



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

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

**Dydd Iau, 21 Ionawr 2010
Thursday, 21 January 2010**

Cynnwys
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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

Lorraine Barrett	Llafur Labour
Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservatives
Helen Mary Jones	Plaid Cymru The Party of Wales
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour

Eraill yn bresennol
Others in attendance

Mary Burrows	Prif Weithredwr, Bwrdd Iechyd Prifysgol Betsi Cadwaladr Chief Executive, Betsi Cadwaladr University Local Health Board
Ruth Crowder	Swyddog Polisi, Cymru, Coleg y Therapyddion Galwedigaethol Policy Officer, Wales, College of Occupational Therapists
Philippa Ford	Swyddog Polisi dros Gymru, Cymdeithas Siartredig Ffisiotherapi Policy Officer for Wales, Chartered Society of Physiotherapy
Peggy Frost	Rheolwr Datblygu Ymarfer, Coleg y Therapyddion Galwedigaethol Practice Development Manager, College of Occupational Therapists
Ruth Jones	Rhwydwaith Rheolwyr Ffisiotherapi Pediatrig GIG Cymru Gyfan All-Wales NHS Paediatric Physiotherapy Managers Network
Ellis Peters	Prif Therapydd Galwedigaethol, Ysbyty Aberhonddu Head Occupational Therapist, Brecon Hospital
Sue Rees	Rhwydwaith Rheolwyr Ffisiotherapi GIG Cymru Gyfan All-Wales NHS Physiotherapy Managers Network
Mike Spencer	Prif Reolwr, Cyfleusterau a Gwasanaethau Clinigol Cyffredinol, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro General Manager, Facilities and General Clinical Services, Cardiff and Vale University Local Health Board
Jan Williams	Prif Weithredwr, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Chief Executive, Cardiff and Vale University Local Health Board

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

Marc Wyn Jones	Clerc Clerk
Sarita Marshall	Dirprwy Glerc Deputy Clerk

*Dechreuodd y cyfarfod am 9.14 a.m.
The meeting began at 9.14 a.m.*

Ethol Cadeirydd Dros Dro Election of Temporary Chair

[1] **Mr Wyn Jones:** Good morning. I call for nominations for a temporary Chair in accordance with Standing Order No. 10.19.

[2] **David Lloyd:** Hoffwn enwebu **David Lloyd:** I would like to nominate Andrew R.T. Davies. Andrew R.T. Davies.

[3] **Mr Wyn Jones:** Diolch yn fawr. A **Mr Wyn Jones:** Thank you. Are there any oes unrhyw enwebiadau eraill? Gwelaf nad further nominations? I see that there are none. oes.

[4] I therefore declare that Andrew R.T. Davies has been duly elected as temporary Chair of the committee.

*Penodwyd Andrew R.T. Davies yn Gadeirydd dros dro.
Andrew R.T. Davies was appointed temporary Chair.*

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introduction, Apologies and Substitutions

[5] **Andrew R.T. Davies:** I will touch on a few housekeeping points before we start with the main item of business this morning. Although there is no-one currently in the public gallery, I will still point out that translation facilities are available via the headsets and that if anyone wants to have an explanation of how they work, please make yourself known to the ushers, who will show you how the headsets work. We do not have a fire alarm test scheduled for today, so if the alarm does sound, please follow the instructions of the ushers, who will escort you to the nearest exit. I remind witnesses and Members that the microphones come on automatically when you start to speak, so there is no need to touch the buttons.

[6] I welcome everyone to the meeting, and ask our first witnesses to come to the table.

9.15 a.m.

Ymchwiliad i Wasanaethau Cadeiriau Olwyn: Tystiolaeth gan Ffisiotherapyddion Inquiry into Wheelchair Services: Evidence from Physiotherapists

[7] **Andrew R.T. Davies:** Thank you for coming. I extend the apologies of the usual Chairman, Darren Miller, who is unable to be here. We also have two other apologies from members of the committee—Ann Jones and Irene James. I invite Members to declare any interests before we move into evidence-gathering. I see that no-one has any declarations to make.

[8] I extend a warm welcome to the three witnesses: Phillipa Ford, a chartered surveyor of physiotherapy, Ruth Jones of Aneurin Bevan Local Health Board, and Sue Rees of Cardiff and Vale University Local Health Board. Thank you for coming, and for providing the written evidence that Members have had the pleasure of reading over the last couple of days. I will not ask for introductory remarks; we will move straight into questions because of the limited

time available. I am sure that you are familiar with procedures here, but if you are unsure of anything, please do not hesitate to ask.

[9] I will kick off the questions. I would be grateful for your views on the operation of wheelchair services across Wales at the moment.

[10] **Ms Ford:** We are very pleased to come to give evidence today. We are from the Chartered Society of Physiotherapy, and not chartered surveyors, but thank you. Ruth will start on answering this question.

[11] **Ms Jones:** I will just make sure that the microphone is on. My name is Ruth Jones, and I am a physiotherapy manager for children's services at the Aneurin Bevan Local Health Board, but I am here to represent the all-Wales physiotherapy managers network. We have access to information across Wales, and we would like a clearer structure for the organisation of wheelchair services—clearer to us as physiotherapists and for the families that we work with. People working within the service understand the structures, but for people trying to access the service, it is a little difficult to understand where a patient referral is in the system. We do not necessarily always know that, and, if we do not know, then we cannot pass information on to families. So, a clearer structure for us, and for the families we work with, would be useful.

[12] **Andrew R.T. Davies:** There is no need to touch the microphones—sorry, I thought that I had said that. They come on automatically.

[13] **Ms Rees:** I will just mention for the record that I am here on behalf of the Chartered Society of Physiotherapy in my professional capacity as representing physiotherapy managers of adult services across Wales, and not in my capacity as someone who works for a local health board.

[14] Following on from Ruth's comments, one reason for the lack of clarity for service users and therapists is the fact that it is a two-part service. The first part concerns the management of non-complex cases where there is not so much of a clinical need from an assessment perspective and it is more about a procurement process in service delivery. However, there might be an urgent need, because you might have a patient with multiple sclerosis who deteriorates suddenly and needs immediate wheelchair access, but generally it is more of a procurement-type process. The second part is far more complex, and is where you are dealing with individuals with complex clinical needs requiring a clinical assessment that may or may not involve rehabilitation engineering and the involvement of occupational therapists and specialist local therapists. People are unclear about what is involved in that, and become confused, so clarification would be helpful. Another element that is not, I think, currently part of the Artificial Limb and Appliance Service, but is certainly a need for service users in Wales, is access to short-term loans for individuals who attend accident and emergency units, for example, in order to facilitate discharge from hospitals, and others who need short-term, immediate loans. That is currently unclear and depends on immediate local services, the third sector, and a number of different parties. There is no clear process, and people muddle through as best they can. That has a broad impact, and it also affects those who are waiting for wheelchairs. If that were resolved, it might reduce the pressures and the impact of any delay between the assessment and the receipt of a wheelchair—or might reduce the impact on the standard process.

9.20 a.m.

[15] **Ms Ford:** It is complicated—for the patients, their families, and the therapists. The key message from us is that there are many different elements within the whole service. There are other aspects in respect of repair and maintenance. There are many elements within the

entire wheelchair service, so no wonder it is complicated. That is our view.

[16] **Peter Black:** The picture that has been painted for us is of a very centralised service, which has many delays built into it. Do you consider that physiotherapists are sufficiently involved in the process of providing wheelchairs? If not, what are the barriers to your involvement?

[17] **Ms Jones:** In respect of children, we have paediatric physiotherapists who have undertaken training at both ALAS centres. The picture is not clear across Wales. Staff have undertaken training to level 1 or 2. It is about accessing prescriber rights, so that the local therapists, who know the children and their family situations well, are in a position to assist ALAS with the prescription of wheelchairs. Local therapists are more than willing to get involved in that. We would like to see a clearer way of accessing the training and to see the accreditation process being completely clear and transparent. Local therapists are more than happy to play their part, because, at the end of the day, it is their patients who benefit.

[18] **Peter Black:** Is not enough use being made of you as local therapists to facilitate the service?

[19] **Ms Jones:** Many therapists get involved directly; they go to ALAS centres with the patient because they are keen that the right chair should be prescribed. Communication is sometimes an issue in that you may not always know exactly when the patient is being seen, or—and this is a classic example—the patient turns up and is seen early, and, when the therapist arrives at the right time, the patient has already been seen. That is very frustrating. Communication is an issue sometimes, and we are sure that we could work with ALAS to ensure that communication is clearer.

[20] **Ms Rees:** Those comments also apply to adult services, but there is also perhaps an opportunity to look at more shared care models. There are local prescribing therapists who, as Ruth has said, will attend with their patients, but we need to share expertise. A local specialist therapist probably has a better knowledge of the individual, and outreach therapists can work with the therapist who has the specialist knowledge—which may be neurological, say—and can share their expertise. Those with knowledge of the individual, those with knowledge of the clinical condition and experts in seating would therefore be working together, which would help to develop the local individual's understanding of seating. That is what we would propose. It does happen, but it is a model that could be optimised. There might be resource implications to that, but it would allow better access and better holistic care across Wales for the individuals.

[21] There are concerns that, if you load someone into an ambulance and rattle them all the way down to Cardiff, they may have tonal issues, and their problems with posture and tone will increase if they are not seated in an optimum position. So, there are distinct advantages to providing seating services to people locally. It is a very specialist service, and the fact that a hub is in a particular area is not necessarily a negative point, because we need experts, and sometimes that is about getting a core of skills. However, it is about how those two work together. We feel that there are some good models of shared care and of utilising and optimising skills. That could perhaps be a direction of travel that is expanded further, but that might well have resource implications.

[22] **Peter Black:** Suggestions have been put to us about the way in which wheelchair services in Wales are structured. We have two main centres, one in the north and one in the south, and the travel time to the assessment can be quite long. People have said that they do not tend to use their time effectively, which adds to the delays. Do you think that any improvements could be made to the way in which wheelchair services are organised in Wales?

[23] **Ms Rees:** We have mentioned the shared care model; there are also opportunities in education and using expertise in the local health boards. Ruth has described the three-tier method of training. If we develop local expertise in the health boards we would be able to provide mentoring and supervision, and perhaps that would clarify issues. There is also, as we described earlier, a slight tension between non-complex cases and those that require greater clinical expertise. Teasing out that issue would, perhaps, allow a greater focus to meet the clinical needs of individuals. There are many training opportunities that can be delivered in a locality or with groups of patients. We have regional experts in multiple sclerosis, for example, and if we were to group those patients we could make better use of the therapists. We could also ensure that clinics were tailored to individual needs. I am sure that that exists to some degree, but it could be a model that we look to replicate for different conditions.

