Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 1 - Y Senedd

Dyddiad:
Dydd Iau, 26 Ebrill 2012

Amser:
13:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:

Llinos Dafydd
Clerc y Pwyllgor
029 2089 8403
HSCCommittee@wales.gov.uk

Agenda

1. Cyflwyniad, ymddiheuriadau a dirprwyon

2. Ymchwiliad i ofal preswyl i bobl hŷn - tystiolaeth gan sefydliadau a darparwyr y trydydd sector ac ar fodelau amgen (13.00 - 14.30)

Ymchwiliad i ofal preswyl i bobl hŷn - tystiolaeth gan Gynghrair Ailalluogi Cymru (13.00 - 13.45) (Tudalennau 1 - 6)
HSC(4)-12-12 papur 1
Ed Bridges, Gwasanaeth Brenhinol Gwirfoddol y Merched
Philippa Ford, Cymdeithas Siartredig Ffisiotherapi

Ymchwiliad i ofal preswyl i bobl hŷn - Tystiolaeth gan UK Home Care (13.45 - 14.30) (Tudalennau 7 - 17)
HSC(4)-12-12 papur 2
Francis McGlone, Uwch Swyddog Polisi
Colin Angel, Cyfarwyddwr Polisi a Chyfathrebu

3. Papurau i'w nodi (Tudalennau 18 - 21)
Cofnodion y cyfarfodydd a gynhaliwyd ar 14 a 22 Mawrth
HSC(4)-10-12 cofnodion
HSC(4)-11-12 cofnodion

Blaenraglen waith - haf 2012 (Tudalennau 22 - 24)
HSC(4)-12-12 papur 3

Y Bil Sgorio Hylendid Bwyd (Cymru) Drafft – gohebiaeth oddi wrth y Gweinidog Iechyd a Gwasanaethau Cymdeithasol (Tudalennau 25 – 27)
HSC(4)-12-12 papur 4

Ymchwiliad i ofal preswyl i bobl hŷn – papur gan yr Athro Andrew Kerslake
(Tudalennau 28 – 43)
HSC(4)-12-12 papur 5

Deiseb P-04-329 rheoli sŵn o dyrbinau gwynt sy'n peri diflastod (Tudalennau 44 – 46)
HSC(4)-12-12 papur 6

Deiseb P-04-375 rhoi terfyn ar system eithrio ar gyfer rhoi organnau
(Tudalennau 47 – 49)
HSC(4)-12-12 papur 7

4. Cynnig dan Reol Sefydlog 17.42(vi) i eithrio'r cyhoedd o'r cyfarfod ar gyfer eitemau 5 a 6 (14.30)

TORIAD 14.30 – 14.40

Sesiwn breifat

5. Ymchwiliad un-dydd ar wasanaethau cadeiriau olwyn yng Nghymru – ystyried y prif faterion (14.40 – 15.00)

6. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – trafod yr adroddiad drafft (15.00 – 15.30)

Welsh Reablement Alliance

Welsh Reablement Alliance,
c/o WRVS,
Beck Court,
Cardiff Gate Business Park,
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Committee Clerk,
Health and Social Care Committee,
National Assembly for Wales,
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HSCCommittee@wales.gov.uk

8th December 2011

Dear Sir / Madam,

Re: Committee inquiry into residential care for older people

Further to your request of 24th October for responses to the above inquiry, please find below a submission from the Welsh Reablement Alliance.

The Welsh Reablement Alliance is an umbrella organisation for professional associations, voluntary sector partners and care providers who provide reablement services in Wales. We believe that by speaking with a united voice on reablement, we can give a clear indication of what is needed to improve reablement provision. The Alliance is comprised of:

- WRVS
- The College of Occupational Therapists
- Age Cymru
- The Stroke Association In Wales
- The Chartered Society of Physiotherapy
- Care & Repair Cymru
- MS Society Cymru
- Crossroads Care
- United Kingdom Home Care Association
- Alzheimer's Society
- Mind Cymru
- British Association of Social Workers Cymru

We have confined our response to the first point of the inquiry's terms of reference, namely **the process by which older people enter residential care and the availability and accessibility of alternative community-**

based services, including reablement services and domiciliary care.

Health benefits of reablement

Dedicated and consistent reablement services help to prevent costly hospital readmissions and help to improve people's quality of life. This is not only important for personal wellbeing, but also saves money in the longer term through reducing costs to the NHS and social services. The need for better discharge planning in Wales has been supported by the Older People's Commissioner; both the Social Services Improvement Agency and the new NHS vision "*Together for Health*" also call for a radical reconfiguration of social services in Wales in favour of a shift towards a reablement approach.

The case for properly-funded and effective reablement is therefore a compelling one. Glendinning *et al* (2010) concluded that reablement was significantly associated with better health-related quality of life and social care outcomes compared with the use of conventional home care. The same study also concluded that there is a high probability that reablement is more cost effective than conventional home care and therefore worth investing in. The Social Services Improvement Agency identified that 60% of older people who enter a reablement service do not require further services after a six week intensive period of help and assistance (Social Services Improvement Agency 2011).

A 2007 study for the Care Services Efficiency Delivery Programme found that, following reablement, up to 68% of people no longer needed a home care package and up to 48% continued not to need home care two years later (CSED Programme, Homecare Reablement Workstream 2007). Building on the body of evidence contained within the Homecare Reablement Discussion Document published in January 2007, a retrospective longitudinal study was commissioned by CSED with the Social Policy Research Unit at the University of York. Examining the experiences of four councils and schemes, the study shows that in three of the four schemes:

- 53-68% left reablement requiring no immediate homecare package;
- 36-48% continued to require no homecare package two years after reablement;
- Of those that required a homecare package within the two years after reablement, 34-54% had maintained or reduced their homecare package two years after reablement;

In the fourth service (which operated on a selective basis) the results were significantly higher.

A study of COPD (chronic obstructive pulmonary disease) patients in Wales found that where access to rehabilitation services were available, readmission rates could be cut from 33% to just 7% as well as halving hospital stays and reducing the number of GP home visits required (Chartered Society of Physiotherapy 2011). A pilot study of stroke survivors in Wales found that an early supported discharge scheme saved a total of 164 bed days in a six month period (Chartered Society of Physiotherapy 2011). The Stroke Association reports that 25-50% of people in a care home will have had a stroke and 11% of all stroke patients will be newly admitted into care homes. It is vital that these stroke survivors are given access to

specialist stroke rehabilitation whether they return home or are admitted to residential or nursing care – yet this is not always available.

Finally, it is also worth emphasising the clear health benefits of the social aspects of reablement. As part of the Shaping Our Age research project between WRVS, Brunel University and De Montfort University (WRVS 2011), older people from across the UK were asked to discuss their understanding of wellbeing. The most frequently-mentioned factor which dictated wellbeing and quality of life was relationships and social contact with family, friends and neighbours. If these relationships are absent, then there is significant potential for isolation and loneliness – and this can be magnified when commercial and state services become more remote. This supports the work of Allen & Glasby (2010) who found that social contact, rewarding activity, opportunities for engagement and participation are essential for the promotion of wellbeing and mental health – and this may have knock-on consequences for physical health and sustaining independence. Any provision of reablement should therefore have a dual focus – both on the physical support needed for good health, but also the social support required to provide all-round quality of life.

Economic benefits of reablement

Due to its aim of restoring or regaining function, reablement requires enhanced competencies in assessment and goal setting (Social Services Improvement Agency 2011). The added expertise and involvement of occupational therapists in reablement teams contributes to successful reablement services (Rabiee & Glendinning 2010). Riverside Community Health Care NHS Trust (1998) found that in 50% of cases reviewed by occupational therapists, the care package was removed, producing substantial savings. In the remainder of cases, the care package was significantly reduced. The review of 85 service users' care packages saved £170,000, met service user goals and encouraged greater engagement with the local community. One study that explored the relationship between provision of equipment and reduction on care package costs and residential care found cost savings of over £60,000 over an eight week period (Hill 2007).

