

Y Pwyllgor Iechyd, Lles a Llywodraeth Leol

The Health, Wellbeing and Local Government Committee

Dydd Iau, 4 Mawrth 2010
Thursday, 4 March 2010

Cynnwys Contents

[Cyflwyniad, Ymddiheuriadau a Dirprwyon](#)
[Introduction, Apologies and Substitutions](#)

[Cynnig Trefniadol](#)
[Procedural Motion](#)

[Ymchwiliad i Wasanaethau Cadeiriau Olwyn: Tystiolaeth gan Grŵp Llywio Cymru Gyfan ar Symudedd ac Ystum Corff](#)
[Inquiry into Wheelchair Services: Evidence from the All-Wales Posture Mobility Steering Group](#)

[Ymchwiliad i Wasanaethau Cadeiriau Olwyn: Tystiolaeth gan y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol a Chomisiwn Iechyd Cymru](#)
[Inquiry into Wheelchair Services: Evidence from the Minister for Health and Social Services and Health Commission Wales](#)

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynndi 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
Ann Jones	Llafur Labour
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Leanne Wood	Plaid Cymru (yn dirprwyo ar ran Helen Mary Jones) The Party of Wales (substitute for Helen Mary Jones)

Eraill yn bresennol Others in attendance

Simon Dean	Cyfarwyddwr Strategaeth a Chynllunio, yr Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Director of Strategy and Planning, Department for Health and Social Services, Welsh Assembly Government
Dr Kevin Fitzpatrick	Cadeirydd, Grŵp Llywio Cymru Gyfan ar Symudedd ac Ystum Corff Chair, All-Wales Posture Mobility Steering Group
Edwina Hart AM	Aelod Cynulliad, Llafur (y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (the Minister for Health and Social Services)

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 10 a.m.
The meeting began at 10 a.m."

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introduction, Apologies and Substitutions

Darren Millar: Good morning everyone. I welcome Members to the meeting and any members of the public that might join us in the public gallery. I remind you that headsets are available for simultaneous translation and sound amplification. If anyone has any problems using these, they should indicate that to the ushers, who will provide assistance. Committee members and members of the public may wish to know that the simultaneous translation feed is on channel 1 while channel 0 is for amplification of the sound and the language being spoken. I would be grateful if Members and members of the public would ensure that mobile phones, BlackBerrys and pagers are switched off. If it is necessary to evacuate the room or the public gallery, everyone should follow the instructions of the ushers who will guide people to an appropriate exit. I remind Members that the microphones are operated remotely.

We have received apologies from Irene James and Helen Mary Jones. Leanne Wood is substituting for Helen Mary, but I understand that she needs to leave about 10.55 a.m.. Welcome to the committee, Leanne. Does any Member want to make any declarations of interest under Standing Order No. 31.6? I see not.

10.01 a.m.

Cynnig Trefniadol Procedural Motion

Darren Millar: To discuss items 3 and 4, 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)."

I see that the committee is in agreement.

"Derbyniwyd y cynnig.
Motion agreed."

"Daeth rhan gyhoeddus y cyfarfod i ben am 10.01 a.m.
The public part of the meeting ended at 10.01 a.m."

"Ailymgynullodd y cyfarfod yn gyhoeddus am 10.06 a .m.
The committee reconvened in public at 10.06 a.m."

Ymchwiliad i Wasanaethau Cadeiriau Olwyn: Tystiolaeth gan Grŵp Llywio Cymru Gyfan ar Symudedd ac Ystum Corff Inquiry into Wheelchair Services: Evidence from the All-Wales Posture Mobility Steering Group

Darren Millar: To continue with our inquiry into wheelchair services, we are taking evidence this morning from the all-Wales posture mobility steering group. I am delighted to welcome Dr Kevin Fitzpatrick, who is the chair of the steering group. We have been provided with an evidence paper, which has been circulated to Members. If Dr Fitzpatrick is content, we will move straight to questions. I see that he is content with that.

Can you give us an overview of the work of the steering group? What does it actually do? What improvements have been made in posture mobility services in Wales in the past few years?

Dr Fitzpatrick: The all-Wales posture mobility steering group is an advisory group to Health Commission Wales. It was set up on the back of a very good consultation exercise that was conducted by the then commissioner for the Specialised Health Service Commission for Wales, which was the predecessor organisation. The intention at that time was that users would not be held in some kind of user forum, as that often means that people are excluded from the decision-making processes that affect their lives. Our intention was that users would be at the heart of helping the service to develop and, in principle, that means that service users help not only to determine the delivery of services but also to scope and design those services.

I will give you an example of the work that has been done. In the six years since the steering group was set up, we have taken a mature, if difficult, decision on the grounds that the service was being pressed, and three successive health Ministers seriously lobbied, by an individual on behalf of his son, in order for him to be provided with lights for his electric wheelchair so that he could go out at night to the local pub. Notwithstanding some of the inherent difficulties in that case, the issue caused the then commissioner to try to develop some advice to provide to the Minister about the idea that the service should routinely be providing lights, particularly on electric outdoor wheelchairs. As a result I, as a user myself, together with one of the members of the all-Wales posture mobility steering group, who is a lifetime carer to a young disabled daughter, and the service formed a small task and finish group to examine the issue. I have no difficulty in saying that, in going into that investigation, the weight of our feeling was that routinely providing lights was an obvious thing to do.

When we began to investigate, as you will be aware from your own inquiry, we saw that the provision of chairs and any equipment that goes on those chairs is a complex issue. As we realised the complexity of the issue and looked at what the industry was prepared to do and at the costs involved, either to fit at the point of assembly of a new chair or to retrofit lights to electric wheelchairs, and, working on the principle—as I do—that what one person can have, everyone should have, we have to do the level best that we can, with the resource envelope that we have, to create an equitable service.

10.10 a.m.

We realised, over the period of the investigation, that in fact the cost pressure would be enormous. As I said at the beginning, we came to a difficult, but mature, decision. At that time the service was not required to provide, or could not provide routinely, lights on electric wheelchairs, or on any other type of wheelchairs. We reached the unfortunate decision that, if the service were required to do so, the cost pressures in the service—because no new money was attached to this—would mean that other parts of the service would be seriously damaged and affected. We could not, in all conscience, require the service, nor advise the commissioner to advise the Minister to require the service, to provide lights on wheelchairs. It was a difficult decision. The evidence demonstrated categorically that that could not be done without the new money that might have been available to do so, as the service would have acquired a cost commitment of somewhere between £2 million and £5 million over the lifetime of that decision, which has stood for about six years—although the individual has managed, through a technicality in law, to get the service for his son.

Before I finish, I do not want you to think for a second that I am ever unsympathetic to the needs of wheelchair users. I would be categorical about the fact that, during the lead-up to this inquiry, and, as a wheelchair user for 36 years, I have had every concern for every wheelchair user and want to get them everything that they possibly can get. We ended up having to make a decision to advise the then commissioner to advise the Minister that, under current resource levels, it was not possible to require the service to routinely provide lights on wheelchairs.

Darren Millar: Thank you for those opening remarks. In your paper, you refer to a sum of £30,000 that was supposed to be available each year in order to support the work of the steering group, and to the fact that that has since been withdrawn. You say that, since then, you have been relying on limited support from HCW and the south Wales ALAS. Is that right?

Dr Fitzpatrick: In effect, it was never provided in the first place, so it was not withdrawn. As I told you, there was an excellent consultation across Wales as a result of the Audit Commission's report in 2000, which, in fairness, was fairly damning of the Artificial Limb and Appliance Service across the country. The then commissioner set about undertaking a consultation exercise with wheelchair users across Wales to determine the levels of resources and needs, and to determine what the service was doing. In truth, the service was receiving a huge number of complaints at that time, and I will come back to those complaints in a moment.

At that time, it was felt that a number of recurring and non-recurring investments should be made in the service. The steering group, as I pointed out at the beginning, is not a user group. In my experience, user groups have been marginalised, sidelined and used in many ways to bypass the wishes and demands of users or the value that users can bring to designing and scoping services. The posture mobility steering group—it is an unwieldy name, unfortunately, but it reflects what we do—is an interface between users, services, commissioners, providers, clinicians and anyone else who is involved. It was recommended that a reasonable sum of money should be invested in the work of the posture mobility steering group to ensure that it could do the work and achieve things. The truth is that, without that investment, which, as I said, was never forthcoming because of financial pressures at the time, we have not been able to develop as well as we would have liked. However, we have done some good work, as I indicated in the example that I gave, in the years that we have been running. It would be wonderful to have that investment to go forward and take this work to the next level. As I have set out in the paper, it is an exemplar of what partnership in healthcare is about.

To give you a picture, back in 2004, the then Minister was about to launch the five-year plan on the strength of the consultation exercise, which, as I said, was incredibly thorough and was run through the Welsh Institute of Health and Social Care. I have to acknowledge the fact that I have a recent interest in the Welsh institute; I did not have that in 2004, but I have recently become an associate of that department. However, it was a thorough exercise, it was well done, and the investment was recommended.