[24] **Ms Ford:** On balance, we feel that it should be an all-Wales service, but there is great opportunity to use the LHBs better and, as Sue said, perhaps have key groups of therapists who are trained to a higher level, who could provide that mentoring and support at a local level. We want equality of service for all, no matter where you live in Wales. You therefore need to have an all-Wales service, and using the hubs and spokes effectively would provide that. Then you will not have differences around Wales.

[25] **Ms Jones:** The rehabilitation engineering arm of ALAS, which all therapists are complimentary about, is an excellent service. It is an outreach service; its staff will go to a special school and will spend all day there. It is an excellent model. All therapists are happy with that system and how it works at the moment.

[26] **Val Lloyd:** When you say that the staff spend all day at a special school, would they be seeing one patient or more than one?

[27] **Ms Jones:** More than one. The idea is that we group the children that need to be seen that day. They may see four, possibly even five.

[28] **Val Lloyd:** It is good to hear that, because we have not heard that in evidence before. I will now ask about waiting times and meeting individual needs. In your written evidence, you refer to problems with waiting times, both for the assessment and the provision of wheelchairs, and that there are several component waits between referral and receipt. What do you think is the cause of these problems?

[29] **Ms Jones:** We know that Health Commission Wales's recommendation is 12 months for children. Please bear with me; I am focused on children. The 12-month wait is not at odds, but we are well aware of the national service framework for children, which recommends a six-week wait for assessment and then eight weeks for provision. That is quite different to 12 months. We understand that there will be a need to get the component parts for a specialist wheelchair together, but 12 months for a child is too long. A child grows; you would not keep the same pair of shoes on a child for 12 months, so why would you expect a child to wait 12 months for a wheelchair? I appreciate that the standards are there, but we would say, as paediatric therapists, that it is too long.

[30] **Ms Rees:** You asked about the causes of waits. I think that one of the causes is that equipment is ordered from all over the world, particularly for complex cases. Therefore, the lead time—the wait for a specific part of the wheelchair—might be excessively long. The wait is for the receipt of the wheelchair as a whole. That issue may or may not be resolvable. One of the issues that individuals face is what happens in the interim. As Ruth highlighted, children grow, and adults with complex and deteriorating conditions will also change. By the time that they have received the equipment they might have clinically changed and it might no longer be suitable. What we have discussed is the issue of whether there is an interim

solution. Are we able to provide an individual with a best-fit piece of equipment if that particular component is not available? Then we are meeting an individual's needs as best we can until we can complete the prescription.

9.30 a.m.

[31] We know of some trial work that is going on with ALAS. A pilot piece of work is under way at Rookwood Hospital, looking at modular chairs so that they can be built up piece by piece. The two key issues with waiting times is the length of those times and the impact that they have on the individual. We need to consider whether there is a way of addressing those issues so that the time an individual waits is not as significant for their clinical deterioration.

[32] **Ms Ford:** When people want a wheelchair, their order is placed, and it is the time until they get it that is important. There is a lot of information that people need to know about all the different aspects of that wait. Part of the issue is with communication: it is about being quite clear with people where and why they are waiting.

[33] **Val Lloyd:** We have heard in previous evidence that there is a geographical variation in waiting times. Can you explain the reason for that to us?

[34] **Ms Jones:** We are certainly aware that there is a difference between north and south Wales in children's services, and the geography of Wales obviously plays a part. For example, Ceredigion is split between services in the north and south and neither part receives a truly local service. People in Ceredigion have to travel either to Wrexham or Haverfordwest. That is an issue for rural areas.

[35] **Ms Rees:** We also have slight concerns about the competition to meet targets. We have an ongoing tension between waiting time targets and meeting the standards set versus clinical priority. People who are not urgent cases become so and supersede the urgent cases in the interests of meeting waiting time targets, so there are competing interests that make service delivery models difficult.

[36] **Val Lloyd:** Thank you, as you have just answered my next question about the priority given to waiting times over need. Would you say that wheelchair services in Wales are meeting the needs of each individual, including those who have complex needs and who require powered or specialist wheelchairs?

[37] **Ms Jones:** We understand that ALAS works according to health need, but these children, patients or clients do not necessarily have only health needs; they also have social, educational, cultural and lifestyle needs. Although ALAS is fulfilling their health needs, we believe that those parameters may be too narrow. We should enable somebody to access all aspects of their life fully, such as the right of children to go out to play, socialise, go to school, and all the other things that they need to do. If they cannot do so in a suitable wheelchair, they are being limited, and that is not fair.

[38] We can see where ALAS is coming from and we understand its parameters, but, for us, the children whom we see should not be limited by anything. I am sure that you will have seen examples from other organisations, but a child who needs to go to school can be fully independent with the right chair. However, they also need to be able to use that chair at home. It is no good for them to be independent at school only, and not at home, because that is not appropriate.

[39] **Ms Rees:** There is a range of equipment available in Wales that would be the envy of our colleagues in England. However, one of the challenges that Ruth has identified is whether

we are meeting all the needs of an individual. We are meeting people's health needs, but we are sometimes seeing a duplication of the equipment. So, some equipment will be for work or for school, or for different purposes. Perhaps an individual has raised massive amounts for charity and there is no guidance on the type of equipment needed, so they spend £20,000 on a piece of equipment that does not meet their needs.

[40] We need to establish a link between need and appropriate equipment, and look at the opportunities to pool existing budgets. In that way, overall expenditure on all the different elements would be reduced, but we would be meeting the individual's needs by providing a piece of equipment that can be used in a number of settings. That would be better than spending a vast amount of money on three different pieces of equipment funded through three completely different sources.

[41] I have mentioned the opportunity to top up. Individuals are quite often keen on getting professional advice and then going for a higher range of equipment. They appreciate that this equipment is not available to them through the NHS, but they are willing to make up the additional cost, either personal, through charity or individual donation, or by using allowances or income from another source. It might allow them to top up their funds and receive a more complete piece of equipment that meets their needs.

[42] **Val Lloyd:** This is my final question. In your evidence, you said that waiting for a wheelchair is only part of the picture and there are additional waits for adaptation, maintenance, replacement, and review. What is causing those delays and how could improvements be made?

[43] **Ms Jones:** For repairs and maintenance, we are well aware that the situation at the moment is not what we would hope for. We understand that the approved repairers and maintainers often do routine clinics, which are excellent, and people have no problems at all. The difficulty is in being exact and specific. If an emergency crops up and the brakes fail on a chair, you cannot wait weeks for that to be repaired. This is what happens at times. The local approved repairers come in to hold a clinic and people will ask them, 'While you are here, could you look at so-and-so's chair?', but they cannot, because that is not part of the plan. You would not drive a car if the brakes were dodgy; you would want them fixed straight away. The same is true for that child, patient, or client who needs their wheelchair repaired. It is just as essential that repairs are carried out quickly and efficiently.

[44] **Ms Ford:** It is obviously a worry if your wheelchair has to be taken away to be repaired. There is no option for a replacement of some sort while you are waiting for your chair to come back.

[45] **Val Lloyd:** Could you suggest any way to improve it?

[46] **Ms Jones:** It comes back to communication. Local therapists are quite diligent with regard to getting on the phone. Sometimes, it is difficult for them, because the names and numbers of approved repairers change. Online facilities, as well as e-mail and the telephone, are always useful. Everyone will try everything. They are more than happy to do that, and it is just a question for what is best for ALAS as well. We want to work with it to make the service better.

[47] **Ms Ford:** It is also to do with looking at the performance management system for all wheelchair services. I am sure that we will come back to this. If that part needs to be looked at, to set some standards and protocols on when things have to happen, that would be a way of making it improve. It is difficult to try to come up with solutions. We have said in our evidence that there are so many different stakeholders in relation to wheelchair services, that the people who might be doing the repair and delivering the wheelchairs are different from

the people who families and children have been working with in ALAS. So, there are different stakeholders, which causes problems. Named contacts and providing specific ways of getting in touch with people, getting them to come to sort out your problem as quickly as possible, might help.

[48] **Andrew R.T. Davies:** I do not want to cut anyone off, but we are working to a specific time, and this session is due to end at 9.55 a.m.. Knowing some of the questions that have yet to be asked, I am aware that you will be able to enlarge on some of these points in future questions. I call Helen Mary Jones to ask her question.

[49] **Helen Mary Jones:** I want to talk a bit more about the referral system, which we have just touched on. In your written evidence, you mention the need for improved access to training for therapists to become approved referrers to ALAS. You also talk about the possibility of developing an online referral system, which Ruth has just mentioned. Could you tell us a bit more about the problems with becoming an approved referrer and explain what benefits you think might come from an online referral system?

[50] **Ms Rees:** The problem with approved referrers is the training provision. At the moment, training has gone to level 1 and 2, but the training at level 3, which is more advanced, has been limited. I am not sure of the current state of play. Is there still training being delivered?

[51] **Ms Jones:** Not that we are aware of.

[52] **Ms Rees:** However, there has been training previously. Anyway, there is a limited number of people at that more advanced level. If we best use people's clinical input and clinical experience to inform the referrer, that reduces the demand on the ALAS therapists, which ensures that we are making the best use of them. We also felt that, although there are data protection challenges, the aspiration of using an online referral system might also enable some form of online training. Many organisations receive their mandatory training online. We could look at meeting individuals' needs to a level through that. It is about cascading it, and making it local and accessible.

[53] **Helen Mary Jones:** What is the problem with the training? Is there not a sufficient budget, or is it difficult for people to get released to do it? It seems extraordinary that you train people to level 2 and then you do not train them to the next level.

9.40 a.m.

[54] **Ms Rees:** There are resource issues, but I am not clear why—

[55] **Mr Jones:** Certainly, therapists are keen to get training. They are doing level 1 and are asking to do level 2 and then level 3. It may be that there are limited numbers of trainers in ALAS, but that is for the therapists at local level. As a therapist, you need to have this personal identification number for accreditation. You can feel confident to prescribe because you know what the situation is.

[56] On building links with ALAS at a local level, when the trainers come out to us, it is nice to put a face to the system, and you then know of someone to whom you can refer at a later date. As Sue said, building up the training is important.

[57] **Ms Rees:** You would also be offered a consistent level of expertise throughout Wales, which is what we want. We want individuals' needs to be met irrespective of where they are living, and that would enable that to happen.

