure that people get a good service?

[182] **Mr Phillips:** Obviously, the providers work very closely with charities and local services. In terms of planning from WHSCC and the partnership board, we have about eight or nine user representatives on the partnership board, and we wrote to a broad section of voluntary organisations asking them whether they wanted to nominate people. We had applications in, and we sifted those to see that we could get a geographical representation and representation from different segments of the community. People identified what they thought they could contribute. We have a diverse group of users; some represent charities as agents, some are the representative voice of a community, and some are individual service users.

[183] **Lindsay Whittle:** So, there is a good cross section and their input is valued.

[184] **Mr Phillips:** Very much so. There is the work going on through NLIAH and the Kafka Brigade on setting up a more embedded system for engaging service users over time. That is quite novel and ambitious work. However, the service users on the partnership board have been very vocal about the significance of what appear to be small problems for individuals, but which can have a dramatic impact, and about the facts that their experiences of waiting times, historically, are poor, and that communication has been poor. It is difficult for me to put words into their mouths, but the last meeting was much more positive than what we have seen previously. I think that we have good engagement, and we have made alterations to the way in which the board works to ensure that their views come early in the meeting, that they are clearly engaged and that they have an opportunity to provide feedback at the beginning of the meeting on what their networks and stakeholders are telling them. Clearly, there is that message that the professionals are starting to see change, and some users are seeing change, but it has not got out yet to every user.

[185] One of the problems that we were talking through with the user representatives is that any individual will have relatively infrequent contact with the service. So, it is difficult to assess whether an individual has noted an improvement, because you do not know what time frame that will come in. We do, I think, have quite a good mechanism, but there is still plenty more to do. It is a huge challenge.

[186] **Lindsay Whittle:** Their input into the future strategy is vital, because they have a whole raft of experience and knowledge of the issues.

[187] **Mr Phillips:** Yes, and I will be absolutely straight: I have learned a great deal about the impact that this sort of disability has on people by having those users in the room.

[188] **Mark Drakeford:** Kirsty, do you want to follow up the point?

[189] **Kirsty Williams:** It is a different point, if I may, Chair. We heard some evidence this morning about how greater individualisation, the use of personal budgets and the ability to top

up could empower people more than the current system and perhaps afford individuals greater levels of choice. From a planning perspective, what are the risks and opportunities, if the Welsh Government was to be persuaded of such a way forward?

[190] **Mr Phillips:** I would see that primarily as a policy issue rather than a planning issue. I know that it has been explored at different points over the last five or 10 years. I am conscious that that is more the approach that is used in England, where I think voucher schemes of some sort are in operation.

[191] **Kirsty Williams:** If the Government wanted to pursue that policy, it would impact on your work in terms of planning the service.

[192] **Mr Phillips:** Obviously, there are risks and benefits in any approach. You can argue about autonomy for individuals versus the risks to those who are less able to deal with the arrangements that you have to put in place to facilitate that autonomy.

[193] **Kirsty Williams:** Is there any evidence that the ability of an individual to engage in the system of direct payments is any more confusing, bureaucratic, frustrating or annoying than a system that is operated by the state that fails to deliver you an adequate assessment in a timely fashion and a wheelchair when you want it? Is there any evidence to suggest that it is more complex for an individual to engage with that system than with the existing system?

[194] **Mr Phillips:** I very much doubt it.

[195] **William Graham:** We heard evidence that further resources are required to sustain progress and improvements made in adult services. Are there any particular targets there that you would like to see reinforced?

[196] **Mr Phillips:** In the financial sense, or in the sense of waiting times?

[197] **William Graham:** In the financial sense, particularly.

[198] **Mr Phillips:** I think that we do not know the scale of the problem yet. As I have said, I think that we will within a few months, and then decisions will have to be made by the health boards or the Minister about what they want to do and by when. We will engage in that process, but in the foreseeable future, we will know the scale of the mountain and whether we are going to plough our way through it with the current systems or not.

[199] **William Graham:** So, there is likely to be further delay.

[200] **Mr Phillips:** No—

[201] **William Graham:** You only meet twice a year.

[202] **Mr Phillips:** No; we meet quarterly, but we report to the joint committee six monthly.

[203] **William Graham:** Are you conscious that you will be able to make recommendations pretty soon?

[204] **Mr Phillips:** Yes.

[205] **Rebecca Evans:** The existing access criteria say that the service would provide equipment to meet essential posture and mobility needs only, but the WHSSC evidence states that the work stream will explore options for delivering a service that is also able to address

the broader social and lifestyle requirements of users. Could you provide us with some further information on the options that you are looking at?

2.45 p.m.

[206] **Mr Phillips:** There is clearly a big issue about the fact that it is not simple for users, or potential users, to understand what we do or do not provide. One of the key things that we need to do is to get that out in language that I and the users can understand, because it is very complex at the moment. It tends to be communicated one-to-one and there is no clear message about what we do on any website. The work group has been set up to do that piece of work, but the users, rightly, are challenging us and are saying that they have other needs. They talk about the social model of disability and not just about health and their healthcare needs. So, we have asked the work stream to look at what the other issues are so that decisions could be made by health boards or the Minister about the options. So, if we look at this in stages, the first thing for us to do is to set out more clearly what we currently do. The second is to look at what the users would say if we were to change what we do that is important to them, and to consider how that fits between health and social care. That is always a difficult issue. The idea is to do that in one place and then consider how to sort out the problem once it has been identified.