At that time, the Specialised Health Service Commission for Wales was being disbanded and Health Commission Wales was being formed. In the transition, as I understand it—and please forgive me if I do not fully understand all of the workings of the finances—we were going into a process where finances across Wales, in the health service in this case, were stretched and strained. We had moved into the second Assembly and we were in a position where every service was being required to look for cost improvements and efficiency savings. I do not know if you know, but I am also on the board of the Welsh Ambulance Services NHS Trust, and there was exactly the same issue with regard to that. The service change and efficiency programme has cost a lot of people a lot of time and there has been a lot of pressure to try to meet those financial demands. So, as a result of that financial picture and the changes in the demands that were being made on resources, the investment could not be made in the posture mobility steering group or in other parts of the programme that required development.

Darren Millar: We will touch on the five-year plan and some of the funding arrangements as we go through Members' questions in this session. Do you want to come in on that point, Andrew?

Andrew R.T. Davies: I would like to seek clarification. You said that funding was under pressure in 2004. I am a relatively new Member of the Assembly, but I am looking at the faces of some of the Members who have been here for two or three Assembly terms for clarification. My memory is that, in 2004-05, there was more money around than there has been in the time that I have been in the Assembly. Is it the case that money was becoming tighter for certain services within the health portfolio because, at that time, there was considerable pressure to reduce waiting lists and the money that was coming into the health department was being targeted at certain priorities, rather than the situation that we have today, where less money is received overall?

Dr Fitzpatrick: Part of the difficulty is that, when we talk about people's needs, it is extraordinarily difficult to find clear, concise and easy ways to prioritise those needs. If you remember, at that time, as part of the backdrop, there was a huge amount of interest in anorexia and the kind of difficulties that young people faced and the lack of services. The service was not being provided to them. That was one area that I was aware of as being a big pressure. There were no services and those services needed to be implemented. I do not know whether that caused pressure in other areas, but I understand that there was pressure across health services, not just on the wheelchair service.

Everyone was being asked to make cost reductions and efficiency savings. As I said at the beginning, please forgive me if I do not understand all of the detail of those pressures, but at least one thing is clear: at that time, it was not possible to implement the recommendation that new investment should be made. In fact, the opposite was happening and cost reductions were being required. I cannot be clear about whether that was based on need, service delivery, the absence of other services or cost pressures on one part of the NHS being driven into others.

Andrew R.T. Davies: Would it be fair to say that, had the service been given as much of a priority as other services at that time, there would have been money within the budget to facilitate the five-year plan? It is my understanding that resources were available. It was different to the era that we are in at the moment, when there is a general consensus that there is a tightening of budgets and all aspects of the department are being asked to make efficiency savings.

10.20 a.m.

Is it the case that if it had been a priority, the money could have been found to implement the five-year plan, which would mean that we would not be sitting around this table today?

Dr Fitzpatrick: That is a difficult question to answer because, as I said at the beginning, the difficulty is in knowing how to prioritise. If you asked me whether we should prioritise, in this service, the needs of children over the needs of adults, I could not give you a clear answer. How do I prioritise the needs of a child wheelchair user, who has posture mobility needs, which are impacting on their health, wellbeing and growth, over, for example, those of an adult, who might be at risk of losing their job, if they did not get the service that they needed? In a sense, if you will allow me, I will refuse to answer the prioritisation question because I do not see how one can answer it. There are some really difficult and tough decisions being made at these levels. I do not want to point the finger at the commissioner because of his workload, which includes plastic surgery as one of the specialised services. As someone who has benefited from plastic surgery—and I do not mean in terms of my looks; I certainly would not claim to have benefited from it in that sense—in terms of the kind of operations that surgeons undertake to help people, like myself, with their posture mobility needs, I know that that kind of work required huge investment because it had been underfunded. I can say to you, however, that there are people who would say of the wheelchair service that it has been a cinderella service in terms of funding.

Darren Millar: We will now move on to Peter Black, who will ask for more detail on the five-year action plan.

Peter Black: You touched on the five-year action plan and particularly on the funds that we need for that plan. It is clear from your paper that some of the actions in it were achieved and a number were not achieved. Could you give us a brief outline of the impact on the wheelchair service in Wales of not achieving some of those actions?

Dr Fitzpatrick: For a start, as I understand it, we have an inquiry that has been driven by the needs of young people and children who are not getting the service that the five-year plan developed as a major, recurring investment. Initially, the investment was to be £500,000 in the first year, with a recurring investment of £400,000 annually to drive up the service. The consultation exercise had understood that the service was not as it should be for children and young people. I would temper that a little with the knowledge, for example, that, at that time, the industry did not provide bespoke wheelchairs for children; all that it did was downsize adult chairs. That was not meeting children's posture mobility needs.

In that context, one thing that has been clear is that the big pressure is about waiting lists and complaints about the approved repairer. Since then, a clinician has been appointed to develop, from scratch, a training programme in order to go back out to train people in the community to undertake assessments. I do not know why it always seems to work out this way, but according to the 80:20 rule, 20 per cent of the people who are supplied with wheelchairs in Wales have what you would call multiple complex needs; the other 80 per cent use a wheelchair that is pretty standard and does not need a prescription. My chair, for example, is made to a very tight prescription and it needs to be because even a millimetre of difference will make a difference to its performance and to how I can live my life. So, one thing that is clear is that the assessment process has become more complex for a couple of reasons. For example, one thing that the consultation exercise demanded was to make a bigger range of wheelchairs available for users. We have developed that over a period of time and Wales boasts one of the most extensive ranges of wheelchairs in the country. However, part of the difficulty is that that increases the complexity of the assessment. So, when you have someone who has complex assessment needs or complex posture mobility needs, you have to develop a complex assessment process alongside that, and that creates delays.

The roll-out of that training programme should show benefits. Other things have also happened, such as the appointment of a rehabilitation consultant clinician. I have mentioned in the paper, for example, that one of the things that the service has managed to introduce is a psychology service, which is simply exemplary, because I do not know of anywhere else that has one. Investments have also been made in other professionals and therapists. There is a transport manager in north Wales and the posture mobility steering group has been supported through the current funding resource. There has been a range of benefits. The five-year plan, despite not being invested in, was recognised as something that needed to be done. So, an awful lot of work has gone on that, in many respects, has not been acknowledged. Nonetheless, no-one in the service would ever say to you that it is perfect, that it is working well, or that they could not do with more resources. I have pointed out to you that the Scottish service, which was in a similar situation, had its funding doubled.

Peter Black: Would you say that the complexity of needs is one of the direct reasons why the service faces its current problems of waiting times for repairs and assessments, because things are now so much more complex? Is it just a case of throwing more money at it to tackle the problem?

Dr Fitzpatrick: Yes and no, because there are structural and process aspects that could change. We know that the development of good quality, first and second-level assessment in the community, by professionals who could do this work, would be extremely helpful. Part of the difficulty, dare I say, is that some of them do not want to do it, but that is another issue.

We are in a position where funding would make a huge difference. This is historical, going way back, before even the time of the Assembly. However, it is not sufficient. You will be aware that the Minister instigated a review, the first stage of which is to ensure that all the efficiency plans that have been put in place are actually working. The service has been working to a lean principle for some time, and it has worked hard to achieve that. While I am not an apologist for the service, as I have told you before, I feel that the difficulty, in part, is that people have had to struggle really hard to implement what they saw as being the benefits for and, indeed, the demands of wheelchair users across Wales, and they did so not with an increased funding resource, but against a cost reduction plan. They have worked very hard to implement as much of that plan as they could, and they still find themselves hugely criticised for what they have not been able to do. The truth, however, is that, without new resource, some of those services just could not be provided. That is an incredibly difficult place to be.

Darren Millar: I would ask for concise responses because of the time that we have left. I am sorry to have to make that point. I ask that the questions are concise as well, because the clock is against us and we have a lot of territory to cover. Dai Lloyd, you are next.

David Lloyd: I think that most of the next question has been covered by very full answers, Kevin, so I will try to flesh things out. In your evidence, you say of the posture mobility steering group that you share the aspirations of all users that those who require complex equipment and those with the most urgent needs should have those needs met as quickly and as well as possible. Do you think that that aspiration is being met, in general terms?

Dr Fitzpatrick: No.

David Lloyd: Following on from that, are the current standards for wheelchair services effective, and would you like to see them altered in any way?

Dr Fitzpatrick: The standards are not effective, but we have known that for some time, and they have not been developed well. However, the service would welcome a better service standard because that would help the service to measure its progress and allow it to say to you clearly, 'This is where we are making progress and delivering and we can tell you that all standard wheelchair users actually get their wheelchairs within 21 days'. We have to be clear that, if there are 80,000 users in the country, and 80 per cent of them are getting a service within the set time, the difficulty comes back to the people who, like me, have more complex needs. The difficulty that the service has in meeting those needs, and the reason why the short answer is 'no'—for all the reasons that we have rehearsed—is not that the service does not have that aspiration; of course it does, and everyone in that service is trying to work towards that end, but the constraints are huge. I have been asked to be brief, so I will be brief.

10.30 a.m.

David Lloyd: No, that is fine; that was a very full answer.

Darren Millar: You have been excellent at it.