[58] **Ms Ford:** The online system would allow people to come through a system and to make choices. So, if you choose something, you cannot have those options. It would be helpful to be able to send someone down a route so that the form that is submitted is completely correct and meets all the specifications that ALAS looks for. Such a system could be useful, although I understand that data protection would be an issue.

[59] **David Lloyd:** You touched on this earlier, but what targets and standards would you like to see applied to wheelchair services in Wales?

[60] **Ms Rees:** There is a need for expediency and we all understand the need for some measure of weighting in the process. However, that should be based on clinical risk. We know that our members felt that, if the process were clearer and leaner, it could be redesigned to tackle resource implications. That might involve new resources, but we should look at the clinical risks associated with delays, or even just at the standard process, to ensure that we are addressing that risk throughout that process, from assessment to receipt. Currently, there are gaps in the waiting period.

[61] **Ms Ford:** We felt that this was an area in which the intelligent target process that the Government has been looking at could be useful, because you need to look at the whole of the wheelchair service. There are so many component parts that could all be within that. That could be very useful.

[62] **Helen Mary Jones:** Could I ask a supplementary question to that? To play devil's advocate here, we often hear from clinicians that you do not want numerical targets, but qualitative ones, and you want to be able to assess according to clinical need. However, it seems to me that part of the problem with doing that is working out who decides what the clinical need is. So many people are involved in making the assessment about someone's wheelchair needs, so who ought to decide?

[63] Philippa knows that I am sympathetic to the notion that it should not just be a case of, 'Well, so-and-so has been waiting nearly six months, so they have got to go even if their need is not as great as someone who has been waiting only a month', but where should that decision on clinical need lie in this process? If it is a question of clinical need and not time, the buck has to stop with one of the clinicians involved. From the evidence that we have received so far, part of the problem with the wheelchair process is that there are so many. Looked at from the service user's point of view, so many clinicians are involved. So, do you have a take on who that ought to be?

[64] **Ms Rees:** I think that that is probably a shared decision because, going back to the clinical risk issue, we need to identify the clinical impact on an individual of not being provided with a wheelchair. When does that get to a critical level? Again, it is about ensuring that we ask the right questions of the right people at the right time. We need the expertise of how that problem can be managed from ALAS, but we need the local patient knowledge and that of the local therapist. It is a decision between those two. I would not specify those at this point, but there are key trigger points for a risk that goes to unacceptable levels and that therefore needs to be managed now.

[65] **Helen Mary Jones:** I have one other brief follow-up question. If we are talking about basing this assessment on clinical need, Ruth mentioned earlier the need to build social need issues into that, too. There are times when someone's clinical need might be great, but, for example, if a young person cannot get to school, that might not lead to a deterioration in their health, but it has an impact on the rest of their life. When you say that you would like the targets to be more about the patient experience and clinical need, do you envisage that including the social impact of someone not having access to, or having to wait longer for, a chair?

[66] **Ms Rees:** That certainly has a weighting, and that is why we suggest intelligent targets because all these have a weighting. I am speaking about health need because that is probably the point that we are at, but that might not be the point that we want to be at. All these need to have a weighting, because they have a significant impact.

[67] **Helen Mary Jones:** Thank you, that is really helpful.

[68] **Ms Jones:** With children and young people, it helps if they know at assessment what they are being assessed for and that they may perhaps wait longer because it is a specialist bit of kit or whatever. As long as there is communication, people understand what they are waiting for and, while they may not be content, they understand why there is a wait.

[69] **Lorraine Barrett:** I would like you to clear up something that I picked up in your paper regarding re-referral. You say that:

[70] 'If there is no contact for 3 months then re-referral is deemed a new referral'.

[71] Why might that lack of contact arise? Whose fault would that be? Where would you be waiting for the contact to come from?

[72] **Ms Jones:** If a patient receives a wheelchair, and it is fine, it fits and everything is hunky-dory for the first few months, there may well be no contact with ALAS for three months because there is no need—the child or patient is using the chair and is perfectly happy with it. If something goes wrong after, say, six months, or the chair needs to be adapted or something is broken and a new chair is needed, you cannot immediately go back and say, 'This is someone who is known to the service'; it must be treated as a new referral. So, we have to do the whole process again, which is frustrating for therapists, who have to fill in a new referral form.

[73] **Lorraine Barrett:** We could take that up as an instance of bureaucracy gone mad.

[74] **Ms Rees:** There is a process for those cases to remain open, and so I think that it is a communication issue. If the referrer knows that he or she needs to make contact within three months if there is any doubt, the process would then kick in, with the case remaining open. It is due to a lack of understanding of process that the case is closed, and contact perhaps made after four months, which is beyond the threshold. We have mentioned that situation in our evidence, because that is what happened, but the issue is that lack of clarity. That is the important issue.

[75] **Lorraine Barrett:** Okay, thank you. Can you say something about the voucher system that operates in England, and the possibility of top-up funding so that wheelchair users can get the chair that they really want, and top up the funding themselves? Would that work in Wales?

[76] **Ms Rees:** From what colleagues in England have said, they have smaller units with their DLCs and operate a voucher system. I confess that I am not fully au fait with that system. It allows an individual to select a wheelchair based on—

[77] **Andrew R.T. Davies:** Sorry, but did you say 'au fait' or 'in favour'?

[78] **Ms Rees:** 'Au fait'. When I speak to my colleagues in England, they are in admiration of the range of equipment available to Welsh users. Perhaps there should be combination of the two elements, that is, allowing individuals through whatever means to access appropriate equipment—there are a number of individuals with highly complex needs,

perhaps as a result of a traumatic event, who might have compensation packages and a huge range of additional income—but also, in order to look after the health of the population of Wales, ensuring that people access the right equipment. Where people have other avenues of funding, we perhaps need to look at that. However, the top-up vouchers involve individuals purchasing a wheelchair, and I feel that the Welsh model is a better one.

[79] **Ms Ford:** A top-up could be made through a private contribution or from charity—there is a different range of top-ups. There are issues once you look into that, because if the chair was not agreed as the chair of choice by ALAS, there would not be a responsibility on ALAS to maintain and review that chair. We have given some examples of that in our evidence, I think.

[80] **Andrew R.T. Davies:** Helen Mary has a supplementary question.

[81] **Helen Mary Jones:** I have a question on top-ups, because I have been talking to people about the voucher system in England. If we go down that route, is there not a risk that it will reduce the range of services that is provided in the basic service? Is there not also a risk of inequity? It is always easier to raise money for a sweet-looking child than it is for a perhaps less appealing-looking teenager, if you see what I mean. I am not saying that I am necessarily against it, but is there not a risk that you will end up with an inequitable system, because some people, either because of private wealth or compensation, or because they belong to an appealing category of people, will be able to get a Rolls-Royce service? Instead of providing the Vauxhall Vectra service that we do at the moment, is there not a danger that we will drive that down to a basic old Ford Transit van service? That was a ridiculous metaphor. Can we strike that from the record, please?

9.50 a.m.

[82] However, you know what I mean: at the moment, there is a fairly decent service, available to everyone, which provides a range of equipment. If you go down the top-up route, will that mean that some people will get the good stuff, but that the standard of what is available to people receiving basic services is driven down?

[83] **Ms Rees:** The top-up might be that we signpost people to a different route. People are currently providing equipment from personal funds that might be inappropriate, which might have a health impact, because we might have to manage the results of them being inappropriately seated, in the healthcare system. The suggestion is, therefore, perhaps about signposting as opposed to using resources, so that we can guide the clinical management of individuals, as opposed to using public spend inequitably.

[84] **Helen Mary Jones:** That is helpful.

[85] **Ms Ford:** There is also the issue of joint funding and looking at partnerships with education and health coming together, for example, to look at the wheelchair, what the person wants to use it for in school, for example, and whether there is any funding that can link with whatever is being provided clinically from a health perspective. There could be a useful coming together of funding.

[86] **Lorraine Barrett:** I want to ask about the adequacy or otherwise of short-term wheelchair loans, when someone is waiting for a long-term wheelchair. Is that working and could it be improved?

[87] **Ms Rees:** There are some very ad hoc arrangements. Currently, certainly in hospitals, a lot of people are signposted to the British Red Cross or other local organisations, such as Shopmobility services and a range of others. The difficulty with that is that there is no

consistency, which has a significant impact. It has an impact on hospital admissions, on discharging patients from hospitals and on how we meet individuals' needs while they are waiting for equipment. It is done on a very ad hoc basis. There are small stocks in hospitals, which vary in each local health board.

[88] **Ms Ford:** We would like to see all the LHBs look at that issue across their patch. It is not ALAS's responsibility, but in the whole scheme of wheelchair services, it needs to be looked at. If every LHB were to look at which hospital wheelchairs it has and what it is doing with short-term loans, its community equipment stores and its relationships with partners such as the British Red Cross, that would be useful as part of the whole solution.

[89] **Andrew R.T. Davies:** Helen Mary has a supplementary question.

[90] **Helen Mary Jones:** Philippa, you mentioned working with the voluntary sector, and I know that, in Carmarthenshire, health and social services have developed a joint equipment store. To address some of the short-term issues, would there also be a benefit from more consistent joint working between health and social services? I have an idea that we probably have unused chairs in a social services store and a shortage in the health sector or vice versa in some parts of Wales.

[91] **Ms Jones:** That happens in other parts of Wales. Gwent has an integrated community equipment store. It can work well, but it needs to be slick and transparent. People need to know what stock is available and get it out quickly, because the whole idea of a short-term loan is that you need it within 24 hours.

[92] **Ms Rees:** It is key that most health boards have some form of joint equipment store, whatever its name is, in that locality. It is about having immediate access. Although the British Red Cross, for example, is quite responsive in that it has a three-day response, if you had multiple sclerosis, you could suddenly not be able to stand on your feet, which would require admission, but the management of your condition might require a wheelchair immediately for two or three days, and we are not able to meet those sorts of needs, so it would be beneficial.

[93] **Andrew R.T. Davies:** Are Members happy with that, and that they have asked the questions that they wanted to ask? I see that that is the case. Thank you, once again, for coming in this morning and for both your written and oral evidence. You will be sent a draft copy of the Record of Proceedings, and you can liaise with the clerk if you have any issues with the record. Thank you again for an informative session and I hope that our report will be of benefit.

9.54 a.m.