[207] **Rebecca Evans:** To what extent are users currently able to prioritise within the options available to meet their own needs?

[208] **Mr Phillips:** If it is to do with meeting their health needs, the patient is assessed and he or she contributes to that assessment. One of the things that we have focused on is being clear in measuring whether or not a patient is satisfied. A wheelchair might arrive—and I think that an example was mentioned earlier—and while it might do what someone thought it would do technically, it might not meet the patient's needs. That situation has never been quantified before. There is an expectation gap. So, they are actively involved in that now, but we will be able to measure that.

[209] **Rebecca Evans:** So, there is a difference between meeting health needs and, perhaps, allowing the person to live the life that they would like to live.

[210] **Mr Phillips:** Yes.

[211] **Rebecca Evans:** So, are you moving towards meeting wider needs?

[212] **Mr Phillips:** We are not moving towards that; what we are doing is first making it clear what we do and do not provide, in a way. It is not well laid out now. It is difficult for people to engage with the service without an individual practitioner taking them through it. So, it is clear at that level. We then identify the issues so that they can be explored. We are not definitely shifting the boundaries; that is not in our gift as a partnership board. We are doing the work that would then advise the joint committee, health boards or the Minister on the issues and we would then ask how they would like them to be addressed. So, there is a distinction between the partnership board with the users, which looks at what issues are important and makes recommendations as to what we should do, and then the authority to make those decisions—the resource decisions that fit with that—which lies with the health boards and the Minister.

[213] **Rebecca Evans:** So, these are policy and funding issues above all.

[214] **Mark Drakeford:** I will move on to Darren in a moment, but I would like to ask one question before I do. The very first recommendation in the previous report was that a full national service specification should be developed. That seems to me to be a straightforward

planning issue. We saw in your evidence that there was a meeting on 1 March at which further progress towards that was going to be made. Could you just update us on where you think we are in meeting that recommendation? How close are we to it?

[215] **Mr Phillips:** We are further away than I wanted to be. We received a draft, which focused primarily on clarifying this issue. It received constructive comments around the table, but it needs quite a lot more work. I think that we are several months away from having the service specification completed. However, in preparing for this, when I looked through the papers, I recognised that that was the first recommendation and realised that we really have to step up to the mark.

[216] **Mark Drakeford:** Could you give us your best guess as to when the work will be completed and we can say that that recommendation has been met?

[217] **Mr Phillips:** I hope that it will be done by the autumn, but I would need to plan that, rather than giving you a categorical assurance.

[218] **Darren Millar:** I am not sure why it takes several months to come up with a service specification from a recommendation made two years ago, frankly, but perhaps you can answer that another time. Earlier, with regard to waiting times, you indicated that you would like to see some of the issues reported more openly on the internet. Are the agendas and minutes of your meetings published online?

[219] **Mr Phillips:** No—

[220] **Darren Millar:** Is there any reason why they should not be?

[221] **Mr Phillips:** I cannot think of any.

[222] **Dr Rogers:** Are you referring to the partnership board?

[223] **Darren Millar:** Yes. I think that it would be really helpful in keeping people up to date.

[224] **Mr Phillips:** The summary reports that go to the joint committee are published online and are publicly available.

[225] **Darren Millar:** However, publishing your agendas would be useful so that stakeholders know where things are at. If you want to shout something from the rooftops, so to speak, there is nothing like an online presence. I have looked at the membership of the partnership board. That has all the right people in the right places, but I noticed as absent stakeholder organisations with an interest in monitoring what is going on, such as the Wales Neurological Alliance, the Motor Neurone Disease Association—which said in a recent report that some of the people that it deals with are dying while they are waiting for wheelchairs—and Scope Cymru. Would you be prepared to add those to your membership?

[226] **Mr Phillips:** I think that one of the representatives is a member of Scope.

[227] **Darren Millar:** I could not see one on the list. I could see someone from Children in Wales—Lynne Hill—but I could not see—

[228] **Mr Phillips:** It is Michael Butterfield.

[229] **Darren Millar:** His name was not on the list—that was all. Clearly, those organisations in particular have helped our inquiry today and in the past.

[230] **Mr Phillips:** Absolutely. We would welcome that. I did check that the WNA was asked to nominate someone, and it would appear that we did not receive a nomination. However, I will go back to that, because we work well with the WNA. We have no problem engaging with it, although I did check before I came.

[231] **Darren Millar:** That would be really useful, and I would be grateful for that. When exactly was the partnership board established?

[232] **Mr Phillips:** It had a shadow meeting in November 2010, I think. It had its first meeting in April 2011 and the terms of reference were signed off at the joint committee last July. So, there has been a shadow meeting and four meetings.

[233] **Darren Millar:** So it did not really get going until July last year.

[234] **Mr Phillips:** There was good stuff going on well before that, and certainly at the April meeting.