Reablement may involve improving the individuals' skills and may also include housing adaptations. Evidence shows these can reduce the need for daily visits and reduce or remove costs for home care, generating savings between £1,200 and £29,000 a year (Heywood *et al* 2007). Postponing entry into residential care by just one year through adapting peoples home saves £28,080 per person (Laing & Buisson, 2008). A recent Joseph Rowntree Foundation (2011) highlights the benefits of preventative services. It states that the national evaluation of the Department of Health Partnerships for Older People Projects pilots (POPPs) demonstrated that 'small' services providing practical help and emotional support can significantly improve older people's wellbeing. It showed that overall, low-level practical support initiatives can have dramatic outcomes – both in terms of increased quality of life and in terms of lower use of formal services and institutional forms of support.

The POPPs evaluation also found economic benefits from targeted intensive interventions to prevent crisis (e.g. falls services) or at a time of crisis (e.g. rapid response hospital admissions avoidance services) or post-crisis reablement services. For every £1 spent on such services to support older people, hospitals were found

to save £1.20 in spending on emergency beds. Similar findings have been demonstrated by pilot projects focusing on prevention and improved inter-agency joint working in Wales. The problem often faced is that the NHS benefits from the savings, but local authority social care budgets do not, making a strong case for a transfer of funding from the NHS budgets to social care or for closer joint working locally between the two in order to overcome this barrier.

There are several projects around Wales which provide a range of different services. Sound evaluations should start to identify learning for use around Wales. The Welsh Government has provided £9m of Invest to Save funding for the Gwent Frailty Project over a three-year period. The project's sustainability is based on its ability to shift resources from acute or institutional care to community based and preventative services that promote independence. Savings should come from:

- reduced admissions to hospital;
- reduced average lengths of stay as a result of operating the 'pull system';
- reduced delayed transfers of care through facilitated supported discharge;
- reduced longer-term care packages through the enabling approach;
- reduced admission to care homes.

The Age Cymru Swansea Bay Hospital Discharge Service is a free service for up to six weeks post-discharge. Through a team of trained staff and volunteers (including qualified nurses, a social worker, a welfare benefits officer and trained staff and volunteers), the service helps people get back on their feet. It ensures people can be discharged on time, into a safe home environment, thus making the transition from hospital to home seamless and stress-free. Feedback from service users includes: "*Without the help I would not have been able to recover from my hip replacement as quickly as I have*", and "*It gave me a change to get my strength back after a long stay in hospital*".

Welsh Reablement Alliance recommended principles

Given the benefits of reablement provision outlined above, the WRA have identified five key principles which need to underpin effective reablement services in Wales:

1) Enablement and reablement should be the starting point for all interventions.
2) Reablement improves ability. It must include physical, social, environmental emotional factors to ensure a person's wellbeing and independence.
3) Reablement and rehabilitation are a seamless continuum. Service users should not see boundaries. Easy, direct access to targeted reablement services will help people maintain their skills in the long term.
4) Reablement requires good quality assessment. This is vital to establish the specific goals of the service user and must
    a. focus on enabling and empowering outcomes
    b. be done in partnership with the individual and their family
    c. determine the content of the reablement service.

5) Reablement Services require
   a. The active participation of the service user and their family
   b. A workforce with an ethos of 'working with' people, rather than 'doing to'
   c. Integration and collaborative working between health, housing and social services.
   d. Appropriate collaboration with services provided by the third and private sector
   e. Adequate funding to deliver sustainable outcomes
   f. Strong leadership of commissioning and delivery.
   g. A focus on prevention and early intervention in order to avert possible crises.
   h. Evaluation which incorporates both social and financial service outcomes.
   i. Training for staff, information and support for families and carers.

In order to fulfil this ambition, we have identified five tangible measures which the Welsh Government could take, as follows:

1) Reablement services should adopt the guiding principles set out above.
2) There must be a commitment to statutory funding, in recognition of the fact that properly funded reablement saves money in the long-term.
3) There needs to be recognition that although reablement services may involve low level interventions, these are critical to the people who receive them. This should be reflected in how local authorities apply social care eligibility criteria.
4) There must be coherent and equitable access across Wales.
5) There should be a framework for the delivery of reablement services, and this should include a whole-person approach.
6) Make signposting to reablement services part of the 50+ health checks where appropriate

We would be more than willing to expand on any of these points when the Committee holds its oral evidence sessions in the spring of 2012. If you would like any further information, please do not hesitate to contact us.

Yours faithfully,

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Health and Social Care Committee

HSC(4)-12-12 paper 2

Inquiry into residential care for older people – Evidence from UK Home Care Association

Mark Drakeford AM
Chair of Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

20 April 2012

Dear Mark Drakeford

Inquiry into residential care for older people

UKHCA welcomes this opportunity to respond to the Health and Social Care Committee's inquiry into residential care for older people.

UKHCA is the professional association of homecare providers from the independent, voluntary, not-for-profit and statutory sectors. The Association represents over 1,900 member organisations across the United Kingdom, including 81 in Wales. Our aim is to support our members to provide high quality, sustainable homecare to allow people to live at home in their community for as long as they choose.

We understand the primary focus of the inquiry is into residential care for older people. However, we believe the Committee may also wish to examine the domiciliary care sector in Wales, in particular the capacity of the sector to meet the demand from increasing numbers of older people, and any additional demand arising from the Welsh Assembly Government's policy to help older people remain in their own communities.

In our response, we have tried to follow the Committee's terms of reference, but have taken the liberty of adding specific information about domiciliary care. We have therefore not provided evidence on the process by which older people enter residential care or the balance of public and independent sector provision in residential care, or alternative funding, management and ownership models in residential care, as this is not our primary focus.

Capacity of the homecare sector to meet demand

Homecare is an important service for a significant number of people living in Wales. In one sample week in September 2010, there were 17,205 older people and 4,603 younger adults in receipt of publicly funded domiciliary care, totalling 21,800 people.[1]

Overall, 11.2 million hours of care were delivered in Wales by both the independent and statutory sector in 2010-11. 68% of state-funded homecare was provided under contract by the independent sector, with the sector providing 7.6 million hours of publicly funded homecare in 2010-11.[2] The pattern is one of increasing use of the independent sector by local authorities, mirroring each of the other three UK administrations.

There were 354 domiciliary care agencies registered with the Care and Social Services Inspectorate Wales (CSSIW) on 31 March 2009. 87% of these were run by the independent sector. Recently there has been an increase in the number of agencies exceeding 200 hours of provision a week, these larger agencies make up 76 per cent of all provision according to CSSIW.[3]

A sector under stress

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[1] Statistical Directorate, Welsh Assembly Government, 2008. First Release – Assessments and Social Services for Adults 2010-2011. Table 7. Published September 2011. http://wales.gov.uk/docs/statistics/2011/110908sdr1552011en.pdf

[2] Statistical Directorate, Welsh Assembly Government, 2011. First Release – Assessments and Social Services for Adults 2010-2011. Table 6. Published September 2011.

[3] Care and Social Services Inspectorate Wales. Domiciliary Care Agencies. 2008-2009. CSSIW (2009). p. 2 and 3. http://wales.gov.uk/docs/cssiw/report/091202domcareen.pdf

Despite the Welsh Government's policy of helping older people remain in their own homes as long as possible, independent homecare providers face significant challenges. Providers' experience locally is one of local authority commissioners exercised by efficiency savings reducing costs of services. The failure to reflect the true costs of care, including regulatory costs, severely impacts on the sector's ability to invest in its workforce and frontline services.

UKHCA is concerned that in the current economic environment councils will attempt to offset their funding problems with a further squeeze, or even cut, on the prices paid to independent sector providers. There is evidence that this is already happening.

UKHCA's commissioning survey

In autumn 2011, we undertook a study of the commissioning practices of local authorities to understand the impact of commissioning decisions in the context of stringent public spending cuts.[4] The survey was an online exercise completed by member organisations of UKHCA, including 21 in Wales.[5] Nothing in our findings suggest divergence in the experience of providers in Wales from the national picture. Findings show that the dignity, quality and safety of elderly and disabled service users could be placed at risk sector from the cut backs that councils are making:

- 82% of councils and health and social care trusts were reducing how much care they would pay for, and reducing the number of homecare visits people receive.