**Ymchwiliad i Wasanaethau Cadeiriau Olwyn—Tystiolaeth gan Therapyddion
Galwedigaethol
Inquiry into Wheelchair Services—Evidence from Occupational Therapists**

[94] **Andrew R.T. Davies:** Good morning and welcome to the Health, Wellbeing and Local Government Committee. Thank you very much for attending this morning. I welcome Ruth Crowder, Peggy Frost and Ellis Peters to the table. They are here on behalf of the College of Occupational Therapists. I believe that Ellis Peters is from Brecon hospital. Thank you for the written evidence that you have supplied to the committee. Members have had an opportunity to read it over the last few days. We are grateful to you for coming to give oral evidence to our inquiry of wheelchair services. Members have a series of questions for you. We do not propose to have any preamble but will move straight to the questions, as we have a

limited timeframe in which to ask them. I will ask the first question. How do you perceive wheelchair services to be configured in Wales at present, and what role does your organisation play in facilitating those services?

[95] **Ms Crowder:** We are the professional body and we represent around 1,500 members in Wales. We thank you for the opportunity to give oral evidence today. We have members working in all services—health, social care, wheelchair and prosthetic services—so we have members working within ALAS as well as in the local health boards and in social services. Ellis is a paediatric head occupational therapist in Brecon, and Peggy is practice development manager and a UK officer for the College of Occupational Therapists. As an organisation per se we do not have a direct role, but we have a direct engagement in supporting our members. Perhaps it would be better if I asked Ellis to talk about the organisation and experience of wheelchair services.

[96] **Mr Peters:** I work in Powys, but I am also here representing the all-Wales network. In Powys, we are in a somewhat unusual situation in that we have a service in the south of the county provided from Cardiff, and another in the north provided from Wrexham. That highlights the differences in the levels of service and in the waiting lists, as regards the wait for assessment and the wait for the provision of equipment. The frequency of clinics and how they are provided vary significantly between the two areas.

[97] **Andrew R.T. Davies:** Would you like to add anything, Peggy?

[98] **Ms Frost:** I do not have anything to add at present.

[99] **Andrew R.T. Davies:** That is fine. We will move to the next question, which is from Lorraine.

[100] **Lorraine Barrett:** Do you consider that occupational therapists are sufficiently involved in the process of providing wheelchairs in Wales?

[101] **Ms Frost:** Generally, or specifically?

[102] **Lorraine Barrett:** In whatever capacity. Is there anything in which you feel that you should be involved and you are not involved, and how you could improve that?

[103] **Ms Crowder:** In our written evidence to you, we have identified the feedback that we have had from members. The therapists in local health boards and local authorities are very clear that they do not feel sufficiently engaged. One comment has been that it is very difficult to find out the process following an assessment and the assessment decisions. Once the assessment has been done by an ALAS staff member, or once the referral has gone in, there is very little communication. I think that Ellis was saying that they do not tend to leave any notes or any decision or action plans with the service user; therefore it is very difficult for anyone to know what the process is, what will happen, and how long it will take for any kind of provision to arrive. People feel that there should be much more communication with the service users and carers and with the local services to make this a much more integrated service so that any decisions about provision are integrated into the whole package of care.

[104] **Lorraine Barrett:** Perhaps you could expand on that a little. In evidence that we have had previously from physiotherapists we heard that, sometimes, they could be on the telephone for hours and communication seemed to be an issue. If you want to get an update, is it difficult for you to get hold of the right person? We heard from the physiotherapists that sometimes people change at the ALAS end, which causes problems. I just have this picture of all of you ringing each other trying to get hold of someone and it all seems to disappear into a hole.

[105] **Ms Frost:** Members have told us that it is difficult to communicate and that there seemed to be gaps in the communication process from, as we said, assessment to the provision. So, there are some big holes. They have had difficulties. Whether that is around the services, I do not know; I do not have direct involvement.

10.00 a.m.

[106] **Mr Peters:** In the past few months, things seem to be changing and it is easier. Wrexham is looking at ways of e-mailing more, and of only giving out the wheelchair service's reference number for the child to keep it confidential. In the south, it is done through telephone calls and leaving messages and waiting for people to get back to us; trying to get hold of the right individual can take some time.

[107] **Andrew R.T. Davies:** When you say 'the last few months', what time frame are you talking about? Have these improvements happened very recently or some six to eight months ago?

[108] **Mr Peters:** In Wrexham, I believe that there is a physiotherapist who has been looking at a project to improve communication. I think that she started the work last summer, although I do not know exactly when she started.

[109] **Andrew R.T. Davies:** We would just like to have a time frame because our inquiry is ongoing.

[110] **Mr Peters:** Some things seem to have moved more in the past three or four months.

[111] **Lorraine Barrett:** Can I ask for clarification on this because I want to get a picture of someone who has certain needs? Would you be working with the physiotherapist with the same person, and would you have a system so that the occupational therapist and the physiotherapist are working together, but only one of you has that contact with ALAS?

[112] **Ms Crowder:** I see what you are asking. Yes, we would be working as part of a multidisciplinary team, and within the team, in a locality, we would be working closely together. So, Ellis would be working closely with his physiotherapy counterpart. It then depends on the needs of the child with regard to who takes the lead in contacting and supporting ALAS. I hope that we would not be harassing them independently and separately. The feeling that comes from practitioners in the local services is that it is quite difficult to get hold of ALAS staff. However, it does not have a large number of staff and they have a large caseload and must move around a large geographical area. So, if staff are out doing clinics, they are not there to answer the phone. That is why we have said that we need to see a clear service specification, which is about the scope and parameters for the whole service. A proper option appraisal can then take place and we can look at a proper workforce review. So, whatever it is that is needed, for instance if they need administrative staff or systems, support staff or more assessors, it can be done holistically and thoroughly, so that we can overhaul the whole service and deliver something that is making a difference for people in Wales because, at the moment, it feels like fire-fighting all the time.

[113] **Peter Black:** I want to follow on from these issues of communication. Do you have any practical examples of how we can further improve the communication within the service?

[114] **Ms Crowder:** Ellis, do you want to talk about the forms that you introduced?

[115] **Mr Peters:** The wheelchair service, to my knowledge, has never given out any written report to parents following its assessments. We have found that a huge challenge

because we were not getting written reports either; nothing is provided in writing. So, we devised a simple form that we fill in during a clinic that we are present at, to say who was present, the issues the parents identified that they wanted brought up and what the ALAS staff member was proposing. I then photocopy the form there and then and give a copy to the parents and to the wheelchair service's OT, and we would keep a copy in our file. They were happy for us to do that, because no other written record is circulated to either the family or other professionals. ALAS was keeping records for itself, but we were not party to those. So, that is the only written communication that we currently have.

[116] **Andrew R.T. Davies:** Has that always been the case?

[117] **Mr Peters:** I have never known it to be otherwise.

[118] **Peter Black:** So, you have a multidisciplinary team and you have ALAS, but you do not really talk to each other properly about how patients' needs are assessed.

[119] **Ms Crowder:** We recognise that it is not always easy to do joint assessments because marrying up busy staff diaries and a family's diary can be difficult. We need to see a much more integrated approach. If the provision of a wheelchair or any specialist equipment is to make a difference to someone's occupational ability and to enable them to live their lives fully then it must be integrated as part of the whole package of care. There has to be a conversation with the education service if it is a child, or with work or other services to ensure that the solution meets their needs wholly.

[120] If you cannot be there at the time of the assessment then that is a shame, but sometimes realities and resources get in the way. Joint assessments would be wonderful, and joint, or at least shared access to records. Some communication afterwards would be a good start. We also need a clear specification of the service, and I do not think that people are clear about eligibility criteria. When they apply for support there are rules that children of a certain age must have a buggy rather than a wheelchair, and so on. Some of the parameters of the service could be made more overt so that people are clear about that. We could also improve communication around review times because it has been reported to us that occupational therapists will send information about a recent assessment—because we do case reviews in the community as well—but because there is no review process, that triggers a brand new referral, and by the time you get to assess that child, the assessment information from the local OT can be out of date. Timeliness is a factor in effective communication. As I have already said, we could also improve communication of what is happening once the decision has been made. We are aware that clients feel there is a long gap between the assessment and provision, and we recognise that our members within ALAS are having to make difficult judgments about whether something is working, and if it is not, they have to try something else. If you do not communicate the complexity of the work that is going on in the background, then the service user feels that you are not doing anything. With a washing machine repair, you are told that the engineer will be with you in two hours, but with a wheelchair repair you do not know what is happening to it. Perhaps the first idea that was tried did not work, so they go back to square one, and it will take a few weeks. Communication of what is happening is important, and keeping people informed of the development—

[121] **Ms Frost:** On communication, the other issue is transparency around those parameters—the eligibility criteria, and all that information.

[122] **Andrew R.T. Davies:** We will touch on that later. We will be coming on to the question of meeting individual needs.

[123] **Peter Black:** Has ALAS given any reason why it is not communicating? Is it because

of confidentiality, or are there data protection issues, or does ALAS just not get around to it?

[124] **Ms Crowder:** You need to ask ALAS.

[125] **Peter Black:** We will, I am sure, but I wondered whether you had asked that.

[126] **Mr Peters:** I have asked the question, because we have met with ALAS managers a number of times because of our concerns in Powys, and I was told that it was a resources issue.

[127] **Peter Black:** Is it worse in Wrexham or Cardiff, or is it equal?

[128] **Mr Peters:** It is the same.

[129] **Helen Mary Jones:** You have mentioned a few times the need for a clear service specification, and that comes up in your written evidence as well. Could you tell us a bit more about what you think the service specification should include, and what it should address? You have been fairly clear about the benefits of that, but if there is anything more that you want to add, please do.

[130] **Ms Crowder:** If you look at the commissioning policy, the statement—I am struggling to find it among my papers; here it is—says that the service:

[131] ‘is designed to support an individual in order to maximise their social and occupational roles’.

[132] That is excellent, and we would applaud it—that has to be the purpose of providing equipment or any service. However, the statement goes on to say that:

[133] ‘ALAS is resourced to provide essential equipment whilst striving to meet lifestyle needs’.

[134] We find that that places staff in a difficult situation because if there is not enough resource, they are left to decide whether to ration the number of people that they see, and concentrate on fully meeting the needs of a few, or making a judgment that they can only meet a certain type of need, or provide a certain type of service. So, the first thing is that we need a clear statement about the purpose of the service, and what it is to achieve. Is it intended to enable occupation, to enable people to live independent lives, and to meet all the needs of service users as a quality service that improves their health and allows them to participate in and contribute to society, or does the service just put the client in the right seating position? I am being wildly unfair in saying that, but that decision needs to be made at a commissioning level and not at the level of the individual staff member, who is trying to juggle a heavy caseload.

10.10 a.m.