Lorraine Barrett: Thank you for your paper, which is well set out and easy to read, and it touches on all the right areas. You say in your evidence that the steering group is committed to the view that all users must have responsibility for making decisions about themselves, which requires service users to be afforded the tools and instruments of their own independence. Can you expand on how service users can make some of the decisions themselves, and clarify exactly what you mean by that?

Dr Fitzpatrick: I can tell you exactly what I mean by that. First of all, let us be clear that the group is a steering group, which brings together not just users, but service heads, clinicians and the commissioner. So, it is a group of committed people, and, when I say that the group is committed, I mean that everyone is committed to that aim and aspiration.

On the decision-making process, I am doing some work elsewhere around the whole notion of partnership and healthcare, and it is my view that there is no service user of any healthcare service who should not—and I will put it like this for brevity—be able to be the chair of their own case conference. What that means is that we get away from the medical model of 'doing something to someone', but we do not throw away medical input. It is the opposite, in fact—if I am sitting here as a user of services and you are medical professionals, I want you to give me the best of your knowledge and then I want to be able to make an informed decision with you. To do that, someone with a learning disability might need an advocate who can work with them before and after to understand the implications of what they are doing. However, it is a model, and it is one that I think can be rolled out.

As a model, it leads to best-quality outcomes for individual patients and groups. It leads to the cost benefits that I mentioned a moment ago. It is a cost benefit to the service of some millions of pounds. If you want user-determined outcomes, with the user being an equal partner in the decision-making process about their healthcare, you will get a good-quality service that saves money.

Lorraine Barrett: You gave an example at the beginning about lights on wheelchairs and someone's lifestyle needs; they need lights when they go out at night. Do you think that all the needs of individual wheelchair users—you have already touched on this in a way—are being met with regard to their lifestyle needs, and not just their clinical needs? What can be the barriers to this being achieved? It may not be simply about money.

Dr Fitzpatrick: The difficulty about the lifestyle issue is that many different demands come under that heading. I think that I pointed to a difficulty in the paper, if memory serves, in that people surf the internet looking for wheelchairs. What they come up with in terms of their demands for a wheelchair is not only outwith the service because the industry will not give us that chair to put in the range, because it prefers the profit, but the chair is inappropriate because it does not meet health and safety standards, and so on. I gave the example of people in the United States having accidents and being burnt because the canvases on their chairs were not right.

There is a very difficult discussion to be held, and we need to have a really good discussion about the difference between a lifestyle need and a clinical need, and about what the service's requirement should be. Clinically, I would benefit from having a chair with a riser mechanism, to be able to stand up. However, the truth is that any wheelchair user would benefit from being able to stand because of their kidney function, so there is an argument that every wheelchair user should have a riser mechanism on their chair. The cost to the service, the country, the taxpayer and the NHS would be enormous, but, in an ideal world, we would be able to do that. It would mean that I would be able to pick books off shelves as well. However, as a wheelchair user for 36 years, I have had to ask people to take things off shelves that I cannot reach. Should I demand that of a service?

<p>Lorraine Barrett: It is difficult, is it not? It is an issue of equality, at the end of the day.</p>
<p>Dr Fitzpatrick: I would love to be able to say that I can demand it because the service should not only provide it, but be funded to provide it. However, if I am a realistic user—this is where we are talking about the tools to make decisions—I must recognise that, at some point in time, my demands cannot be met because of current resource constraints. Much as I would love them to be, what do I do? I must make a judgment somewhere in this process, and that is where being an equal partner in the decision-making process requires me to have some responsibility.</p>
<p>Lorraine Barrett: Do you think that sufficient training and support are available for wheelchair users?</p>
<p>Dr Fitzpatrick: I do not think that there is sufficient training and support for patients and users of any service. I would like to see greater resource to do that and I am working on that with WIHSC.</p>
<p>Lorraine Barrett: I have one last question with regard to meeting the needs of service users in terms of language, including speakers of Welsh and people from ethnic backgrounds and the other languages that are prevalent in Wales.</p>
<p>Dr Fitzpatrick: Is the question whether we should be doing it?</p>
<p>Lorraine Barrett: What level of service is available, if any?</p>
<p>Dr Fitzpatrick: There are first-language Welsh speakers in the service and they are used to providing the service, particularly in north Wales, where possible. I do not know about the level or use of that service. We know that, when canvassed, a high proportion of Welsh-speaking users say that they are comfortable or okay. I am not suggesting that that is the result—the service should be there; there is no doubt about that.</p>
<p>Lorraine Barrett: I will not expand on this now, but, maybe, at some point, we can look again at the needs of people from black minority ethnic communities, where it is not only a linguistic issue, but a cultural issue, and it is about access to services generally.</p>
<p>Dr Fitzpatrick: It is not just a case of access to services, but of how people perceive disability in those cultures and what they feel should be done with regard to accessing services. That is part of the barrier.</p>
<p>Darren Millar: We will take a look at the funding now.</p>
<p>Ann Jones: Your paper states that you welcome the ministerial review, and then the group goes on to say that</p>
<p>'if we take the Scottish example, it is likely that we will need to see a doubling of current levels of funding'.</p>
<p>How much funding exactly are you looking at? You refer to doubling the levels, but how much are we talking about and how should those extra resources be used?</p>
<p>Dr Fitzpatrick: One of the difficulties is to know what we are funding. We have to be specific. If we say, for example, that we want to fund a discrete service within the service for children for their posture, mobility and steering needs, we can work that out. As you have seen, there was an indication of £500,000 to start off with and a recurring £400,000. Having said that, even at that point, it is difficult to determine exactly what the resource level need is. That is partly because, as we move towards more complex equipment and as people are living longer and, as a result of the other health services, surviving, we are finding that the level of demand is going up disproportionately. We have somewhere in the order of 80,000 wheelchair users in the country, and 20 per cent of those, as I said, have complex needs, but the service is currently receiving in the order of three to four times that number of referrals. So, we are talking about 220,000 adult referrals and 2,000 of what would be classed as paediatric referrals annually, with an existing group of 80,000. In that context, how do you determine the resource envelopes?</p>

One of the things that the five-year plan determined was—and we got close to this happening with the National Public Health Service for Wales at the time—that we need a clear, scientific view of future service needs and demands. That means that we need to know whether there is a greater prevalence of multiple sclerosis or motor neurone disease in the country or whether more people are surviving car accidents. We need to know what the service level will be. We can determine the funding in a discrete way. We can say, 'Crikey, any funding would be really useful and will be well used'. However, in that context, we need to be clear about what specifically is being asked for and what the funding need is, and whether it is for the whole service, whether it is to deliver all the lifestyle stuff, because that will be one cost, or whether it is to deliver on a clinical-needs basis, which is another cost, and if it is something in between, then it is another cost. So, we have a real problem.

10.40 a.m.

Ann Jones: Are the available resources used effectively?

Dr Fitzpatrick: Yes. The review team came in—and I should not judge what it said—to discover whether there were any cost-efficiency savings to be made. It found little that could be done to make better use of the resource. Having said that, we know about community resources, for example, and we know that there are ways in which we can develop these things. However, the other side of that, in terms of the investment made in clinicians, is that those people had to be trained to a certain place where they were able to start delivering. That is what has been happening.

Darren Millar: As part of that discussion, did you not compare the use of resources with the use in other parts of the United Kingdom where better results are achieved with regard to assessment times?

Dr Fitzpatrick: To benchmark against other services is quite a tricky thing to do. For example, one thing that we know is that the lobby groups and those who were consulted in the 1990s about a voucher scheme, which would be a top-up scheme, were quite clear that they wanted an equitable service in Wales and not a two-tier service where those who could afford to pay got a better service. So, if you look at results in some parts of England, for example, where vouchers are available, you are not benchmarking or comparing the same two services. We have rurality issues in Wales, as in Scotland, but they do not have those issues in the Wirral, for example. So, it is a difficult comparison to make. I was not suggesting that assessment processes were better in one place or another; we need to dig into the detail to be able to make those judgments.

Darren Millar: That, of course, is what our committee has attempted to do since the start of the inquiry. Andrew R.T. Davies, do you want to come in on the voucher scheme?

Andrew R.T. Davies: I want to take you up on a point. I appreciate that I might be somewhat critical in saying this, but I was a little disappointed at the vagueness of the answer on additional resources. I appreciate that we need to know where we want to be, and it would be good to try to get a feel of that, but your answer implied that an enormous amount of research still needs to be done into a whole range of issues, such as motor neurone disease and car accident survival rates. On my way into the Assembly today, I heard on BBC Radio Wales that the Minister was to make an announcement on additional resources for wheelchairs, and I presume that that would be in advance of her meeting today with our good selves.

Dr Fitzpatrick: I did not hear that announcement.

Andrew R.T. Davies: So, she must be having some form of input in terms of what resources are required. I was just reading the brief about how you were established, and it would be helpful if you could say a bit more about where you think that additional resource would be helpful and the amount of that resource. That type of evidence is helpful in putting together a report, because it comes from an informed source.

Dr Fitzpatrick: I can say two things. First, to repeat what I said before, it is incredibly complex to decide on that, because if you decide, for example, that the service should routinely give every wheelchair user the option of having a riser on their chair, then the funding for that is huge. It is not a problem to work that out, because, although there is some complexity around the assessments, there is a unit cost. So, if you want those figures, they can be worked out. Secondly, it is reasonably simple, in a sense, to take a benchmark for the resource issue, because you have the five-year plan and you can simply cost those figures.