- 58% have cut the price they pay independent and voluntary sector providers for homecare.

- 76% were reducing the number of visits that people receive by careworkers. The average visit length (calculated from 50 case studies in the survey) was reduced by around 10 minutes, from 48 to 38 minutes.

[4] United Kingdom Homecare Association Commissioning Survey 2011.

[5] In total, 158 providers responded to the survey, supplying 206 individual reports about 111 different councils or trusts.

- The use of short visits of around 15 minutes or less to undertake personal care appears to be increasing rapidly.

- More than one-fifth of councils or trusts had stopped funding safety check visits, and a further half had reduced them.
- The majority had cut funding for social contact visits, help with washing, bathing, continence issues and managing finances, cleaning, shopping and laundry.

- 10% of providers had turned down work in rural areas or where visit times had become unprofitable or otherwise inadequate.

- 41% of councils were reducing the use of pairs of careworkers in a single visit. These double-ups are generally used for safety reasons during manual handling procedures.

- 18-21% of councils were removing one or more of the payments they had previously made towards careworkers' travel time or travel costs, or premium payments to incentivise work in rural areas, where travel time can be considerable.

Vulnerability to public sector purchasing

The reason why local authorities can exert downward pressure on independent provider's costs is that they act as a near monopsony (a single buyer) for the purchase of homecare in their local area. In 2010-11, 68% of state-funded homecare in Wales was provided under contract by the independent sector.[6] This purchasing advantage is increased in economically deprived areas of Wales, where the local population have limited means to fund their care through private arrangements.

The trend towards more council outsourcing care services is likely to continue. For example, Wrexham has now contracted out almost all of its services to the

[6] Assessments and Social Services for Adults, 2010-11, Statistics for Wales, 8 September 2011, p5-6. http://wales.gov.uk/docs/statistics/2011/110908sdr1552011en.pdf

independent sector – around 85% of domiciliary care and almost all of its residential care homes.[7]

The major reason councils in Wales are outsourcing their care services is because the cost of council in-house run domiciliary care services is significantly higher than similar quality services run by the independent sector. Taking the case of Carmarthenshire County Council, independent sector domiciliary care is £14.73 per hour (including travelling), whilst in-house domiciliary care is £21.91 per hour.[8]

Implications

The cuts in fees paid to providers are not sustainable and could be disastrous for the sector. Already one in five providers expects to go out of business as a result of council cuts to their fees.[9] This could force some users into more expensive services such as residential care and acute hospitals. It will also lead to job losses. A third of adult social care providers have already cut jobs and most anticipate job losses in 2011-12.[10]

Already, the low levels of fees make it impossible for providers to reward their staff sufficiently for the vital work they do. The result is a workforce which is typically pay sensitive, characterised by an undesirable "churn" as workers change employers for relatively small increases. This is costly in terms of the recruitment and induction costs for care staff, and fails to provide the continuity of care which is so valued by service users. It will also be highly damaging to Welsh Government policies and initiatives for dignity and dementia care.

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[7] Better Support at Lower Cost, SSIA, April 2011, p.58.
http://www.ssiacymru.org.uk/media/pdf/2/b/Better_Support_at_Lower_Cost.pdf

[8] Better Support at Lower Cost, SSIA, April 2011, p.58.
http://www.ssiacymru.org.uk/media/pdf/2/b/Better_Support_at_Lower_Cost.pdf

[9] One-fifth of social care providers expect to close next year, Community Care, 16 February, 2011.
http://www.communitycare.co.uk/Articles/2011/02/16/116286/one-fifth-of-social-care-providers-expect-to-close-next-year.htm

[10] One-fifth of social care providers expect to close next year, Community Care, 16 February, 2011.
http://www.communitycare.co.uk/Articles/2011/02/16/116286/one-fifth-of-social-care-providers-expect-to-close-next-year.htm

There is significant interest in recent judicial reviews in England and Wales among independent providers. UKHCA has found it necessary to write to the Chief Executive Officers, officers and elected members to share these concerns and to ensure that councils responding to judicial reviews from the residential sector also give full consideration to their commissioning of homecare services.

Welsh Government's initiatives

Credit must be given to the Welsh Government for its efforts to bring relevant parties together and agree a way forward. In February 2009, the Welsh Government brought together the Welsh Local Government Association, ADSS Cymru, Care Forum Wales, the Registered Nursing Home Association and UKHCA to agree a way forward for the care sector in Wales. The five signed a Memorandum of Understanding which set out how they would work together to deliver sustainable services and resolve disputes in a co-operative manner.[11]

Credit must also be given to the Welsh Government for publishing in August 2010 new statutory guidance on commissioning social services, which set out local authorities' responsibilities in this area. The guidance, *Fulfilled Lives Supportive Communities Commissioning Framework and Guidance*, listed thirteen standards against which local authorities are expected to achieve, including setting fees that "*take into account the legitimate current and future costs faced by providers as well as the factors that affect those costs.*" [12]

The reality facing providers

Despite these important initiatives by the Welsh Government to support the independent care sector, the reality is that local authorities are, as we said above, exerting pressure on providers to reduce their costs and make efficiency savings while, at the same time, annual contract price reviews barely recognise additional statutory and regulatory costs. Typical actions by councils include

[11] WLGA, ADSS Cymru, UKHCA, RNHA, Care Forum Wales. Memorandum of Understanding, Securing Strong Partnerships in Care (2009), paragraph 27. www.wlga.gov.uk/english/press-releases/securing-strong-partnerships-in-care/

[12] Fulfilled Lives, Supportive Communities: Commissioning Framework Guidance and Good Practice, Welsh Assembly Government (2010). http://wales.gov.uk/docs/dhss/publications/100810commissioningguidanceen.pdf

- Reducing the number of providers they contract with.

- Requesting price cuts in existing contracts and when contracts are extended.

- Not offering up-lifts for inflation and increasing regulatory costs.

- Setting very low maximum ceilings in bids for new contract tenders.

- Reducing the time allocated for homecare tasks – many more 15 and 30 minutes calls as opposed to hour long calls.

- Paying a flat rate price without enhancements for weekends or public holidays.

- Not paying an increased rate for more senior, experienced staff.

- Requesting single handled calls when it should be a double handled call because of the complexity of the service users' needs.

- Allocating more complex and difficult cases to homecare.

Another factor undermining the sustainability of the independent homecare sector in Wales is the very low level of direct payments paid to service users. A 2009-10 survey found some local authorities were offering direct payment rates of £7 or £8 per hour. Caerphilly offered just £6.58.[13] These rates would not allow a direct payment user to purchase a regulated homecare agency's service unless they can afford to "top up" their care; ironic given the principle of direct payments is to extend service user choice.

It is therefore not surprising that the Welsh Government had to step in to save the Memorandum of Understanding following a spate of rows between councils and social care providers over care fees.[14]

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[13] *Better Support at Lower Cost*, SSIA, April 2011, p.55. http://www.ssiacymru.org.uk/media/pdf/2/b/Better_Support_at_Lower_Cost.pdf

[14] Community Care, *Welsh government bids to cool social care fee row*, 22 June 011.http://www.communitycare.co.uk/Articles/22/06/2011/117058/Welsh-government-bids-to-cool-social-care-fee-row.htm

Quality of care services, effectiveness of regulation and financial viability

Improving care services

CSSIW has found that there had been significant improvements in the quality of homecare services in Wales and homecare providers are performing well in a number of areas, including care planning, quality assurance and medication.[15] Over 90% of domiciliary care agencies in 2008-09 were found to have appropriate quality assurance systems in place that meet requirements, and there had been improvements in how the views of service users and their relatives are incorporated. Workforce issues have also improved with:

- an increase in the proportion of managers who have achieved the appropriate qualification;
- fewer requirements made relating to staff having the competences to carry out their work; and,
- a significant increase in the level of supervision being overtaken.