[135] It needs to state the criteria for commissioning, set transparent parameters for the service, and say whether there will be eligibility criteria and limits on service specifications, as well as what will be provided. It also needs to identify whether there is a policy on top-up, shared and pooled funding. We think that pooled funding should be borne in mind in respect of provision for education. Why would a child have separate provision for school, or an adult have separate provision from Access to Work? Why can we not fund those two things and provide a single all-singing, all-dancing piece of equipment that meets all their lifestyle needs? That might be unrealistic in certain situations, but is the service prepared to look at that?

[136] We believe that any priorities and related parameters should be clear, whether they are in respect of times, urgent need, or anything else. Any service specification by a commissioner needs to identify the workforce and equipment resources that will be provided. That needs to be reviewed wholly. There also needs to be something about integration with the overall service.

[137] **Ms Frost:** I would also mention something such as having a performance monitoring framework that focuses on outcomes for service users and their carers, as it would be something that can be measured against.

[138] **Helen Mary Jones:** Thank you; that is really helpful.

[139] You also recommend in the written evidence that a single, all-Wales service should be established. Ellis has already talked about dealing with two different services that operate in different ways, which must be confusing. Why do you think that that would be a good thing? Do you have any thoughts—although perhaps this question is not for you—about how that service should be structured and managed?

[140] **Ms Frost:** One issue is the postcode lottery, that is when you have people who live two streets apart getting different levels of service, and some people getting provision when other people do not. So, an all-Wales service would be able to offer more parity, and performance could be measured against a national framework. The lack of parity with regard to the service and of equitable access to services is one of our members' biggest concerns.

[141] **Ms Crowder:** I was going to add this point to my answer to the last question, but it is relevant here as well, namely that it is about having a review and some sort of process for review built into the parameters of the service. Once you have a single commissioning document that specifies what the service is, that starts to indicate how the service should be delivered. At the moment there is only a general statement that has a contradiction in it about meeting essential need. Therefore, the two organisations that are delivering the service are left to interpret that, to create their own priorities and to do their own quality monitoring. They have attempted to do that to the best of their ability, but a single service specification gives direction to those two organisations that host the service in the north and in the south. It also starts to make the issue of how performance management should be delivered more coherent. That is what you were saying, Peggy, namely that it is not necessarily about having a single centre, because the geography of Wales makes it difficult to do that. There is nothing the matter with having two centres, but there needs to be more consistency in the service.

[142] **Andrew R.T. Davies:** It is about the ideology.

[143] **Ms Crowder:** Yes. A single specification that identifies the quality, the priority processes and that puts in clear procedures retains the benefits of all-Wales procurement, of professional leadership and supervision, peer mentoring, continuing professional development and the benefits of the opportunities for keeping the specialist skills of staff. You also have flexibility in respect of managing around Wales, but it is a much more consistent system as there is less freedom to interpret on the part of the two organisations, who have other priorities to look at.

[144] **David Lloyd:** You have touched on this issue as well. How effective are wheelchair services in meeting the needs of individuals, including those with complex needs and those needing powered wheelchairs or wheelchairs with special features. A short one-word answer will do.

[145] **Ms Crowder:** Members with complex needs are telling us that it is not that great.

[146] **Mr Peters:** It varies tremendously. The more complex or unusual the need, the greater the challenge to get that need met.

[147] **David Lloyd:** To move on to other issues that have been touched on, not just today, but in previous committee meetings, namely the waiting times for assessments and the provision of wheelchairs, do you consider that cases are prioritised effectively in the assessment?

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

[149] **David Lloyd:** In that case, what improvements could be made?

[150] **Mr Peters:** Again, my understanding is that prioritising is not being done prior to assessment, so, while the child is on the waiting list, he or she is not being prioritised. Also, we do not know what the criteria are. We have had a child with a developing scoliosis, the consultant has written to chase the referral, the orthopaedic consultant has written to flag up concerns that the child is deteriorating, but the child was still waiting in excess of 15 months.

[151] **Ms Frost:** It is difficult to separate the seating from the wheelchair and mobility provision. The whole thing needs to come together, because a child such as that needs both elements to work together.

[152] **Val Lloyd:** I have a quick question. We have been made aware of delays with regard to reassessment, repairs and improvements to chairs. What contribution could occupational therapists make in reducing those delays?

[153] **Ms Frost:** Sorry, delays with what?

[154] **Val Lloyd:** Assessment. We have heard time and again about delays with regard to reassessments, repairs and improvements to chairs.

[155] **Ms Frost:** With regard to assessment, it may be that we need a review of the criteria for who can do assessments. There are three tiers of people who can do assessments. The first tier, at the moment, is local therapists, but the second and third tiers remain with the ALAS therapists. There might be something around reviewing that to see whether it can contribute to improve matter.

[156] **Mr Peters:** It is predicable that children grow. So, from the moment that they have their new wheelchair delivered, the clock is ticking for when they will need a review. That is particularly true of children with complex needs. We have been told that we cannot put in a request for a review straight away. However, it might take a year to get the review, as the children go back on the waiting list. If we wait a year before we put in the request, or wait until the children need the review, then they have to wait again. We are in an impossible situation. We either have to comply with what ALAS tells us, that we cannot put in a request for a review until a child needs it—but they have to wait such a long time that that takes them beyond the time when they needed the review—or, if we go with what the child needs, we put in a request immediately after the new chair is delivered. We can do that, but we are told that that is unacceptable.

[157] **Val Lloyd:** Thank you, that is very clear.

[158] **Lorraine Barrett:** Could you say something about your views on the wheelchair service and how it meets the needs of Welsh-speaking communities and black and minority ethnic communities, where there may well be different language needs?

[159] **Ms Crowder:** I cannot comment on that. We have not had any specific feedback. The many difficulties for so many service users have overshadowed that. I do not think that there is a better or worse service. We are not hearing positive responses from those with complex needs at any level. I am not aware of any Welsh-speaking therapists within the service, but that is not to say that there are none or that there are no rehabilitation engineers who are Welsh speaking. We have not looked at the workforce make-up and people have not picked that out as an issue, because there have been so many other things to pick out. That is as much as we can say at the moment.

[160] **Lorraine Barrett:** Thinking about the question and about some of the families that I know in my constituency, it is often the case that the mother in the family does not speak English, but the children do. I can imagine an engineer or someone going to the house to assess the child and the possible communication difficulties. However, there may be communication difficulties at your end from the therapists as well; I am not sure. How would you deal with a Somali family that spoke very little English?

10.20 a.m.

[161] **Ms Crowder:** We would use translation services. We would always try, as best practice, to avoid using family members. The local health boards and local authorities have access to translation services. Clearly, timing and funding might get in the way of that, but the service exists. My presumption would be that ALAS would have the same access to that service, but you should check that with it. However, no-one has identified to us a significant difference in the service received by any particular group. We are hearing that if you are standard and need a simple, standard service, you get a good, rapid service. However, as soon as you get someone with a more complex need, that is where the issues are experienced, but they appear to be experienced across the board.

[162] **Peter Black:** Your written evidence refers to the national service framework for children, young people and maternity services, which is currently being reviewed. Do you believe that those protocols and standards are sufficient? Would you like to see further targets or standards introduced for wheelchair services? For example, you refer in your written evidence to the NHS waiting times initiative.

[163] **Ms Frost:** Yes, I think that we would like to see more standards in the performance framework. The move is very much to quality standards and it would be outcomes-focused to meet the needs of the service user. The NSF is being rewritten, but it also has waiting time targets in it, which, I understand, have not been met either.

[164] **Mr Peters:** We had a whole list of targets in the NSF, none of which have been met. That is my understanding. So, unless they are flagged, I do not know how you could ensure compliance with them.

[165] **Peter Black:** So an action plan needs to be attached to this, with resource, do you think?

[166] **Ms Frost:** We need reviews and services reviewed alongside these things so that they perform better ultimately.

[167] **Peter Black:** Any target added to the qualitative outcome target would also need to have the same—

[168] **Ms Frost:** Yes, it would have to have the same; otherwise, we will never see any improvement or change.

[169] **Ms Crowder:** They do not compete with the other priority demands placed on health and social care organisations. You need to ensure that standards are monitored and are effective, measurable standards. We would want to see outcomes measured. That is something that is really not in place. For example, when equipment is provided, if it is not being reviewed and there is no return, how does anyone know whether that equipment is meeting the need? Who is looking at whether the money that is being spent is being spent effectively? We need to see a real focus on outcomes and proper service evaluation as part of the priorities for the service structure. Where NSF standards are not flagged, they are not a priority for local health boards. It is the annual operating framework and other priorities, which have a pressure attached to them, that are met before anything that is not flagged. So, whatever is not flagged as a priority in the NSF is not met.

[170] **Helen Mary Jones:** In your evidence, you talk about choice being an important factor in wheelchair provision. We have already touched on that. You refer to trade-offs and top-ups and joint funding options. I will be honest and say that I am concerned that choice for the few can drive down generic provision for the many, but I am open to being convinced. So, could you talk a bit more about the possible funding options? How would you see that sort of scheme working and what improvements could that lead to, by meeting the individual need that we discussed earlier?

[171] **Ms Frost:** There are a number of different options. One is a type of top-up system, where people are assessed as eligible for basic provision. However, to give them a choice, as happens in England, they are given a voucher that is of an equal value and which they can then take to an accredited supplier. As long as the chair that they buy with that voucher meets the basic needs agreed by the assessment for the provision of that voucher, they can add extra funding to it. So they can change the colour and seating and put some additional features on it. That is one way of giving a service user choice.

[172] There are other ways. Top-up is one option. Another way is through an individual budget—and I am mindful that it is an NHS provision. It is similar to the voucher, but it is an individual budget, so somebody goes away and buys something with it. Another way is to use joint funding with charities more effectively. Charities can buy components and parts, or add value to the cost of the chair so that, again, people have a choice.

[173] With regard to trade-offs, there is not usually one chair that does all things and is an all-singing, all-dancing chair for one person. Think of footwear: people will have a pair of trainers, a pair of dancing shoes, and a pair of work shoes. Similarly, different wheelchairs will have different functions. A sports wheelchair or a basketball chair will not be the same as a marathon chair, and will definitely not be the same chair that I take to work. There are different functions for different chairs, so some sort of trade-off may be needed if we can afford only one chair. The question then is: what is the most important thing for me to do? Is it to go to work, or is it to run the marathon in my wheelchair? That might be where the trade-off happens, and it must involve an informed choice for clients and for their carers—because, sometimes, a carer is involved in pushing a chair—so that they know what the risks and benefits are and what they are losing, and know about the shared risk that goes with that.