Andrew R.T. Davies: What do you think that figure would be?

Dr Fitzpatrick: For example, if you want to develop a paediatric service that was originally, as I said, costed at £500,000 for the first year and £400,000 thereafter, then the figure should be increased to £750,000 as a starting point, which is a serious investment, in order for us to get the work done, to get the service right and to get the right resource dedicated to the service. If that is the priority that you decide upon—and I cannot make that decision—then use that funding and have recurring funding behind it of, say, £0.5 million a year. We know that the service in north Wales is hugely taxed by its historic waiting list, and I know that it has told you that to maintain a steady state would require £1.8 million. That is its figure.

Andrew R.T. Davies: Did you say £1.8 million?

Dr Fitzpatrick: That is for a steady state, but it does not mean that the service can go forward. You would be talking about resources of a couple of million more to make that work, which means getting waiting lists down to a level at which they are manageable. They have to be managed well, and that just cannot be done without resources, but part of the complexity of this is that the clinicians need to be trained, and there is a timescale to that. They also need to be paid, and there has been a real dearth of professional occupational therapists across the country. We cannot attract people unless we can pay them more. How do you balance all that? It depends what you want to have costed. Do you want the whole shebang? If so, do you want lifestyle taken into account? Should everyone have everything?

Andrew R.T. Davies: My view is that you start with a base and work up from that. If you go for a basic service, you can then add the aspirational elements that you referred to. However, you were saying that you would like to have a lifter, but is that fair on the taxpayer? You said that you have made accommodations for your lifestyle, and there are many things in life that we would like to do, but surely there should be an aspiration to deliver the basic service well, and then, if we can afford the add-ons, we could provide those, too. I am just trying to get a feel for where we should be in providing that basic level of service, because the evidence that we have received is that we are not even doing that at the moment.

Dr Fitzpatrick: As I said, the difficulty that arises is this: what question are you asking? The basic service is being delivered well, in many respects. ["Interruption."] Yes, it is.

Darren Millar: You are talking about the non-complex chairs, are you not?

Dr Fitzpatrick: No, I am talking about complex chairs as well. The waiting lists are the biggest issue, and a very public one at that. However, the vast majority of people are not waiting; the vast majority are getting a good service, even at a complex level. What is happening is that some people who have very complex needs are being made to wait a long time, and some of that is because of bottlenecks in the supply chain, but that is not about the service. It is not always within the gift of the service to solve that kind of problem.

Darren Millar: That is not what the evidence has suggested, actually, regarding the supply chain. The evidence that we have received and been able to confirm is that the supply chain is robust, and there is no problem with the turnaround once a prescription for a chair is made. The turnaround is very quick.

Dr Fitzpatrick: That is the case now, is it?

Darren Millar: Yes.

Dr Fitzpatrick: The truth is that we are talking about historical waiting lists that grew over a period when the industry was not able to provide that quick turnaround.

Ann Jones: On the historical waiting list for north Wales—correct me if I am wrong—I thought that the north Wales service received a one-off payment to clear its waiting lists. I think that that was the evidence that we received.

<p>Darren Millar: Yes, it had £0.5 million.</p>
<p>Ann Jones: Yet we still have these historical waiting lists that people keep referring to. Somewhere along the line, the system is not working, because if you clear those historical waiting lists, you can no longer refer to them. That is what has happened, surely, and yet we still have people waiting in north Wales, so the system is not working, is it?</p>
<p>Dr Fitzpatrick: I am not suggesting that the system is working as well as it could with extra funding.</p>
<p>Ann Jones: You told me that you considered that the current resources available were being used effectively. Obviously, they are not.</p>
<p>Dr Fitzpatrick: On the historical waiting lists, £0.5 million was not enough to clear them.</p>
<p>Darren Millar: I think that the evidence that we received was that that brought the waiting lists down to something like 15 months. However, we still have a situation in which some individuals, in north Wales in particular, are waiting two years for an assessment. Even under the current regime, there is no excuse for that, is there?</p>
<p>Dr Fitzpatrick: There is no excuse for that, and I do not think that anyone in the service would want you to think that they were excusing themselves for that. However, there is a difference between saying that the current resources are being used effectively and saying that, with further resources, more could be done. You are quite right about the waiting list issue, but the problem is that driving a waiting list down, even reducing it by 50 per cent, is an outcome, but it is not sufficient. The investment has not been sufficient to drive it all the way down, and then to create a service that will—</p>
<p>Ann Jones: Neither is it sufficient to keep going on about historical waiting lists to mask the problem in north Wales. There are obviously further problems in north Wales, as we have people waiting two years.</p>
<p>Darren Millar: You have suggested, doctor, that around £1.8 million would help to clear the waiting lists in north Wales.</p>
<p>Dr Fitzpatrick: That is their figure. That came from the turnaround team at the LHB. Could I just say, as a matter of record, that one of the dangers to the service is the idea that it will be taken into an LHB in any way, shape or form? This is an all-Wales service. If we are to keep an equitable all-Wales service, we need one service and, yes, it needs investment and some support, but what I do not think we need is seven LHBs running seven different wheelchair services across Wales. So, I am anxious about the suggestion that the north Wales service will be absorbed into the Betsi Cadwaladr LHB.</p>
<p>10.50 a.m.</p>
<p>Darren Millar: Thank you for that. Perhaps we will touch on that later.</p>
<p>Val Lloyd: Dr Fitzpatrick, I have a question about maintenance and repair. There is a section in your paper on that. You tell us that your steering group has argued that in-house provision for repair and maintenance would lead to better outcomes for wheelchair users. We have learned that Cardiff Artificial Limb and Appliance Centre has brought provision in-house. Are you aware of any repair and maintenance issues in north Wales? Would you recommend that the service in north Wales should also be brought in-house?</p>
<p>Dr Fitzpatrick: The service in north Wales has a better relationship with the contractor. On why that is, historically, those staff have been TUPEd across from different organisations—that is, under Transfer of Undertakings (Protection of Employment) Regulations—and so they have that level of consistency. This is actually about what the contractor has done. The service has just come in-house, but the contractor up to 1 February was a previous contractor, who had lost the contract before for not providing the service well enough. Another contractor was brought in, and it was not doing the job properly either, so the first contractor, Serco, came back in, promising the sun, the moon and the stars to the service.</p>
<p>Val Lloyd: Do you mean to the north Wales service?</p>

Dr Fitzpatrick: No, it bid as an all-Wales service. Only five contractors made it to interview stage, because of the level of service that people were able to provide. One of those five was bidding only for the north Wales contract as a separate stand-alone service so, in effect, there were four potential contractors in that process. I have to say that this is extraordinary, but it is how private contractors are doing this: the approved repairer, the company that takes on the contract, sends its technicians out, and that is the face of the service to most people. That is why it has generated so many complaints in the past. Looking at the relative numbers, we see that the number in the south is three or four times that in the north. You would expect the complexity of the contract to be greater, but it was meant to be run as an all-Wales service. Why the contractor is able to provide a really good service in the north and not in the south is beyond me, but the truth is that it cuts corners.

I am currently using solid tyres because I will not use pneumatic tyres. Why? Because the contractor would not even give its technicians who were coming out on a routine or emergency visit a supply of inner tubes. So, to give you a real example, on Friday night, I had a puncture and I had to get to the airport the next morning to pick up my partner, but I had no wheelchair, so I was effectively immobilised. There was nobody at the end of the phone. I ended up going to the car, driving to the airport, and forcing the contractor, on a Saturday morning, to meet me at the airport with the right size of tyre. He had to get his manager to open the depot to do that. I am sorry, but that is not how the service should be run. For some time, we have argued that it would be better to bring the service in-house, because the technicians are there, and the people who do the work know the chairs really well—it is a part of that business about offering the whole range. So, we are hoping, and I believe, that the service in the south will be much better for having been brought in-house. Should it be brought in-house in north Wales? Why fix something that is not broken? It is a difficult one.

Andrew R.T. Davies: I attended the centre at Rookwood Hospital, and I heard the story about bringing the service in-house. The following week, the north Wales service came to the committee to give evidence and said that it had no problem at all with its contract; in fact, I think that it had not had an official complaint for 12 months. There is quite a stark difference between the north and the south. However, the services that both are providing would be similar, so why is there such a difference? Surely, it is down to the management of the contract or the specification of it. The anomalies were massive. In the north, there was not one complaint in 12 months, and yet, in the south, there had been a whole string of complaints, and you, Kevin, gave an example of how you have suffered. That, surely, is down to the management of the contract.

Dr Fitzpatrick: I cannot speak for those who are managing those contracts with you, the external contractor, and the approved repairer, as I am not aware of all the pressures, but I know that a lot of pressure has been put on them to do the work. There is probably an economy of scale involved in this. If you look at the relative numbers and then drop down to the 20 per cent who have complex needs in the area, you see that the numbers that the north Wales approved repair contractor is servicing are quite small compared with those in the south. That may be a factor. I am not completely clear about how it has done it, but I know that the head of the service in north Wales is clear about the continuity in its relationship with the people, as opposed to what has happened in the south, where people have come in and out of it.