Financial viability of providers

The case of Southern Cross Healthcare has raised the question of whether there is a need for an economic regulator to monitor the financial standing of private care providers, in particular the finances of large providers. However, it is important to recognise that the problems of Southern Cross stemmed from unsustainable rent bills, falling bed occupancy rates and a drop in revenue from councils. What made Southern Cross a particular problem was the scale and concentration of its care homes, which no single local authority could manage. Southern Cross was also a complex company with complicated models of finance which involved loan financing and equity financing.

The homecare sector is fundamentally different from the residential care sector. Care is carried out in a person's own home and not in a care home. Therefore, homecare providers do not own or rent properties, except for their

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[15] Care and Social Services Inspectorate Wales. Domiciliary Care Agencies. 2008-2009. CSSIW (2009). p.1. http://wales.gov.uk/docs/cssiw/report/091202domcareen.pdf

Head Office and, in the case of larger providers, any branches they have. Financial barriers to entry are lower for homecare than for care homes, as capital investment is less. Also, homecare providers operate on more modest operating costs. An analysis of the social care market for older people in London by RS*e*consulting found that private sector profit margins in homecare were between 5 and 10%.[16]

Unlike the residential care sector, the homecare sector is mainly made up of small and medium homecare providers, with most having fewer than 100 people using their service.[17] A recent National Audit Office (NAO) report found that the top ten homecare businesses in terms of market share represent only 15% of the market.[18] This is well below the 40% market share which, according to the Office of Fair Trading's criteria, indicates potential dominance.[19]

Given the large differences between the two sectors, UKHCA believes it would be highly disproportionate for the failure of a single large residential care provider to lead to the economic regulation of the homecare sector.

New and emerging models of care provision

The independent homecare sector is at the forefront of developing new forms of care provision. A large number of domiciliary care providers in Wales are already involved in providing innovative and integrated services that support and enable better outcomes for older people, e.g. palliative care, reablement, dementia care, telecare and telehealth. UKHCA supports the closer integration of health and social care to better meet the needs of individuals and provide an enhanced patient/user experience. We believe that integrated services are necessary to meet the increasing demands of an ageing population, especially in this time of economic austerity.

If local authority fees reflected the true cost of service provision, including recovery of recruitment costs, workforce development and a sustainable pay-

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[16] Analysis of the Social Care Market for Older People's Services in London, RS*e*consulting, 2008. http://bit.ly/eYRnuc

[17] The state of social care in England 2007-08, Commission for Social Care Inspection (2009).http://www.cqc.org.uk/_db/_documents/SOSC_07-08_easyread_web.pdf

[18] Oversight of user choice and provider competition in care markets, National Audit Office, 2011, p28. http://www.nao.org.uk/publications/1012/oversight_of_care_market.aspx

[19] Oversight of user choice and provider competition in care markets, National Audit Office, 2011, p26. http://www.nao.org.uk/publications/1012/oversight_of_care_market.aspx

rate that retains skilled and qualified domiciliary care workers in the sector, homecare could increase service user independence, prevent early admission to residential care, and reduce the number of emergency re-admissions to hospital following discharge. Working with other local services, homecare can also support people to manage long term conditions in the community and receive high quality palliative care at home. Indeed, there is an argument that the commissioning costs of local authorities could be significantly reduced by the use of Individual Service Funds, with those savings invested into front-line services.

Summary

Despite the Welsh Government's policy of helping older people remain in their own homes as long as possible, independent homecare providers are under stress as never before. Providers' experience locally is one of local authority commissioners exercised by efficiency savings reducing costs of services. Already one in five providers expects to go out of business as a result of council cuts to their fees. This could force some users into more expensive services such as residential care and acute hospitals, and lead to job losses.

There have been significant improvements in the quality of homecare services in Wales. CSSIW has found that homecare providers were performing well in a number of areas, including care planning, quality assurance and medication. CSSIW also found that workforce issues had improved.

The case of Southern Cross Healthcare has raised the question of whether there is a need for an economic regulator to monitor the financial standing of private care providers, in particular the finances of large providers. However, the homecare sector is fundamentally different from the residential care sector in both its operation and financial structure. Given the large differences between the two sectors, UKHCA believes it would be highly disproportionate for the failure of a single large residential care provider to lead to the economic regulation of the homecare sector.

The independent homecare sector is at the forefront of developing new forms of care provision, with a large number of domiciliary care providers in Wales already involved in providing innovative and integrated services. With local authority fees that reflect the true cost of service provision, homecare can increase service user independence, prevent early admission to residential care, and reduce the number of emergency re-admissions to hospital following discharge.

We trust that this information is helpful to the Committee's inquiry. If the Committee requires any further evidence on the domiciliary care sector in Wales, please do not hesitate to contact us.

Yours sincerely,

Francis McGlone
Senior Policy Officer

Direct line: 020 8288 5291
E-mail: francis.mcglone@ukhca.co.uk

Alternative formats: If you would prefer to receive this letter in another accessible format, including e-text, 'clear print', large print or audio cassette, please contact us on 020 8288 5291 or accessibility@ukhca.co.uk.

Eitem 3

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Mercher, 14 Mawrth 2012**
Amser:	**09: – 10:30**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200005_14_03_2012&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Carol Shillabeer, Powys Teaching Health Board**
Staff y Pwyllgor:	**Meriel Singleton (Clerc)** **Catherine Hunt (Dirprwy Glerc)** **Philippa Watkins (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Ni chafwyd ymddiheuriadau na dirprwyon.

2. Ymchwiliad i ofal preswyl i bobl hŷn – Tystiolaeth gan Fyrddau Iechyd Lleol

2.1 Bu Ms Shillabeer yn ymateb i gwestiynau gan aelodau'r Pwyllgor ar ofal preswyl i bobl hŷn.

2.2 Cytunodd Ms Shillabeer i ddarparu rhagor o wybodaeth am sut y mae'r patrymau gwahanol o gomisiynu a ddefnyddir gan awdurdodau lleol yn effeithio ar fyrddau iechyd.

3. Papurau i'w nodi

3.1 Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 29 Chwefror.

Trawsgrifiad

Gweld trawsgrifiad o'r cyfarfod.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Iau, 22 Mawrth 2012**
Amser:	**09:30 – 13:00**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200000_22_03_2012&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Yr Athro John Bolton, Institute of Public Care, Oxford Brookes University** **Luisa Bridgman, Rhondda Cynon Tâf County Borough Council** **Parry Davies, Ceredigion County Council** **Bob Gatis, Rhondda Cynon Tâf County Borough Council** **Susie Lunt, Flintshire County Council** **David Street, ADSS Cymru** **Emily Warren, Cymdeithas Llywodraeth Leol Cymru**
Staff y Pwyllgor:	**Meriel Singleton (Clerc)** **Catherine Hunt (Dirprwy Glerc)** **Stephen Boyce (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Ni chafwyd unrhyw ymddiheuriadau na dirprwyon.

2. Ymchwiliad i ofal preswyl i bobl hŷn - Trafodaeth gyda'r Athro John Bolton

2.1 Bu'r Athro John Bolton yn ateb cwestiynau gan aelodau'r Pwyllgor ar ofal preswyl i bobl hŷn yng Nghymru.

3. Ymchwiliad i ofal preswyl i bobl hŷn - Tystiolaeth gan Gymdeithas Llywodraeth Leol Cymru a Chymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru

3.1 Bu'r tystion yn ateb cwestiynau gan aelodau'r Pwyllgor ar ofal preswyl i bobl hŷn.

3.2 Cytunodd Emily Warren i ddarparu copi o'r cynllun gweithredu a ddefnyddir gan awdurdodau lleol sy'n gweithio mewn partneriaeth â'r GIG, yn ogystal â gwybodaeth am y cynnydd a wnaed gan awdurdodau lleol o ran datblygu gwasanaethau ail-alluogi.

4. Ymchwiliad i ofal preswyl i bobl hŷn - Tystiolaeth gan awdurdodau lleol

4.1 Bu'r tystion yn ateb cwestiynau gan aelodau'r Pwyllgor ar ofal preswyl i bobl hŷn.

4.2 Cytunodd y tystion i ddarparu gwybodaeth am nifer yr achosion, yn flynyddol, lle bu'n rhaid i bobl a oedd eisoes yn ariannu eu gofal preswyl eu hunain ofyn i awdurdod lleol ariannu eu gofal ar ôl iddynt wario eu harian personol i gyd.