[174] **Ms Crowder:** That is why it has to come back to communication. If you are not part of the assessment decision, you will not be in a position as the user to make choices about the trade-offs and which feature is the most important for you.

[175] A key point that I would like to raise is that a wheelchair is part of somebody's self image. It is so fundamental to how somebody is seen, and to have an assessment that is not done in partnership with the service user leaves all the decision making and risks, as Peggy said, with regard to the choices that are made, to the service, and any dissatisfaction then lies

with the service. It is better to have an intelligent, sensible and open conversation with someone, saying, for example, 'If you want to climb Pen-y-fan in your wheelchair, you will then not be able to get it in and out of the car on your own, so which is the most important feature for you, because that kind of wheelchair is very heavy and it may not fit into your car?' You need an open debate. So, we recommend more communication, more partnership, and the inclusion of local therapists in the debate wherever possible, so that the lifestyle of the person informs choice, leads to better decisions and means that public money is used better, rather than us telling someone, 'Yes, you should be able to go off and get yourself an all-singing sexy wheelchair if you have the money', while somebody who does not have the money cannot do that. It has to be about getting the best outcomes for the service user.

[176] **Ms Frost:** Another option with joint funding or top-ups is sharing budgets. If we provide the best wheelchair, it can be used in different environments. For example, a child might use a chair at home, at school and for leisure, but if we do not get the right wheelchair, the child will perhaps have to have a different chair at school to the one used at home. Looking much more closely at joint funding between the different health trusts, health boards and education—and work in the case of adults—offers another opportunity for top-ups, and joint-funded opportunities. Providing choice may therefore not be as expensive an option.

[177] **Andrew R.T. Davies:** Lorraine, I think that you have the last question.

[178] **Lorraine Barrett:** I am not sure whether you feel that you can or want to reply to this, but do you feel that sufficient specialist knowledge and skills are available in the current wheelchair services to meet users' needs?

[179] **Ms Crowder:** It is my understanding that we have some highly skilled staff in that service. The quantity of those staff needs to be looked at, as well as the size of their caseloads. Having read the papers from your next witnesses, I see that they have had short-term funding. Whenever there is a problem, they have an amount of money to remove the waiting list, but unless it is a part of a sustainable review of the service that seeks to find out how many staff are needed over the long term, and unless the funding for that is recurring, we will not have enough specialist staff.

[180] Coming back to the issue of training, there is a lot of expertise in local services that we could use better, were the service more integrated. We have already touched on the level 1 training, which has been rolled out and proved hugely useful. A debate needs to be held on whether there are benefits to having more level 2 and 3 training for other therapists, where people have a huge amount of existing expertise.

10.30 a.m.

[181] Some have built up expertise in relation to specialist seating because of their particular caseload. Should we be passing out assessment and using the resource that that frees up, or will that result in a huge amount of assessments coming in, creating another bottleneck because we do not have the resource to meet them? That is why we think that the service needs to be looked at thoroughly. We need a whole-service specification, to look across the pathway to consider the resources needed to deliver the service that has been specified. Until you start with that specification and know the outcomes that you want to achieve, you cannot identify the resources needed.

[182] **Lorraine Barrett:** That is very useful, thank you.

[183] **Andrew R.T. Davies:** You identified earlier that it does not matter how many centres there are, but there needs to be one service to get that corporate ideology of delivery. Thank you very much for your evidence. Are there any other points or lines of questioning that

Members have not covered? We have two or three minutes left.

[184] **Mr Peters:** You mentioned the funding options, but it is really about the range of chairs available. ALAS suggested that a very small number of children throughout Wales need the most sophisticated powered wheelchairs, which are the most costly. Should they be joint funded? For a child who has a severe growth restriction, with the technology that is available, they could have a powered wheelchair, which they need for their mobility because their joints are affected, and that has a high/low seat that they can get into and out of independently. Using the conventional wheelchair provided through ALAS, they would need to be hoisted in and out, which would be disabling them. However, the funding for that would have to be given jointly with the charity. It is an essential need for that child. Powered wheelchairs have a powered standing facility for a child or a young lad who has muscular dystrophy or some other condition with which they need to stand, to stretch and maintain their joints. Should there be core funding for those wheelchairs, rather than having to go cap in hand to charity, because the needs of the user are above and beyond what our core services are providing?

[185] **Andrew R.T. Davies:** Thank you for that. Ruth has a very quick point.

[186] **Ms Crowder:** One thing that we have not talked about is the maintenance of a bought or a charity-funded wheelchair. If someone has a chair provided by ALAS but a cushion or some kind of adaptation that they have paid for themselves, we need some clarity on the situation. If that person has done something to the chair or bought something for it separately, should they be totally abandoned by ALAS? Is there a way of dealing more flexibly with maintenance and review support, rather than just saying, 'Well, you have bought your own, so off you go; the whole responsibility is yours'?

[187] **Andrew R.T. Davies:** We received that evidence from other witnesses, too, but the more witnesses who talk about it, the greater influence it will have in the conclusions that we reach. Thank you very much for taking the time to come here to present your oral evidence, which complements your written evidence. If you wish to expand on any other points on reflection, you should liaise with the clerk who will make that information available to Members. You will be given the Record of Proceedings of this meeting and, if you have any observations to make on it, you should liaise with the clerk. Once again, thank you very much.

[188] **Ms Crowder:** Thank you all very much, and thank you for reviewing this important topic.

[189] **Ms Frost:** Likewise.

[190] **Andrew R.T. Davies:** With Members' permission, we will now take a short break while we crank up the technology. They are going to put 50p pieces into the television so that we can get the video link up and running. We propose to restart the meeting at 10.40 a.m. if Members are content with that. I see that you are.

*Gohiriwyd y cyfarfod rhwng 10.34 a.m. a 10.41 a.m.
The meeting adjourned between 10.34 a.m. and 10.41 a.m.*

Ymchwiliad i Wasanaethau Cadeiriau Olwyn: Tystiolaeth gan Sefydliadau'r GIG

Inquiry into Wheelchair Services: Evidence from NHS Organisations

[191] **Andrew R.T. Davies:** We will now resume our third evidence session in today's

meeting, continuing our inquiry into wheelchair services. We have tried to split the questions so that we go by video link to the Betsi Cadwaladr University Local Health Board first and then come back to the witnesses here in the committee room. If you feel that the points that you wanted to make have been covered, we can move onto the next set of questions. I will get the ball rolling. Mary, how well do you believe wheelchair services in Wales are currently structured, and what is the role of a local health board in that structure?

[192] **Ms Burrows:** Wheelchair services are currently structured in two ways, as you know, in south Wales and north Wales. North Wales currently covers a larger area, extending to Powys and Ceredigion. You will know, through the evidence, that they are also commissioned by Health Commission Wales. My view is that, with the reforms, the two health boards—but I speak on behalf of my health board only—need to integrate the services so that they are run as an integral part of disability services overall, for children and adults.

[193] **Ms Williams:** We support that. You will see from this map that I am holding up that this is the south of Wales, and here is our current borderline. Mary and I have talked about how we would streamline our provision. For example, for the people of Ceredigion, we would provide the service rather than north Wales. We fully support the idea of having one service delivered through the two local health boards based on an agreed national specification, which we do not have currently. We are in agreement.

[194] **Andrew R.T. Davies:** Thank you for that. Would you like to start with your questions, Lorraine?

[195] **Lorraine Barrett:** Yes. What is your relationship with Health Commission Wales and what is your level of accountability for wheelchair services?

[196] **Ms Burrows:** My relationship with HCW is that of commissioner and provider: it commissions services from us and we provide them. My accountability is through the performance arrangements for the service through to NHS Wales, which I believe will be the same for Jan.

[197] **Ms Williams:** Yes. To confirm, we are also a provider to Health Commission Wales. I answer through our board and then up to the Welsh Assembly Government based on the Assembly Government's guide to good practice on waiting times management particularly, because we do not currently have other performance standards for ALAS services.

[198] **Helen Mary Jones:** I will jump back slightly to the first question, because I did not quite understand the responses. Either Mary or Jan can respond. Are you suggesting that your two local health boards ought to take charge of running wheelchair services for the whole of Wales? Where does that leave the other local health boards, and would there be any risk, because we have just heard evidence about a postcode lottery under the current system? Therefore, how would you avoid ending up with different standards of service in different parts of Wales? I suppose that I am speaking for the Hywel Dda Local Health Board, which is clearly not part of this carve-up as yet.

[199] **Ms Burrows:** I am sure that Jan will come in on this after me. We currently provide services to all the areas of Wales—Cardiff and Vale University Health Board has its area and Betsi Cadwaladr University Local Health Board has its area. That is done through the commissioning arrangements, but, as you know, as a result of the reform and because we have fewer bodies, it makes sense that Jan and I work together as two providers for the whole of Wales, working to a common standard, common performance targets and metrics that will improve the outcomes for individuals who need our services. The work will increase over time, if you consider the demographics. Jan, do you have anything to add to that?

[200] **Ms Williams:** Page 2 of our evidence spells out the current geographical scope of the different services that we provide. As Mary has described, we provide some for all of south Wales, and some for south-east Wales or whatever, and that makes sense in the context of streamlining, but I cannot emphasise enough the need for a national commissioning specification, which I know that you were discussing in earlier evidence. We support that completely and would welcome it, and, in fact, we hope that that will come out of the next phase of the review work that the Minister is commissioning.

[201] **Peter Black:** May I ask for clarification because I am little confused? You are both commissioned by the same body, which is Health Commission Wales, but there is no national specification. Is that right?

[202] **Ms Williams:** There has not been a formal written specification. We work to waiting-time standards for children and adults, which you heard about earlier, and we work to the overall guide to good practice on waiting-times management in the absence of other performance-management arrangements. Cardiff ALAS last year produced an outline specification that we are working to within the framework, but it is the case that there is no written specification on standards. We know that that is understood; it came through the phase 1 findings, and we hope that that will be addressed in phase 2.

[203] **Peter Black:** Would that not be part of the commissioning process? Should Health Commission Wales, as part of the commissioning process, have stated, 'This is a specification that we are commissioning to'?

[204] **Ms Williams:** Yes.

[205] **Ms Burrows:** Yes.

[206] **Peter Black:** But it has not.

[207] **Ms Burrows:** As for what we think the future arrangements should be, the question is about whether we will have a commissioner/provider split or whether we will work together as seven local health boards, with the Welsh Assembly Government, to determine what the standards should be and what our aspirations around wheelchair services are, and then be held to account for providing those on behalf of all the local health boards. That will probably come into phase 2.