It has been more difficult to manage the scale of the service in the south. Again, you would have to ask the service for the detail, but I have been clear about the fact that, over the lifetime of approved repairer contracts in my time—and I have been involved with three—the contractors have done everything that they can to increase profits and to minimise costs to themselves, at the expense of the service user. It is a joy that it is working so well in north Wales, but that does not mean that it will be able to work on the scale on which it is working in south Wales, given how the external contractors behave.

As users, we were involved in some of the contracting process, and the private contractor promised faithfully that there would be pre-planned maintenance of wheelchairs, particularly electric wheelchairs. A lot of that has not been done. They send out surveys, for example—and this might be part of the answer—but they canvass two people a month, and I am sure that they hand-pick them. They then say that the service is getting a 100 per cent result, but we know that that is not true. What the contractor is saying is not true. I cannot be clear about the personal relationships, but it is clear that the manager in the north is saying that, as there has been that continuity and the length of continued service for maybe 10 years, although I cannot remember what it is exactly, it was able to work with the contractor to keep on doing that work. However, we have not had that luxury in the south.

Darren Millar: We have covered all the territory that we need to cover this morning, Dr Fitzpatrick. Thank you for the written and oral evidence that you have provided. It has been extremely helpful to the inquiry. I am sure that it will be referred to extensively in our report. Thank you for your time.

10.59 a.m.

Ymchwiliad i Wasanaethau Cadeiriau Olwyn: Tystiolaeth gan y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol a Chomisiwn Iechyd Cymru

Inquiry into Wheelchair Services: Evidence from the Minister for Health and Social Services and Health Commission Wales

Darren Millar: I am now delighted to welcome the Minister for Health and Social Services, Edwina Hart, and Simon Dean, director of strategy and planning in the Department for Health and Social Services. Welcome and thank you, Minister, for the paper that you have provided to the committee. Before we move to questions, I understand that you will make an announcement of some sort today about wheelchairs. Perhaps it would be helpful to get that on the record before we start.

The Minister for Health and Social Services (Edwina Hart): There is agreement, across the parties and particularly on the Government side, to try to get a first-class service for all wheelchair users in Wales. We are committed to that.

11.00 a.m.

I recognise the importance of essential equipment being made available to those who need it and the impact on people's lives if the right equipment is not available at the right time. We have to put the discussion in context. The difficulties arise when cases are complex. Normally, when cases are straightforward, we do very well on the time and turnaround in dealing with the equipment issues. I accept that the current standards of provision across Wales are uneven and that waiting times are excessively long; that has been particularly illustrated in the case of north Wales. That is why I commissioned a review of the all-Wales provision. Like you, I am disappointed that the review has taken so long and is in two parts. That is not because there was not a need for a review or that there was no momentum for a review; as the review progressed it became more complex to look at some of the issues that arose. Following on from phase 1 of the all-Wales posture and mobility review, I am pleased to announce plans for phase 2. It will include a review of the current waiting list management processes, which is important. My aim is to ensure that waiting times are managed effectively and that future investment leads to greater reduction in waiting times. When targets were set for the service previously, it was easy to say that we would always be able to put money in to deliver on them, but we are in a much more complex area than straightforward targets and putting money in to follow them through.

Also, the review of wheelchair waiting list management processes, in line with the referral to treatment guidance, is important, as is the development of robust key performance indicators, which set out exactly what the service will deliver. The service has been too inward looking and has not had the appropriate links with wider health services. The service itself is commissioned by Health Commission Wales. This will change from 1 April, and will also lead to improvements. The key performance indicators will drive the performance improvement agenda and allow us to target appropriate areas. We are reviewing the most appropriate model for a proposed single lead organisation that would have responsibility for managing and delivering services currently provided by the Artificial Limb and Appliance Service. We have engineering units and I, in conjunction with the service group, want to look at what that model should be. You have already taken evidence from Dr Kevin Fitzpatrick this morning, which indicates the direction of travel on phase 2. I want to ensure speedier access to equipment for those patients who are currently experiencing delays. The recommendations from phase 1 of the review have shown the way; the task now is to bring about improvements in wheelchair services.

I would be wrong, Chair, if I did not acknowledge the financial and investment issues surrounding this. I am likely to have demands made for investment on the second stage of the review. I approach this committee with openness and transparency. I realise that it has been difficult for Members to deal with some of the casework arising from this on an individual basis. The impact on families, particularly with regard to children's wheelchairs, has made family life quite fraught. We also need to recognise that in Wales, we offer a far greater choice of equipment than anywhere else. We also offer more complex equipment, which we then need to ensure that we can repair. There are issues around that. I am sure that you have seen from your inquiry that the issue of repairs and parts is complex and that it is not as simple as 'I say this, you say that, and it will be done' when it comes to wheelchair provision.

Darren Millar: We welcome those opening remarks, Minister. Many of us have had casework that we have had to bring to your attention in order for it to be resolved. I thank you personally for your intervention in respect of some of the casework in my own constituency. You have made some remarks this morning about this being a priority. You have made those sorts of remarks in the Chamber in the past and you announced a review in May 2008. However, the evidence that we have received suggests that there has been a lack of momentum behind that review and the formal meetings to ensure that the review was progressing. There was no formal meeting until January 2009. In fact, there has only been one other formal meeting, in July last year. Why was that momentum not there, given your commitment as Minister to ensuring that this matter was taken forward?

Edwina Hart: Work was undertaken during those periods, but I openly admit that that work—the way that officials and others in the service dealt with it—did not have the momentum that I would have wanted. That is one of the issues that I would raise and try to move on. It is quite a difficult group to get together because there are a lot of people involved in it. Sometimes, I think that these people were concentrating on their day jobs rather than looking at the future of the service. However, now that we have gone through the difficult stage of establishing what happens in phase 1, I think that there is a great deal more momentum for phase 2. I have the commitment of some very good people to take the project forward and I hope that it will not be delayed.

Darren Millar: I would like to hope that our inquiry has helped to shine a light on this issue and ensure that some progress has been made. I am delighted to hear the update that you have given us today.

Andrew R.T. Davies: One of the first bits of evidence that we received in this inquiry was from representatives of the children's commissioner. These representatives said that they were not even invited to be a part of the review group. Participants in other events that have been held here—under the auspices of Whizz-Kidz and other groups—have indicated that there is a feeling of detachment. Although they are a part of the group, they do not know, necessarily, its direction of travel. You touched on the idea that officials are, perhaps, not providing the impetus to the group to get things moving. What remedial action have you taken, as Minister, to ensure that the second phase of the review is more robust in its actions? Can we be confident that there will not be a repetition of the lengthy process of the first phase, which frustrated many people?

Edwina Hart: I share the committee's disappointment on the first phase. As a result of your disappointment, my disappointment and the disappointment of others, Simon—who is with me today—and his team are now involved in the arrangements to replace Health Commission Wales. Simon has the benefit of being the previous director of Health Commission Wales and now has the responsibility of seeing what goes on at the commission. He is taking a lead on this, and his foot is very much on the accelerator to ensure that we get a better buy-in from organisations. We recognise that my officials and others in the service are not necessarily the people who will give the best advice on what we should be doing in future. Sometimes, there has been reluctance across the NHS to share better experience from others outside the service. It has been very inward looking, with individuals thinking that they should get their heads down to see what they can do about a situation, without recognising that there is a lot of assistance out there for them. I welcome the work that the children's commissioner has done for me in many areas. I had a particularly interesting discussion recently with him about child and adolescent health services, and how he can assist in that area. I can assure Members that we will not see a repetition of the slow way in which the first phase of the review was dealt with.

Peter Black: We have heard evidence from the Artificial Limb and Appliance Service in north Wales that the longest wait for paediatric wheelchairs is 23 months. Why are waiting times so long, and when can we expect to see a significant improvement?

Edwina Hart: I expect to see improvements and developments quite quickly as we move into phase 2. The key performance indicators will help in this area, and phase 2 will review the waiting list management processes. However, we would not want to underestimate the difficulties that arise sometimes in dealing with the technical requirements associated with children's wheelchairs. I would be a very unwise health Minister if I said to you that this situation will change overnight because it will not. We have to wait for the conclusions of the waiting list management processes review. We can then, hopefully, look at what would be satisfactory performance indicators that would lead to shorter waiting times for individuals. The needs of a child can change in a very short period of time, so if one is slow in getting things off the ground, another wheelchair has to be found. This is a very difficult and complex area, but it is something that I am determined to get right with the implementation of phase 2. I do not think that we can satisfy everybody; even if we strive to get it right, there will still be problems with the system.

David Lloyd: I want to flesh out the issue of the use and effectiveness of performance and quality indicators. We have heard evidence that Health Commission Wales sets targets of 12 months from referral to the delivery of wheelchairs for children, and 15 months for adults. Are you satisfied that these targets are sufficiently ambitious and robust?

Edwina Hart: I am afraid that I expect wheelchairs to be provided within reasonable timescales, and the key performance indicators will help to define clearly what these should be.

11.10 a.m.