5. Ymchwiliad undydd i farwenedigaeth yng Nghymru - Ystyried y cylch gorchwyl

5.1 Cytunodd y Pwyllgor ar gylch gorchwyl ei ymchwiliad undydd i farwenedigaeth yng Nghymru.

6. Papurau i'w nodi

6.1 Nododd y Pwyllgor gofnodion y cyfarfodydd a gynhaliwyd ar 8 Mawrth.

6.1 Gwybodaeth ddilynol o gyfarfod 25 Ionawr - materion yn ymwneud â'r UE - Gofal preswyl i bobl hŷn yn aelod-wladwriaethau'r Undeb Ewropeaidd

6.2 Nododd y Pwyllgor y papur ar ofal preswyl i bobl hŷn yn aelod-wladwriaethau'r Undeb Ewropeaidd.

Trawsgrifiad

Gweld trawsgrifiad o'r cyfarfod.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-12-12 papur 3

Blaenraglen Waith y Pwyllgor Iechyd a Gofal Cymdeithasol: Ebrill – Mai 2012

At:	Y Pwyllgor Iechyd a Gofal Cymdeithasol
Gan:	Gwasanaeth y Pwyllgorau
Dyddiad y cyfarfod:	26 Ebrill

Diben

1. Mae'r papur hwn yn gwahodd yr Aelodau i nodi amserlen y Pwyllgor Iechyd a Gofal Cymdeithasol, sydd wedi'i atodi fel Atodiad A.

Cefndir

2. Yn Atodiad A, ceir copi o amserlen y Pwyllgor Iechyd hyd at doriad hanner tymor Y Sulgwyn 2012.

3. Fe'i cyhoeddwyd i gynorthwyo Aelodau'r Cynulliad ac unrhyw aelodau o'r cyhoedd a hoffai wybod am flaenraglen waith y Pwyllgor. Bydd y Pwyllgor yn cyhoeddi dogfen o'r fath yn gyson.

4. Gall yr amserlen newid a gellir ei diwygio yn ôl disgresiwn y Pwyllgor pan fydd busnes perthnasol yn codi.

Argymhelliad

5. Gwahoddir y Pwyllgor i nodi'r rhaglen waith yn Atodiad A.

ATODIAD A

DYDD IAU 26 EBRILL 2012

Prynhawn yn unig

Ymchwiliad ar ofal preswyl i bobl hŷn
Sesiwn dystiolaeth lafar

Ymchwiliad un-dydd ar Wasanaethau cadair olwyn yng Nghymru
Ystyried y materion allweddol (preifat)

Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru
Ystyried yr adroddiad ddrafft (preifat)

DYDD MERCHER 2 MAI 2012

Bore yn unig

Ymchwiliad ar ofal preswyl i bobl hŷn
Sesiwn dystiolaeth lafar

Papur Gwyn ar Roi Organau
Sesiwn dilynol gan swyddogion Llywodraeth Cymru

DYDD IAU 10 MAI 2012

Bore a phrynhawn

Ymchwiliad ar ofal preswyl i bobl hŷn
Gweithgareddau ymgysylltu allanol

DYDD MERCHER 16 MAI 2012

Bore yn unig

Ymchwiliad ar ofal preswyl i bobl hŷn
Sesiwn dystiolaeth lafar

Papur Gwyn ar Wasanaethau Cymdeithasol
Sesiwn friffiol ar y materion technegol gan swyddogion Llywodraeth Cymru

DYDD IAU 24 MAI 2012

Bore a phrynhawn

Ymchwiliad un-dydd ar atal thrombo-emboledd gwythiennol (VTE) ymhlith cleifion mewn ysbytai yng Nghymru
Sesiwn dystiolaeth lafar

ATODIAD A

DYDD MERCHER 30 MAI 2012

Bore yn unig

Ymchwiliad ar ofal preswyl i bobl hŷn
Sesiwn dystiolaeth lafar

Dydd Llun 4 Mehefin 2012 – Dydd Sul 10 Mehefin 2012: Toriad hanner tymor y Sulgwyn

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Eitem 3b

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref LF/LG/0093/12

Mark Drakeford AM
Chair - Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

28th March 2012

Dear Mark

Food Hygiene Rating (Wales) Bill – additional information for the Health and Social Care Committee

During the Health and Social Care Committee meeting of 2 February, a technical briefing on the Food Hygiene Rating (Wales) Bill was provided by my officials. During the briefing, Members of the Committee requested some additional information, not available at the time, which I have since provided in my letter dated 21 February 2012.

Following the review of my letter by Committee Members, I am now in a position to provide the additional information requested with regards to the total number of hospitals in Wales. This follows the information provided in the Annex of my original letter which provided details of the number of hospitals in each food hygiene rating category with the caveat that 'not all NHS hospitals in Wales may have received a rating'.

The Food Standards Agency (FSA) assures me that the information attached at Annex 1 of this letter, is an accurate estimate of the number of 'hospitals' within the Food Hygiene Rating Scheme (FHRS) in Wales, and the number of these which contains a rating. Committee Members may wish to note the below caveats on which is this additional information is based.

There are 115 hospitals in Wales. The FSA have received information from local authorities advising that 91 hospitals are eligible to have a FHRS rating. I can confirm that the total number of hospitals in Wales that the FSA would expect to receive a FHRS rating is 91. A hospital might generate a number of ratings if there is more than one food business unit on site so the total number of ratings for hospitals in Wales will be higher than 91.

I can also confirm that of these 91 premises, 73 have been rated, and 12 are scheduled to be done in within the next few months, in accordance with local authorities' programmes of inspections. Of the 73 with ratings, 39 are rated 5, 26 rated 4, 7 rated 3 and 1 rated 1.

I have therefore provided a breakdown of numbers by each food hygiene rating category at Annex 1 for Members information.

You may wish to note that I aim to publish the Summary Report of Consultation responses on the Food Hygiene Rating (Wales) Bill on 30 March 2012.

Kind Regards

Lesley

Lesley Griffiths AC / AM

Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

The Number of hospitals in Wales in each food hygiene rating category
(Not all NHS hospitals in Wales may have received a rating)

	Rating						
Local Authority	Very Good 5	Good 4	Generally Satisfactory 3	Improvement Necessary 2	Major Improvement Necessary 1	Urgent Improvement Necessary 0	Total number of rated hospitals
Anglesey	2	0	0	0	0	0	2
Blaenau Gwent	1	0	0	0	0	0	1
Bridgend	1	1	2	0	0	0	4
Caerphilly	0	0	0	0	0	0	0
Cardiff	1	3	1	0	0	0	5
Carmarthenshire	4	0	0	0	0	0	4
Ceredigion	1	0	1	0	0	0	2
Conwy	2	1	1	0	0	0	4
Denbighshire	5	0	0	0	0	0	5
Flintshire	0	4	0	0	0	0	4
Gwynedd	3	1	0	0	0	0	4
Merthyr Tydfil	1	1	0	0	0	0	2
Monmouthshire	3	0	0	0	0	0	3
Neath Port Talbot	1	2	1	0	0	0	4
Newport	0	1	1	0	1	0	3
Pembrokeshire	2	1	0	0	0	0	3
Powys	3	2	0	0	0	0	5
Rhondda Cynon Taf	2	3	0	0	0	0	5
Swansea	3	3	0	0	0	0	6
Torfaen	2	0	0	0	0	0	2
Vale of Glamorgan	0	2	0	0	0	0	2
Wrexham	2	1	0	0	0	0	3
Total	39	26	7	0	1	0	73
Total as percentage	**53.42**	**35.62**	**9.59**	**0**	**1.37**	**0**	**73**

institute of public care

Institute of Public Care
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OXFORD BROOKES UNIVERSITY

Health and Social Care Committee
HSC(4)-12-12 paper 5
Inquiry into residential care for older people -
Paper by Prof Andrew Kerslake

Evidence and analysis for the Framework of Services for Older People: A collection of papers for the Welsh Assembly Government

Paper 4: Issues and interventions at the health and social care interface.