[208] **Ms Williams:** There will be the mechanism from 1 April, through the Welsh Health Specialised Services Committee, for the other five local health boards to hold Betsi Cadwaladr University Local Health Board and Cardiff and Vale University Local Health Board to account, because we are delivering a service on their behalf. So, there is a mechanism to ensure that there is equity and that we are all working to the same specification.

[209] **Val Lloyd:** Mary, I will now move to a different level, from commissioning to management. What is your involvement in the management of the artificial limb and appliance service?

[210] **Ms Burrows:** I do not manage it operationally, as you would expect, but I have management arrangements in place through a chief of staff for therapies and clinical support, who oversees rehabilitation, engineering and the service itself. So, that it is now integral to the health board.

[211] **Val Lloyd:** I now put that question to Jan.

[212] **Ms Williams:** Mike, within his remit, is currently the ALAS general manager. From

1 April, we will be introducing divisional director structures, which will mirror Mary's chiefs of staff arrangements. That means that we will have a divisional director for diagnostic and therapeutic services. ALAS will fit into that, and we will be moving the rehabilitation engineering service into that, because they have been split up until now, and previous evidence that we have heard indicates that that is not ideal. So, in our new arrangements, they will be integrated.

[213] **Val Lloyd:** Thank you; that is clear.

10.50 a.m.

[214] **Peter Black:** I will start with Jan, just for a change. Is sufficient funding given to wheelchair services in Wales, and what mechanisms do you have in place to ensure that these resources are used effectively?

[215] **Ms Williams:** Cardiff and Vale University Local Health Board has met the standards as regards the service that it currently provides, but, as you heard previously, it is not able to maintain a review service for everyone who has been issued with a standard or complex wheelchair. We have to close the referral down after three months with nothing going wrong, unless there are specific issues. However, if we really need to keep a referral open, we do so—it is not closed down automatically after three months, and you will hear about that when you visit ALAS Cardiff next week.

[216] With the current resources, we have just one training officer for the whole of Wales, so we cannot undertake all the training that we would like. I would like to say a little more about that, because I have some issues with it. At the moment, 70 per cent to 80 per cent of our referrals are for standard wheelchairs, which we despatch within about 21 days, but because people are living longer, with a greater range of long-term conditions, we are seeing increases in referrals for complex wheelchairs, which are expensive. We have one—and I do not know whether this has been concluded yet—that has cost £24,000. They range from the very standard, costing £150 to £200, right the way through to £24,000 to 25,000, and that figure will increase. That is all part of the service that we provide within the current waiting-time standards set down by Health Commission Wales, and we are delivering on that. However, we know that we can do a lot more, and, let us be fair, we have just under 50,000 wheelchair users in Cardiff and south Wales alone. That is why we welcome the review, and we welcome moving into phase 2 because we are confident that these issues will be addressed.

[217] **Peter Black:** Do you want to expand on the training issue? That was raised earlier by the—

[218] **Ms Williams:** I want the opportunity to explore this with the Chartered Society of Physiotherapists and the College of Occupational Therapists. I do not understand the undergraduate curriculum at the moment, or how much input there is on posture and mobility support. I would like to ask the ALAS training officer why we spend training time on level 1 posture and mobility support. I am not sure if colleagues who gave evidence earlier went to the gallery to listen, but I would welcome a debate with them on this. I am not a physiotherapist or an occupational therapist, and so I am not sure what should be expected of level 1 capability within the undergraduate curriculum, and whether levels 2 and 3 would be better done through some kind of postgraduate course. I do not know, but we would have to skill-up our community therapists to deliver a more integrated, partner-based service, and with just the one training officer, that is not possible for ALAS. That training officer covers north and south Wales, so we will never be able to train-up community therapists using that route. However, I would welcome further debate outside the committee on what could be done.

[219] **Peter Black:** Mary, do you want to answer my question about resources and sufficient funding?

[220] **Ms Burrows:** At this point, I will apologise to the committee because we are not meeting the waiting time standards, and the evidence in front of you will indicate that. The resource allocation from Health Commission Wales is just over £4.5 million, but the service that we are running costs over £6 million. As a previous trust chief executive for north-east Wales, I would like to say that we have been topping up the service, if you like, to try to meet the needs of the population in our area. So, the short answer to the question of whether we have sufficient funding is 'no', but, having said that, we have commissioned a full review of the service, and are looking at how we can integrate it, because we think that there could be some improvements. I particularly take Jan's point around community therapists, having looked at how we have so heavily specialised in the training, and just getting people in and training them up. Along with my chief of staff, Clive Sparkes, who will be giving evidence to you in a couple of weeks, I am of the view that there is no reason why community therapists cannot be trained to be more generic in respect of doing some of these assessments. We would be looking for that in respect of integrating the service to make it more of a disability service, so that we have more skills to be able to do that.

[221] **Helen Mary Jones:** I wish to address this to the Betsi Cadwaladr University Local Health Board first of all. In previous evidence to the committee, which has been extensive, we have been made aware of some serious problems with waiting times for assessment and the provision of wheelchairs. Wearing my other hat as Chair of the Children and Young People Committee, I am particularly concerned about the effect of those delays on children as they grow and develop. What is the cause of the delays in waiting times? It is clear from our evidence that there are differences between the service in the north and that in the south. What accounts for that difference?

[222] **Ms Burrows:** I will not defend that situation in respect of children—it is indefensible. We are currently investigating one case where the waiting time appears to have been two years, which is wholly unacceptable, and I apologise to the committee for that. That has something to do with the way in which the service has been structured, and there are issues about recruitment, retention and training, and Jan has alluded to some of those. As the service has been fragmented, with rehabilitation engineering being one aspect and ALAS being the other, we are almost operating two services. There are issues relating to how the professionals interact within those services. Clive Sparkes will be in a better position to give you more detailed advice about some of the delays. It is a combination of factors, such as how the service is structured, the staff, the skill set, and the attitude of staff towards the integration of services and how those should work together. We have not achieved that integration in the north, which we are trying to address.

[223] **Ms Williams:** As I have said, we are well within the current specified waiting times, but we would like to see those being reduced further, particularly for children. We would like to see that developed in phase 2 of the work, so that there are shorter waiting times for children and adults, but particularly for children. Going back to a point made by both professional groups, we need to bring in review arrangements for children as a matter of urgency. It has been said that you outgrow your shoes, and so you outgrow your wheelchair as well. That is important.

[224] On waiting times, the manufacturing and production of complex wheelchairs is a global business. We work with two suppliers, who source globally, and there can, therefore, be delivery times associated with that. As we get increasingly complex referrals, that will become a bigger issue. Therefore, the issue of what we do on an interim, temporary basis, particularly for children, is another area that we want to explore in phase 2.

[225] **Andrew R.T. Davies:** On the point about global sourcing and the fact that that could be a component part of some delays, in earlier evidence this morning we heard that English colleagues envy the Welsh service as a result of the array of apparatus that is available to it. Is the fact that there is such an array of apparatus that people can choose from complicating the ordering and procurement processes? Would a more targeted approach to availability speed up procurement?

[226] **Ms Williams:** There is the issue of user preference, particularly for children and young people, who want the largest selection possible of wheelchairs, for example with whizzy wheels, metallic colours and so on. I will ask Mike to expand on that, because he is closer to the supplier market than I am.

[227] **Mr Spencer:** That is absolutely correct. It is about finding a balance between the range of choice, colours and different types, and the speed of delivery. That is a delicate balance. The views of the user, provider, and the local therapist on the best solution will always be different. We also go out of range occasionally; even if there is an extensive range, there will be occasions when we have to buy from a particular contract, which can add to the delay. The belief has to be that that is a better solution. As Jan indicated, the key is to provide an interim solution that is satisfactory, because the child or adult cannot do without a chair in the interim, but the final solution may take some time to source.

11.00 a.m.

[228] **Helen Mary Jones:** May I challenge that? We have heard evidence from voluntary organisations that are sourcing in the same global market, presumably, and which are providing equipment for children and young people that fits their specification, such as colour, design and individual features. How do you account for it being more difficult for you to source quickly in that market than for a voluntary organisation that, to be honest, I would not expect to have the same procurement resources and expertise as a big public body like the one you represent? It may be that their evidence to us was inaccurate, but it seemed clear at the time.

[229] **Mr Spencer:** It is less about procurement expertise and more about what different parties are assessing against. You would have to look at individual cases and see what solutions were being offered by the different parties. People come at this from different angles, and when you visit ALAS next week, and take subsequent evidence, that may well be something to explore—how it can help to speed up the process.

[230] **Ms Williams:** We have asked our auditors to look at procurement arrangements, and we have yet to receive any evidence from third-sector organisations that they can procure more cost-effectively and more quickly than we can.

[231] **Helen Mary Jones:** I invite you to look at the Record of Proceedings, because we have had some clear evidence.

[232] **Ms Williams:** We understand that, and we have asked for that information from third-sector organisations so that we can go back to look at our own procurement arrangements. However, that information has never been forthcoming.

[233] **Helen Mary Jones:** It may be difficult for them because you are competing with each other in the same market. May I ask one further question on targets, Chair, before I ask about action on delivery? You said that you are meeting the current targets, Ms Williams; does that include the targets in the national service framework for children and young people?

[234] **Ms Williams:** No.

[235] **Helen Mary Jones:** So you are not actually meeting all the targets.

[236] **Ms Williams:** We are meeting the targets that we are set for ALAS by HCW.

[237] **Helen Mary Jones:** But are you not also bound by the national service framework for children and young people?

[238] **Ms Williams:** For this particular service, we are bound by the HCW requirements, because the service is commissioned through HCW, and that is the organisation that we work to.

[239] **Helen Mary Jones:** So, you do not accept that you are bound by the national service framework for children and young people?

[240] **Ms Williams:** Not when we are given specific targets by HCW.

[241] **Helen Mary Jones:** I will be very interested to take that up with Ministers in my role as Chair of the Children and Young People Committee. You both acknowledged that waiting times for assessment and delivery of chairs are not ideal. Chair, who am I asking first?

[242] **Andrew R.T. Davies:** You are still on the same batch of questions.

[243] **Helen Mary Jones:** Okay, so this is to the representatives of the Betsi Cadwaladr University Local Health Board first. What actions are being taken to address waiting times? You touched on this earlier, Mary.