As I promised in response to an earlier question, there will be much greater use of the indicators in the project group and the wider reference group of people who understand these issues. The important thing to recognise is that the specialist and tertiary services, of which this is a part, are now moving from Health Commission Wales. The fact that the health boards will have responsibility for some of these areas will focus the mind far more on the delivery mechanism because we will be able to see what they do, how they are managed and we will be able to bring them to account.

My concern has always been that the service, the health service and the Assembly Government are separate from each other. We must have far more integration. It was interesting to hear what was said in yesterday's debate. This is an area where there must be more centralised control.

Darren Millar: In relation to targets, I visited the Sefton wheelchair service in Merseyside. Granted, it is a much more urban setting than north or south Wales, but it manages to turn even complex chairs around, from assessment to the delivery of the wheelchair, within five weeks, on average, compared to a 24-month wait for an assessment in north Wales for some individuals. It was working to a target of around 12 weeks in England. In spite of the fact that we have heard on a number of occasions in the Chamber that this is a ministerial priority, and I truly believe that it is something that you want to sort out, why did Health Commission Wales—and perhaps this is a question that Mr Dean needs to answer—not seem to make it as much of a priority as the Minister or the National Assembly for Wales?

Mr Dean: As my former role was that of chief executive of Health Commission Wales, I will try to address that question. The remit of Health Commission Wales is large and complicated, with a range of specialised services that are all resource intensive. It is simply a question of prioritisation regarding the use of available resources. One of the things that interested me, if I recall the evidence correctly, is the notion that there is a long tail to the waiting list, so the majority of patients receive wheelchairs very quickly, and it is addressing the long tail that is critical. We have seen that in other aspects of healthcare.

Part of that will be to do with waiting list management processes, which is why a key part of the second phase is to work with the service to ensure that it is as effective as possible with the resource that is currently available. That will then provide information to help the Minister to make decisions about targeting future resource increases. So, we need to work with the service. We are working with the National Leadership and Innovation Agency for Healthcare and the delivery and support units, which are experts on the process engineering side, along with colleagues in ALAS, who understand the detail of the service, to identify areas where improvements can be made to reduce that tail. In the majority of cases, people receive their wheelchairs quickly. We need to understand what the delays are in those cases that form the tail and we then need to identify those that we can address quickly. We will then provide advice to the Minister to help to guide future decisions.

Edwina Hart: We all tend to look at the worst-case scenarios from the evidence that we get, not the examples where we have successfully managed the process. I will ask Simon whether we can look at the Chair's evidence about his visit. I would be happy to look at some of the evidence that might have come from here and provide it for the second phase of the review.

Darren Millar: That would be helpful. Dai Lloyd, do you want to continue?

David Lloyd: I will stay with the subject of targets. The national service framework for children, young people and maternity services includes standards of six and eight weeks for assessment and provision respectively for children's wheelchairs. However, we have had evidence from witnesses from ALAS that has suggested that it is not resourced to meet these standards. How do you intend to ensure that these standards are achieved?

Edwina Hart: I would expect anyone from the health service to say that they are not properly resourced on any aspect of anything that they discuss when they appear before the committee. However, I acknowledged in my opening remarks that, once we complete the second phase, we will be looking at resources within the limits of budgets and at prioritisation. However, if I decide to give further priority to this agenda, it means that something will be removed from another area. So, I do not doubt the sincerity of the contribution and that it thought that more money would help, but an improvement in systems, the way that the service is managed, and the way that HCW commissioned it would have helped rather than constantly going on about the financial processes. Unless we have the correct systems in place, it does not matter how much money you put into a service, it still will not work, but I will look at the resource implications if I have any recommendations to do so when the second phase of the review is completed.

Peter Black: I accept your point that people always say that they are not resourced, but the standards in that national service framework are not being met. So, what is the process in Government in terms of monitoring that NSF and ensuring that those standards are being met? Have alarm bells not been ringing that the NSF standards have not been met for this particular service?

Edwina Hart: We regularly review all of the NSFs across the piece and we have reports on them. I am aware of the issues that you have raised with me today in terms of what Dai asked about how we deal with the standards issues.

Peter Black: So has any action been taken to address the fact that these standards were not being met in the past?

Edwina Hart: Yes. Action has been taken as part of an integrated approach in terms of the review and that will impact on the NSF standards for children.

Darren Millar: I think, Minister, that we want to know what, historically, Health Commission Wales has done to ensure that these NSF targets have been met, because the evidence seems to suggest that nothing has been done and that it has not been a priority for Health Commission Wales. Mr Dean, do you want to respond to that?

Mr Dean: The Minister made available £525,000, if memory serves me correctly, over the last year to help to address some of the backlog. So, the Minister has taken action to put additional resource into the service where it has been possible to identify it.

Edwina Hart: Yes, we were well aware that we were not meeting our commitments in the NSF and so we did put resource in, but that is a very temporary measure. You have to look at the long-term measures that you have to put in place and the long-term financial stability that you provide.

Darren Millar: Talking of the long term, we just heard evidence from Dr Fitzpatrick suggesting that a five-year plan was drawn up and agreed, effectively, by clinicians and service users, which included an investment strategy and which was going to deal with some of these particular issues. Some cash was made available to start that off and some of the plan was implemented, but not the rest. What was the reason for the rest of the plan not being implemented?

Mr Dean: That links with the topic that we have just been discussing. A range of actions were taken, for example, improving training and improving user involvement in the planning process. I used to meet regularly with Kevin as chair of the posture mobility steering group, in my former role as chief executive of HCW. So, there is an action plan here that describes a range of actions that have been taken, but, as the Minister said, resource issues have not allowed the plan to be fully implemented, hence the review that is under way at the moment.

Andrew R.T. Davies: Substantial evidence over the last couple of sessions has highlighted the difficulty in which the service has been placed by the failure to implement the five-year plan. Various witnesses maintain that we would not be in this situation had that plan been implemented. Do you recognise that many problems that the service now faces emanate from the failure to resource the plan back in 2004-05 and that while the additional £500,000—non-recurring money, I might add—put into the service is welcome, it would not have been required had the five-year plan been implemented in its entirety?

Edwina Hart: It is difficult for me to comment on something that occurred before I became Minister, because I am not aware of the paperwork surrounding the implementation and I am not entitled to see the documents. However, in general terms, it is always useful, if you have the financial resources available and you think that you can squeeze more out of them, to take action when it is required rather than put it off, if that is of any assistance to Members.

Andrew R.T. Davies: Thank you, Minister, it is of assistance.

David Lloyd: To keep harping on about targets and to do this situation to death, you state in your paper that the lack of formally agreed service standards has meant that the performance management focus on the wheelchair service is not as clear as in other specialities that have had waiting list targets as a service driver. So, what do you think would be appropriate service standards and key performance indicators for the wheelchair services in Wales and when will they be introduced?

Edwina Hart: If we could have that appropriate model of one lead organisation, that would improve the situation significantly, because it would have responsibility for managing and delivering the services currently dealt with by ALAS and the rehabilitation engineering units, and that would be the right way forward. I understand that that is one of the first priority areas that will be considered as part of that review and I would like that to be completed as soon as possible, because we are moving into new arrangements with the daughter of HCW, and all the other arrangements that are going forward from 1 April, so it would be useful if this could be one of the first things that is undertaken.

11.20 a.m.

I will not put any time frames on any of this, but I am more than happy, Chair, to drop you a line after further discussions with my officials, if I can flesh out any time frames for the second stage and prioritisation in the second stage for the various issues that the committee has raised with me today.

Darren Millar: Thank you for that, Minister. Witnesses have suggested that if a clear national service specification was developed for wheelchair services, it would ensure greater consistency across Wales. We have talked, and you made some opening remarks, about the differences between north and south Wales, and even rural and urban Wales, in many respects. Do you support the view that there needs to be service specification on a national basis?

Edwina Hart: Yes.

Darren Millar: That is good to know.

Ann Jones: On resources, we have touched on the £525,000 that was put into north Wales to address the waiting times problems there. It was clearly stated that while that went towards reducing the numbers waiting, that cannot be sustained, because more resources are not forthcoming. Why have we put that money in and not then sustained it? Is there a reason for that?

Edwina Hart: When I put the money in, I hoped that I would have reached another stage in the development of the process in terms of the report that is being prepared for me. In the current economic situation, I can understand why people are worried about what will happen to the budget. Also, chairs and seating equipment are, of course, purchased in a global market, and this makes things even more interesting in terms of what you get for the cash that you put into the system. I will therefore be making future announcements on funding when I have received the final report. Recognising the current economic crisis and the recommendations from phase 2 are important.

When we enter a difficult economic crisis, this is an area that you need to protect: you only have to look at the quality of life issues in relation to the provision of wheelchairs. It is one of the core areas in the NHS that you cannot consider if you have to look for any savings. I can give the commitment that I will be looking at further funding, even in a difficult settlement, according to the outcome of the report. That is, of course, if I am asked for more money.