February 2011

Paper4: Part 1 Issues at the health and social care interface

1 Introduction

The following material is based on audits conducted by a range of organisations but chiefly from the Royal College of physicians. Where data is available for Wales that information has been identified and included.

2 Stroke[1]

2.1 Location of stroke patients

Standard: All patients with suspected stroke should be admitted directly to a specialist acute stroke unit unless they need more intensive care, for example on an intensive care unit.

Key findings: The aim should be to admit all stroke patients directly to a stroke unit, but almost half of hospitals report the need to admit patients to non-specialist beds because of bed shortages.

Results: (a) In Wales, there are fewer numbers of beds in stroke units per hospital in 2010 than in England. There are also fewer stroke unit beds than there are stroke patients and far fewer hospitals with stroke units meet the five key characteristics[2], ie, markers of stroke unit organisation.

	All hospitals in the audit	**Wales**	England	Northern Ireland
Median number of stroke beds in stroke units per hospital in 2010	26	**21**	28	15
Ratio: Median number of stroke unit beds per stroke inpatient*	1.07	**0.91**	1.08	1.03
Hospitals with stroke units who meet all five Key Characteristics	38%	**14%**	42%	17%
* A value of 1 indicates that there are equal numbers of stroke patients and stroke unit beds on the day of the audit. If the number is less than 1, there are more stroke patients than stroke unit beds.				

(b) Wales has fewer beds pro rata than England for stroke patients. Given that the population of Wales is approximately 3 million and that of England is 51 million, England is approximately 17 times larger; England has 71 acute stroke

[1] Based on "Organisational Audit 2010", Public Report England, Wales and Northern Ireland, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians of London, August 2010.

[2] The five key characteristics (markers of stroke unit organisation) are:

- Consultant physician with responsibility for stroke
- Formal links with patient and carer organisations
- Multidisciplinary meetings at least weekly to plan patient care
- Provision of information to patients about stroke
- Funding for external courses and uptake

units and using this estimate, Wales should have 4 acute stroke units. In fact it has only 2 acute stroke units.

Acute Stroke Units – beds dedicated solely for the first 72 hours after stroke	All hospitals: 75 units	**Wales: 2 units**	England: 71 units	Northern Ireland: 2 units
Median number of beds per Unit	6 beds	**6 beds**	8 beds	5 beds
Combined Stroke Units - beds used for both pre and post 72 hour care	All hospitals: 146 units	**Wales: 12 units**	England: 122 units	Northern Ireland: 11 units
Median number of beds per Unit	22 beds	**19 beds**	23 beds	14 beds

Key findings: Rapid transfer of stroke patients by ambulance: for acute care to be effective, patients need to be taken as quickly as possible to a unit that is equipped to provide acute stroke care.

Results: There remain some parts of the country, particularly in Wales, where systems are not in place with the ambulance service to identify acute stroke patients and transfer them rapidly to hospital.

	All hospitals in the audit	**Wales**	England	Northern Ireland
Percentage of hospitals with arrangements in place to transport patients with acute stroke symptoms rapidly to hospital	38%	**67%**	95%	92%

Key findings: Only a few stroke services providing care to patients in the first 72 hours meet all the seven quality criteria[3] identified as being markers of high quality.

Results: Criteria used to measure acute quality of care for stroke patients in the first 72 hours after stroke in Wales compared with England and Northern Ireland:

Acute Stroke Units	All hospitals: 75 units	**Wales: 2 units**	England: 71 units	Northern Ireland: 2 units
Stroke unit beds with all 7 acute criteria	13%	**0%**	14%	0%
Stroke unit beds with 6 or more acute criteria	37%	**0%**	38%	50%
Combined Stroke Units	All hospitals: 146 units	**Wales: 12 units**	England: 122 units	Northern Ireland: 11 units
Stroke unit beds with all 7 acute criteria	3%	**0%**	4%	0%

[3] The seven quality criteria are as follows:
1) Percentage of beds with Continuous physiological monitoring (ECG, oximetry, blood pressure)
2) Immediate access to brain scanning
3) Admission procedure to stroke unit
4) Specialist ward rounds at least 7 times a week
5) Acute stroke protocols/guidelines
6) Nurses on duty trained in swallow screening
7) Nurses on duty trained in stroke assessment and management

Stroke unit beds with 6 or more acute criteria	26%	**0%**	30%	18%

2.2 Thrombolysis (clot busting treatment)

Standard: Patients seen within four and a half hours of developing symptoms should be considered for thrombolysis; when given to the right patients, at the right time, it can dramatically reduce the risk of long term disability.

Key findings: There has been a dramatic increase in the number of units providing a 24 hours per day, 7 days a week thrombolysis service for their population.

Results: Progress in Wales on delivering comprehensive acute stroke care including thrombolysis is slow:

Acute Stroke Units	All hospitals	**Wales**	England	Northern Ireland
Percentage of sites currently providing an on-site 24/7 thrombolysis service	28%	**0%**	33%	8%
Percentage of sites currently providing a 24/7 thrombolysis service, on-site only or in collaboration with neighbouring sites	50%	**0%**	57%	25%

2.3 Staffing

Key findings: Overall staffing levels in stroke units in Wales are somewhat lower than in England and Northern Ireland. Results: Median number of qualified staff, per 10 beds, are as follows:

Acute Stroke Units	All hospitals	**Wales**	England	Northern Ireland
Median number of qualified nurses/assistants on duty per 10 beds	3.2	**2.9**	3.2	3.3
Median number of junior doctor sessions per week per 10 beds	8.3	**7.6**	8.3	7.2

2.4 Early Supported Discharge Teams (ESD)

Standard: Community-based stroke-specialist rehabilitation teams, such as Early Supported Discharge (ESD) teams, can provide better and potentially more cost-effective outcomes than exclusively hospital-based rehabilitation for stroke patients with moderate disabilities.

Key findings: There are continued low levels of access to specialist stroke early supported discharge (ESD) with under half of the hospitals having such a team.

Results: Wales lags behind England and Northern Ireland in the provision of this service, as follows:

Access to:	All hospitals	**Wales**	England	Northern Ireland
Stroke/neurology specific early supported discharge multidisciplinary team	44%	**7%**	45%	83%

2.5 Management of Transient Ischaemic Attack (TIA) or mini-stroke

Standard: High-risk TIA patients should be seen, investigated and treatment initiated within 24 hours of onset of symptoms. For low-risk TIA patients the time frame is one week.

Key findings: High-risk patients are still not being seen quickly enough. A third of centres admit high-risk TIA patients in order to access specialist assessment. Almost half of centres admit low-risk TIAs, which is probably a wasteful use of resources.

2.6 Vocational Training for patients of working age

Standard: All people who wish to return to work (paid or unpaid employment) and have persisting problems after their stroke should be offered specialist advice, rehabilitation and support to get back to their work or to find an alternative job.

Key findings: Less than half of services specifically run a service that provides educational or vocational training for patients of working age although this should be regarded as a core element of all stroke services. This seems at variance with government policy (both present and previous) which stated the desire to encourage people off disability and sickness benefits and a focus on improvement in rehabilitation.

2.7 User Involvement and Information

Standard: Patient and carers should be provided with comprehensive information about the services they may need and how to access them on discharge from hospital, as well as on how to prevent further strokes.

Key findings: Over half of stroke services are still lacking comprehensive formal links with user groups of patients and carers that include areas of service provision, quality and planning. 40% of stroke patients are not given a personalised rehabilitation discharge plan and 29% still have no named point of contact on discharge.