[244] **Ms Burrows:** Yes, and again, I believe that you have it in front of you in the written evidence. As a health board, outside of HCW, we have put in some resource to try to get the waiting list down, particularly for children. One of the issues with HCW, which comes back to Jan's point about how the service has been commissioned, is that we wanted to stream paediatrics to separate children's services from adult services, and we were requested to keep them together. One of our recommendations will be that we streamline the service so that we can address some of those highly complex needs, bearing in mind some of the comments that Jan has made around children and young people and their growth needs. So, to answer your point, we have put in additional funding to get the waiting list down; it will still not reach the target, but we are reducing waiting times as much as we can. That will partly be achieved through internal efficiencies exercises and partly through integrating the service more fully over the next couple of months. Clive will be able to give you information on that.

[245] **Andrew R.T. Davies:** Jan, did you want to come in here?

[246] **Helen Mary Jones:** So, steps are being taken to drive the times down.

[247] **Ms Williams:** Yes, and we have put in place waiting times initiatives. I wanted to mention that Mike and I are in the early stages of discussions around moving this to a seven-day service. That is not just for this particular service, but for the NHS as a whole. The waiting times work that we did was based on weekend working, and we found that service users preferred it—they welcomed the opportunity to receive home visits on a Saturday or Sunday, because it was more convenient for them. As we go forward, and we get a better handle on how to bring waiting times down the seven-day service issue, particularly for home visits, is a really important point.

[248] **Andrew R.T. Davies:** Are you happy, Helen? Did you get the answer?

[249] **Helen Mary Jones:** I would not go so far as to say 'happy', but I am prepared to leave it there.

[250] **Andrew R.T. Davies:** Okay. Dai, could you take us to your question to Cardiff and Vale University Local Health Board, first of all, and then to Betsi Cadwaladr University Local Health Board.

[251] **David Lloyd:** It is an attempt to drill down on targets and standards for wheelchair services, although I recognise that a fair amount of drilling has already been done by Helen Mary. What targets or quality indicators are you required to meet in relation to the assessment and provision of wheelchairs, and are they being achieved?

[252] **Ms Williams:** As we said when we were talking with your colleague, the requirements of the NSFs are requirements on NHS Wales, so I am sorry if I gave the impression that we did not see ourselves as being bound by them; clearly, we do, overall. We have been resourced to work to the standard that HCW has set us on this, and we never get anywhere near the 15 months or 12 months standard, so we are well within that standard. However, we would like to see a more responsive and flexible service. We have a rapid response service, so if we have an urgent referral for someone who is deteriorating or has multiple sclerosis, or whatever, we respond immediately. So, we have an early rapid response system. Although the guide to good practice on waiting times talks about treatment on a chronological basis, we also provide a service on the basis of clinical need. We have a dedicated and committed clinical team. As you will have appreciated, ALAS has moved from an administered service to a clinically led service over the last 10 years, and it is part of its success that we are hitting all of the issues on which we succeed. So, we provide on the basis of clinical need.

[253] **David Lloyd:** Fine. Mary, can you answer on the same issue of targets or quality indicators?

[254] **Ms Burrows:** I draw the committee's attention to the top of page 8 of our submission, which outlines the targets that HCW has set. However, for me, we should go well beyond them, as Jan outlined. For our part, we have started to develop our own indicators around the length of episode of care, and we have built in indicators around increasing efficiencies on the collection and refurbishment. So, we have tried to move from what is probably a more administrative process-driven system to one, as Jan articulated, a more clinically led system. We wish to move through our new chief of staff and the review that we have put in place to a more clinically led process. So, in all of these indicators, I am very keen to look at outcomes for individuals, whether qualitative or quantitative outcomes, or a mix of the two. How it has enhanced their life is also very important. Although mapping waiting times is important, quality of life indicators are also important. So, there is quite a lot that we can do on that.

[255] **Andrew R.T. Davies:** The final question is from Peter Black.

[256] **Peter Black:** I have two questions. This first is to Mary. What systems are in place to encourage joint working, for example between ALAS and health and social care services and the voluntary sector? Could there be improvements in the joint working?

[257] **Ms Burrows:** In answer to your second question, there could be improvements and that is what we are striving for. The reforms in place in Wales should help us to do that. As for joint working with health and social care, we have in place some section 33 agreements around equipment, and we are trying to look at how we are doing joint assessments. However, we have a long way to go on that.

[258] **Andrew R.T. Davies:** I will ask Jan to respond, and I will then invite Helen Mary to come in.

[259] **Ms Williams:** I would echo that, because we believe that a unified assessment and moving from a health model to a more social holistic model is the way to go. The NHS reconfiguration gives us the opportunity to do that. For example, in the Cardiff and Vale board, we will be setting up a tripartite programme board on integration, and the unified assessment arrangements, particularly for children, will be high on our agenda. So, we think that that is very much the way to go.

11.10 a.m.

[260] **Helen Mary Jones:** I am encouraged by that response on joint working. One of the things that we have heard from people giving evidence about service provision for children and young people is that education is a source of funding for specialised chairs. The education authorities are obliged to provide equipment that enables a child to learn. Are you, or would you see merit in, exploring how you could include education as well as social services in that? It is all money from the public purse, and it might enable the service to provide a more expensive and specialised chair that would not be affordable if the funding came just from the health service. It could also hit the buttons that Ms Williams was talking about, namely looking at the service user's needs more broadly, not only with regard to their health but in relation to participating in the community and so on.

[261] **Ms Williams:** It happens very rarely now—there are specific one-offs—but we welcome it and think that it is the way to go. There is also a role for the third sector, as you have identified. We are in dialogue with the British Red Cross, but we would view that as relating to short-term loans and interim arrangements rather than to sourcing very complex wheelchairs.

[262] **Andrew R.T. Davies:** Mary, did you want to pick up on the supplementary question that Helen Mary asked on education funding?

[263] **Ms Burrows:** It is a really good point. On integration, this does not just relate to social services; it most definitely relates to education. While we do work with education providers, it would be helpful to have some way of pooling that. We need to avoid cost-shifting, which can sometimes happen if you have different streams of money with different authorities. I am sure that arrangements could be made, as the young person's need is the most important thing. We would just have to look at making sure that we did not have criteria that classified something as health and another as education, and then having everyone fall out over who is going to pay for what. A much better way of doing it would be to have a system in which everyone agrees how to pool that and to work that through. I would welcome the committee's views on that in phase 2.

[264] **Helen Mary Jones:** Would it be helpful to you to have guidance from the Welsh Government about that? I take your point about cost-shifting. I was thinking about cost-pooling, so that you could afford something better, rather than cost-shifting so that it is in and out of someone's budget.

[265] **Ms Burrows:** Absolutely.

[266] **Peter Black:** We heard evidence earlier about communication within the service and, in particular, that information on assessments was often kept in ALAS and not shared with other members of the multidisciplinary team—certainly not in writing. The fact that a multidisciplinary service is not delivered seemed to me to be a major failing. Is there a

particular reason for that? How can that be addressed?

[267] **Ms Williams:** I am not sure that there is any reason in particular; it is the way in which they have always done it. Mike and I have picked up on the need to have a major communications drive. I would like to talk to the Chartered Society of Physiotherapy and the College of Occupational Therapists about that, namely what communications mechanisms they would like to see. It is all part of how we will work more closely with community therapists. When Mike and I were listening earlier, we thought that it would be helpful to have a workshop with our colleagues in the service to talk about how we can improve communications. It will help if we streamline our geographical boundaries as well.

[268] **Peter Black:** Do you have a view on that, Mary?

[269] **Ms Burrows:** It is about historic and professional boundaries, and Jan has articulated that very well. We need to integrate the service in respect of the community and to focus on disability and needs, as opposed to saying that one service provides one thing and another provides something else, and it being a case of never the twain shall meet.

[270] **Ms Williams:** You talked earlier about maintenance, repairs and so on, and you will see in our evidence that we are bringing that service back in-house from 1 February. We had outsourced it, and our users were not happy. So, we hope that, when you visit ALAS, you will see the arrangements that we have made to bring it in-house, which is all part of providing a better service to our users.

[271] **Andrew R.T. Davies:** Are there any other points that Members would like to raise? I see that there are not.

[272] I thank the witnesses for their written and oral evidence for our inquiry into wheelchair services. I know that Members are looking forward to the visits that will be undertaken next week. A record of proceedings will be sent to both parties. If you have any observations or thoughts that you think would benefit the inquiry, please liaise with the clerk. Thank you for your attendance.

[273] **Helen Mary Jones:** Before we leave the inquiry, may I make one further point?

[274] **Andrew R.T. Davies:** Yes.

[275] **Helen Mary Jones:** I have been contacted by the local disabled access group in Llanelli. It is very concerned because it has not been invited to give evidence. It found out from my column in the local paper that we were undertaking this review. It is my understanding that we, as a committee, would rely on the umbrella bodies like Disability Wales and the Wales Council for Voluntary Action to cascade information and to go out to local groups. Would it be possible to ask the clerks to check what is done in that regard? People get sent a lot of e-mails and so it may be that my local group was contacted but did not pick up on it, or it may have gone to the wrong member of the group, or whatever, but the group was very cross, and I was in some considerable trouble. So, it would be worth checking how local groups are consulted. My local group had some useful views, not only on what was wrong, but on what it would like to see done to put things right. I can now feed back to our discussions because I had a good two hours with the group. We ought to be able to rely on the umbrella bodies to ensure that local groups are consulted. Clearly, something has gone a bit awry here, and it would be worth double-checking, because that local expertise can be really valuable.

[276] **Andrew R.T. Davies:** I concur with you entirely, and I am sure that the clerking team have made a note of the observation and will report back accordingly. Perhaps other

Members have found the same thing. There is a limit on how far the boat can go out, as it were, and if we are having to rely on others to cascade the information—

[277] **Helen Mary Jones:** To be clear, Chair, I am not in any way being critical of our clerking team, because they will have contacted the umbrella bodies. I am a little concerned about what the umbrella bodies have—or have not—done. It may be that they have done stuff and that it just has not come through to this one particular group, but I was a bit worried about that so I thought that I would raise it.

[278] **Andrew R.T. Davies:** Okay. The clerking team have made a note of that and will look into it.

[279] **Helen Mary Jones:** I also want to put on record formally how very concerned I am that the chief executive of a major public body in Wales did not seem to realise, even if for only five minutes, that the national service framework for children, young people and maternity services applied to her and her organisation, or that those targets were binding on her. She clearly came back and put it right, but the fact that it was not at the forefront of her mind was a bit of a worry.

11.17 a.m.

Cynnig Trefniadol Procedural Motion

[280] **Andrew R.T. Davies:** With that closing note in mind, I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

[281] I see that the committee is in agreement.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 11.17 a.m.
The public part of the meeting ended at 11.17 a.m.*