Darren Millar: One thing that both services told us—certainly the north Wales service—was that they were petitioning annually for investment in the service to ensure that they were able to manage the waiting lists down. They were constantly applying for extra funds to HCW, but no funds were forthcoming. They had this one-off hit, and they said that that helped to shrink the list, but the fact that it was not recurrent was a problem. Do you accept that applications were made annually, Mr Dean, and what did HCW do with them? How did you discuss them? Were they brought to the Minister's attention, for example?

Mr Dean: I should say that I left HCW just over two years ago, so my comments will be historic. I am responsible for the performance management of HCW currently, so I have a different relationship with it now.

All services, each year, have discussions with all commissioners about the need for additional investment. That is standard across the range of services, because there is always a way of spending more money to good effect in just about any area of healthcare that one can think of. So, the wheelchair services did raise issues about resourcing with HCW, and, to my knowledge, they still do. Those issues are discussed by HCW internally as part of its prioritisation across the range of its responsibilities, and it has to make difficult choices, as, indeed, does the Minister when she is deciding how she wishes to commit the resources that are available to her. Those pressures are in the system, therefore, and they are known. I am aware of pressures in HCW, as I am aware of pressures in other parts of the NHS, in former LHBs and former trusts, and in the current situation. Those pressures are discussed, and then priority decisions have to be made by individual organisations based on the best fit to their available resources and their range of responsibilities.

Edwina Hart: It is fair to say, Chair, that this is how it has been dealt with historically, and it is not satisfactory, because we now deal with issues very differently in relation to long-term planning in the NHS. As you know, I got McKinsey in—for which I was much criticised—to look at some of the issues around five-year planning and how we look at services and everything. The fact that we are now moving to look at not just one, two or three years, but five years, will help in the delivery of services such as this. HCW was set a very difficult task in providing specialist services within the budget that it was asked to manage within. As part of that budget, you have the requests for bariatric surgery and other streams and so on, and it is very difficult to manage. The new health arrangements, which will have the seven boards planning services—we do not use the word 'commissioning', because we are not commissioning, as we do not have the purchaser/provider split any longer. The way that they work together will make a fundamental difference, because there was the whole issue of transaction costs that we had with the purchaser/provider split. That will make a difference, as will the new organisation that will take on the very specialist commissioning from the old HCW, because it is a small, neat organisation working in very difficult areas.

If we return to this topic in 12 months' time, I think that we would see an improvement in the arrangements. In an ideal world, I would not have wanted the arrangements that we had with HCW in terms of the way that we managed budgets, and that is why the organisation is now going and new arrangements will be put in place.

Darren Millar: On the £500,000 that you made available, which was greatly welcomed by the north Wales centre, you obviously knew that the centre was seeking recurrent funding to help manage that. However, it was your decision as Minister not to make that recurrent funding available. Why did you decide not to make recurrent funding available?

Edwina Hart: I made the funding that was available to me at the time available to the centre. I was hopeful that we would have far more integrated plans to look at, which we will be achieving now, in terms of the delivery of the service.

Andrew R.T. Davies: To pick up on that, Minister, in response to Ann and to an earlier question, you gave an insight into the problems with the initial group and the time that it has taken. I believe that your response to Ann was that you had hoped that the group would have provided you with more information, and that you could have been able to provide resource at the time had that information been made available to you. Did I understand you correctly?

Edwina Hart: I would not like to place any blame on the group.

Andrew R.T. Davies: I am not blaming the group; I am just trying to understand the process.

Edwina Hart: I take responsibility for the fact that this should have moved quicker, and I have discussed this with the chief executive of the NHS. I put my hands up on this—some of the issues should have moved quicker and we should have looked more closely at the funding issues sooner. I dread using the expression 'evidence base', but we must have an evidence base to make the decisions. In moving from the first phase of the review to the second phase, I will have an evidence base to make very rational decisions. If I am making the decision to put in money there, I will have to justify where I am perhaps taking it away from other services in the NHS within a very tight budget situation. It is not that I do not wish to answer the question, but I do not want to be seen to be apportioning blame in any shape or form. As Minister, I accept that this was an area of great concern to many people out there. I acknowledge the fact that the majority within the system are serviced well, but a significant minority found it very difficult in terms of the provision. I regard ALAS as a very good-hearted and industrious service, but it was very much in isolation from the rest of the service. An issue that I should perhaps have looked at before is its greater integration with the service.

Andrew R.T. Davies: To refer you back to evidence that you gave earlier, you highlighted that you regretted the fact that officials did not get behind the group to give impetus to it. So, would it be fair to suggest that there was a failure within the department to get to grips with this and move things forward, so that you could have had the information that would, ultimately, have allowed you to put the additional funding in, if that is what the information told you was needed? The information might have told you that it did not require additional funding, and that it was an organisational matter. However, from the evidence that you gave earlier, you clearly indicated that the department has failed.

Edwina Hart: If there is a departmental failure, it is also my failure and I express my regret. I do not think that it would be fair to identify blame in that way, because I am the Minister.

Darren Millar: Ann, did you want to ask your question?

Ann Jones: Well, the Minister has already said that she will make a commitment to put in resources, so I think that the £1.8 million that the north Wales centre was looking for has been addressed.

11.30 a.m.

Darren Millar: Minister, a few moments ago, you used the phrase 'an evidence base', which is so commonly used by some of your ministerial colleagues. The north Wales service has undertaken its own review and provided an evidence base that shows that a further £1.8 million needs to be invested in north Wales in order to bring that service up to scratch. Why do you need to form your own evidence base? Do you not trust them locally on the ground?

Edwina Hart: I need to get an all-Wales view on these issues. I understand from your questioning of me earlier that the committee thinks that it is probably a good idea for me to go to an all-Wales service. So, I will take an all-Wales perspective on it. It is not about trust; it is also important that there is an element of independence in the advice that I have.

Peter Black: We have received mixed evidence on this, but we have heard evidence that wheelchair services would be better integrated with local health board functions to provide a more holistic service. What is your view on that and what arrangements do you envisage being made for the future delivery of wheelchair services across Wales?

Edwina Hart: The important point on the delivery of wheelchair services is that we have a consistent approach for the delivery of services. The second phase will look at whether I should go for one organisation. I will now be asking them if they would be so good as to read through your evidence, if people have been talking about closer links with LHBs, which would be interesting for them to explore. However, my concern is about the inequity of the service and the lack of equality of access to services, which must be the key issue for all of us. Wherever you are in Wales, whether you are in the deepest rural area or in an urban area, or whether you are in the south, north, west or east, you should be entitled to the same standard of service. That is not happening at the moment and that is the driver for me as regards what we need to do next in the service.

Peter Black: Can you confirm that the Welsh Health Specialised Services Committee will retain the responsibility for commissioning wheelchair services?

Edwina Hart: Yes, it will deal with that matter. I think that it will also be interested to see the committee's report when it has its first meeting, to see what use it will be to it. It is a new group and it has to be open to new ideas about how it will deal with issues.

Mr Dean: If I may add something, you need to remember that the Welsh Health Specialised Services Committee is made up of the LHB chief executives, so it is their organisation. It is critical for me to get a national approach that is firmly embedded in local services. It cannot be one or the other; it has to be both. So, the organisation that delivers may be a single national organisation, but it has to be fully linked into the other local services that need to support ALAC and the patients who make use of ALAC services. We have to do both: we must have the national consistency that the Minister has talked about, but appropriate local arrangements that tie services together, so that we do not create difficulties at a more local level. WHSSC is in an ideal position to do that, because it is owned by the chief executives of the local health boards. It is their committee and it is an important step forward.

Edwina Hart: The Chair and the committee might be interested to know that we have had central discussions about a designated and named official who will deal with these issues for me, in the centre, and become a liaison if problems and issues arise that we have not had before.

Lorraine Barrett: I have two questions on short-term wheelchair provision. The British Red Cross has told us that it provides most short-term wheelchair loans, but the demand is increasing and it is concerned that it may be unable to continue to meet that demand. What plans do you have to address the needs of short-term wheelchair users? The British Red Cross also raised an issue with regard to the provision of short-term wheelchair loans to people who are waiting for a permanent wheelchair. So, there are those who have a temporary need for a wheelchair due to an accident or whatever, but there are also those who need the loan of a wheelchair while waiting for their permanent wheelchair to arrive. What do you think about the British Red Cross providing those short-term wheelchairs?

Edwina Hart: The British Red Cross has consistently raised with me, during my engagement with it, the issue of wheelchairs and how it could perhaps assist the national health service in many ways. We have specifically asked that the second phase of the review look at the relationship with the British Red Cross in the light of the two points that you have raised. This is an important issue because it would be good for us to be engaged in a partnership with the British Red Cross. It has a lot of centres across Wales that would be easy for people to access. In fact, I visited an equipment store in Carmarthenshire that has the British Red Cross present and the health service through the LHB. I was looking at the wheelchairs and other things that were there. So, we can build on that, and I think that something positive will come out of the second phase with regard to our relationships with the British Red Cross. However, it is right about the wheelchair issues and the difficulties when people need wheelchairs for short-term periods and it could help us to address those needs.

Lorraine Barrett: Thank you for that answer, because I, like the rest of the committee, felt that the British Red Cross was engaging, positive and enthusiastic and wants to be a helpful partner.