3 Falls[4]

Key findings

- Risk assessments in A&E departments and Fracture services are inadequate.
- Services with Falls Coordinators and Fracture Liaison Nurses have systems in place to identify high risk fallers.
- Most trusts have developed inpatient falls policies, but only a third know their in-patient falls rates.
- Important public health information on fracture rates is inadequate or not collated.
- Only 39% of commissioning trusts report being compliant with the NICE technology appraisal on secondary prevention of osteoporotic fragility fractures.
- Only 24% of commissioning trusts have audited bone health prescribing in their local primary care and even less know their local fragility fracture rates.
- Patients with first fractures are not flagged up for secondary prevention.
- Many of the exercise programmes being provided are not evidence based.
- Too few services use patient-agreed treatment plans.
- Assessments for safety at home could be better. Home hazard assessment along with advice on safe and effective performance of activities of daily living is a proven component of falls reduction programmes, particularly if patients have experienced a recent change in health such as a hospital admission or injurious fall. But only 41% of sites include a validated approach to this aspect of falls prevention.
- Patient uptake and adherence to active interventions that include changes in health related behaviour does depend on information and explanation for patients. This is highlighted in the NSF, but only 35% of sites provide a written agreed intervention plan for their patients after an assessment.
- Half of trusts (52%) providing falls services did not provide any training to care homes or guidance on when residents should be referred to falls services; indeed a quarter (24%) provided no access to these services for care home residents.
- Too few services (51%) use patient's views to support and guide service improvement. The CEEU, in collaboration with Help the Aged, has piloted a patient experience questionnaire suitable for use, which will soon be available for any trust to use.

Results:

- Seven Welsh Trusts and Health Boards[5] (27%) have a written local commissioning strategy regarding falls prevention; the information was not available from 15 Trusts (58%). Nationally, 66% of primary care

[4] National Audit of the Organisation of Services for Falls and Bone Health of Older People, Healthcare Quality Improvement Partnership and Royal College of Physicians, March 2009

[5] The structure of the health service in Wales changed after this audit. Therefore it is assumed that numbers refer to health boards and trust prior to re-organsion in October 2009.

organisations and 30% of Health and Social Care Trusts have a written strategy for falls prevention.

- Two Welsh Trusts and Health Boards (27%) have a written local commissioning strategy for bone health; the information was not available from 15 Trusts (58%). Nationally, 22% of primary care organisations and 30% of Health and Social Care Trusts have a written strategy for bone health.
- Eight Trusts and Health Boards (30%) have a local co-ordinated, integrated, multi-professional and multi-agency falls service. Nationally, 75% of primary care organisations, 50% of Health and Social Care Trusts, and 70% of Acute Trusts have this service.
- 15% of Welsh Trusts have a Fracture Liaison Nurse, compared nationally to 15% of primary care organisations, 60% of Health and Social Care Trusts, and 29% of Acute Trusts.
- 27% of Welsh Trusts provide written, agreed intervention plans which are given to patients, compared nationally to 44% of primary care organisations, 10% of Health and Social Care Trusts, and 28% of Acute Trusts.
- 35% of Welsh Trusts routinely screen older people who fall and attend A&E departments for risk of future falls. Nationally this figure is 33% of primary care organisations, 30% of Health and Social Care Trusts, and 50% of Acute Trusts.
- 32% of Welsh Trusts have a mechanism to record patients' views of the falls and bone health service. Nationally this figure is 58% of primary care organisations, 30% of Health and Social Care Trusts, and 50% of Acute Trusts.

4 Continence[6]

4.1 Care

Key findings: Documentation of continence assessment and management for older people was described is poor even after a specialist assessment, There is a predominance of containment using pads and catheters which are frequently rationed.

Results: 58% of Welsh trusts[7] have a written policy for the management of continence, compared with 86% of primary care providers nationally. Where bladder problems are an issue, 68% of primary care providers across England and Wales have a written continence care plan for patients aged 65 and over; in Wales this figure is approximately 32%. 64% of primary care patients aged 65 and over with bowel problems have a documented care plan; this figure is only 38% in Wales.

Sixty six percent of primary care sites impose a limit on provision. Half of Welsh trusts state that they have a written policy indicating that products are supplied

[6] Based on National Audit of Continence Care – combined organisational and clinical report, Healthcare Quality Improvement Partnership and Royal College of Physicians, September 2010

[7] The structure of the health service in Wales changed before this audit. Therefore it is assumed that use of the word 'Trust' here refers to the 7 new Health Boards.

on the basis of patient need; 42% did not answer this question. 84% of primary care providers nationally answered similarly.

4.2 Management and organisation

Key findings: There are clearly established protocols for integrated continence services yet they do not seem to be being followed.

Results: 50% of Welsh trusts have access to an integrated continence service, compared with 11% of primary care providers nationally. Across England and Wales only 4 services across the country fulfill all of the requirements set out in 'Good Practice in Continence Services (2000)' (DH) and reiterated in the National Service Framework for Older People. 50% of Welsh trusts have a structured programme of staff training for promoting continence, compared with 86% of primary care providers in nationally.

In each service there should be a Director of Continence Services or designated lead with responsibility for organisational change towards an integrated service. In acute hospitals, only 48% of self-reported integrated services have a designated lead or director. In primary care, only 40% of services meet this standard. Only 25% of Welsh trusts have a Director of integrated services, compared with 38% of primary care providers. 50% of Welsh trusts have Continence nurse specialists, compared with 99% of primary care providers nationally.

In hospitals, mental health care and care homes, staff with the requisite skills to perform a continence assessment are not always available to do so despite sites reporting that such staff are available. Structured training in continence care only occurs in 49% of acute hospitals and 39% of mental health care sites.

4.3 User involvement

Key findings: There is little evidence of users being involved in planning or evaluation of services.

Results: Only 16% of Welsh Trusts state that they have a user group for the continence service, compared to 24% of primary care providers across England and Wales. Only one Welsh Trust (8%) state that they elicit patient views, compared to 30% of primary care providers nationally.

5 Dementia[8]

Key findings:

95% of hospitals do not have mandatory training in dementia awareness for all staff whose work is likely to bring them into contact with patients with dementia.

About one-third of patients with dementia did not have a nutritional assessment recorded during their admission.

Fewer than half of patients received a formal mental status test upon admission to hospital or were formally tested for the presence of depression.

Less than a fifth of patients were referred to in-hospital psychiatry services. Less than half of those referred were seen within 48 hours. Over one third had not been seen after 96 hours.

Fewer than one in ten hospital executive boards regularly review re-admission data for patients with dementia, and only one in five regularly review information on delayed patient transfers.

A minority of hospitals said that they had a formal system in place for gathering information relevant to caring for person with dementia.

A minority of patient case-notes contained a section dedicated to collecting information from the carer, next of kin or a person who knows the patient well.

Few hospitals said that they had in place a system to ensure that staff on the ward were aware that a person had dementia and how it affected them, and that necessary information was imparted to other staff with whom the person came into contact.

[8] Based on National Audit of Dementia (Care in General Hospitals) - Preliminary Findings of the Core Audit, Healthcare Quality Improvement Partnership and Royal College of Physicians, December 2010. Results for Wales are not disaggregated. This is also an interim report which summarises the key findings from an analysis of aggregated hospital-level data collected as part of the 'core audit' of the National Audit of Dementia. The final report will be published in late 2011 and will include findings from a more in-depth evaluation and site-specific results. This short interim report is published to avoid delay in making preliminary findings public.)

Paper 4: Part 2 Interventions at the health and social care interface

6 Introduction

The following table draws on a number of research sources in order to develop indications of best practice in the areas outlined in Part. However, it also brings in some of the wider factors at the interface and at the impact that some factors will have on others, ie often older people may have an interrelatedness of falls, strokes and dementia rather than single and separate conditions. It is often the inter-relatedness of these conditions that the health service seems to find hardest to address.

Intervention	Evidence
Interconnection of problems and social isolation	
Check for inter-connectedness.	A lack of mobility may increase the likelihood of someone being incontinent because they cannot reach the toilet quickly enough. [9] Equally falls may occur because someone gets up in the night to go to the toilet. Older people who have had strokes will frequently have ongoing issues with mobility, maybe continence and sometimes dementia. People who fall and have a hip fracture may leave hospital with a continence problem they previously did not have. Support to carers of people who have had a stroke in terms of rehabilitation, benefits advice, lifting and handling may improve both the carers capacity to maintain someone in the community as well as maintain their own health.
Home check for repairs need to make house secure and habitable. Use care and repair services where necessary. Take immediate action where home may increase the likelihood of falls. Check where falls have previously occurred and why the service user thinks this is happening.	Concern over housing repairs can be a source of anxiety and a motivator towards care home admissions. They may increase isolation if people are ashamed of where they live and home circumstances may be a hazard for falls. Older women, especailly those living alone struggle with maintaining homes as they get older in terms of DIY and require assistance with this[10].