[235] **Darren Millar:** Right, but you did not agree your terms of reference until July last year.

[236] **Dr Rogers:** They were not formally agreed by the joint committee until then. We had working terms of reference, but they are not finally agreed until they have come through to the joint committee.

[237] **Darren Millar:** One of the things we have heard about is frustration with the delay and the pace at which these things are moving. Clearly, the report was published two years ago and it took until October 2010 to get a recommendation for the board to be established, agreement was reached to establish it in November 2010, and the terms of reference were not agreed until July 2011. It seems pretty lethargic to be honest. I appreciate that there have been significant improvements in the service over the past 12 months. That is undoubted, certainly as far as children and young people are concerned. However, it seems that progress has been rather sluggish up until the past six to nine months.

[238] **Dr Rogers:** My understanding about the terms of reference was that we wanted the shadow board to have an input to ensuring that it had the right terms of reference. The ratification of those terms of reference did not delay the work of the shadow board. Sometimes, in some systems, you cannot set anything up until you have the terms of reference. However, we have been able to run shadow arrangements, which have made quite a contribution.

[239] **Darren Millar:** Finally, going back to the point that you made earlier about the specification of the service, you said that it was going to take several months before you could reach agreement. Again, that seems rather sluggish. Why can you not secure agreement sooner than that?

[240] **Mr Phillips:** I do not like to overcommit in a situation such as this.

[241] **Darren Millar:** Several months is under-committing, is it not?

[242] **Mr Phillips:** We will go away and look at what we can do.

[243] **Mark Drakeford:** Perhaps I can ask you the question in a slightly different way. Looking forward now rather than reviewing what has happened so far, you helpfully reminded us earlier that the money is recurrent, so it was not just a one-off—there will be

money there next year again. What could you say to us that would help us to feel confident that there is a genuine sense of urgency and momentum going into next year? We understand that things have taken a while to get going, and that the money has not always come through, but we have heard from several witnesses today that things have really got going in the last six months. We are looking forward to the next 12 months. What can you say to us today that would leave us with a feeling that there is a real sense of urgency and momentum going forward?

[244] **Dr Rogers:** You will want to hear from us about clarity on timescales and what is going to be achieved by when, in terms of planning and service specification delivery, and when and what we are going to do about some of the issues that you have raised. One of the reasons why I am here today is to listen very carefully to your comments and to take those back and work with Dan and the partnership board on these issues.

[245] I had a query about something that Kirsty said earlier about personal budgets and choice, because I was not clear whether I had completely understood that particular question. However, we should be able to come back to you after having this discussion today, and give you more of assurance about timings that will at least give you something to allow you to say, 'Okay, by then we would expect to hear x, y or z'. Whether everything can be delivered within a given period—we have to talk to providers about what can be delivered—is a different issue, but we could have some clear expectations for you about what you should be hearing from us. I think that that can be delivered. As you said, we would want to have a clear plan for adults by July, and we should also have a clear plan for some of these other issues. Dan is being cautious, quite rightly in some ways, because one would not want to disappoint, but you need to have clarity coming out of this session.

[246] **Mark Drakeford:** Thank you very much for that—that is a useful place to end for today. Thank you both very much indeed for being with us this afternoon and for helping us to complete this part of our inquiry.

[247] **Dr Rogers:** Perhaps I could have further detail about the question that Kirsty asked.

[248] **Kirsty Williams:** It was a philosophical one, because it is not something that the Government is convinced of at the moment. I am just looking at alternative ways in which we could deliver a service, so it is a rather philosophical question.

[249] **Mark Drakeford:** We had a good run at that question in our very first session this morning, so there will be a transcript for people to see.

[250] **Dr Rogers:** I will look at the transcript and give that question some thought, and we may be able to feed back a little more. Mr Chairman, thank you very much for inviting us today. Assembly Members play an important part in representing constituents and letting us know when things are not working, which is an important part of the system, and I mean that genuinely. I really value hearing—I have been in correspondence with a lot of you—when things go badly and also when things go well. That dialogue is important to us too.

[251] **Mark Drakeford:** Thank you very much indeed. Diolch yn fawr.

[252] Rydym wedi cyrraedd diwedd ein sesiwn gyhoeddus am heddiw. We have to come to the end of our public session for today.

2.58 p.m.

**Cynnig o dan Reol Sefydlog Rhif 17.42(vi) i Benderfynu Gwahardd y
Cyhoedd o'r Cyfarfod
Motion under Standing Order No. 17.42(vi) to Resolve to Exclude the Public
from the Meeting**

[253] **Mark Drakeford:** Cynigiaf fod

Mark Drakeford: I move that

*y pwyllgor yn penderfynu gwahardd y
cyhoedd o weddill y cyfarfod yn unol â Rheol
Sefydlog Rhif 17.42(vi).*

*the committee resolves to exclude the public
from the remainder of the meeting in
accordance with Standing Order No.
17.42(ix).*

[254] Gwelaf fod y pwyllgor yn gytûn.

I see that the committee is in agreement.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 2.58 p.m.
The public part of the meeting ended at 2.58 p.m.*