Edwina Hart: It is a helpful partner across the piece on a wide range of issues. We have a lot to learn from the voluntary sector in some of these areas and greater partnership working with it will improve the quality of life of patients.

Andrew R.T. Davies: To continue on the voluntary sector, one piece of evidence that the British Red Cross gave us was that it often feels that it is not part of the solution and that it is left on the outside. It used the example of its representatives turning up in a small village or town and realising that its delivery vehicles are there along with the service's vehicles. So, with integration, instead of having two vehicles going on one route, there would be one vehicle. If you looked at the transcript of that meeting, you will have seen that it almost made a plea to us to incorporate it. However, I hear what you say about the second phase and that the second phase group may look at that integration.

Edwina Hart: I very much accept what you say and I think that the British Red Cross sometimes feels left out of the loop, although it is not because of any national policy direction by the Welsh Assembly Government, but just because of the relationships on the ground. As I indicated, the centre that I visited last week in Carmarthenshire had the most perfect partnership, with individuals taking the lead to ensure that that partnership is being dealt with correctly. However, I have a wider concern, in that I cannot even get local government to the table sometimes on some of the partnership issues, so the third sector has really had to push its way in. I can only give guidance from the centre about relationships, but I am seeing my chairs later today, and in view of the concerns expressed in committee this morning, particularly about the voluntary sector, I am more than happy to raise the importance of partnership with them once again. That clearly came out in yesterday's Plenary debate on dementia, particularly the partnership between local health boards and the voluntary sector to deliver services and the LHBs' greater awareness of how that can assist them and also provide better value for the public purse.

Andrew R.T. Davies: May I seek clarification on that, Minister? We have heard about the maintenance contract and the fact that north Wales has had a completely different experience to south Wales, which has taken it in-house. Given the 'One Wales' agreement to move the private sector out of the health service, is it the case that when the contract came up for renewal in north Wales, despite the praises that the organisation was singing of the contractor, with no complaints for at least 12 months, the contractor would be unable, because of political ideology, to tender for the contract?

Edwina Hart: At the end of the day, we have the 'One Wales' agreement, and we do not necessarily want the private sector in parts of the public sector. It is important to recognise that we have successfully brought the contract in-house in south Wales and I very much hope that the same could be done in north Wales. However, I do not want to pre-empt the discussions on the renewal of the contract.

Andrew R.T. Davies: However, because of the political ideology, they would not be able to tender.

Edwina Hart: Can we talk about the principles and commitments in the concept of the NHS? At the end of the day, the NHS was established by a Labour Government. It has been supported by people in this country and it is all about the principle of the public sector providing.

Darren Millar: To return to the nub of the issue, the NHS buys supplies and so on, including the repair of boilers, from many private companies. So, I do not think that you are telling us that you are firm on this issue with regard to in-house or out-of-house provision, Minister, but that you are waiting to see the outcome of the review. Is that right?

Edwina Hart: That is correct.

Darren Millar: They are satisfied with the service in north Wales; it has had no complaints in the past 12 months.

Edwina Hart: We will take into account the most satisfactory arrangements for us.

Darren Millar: Returning to the British Red Cross, Minister, one thing that it raises was that there has been an incredible increase in the demand for its services, which is placing quite a burden on it with regard to capacity to meet that demand and on its limited resources, which are generally from donations and some smaller contributions that it receives from the NHS in some parts of Wales.

11.40 a.m.

Can you tell us whether the scope of the second phase of your review will include looking at whether there might be resources that you could make available to the British Red Cross to help to meet that demand?

Edwina Hart: The answer is 'yes'.

Val Lloyd: Before I ask my question, my recollection is that Jeff Collins said that the increase in the uptake of wheelchair services was not entirely down to long-term wheelchair users, but those who needed a temporary wheelchair for other purposes. It was possibly allied to the change in throughput in acute surgery, but it was not always down to long-term wheelchair use.

Darren Millar: That is right. That is an important point, that some of the increase was due to the social use of wheelchairs for a day trip, or whatever.

Val Lloyd: Minister, we heard from witnesses that there is a need for wheelchair services to take account of the holistic needs of users, including social and educational needs. I am sure that, in principle, you would support that, but do you think that the service can provide that kind of holistic approach, rather than meeting basic clinical needs? Will that be part of phase 2?

Edwina Hart: Phase 1 identified the unified assessment needs, which I suppose is part of the answer to this. It looked at key elements like community therapist assessment issues—what you do in the workplace, or at home. The school assessments are completed prior to referral to ALAS. I would have thought that what you are getting at is how we can further develop and build on phase 1. There is an issue for us around encouraging greater co-operation and joint funding between the wheelchair service and other services, and that includes education, as a key element in this area. The phase 2 group will be driven by a project board, supported by a wider reference group. That will have representatives from other bodies that can give advice on achieving a more holistic delivery in terms of some of the services. Do you want to add anything, Simon?

Mr Dean: Just to reinforce that this is about looking at the whole person's needs. There are things that are the responsibility of the NHS, and things that are the responsibility of other organisations. The key is to get those organisations to work together to provide the individual with the service that they require. As the Minister said, we will be addressing that through phase 2 of the work, as we will in a number of other service areas, working with education and local authority colleagues to provide a service that, from the user's point of view, is simply a service.

Edwina Hart: Looking at my notes about how we are taking it forward, we will be making sure that that wider group includes the appropriate representation so that we can take a more holistic view and ensure that all the key partners are involved. There is merit in bringing all these groups together to take that holistic view.

Val Lloyd: You have pre-empted the second part of my question about funding, particularly from education.

Peter Black: Witnesses from Cardiff ALAS told us that they jointly fund wheelchairs with organisations such as Whizz-Kidz, but not individuals. The reason they gave was that they had had a ministerial directive that they could not fund with individuals. Why does the NHS not enter into joint funding arrangements with individuals?

Edwina Hart: I have to say that I am not aware of any ministerial directive, but I will get officials to trawl back to see whether I have issued anything. I am sure that, if I had, it would be on a website somewhere. I will have to put my thinking cap on about this, because I cannot remember such a directive. We do not look at individuals in terms of funding; we look at it more like working with them on stuff. I will have to clarify this with my officials, because I cannot recall such a directive, or the arrangements on this. Would it be okay, Chair, to make further inquiries and drop you a note?

Darren Millar: That would be helpful. I think that Whizz-Kidz was referring to meeting the lifestyle needs on top of the clinical needs.

Peter Black: We had evidence from Cardiff ALAS on this. We specifically asked why they did not joint-fund with individuals, and were told that the Minister for Health and Social Services did not want them to joint-fund with individuals.

Edwina Hart: Could I make some further inquiries about that? There has been some joint funding in the past, and we have done some work on this, but I would not want to mislead the committee in any way, so I will go away and look at that.

Andrew R.T. Davies: It is nothing to do with the top-up, is it?

Edwina Hart: It may be, so I will check on that.

Lorraine Barrett: There was also an issue to do with add-ons or extras; I do not know whether this is linked. If an individual wanted to enhance the chair, ALAS could not take on the responsibility for future repairs. That was another issue.

Edwina Hart: I think that this is what some of this might be about, but may I check it out, Chair, and drop you a note?

Darren Millar: Yes, we would appreciate that, Minister. Finally, before I ask whether Members have any final questions, we have heard that one of the big problems with the service, in addition to the waiting times for assessment, is the lack of communication—the failure of the service to communicate with service users. There have been cases of people being referred to the service and then hearing nothing for 12 to 18 months. What plans do you have, Minister, to address that particular problem? We accept that it is improving in some parts of Wales, and the service has recognised that this has been a weakness. However, from the evidence that we have gathered, it has not been nearly enough of an improvement to register with service users so far.

Edwina Hart: The trouble is that, when you are waiting a long time for something, you need regular updates on why you are waiting so long. That is something that the service will have to look at with regard to key communications in phase 2. It is unacceptable that people are not getting information. If something cannot be done straight away, it is nice to be told, 'You're still on our books, we are trying to do it, and it will be done'. This is fairly basic communication, which we come to expect when we deal with companies as individuals. People are generally kept updated, but I do not think that we have been very good at doing that. We have not been very good at doing it, historically, in the NHS. The situation is certainly improving; we are trying to treat citizens properly, keeping up with communication. This will be dealt with in phase 2; it is absolutely essential. If you are a parent waiting a long time for a wheelchair for your child, you do not want to feel that you have been forgotten about. I have told them in the centre that they might think that it is okay, but that, when you are waiting at home every day for a letter, it is not the same.

Darren Millar: Do Members have any further questions? I can think of only one, which relates to the timescale for phase 2, Minister. When do you expect phase 2 to be completed and those things that you identify in phase 2 to be implemented?

Mr Dean: The Minister has asked me to make this a priority, which I will be doing. So, I am developing the final details of how we are going to carry out phase 2. We have been talking about doing it over just a few months. We will then provide the Minister with recommendations.

Edwina Hart: As the committee does its work and we prioritise what the service is going to do, it might be more helpful if, as it ticks the boxes, one by one, of what it is required to do, we make announcements as we go, rather than wait for the endgame.

Darren Millar: There are no further questions. I thank the Minister for attending today and I thank Mr Dean for his help and the evidence he provided. I formally close the meeting.

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