[9] Slack. M. et al (2008) FAST FACTS: BLADDER DISORDERS. Oxford: Health Press.
[10] Care Services Efficiency Delivery (CSED) – Anticipating Future Needs (2007)

Intervention	Evidence
If person is reluctant to go out due to continence issues look at mechanism and approaches for getting around this, eg, assisting service users to have an outdoor bag with ready supplies, helping service users plan a route out where there will be public toilets.	Improvements in continence can lessen social isolation as people gain greater confidence in going out. [11]
Support worker to develop a 'before' and 'after' activity schedule, ie explore what the person used to do, where they used to go, why that has stopped and what maybe done to overcome potential fears and anxieties. Support worker to facilitate re-engagement with community life.	Higher levels of loneliness have been found to increase the likelihood of nursing home admission and to decrease the time until such an admission. The influence of extremely high loneliness on nursing home admission remained statistically significant after controlling for other variables, such as age, education, income, mental status, physical health, morale, and social contact, that were also predictive of nursing home admission[12].
Mobility	
Where people have had a previous fall(s) carry out a range of assessments such as ADL, mobility and home environment assessment (also cognitive tests if approrpaite) carried out by occupational therapist.	Home Hazard assessment along with advice on safe and effective performance of activities of daily living is a proven component of falls reduction programmes, particularly if patients have experienced a recent change in health such as a hospital admission or injurious fall.[13]
Put in place adaptations work where necessary. Check that adaptations will actively encourage independence rather than increase dependence. In the past research has suggested that service users have had to wait unacceptable amounts of time for equipment that is needed to support independent and comfortable living at home[14]	Research also indicates that having appropriate adaptations in place increases people's feelings of safety and improvement in mental health by 70%[15]. Adaptations are effective and promote physical as well as good mental health[16].

[11] Help The Aged Taking Control of Incontinence, Exploring the links with social isolation (Jan 2007)
[12] Russell, Daniel W.; Cutrona, Carolyn E.; de la Mora, Arlene; Wallace, Robert B. Psychology and Aging. Vol 12(4), Dec 1997, 574-589.
[13] National Audit of the Organisation of Services for Falls and Bone Health of Older People (Royal College of Physicians)
[14] http://www.dhcarenetworks.org.uk/csed/Solutions/homeCareReablement/
[15] Dolan P, Torgerson DJ, The Cost of treating osteoporotic fractures in the UK female population. Osteoporosis International 1998 8: 6-11-17

Intervention	Evidence
Put in place a detailed falls prevention programme. Need to make sure it is of sufficient time duration to deliver lasting results[17].	An effective comprehensive exercise programme should include interventions to address: • Low muscle strength • Poor Balance • Gait deficiencies • Addressing fear of falls. FaME programme is a practical approach that can be set by Physios and individualised to the service user [18] These programmes can be delivered in the home as well as outside the home by a Physiotherapist.[19] [20] [21] OTAGO exercises also effective and established approaches to falls reduction/ prevention[22]
Training for carers of people with dementia	
Construct training programme.	It is widely recognised that providing support for carers of people with dementia may delay care home admission[23] [24]. Brodaty et al found that training carers of people with dementia delays admission to a nursing home by an average of 20 months[25]. Prince Henry Hospital in Sydney, Australia developed a training and support for carers of people with dementia. The interventions included a

[16] Poor G, Jacobsen, SJ Melton LJ. Mortality after hip fracture. Facts, Research in Geratology. 7: 91-109
[17] Skelton D and Dinan M Exercise for Falls management: Rationale for an exercise programme aimed at reducing postural instability
[18] Tailored group exercise (Falls Management Exercise — FaME) reduces falls in community-dwelling older frequent fallers (an RCT)
[19] Royal College of Physicians, (2009), National Audit of the Organisation of Services for Falls and Bone Health of Older People
[20] Lundin-Olsson L. Nyberg L. Gustafson Y 1997 'Stops walking when talking' as a predictor of falls in elderly people. Lancet 349: 617
[21] Lundin-Olsson L, Nyberg L. Gustafson Y 1998 Attention, frailty and falls: The effect of a manual task on basic mobility.
[22] (ibid)
[23] Coon, D. W., Gallagher-Thompson, D., Thompson, L. W., (eds) (2003), Innovative Interventions to Reduce Dementia Caregiver Distress. Springer Publishing Company Inc.: New York.
[24] Association of Public Health Observatories, (2008), Indications of Health in the English Regions: 9: Older People. www.apho.org.uk/apho/indications.htm
[25] Brodaty H, Gresham M, Luscombe G.(1997) The Prince Henry Hospital dementia caregivers' training programme.Int J Geriatr Psychiatry 1997 Feb;12:183–92

Intervention	Evidence
	structured, residential, intensive 10-day training programme, boosted by follow ups and telephone conferences over 12 months. The research found that even if it did not avoid admission then carer training programmes can demonstrably delay placement into care[26].
Health improvement (Podiatry, medication, dental care, nutrition, dehydration).	
Older people are offered a sight check. Transport delivered by support worker. Vision is assessed and reviewed.	Causes of falling can be in part related to vision[27].
Feet are checked and assessed for fungal infections, poor toe nail cutting, growths etc. Podiatry offered[28].	Help the aged estimated in 2005 that 1 in 4 people aged over 65 needed foot care that they were not receving[29].
Dental check offered and carried out. Transport delviered by support worker.	Many older people do not have dental checks and hence have tooth decay, gum diseases or poorly fitting dentures[30] [31].
Support workers should take an initial weight check and regularly weigh until desired weight is sustained. Consideration should be given to vitamin D supplements for people who rarely go outside. If deficiencies are found, energy, calcium, iron and zinc content of meals should reach 40% of the Dietary Reference Values, and the	As activity lessens, calorie requirements fall. However, if insufficient food is eaten, the level of nutrients in the diet can become dangerously low, leading to a vicious circle of muscle loss, even less activity, and even lower appetite. Mouth problems and swallowing difficulties may also lead to low food intake. There are more underweight than overweight older people and, in old age, being underweight poses far greater

[26] Brodaty, H., Gresham, M., Luscombe, G., (1997), The Prince Henry Hospital Dementia Caregivers' Training Programme. International Journal of Geriatric Psychiatry, Vol 12: 182-192.
[27] National Institute for Clinical Excellence (2004) Clinical practice guideline for the assessment and prevention of falls in older people. National Collaborating Centre for Nursing and Supportive Care
[28] See Feet for purpose, Age Concern 2007, for good practice examples.
[29] Best foot forward: Older people and foot care, Help the Aged 2005.
[30] The orodental status of a group of elderly in-patients, McNally, Gosney, Dopherty, Field, Gerentology Volume 16 December 1999
[31] Pearson NK, Gibson BJ, Davis DM, Gelbier S, Robinson PG, The effect of a domiciliary dental service on oral health related quality of life: a randomized control trial, Nritish Dental Journal 2007, 2003.E3

Intervention	Evidence
folate and vitamin C content to 50%[32]. Where there is evidence of malnutrition or of dehydration then a plan for addressing this should be developed and put in place.	risks to health than being overweight. Good guidelines exist for the nutritional intake required by older people[33]. Buckinghamshire in 2005 estimated that 30% of older people referred to accident and emergency services had a dehydrated related condition[34].
Medication is reviewed and systems in place for safe administering of medication.	Evidence shows that some medication can increase the risk of falls[35]. Adjusted medication regimes can be effective in reducing falls. For example gradual and assisted withdrawal from some types of drugs for sleep deprivation, anxiety and depression has been shown to reduce incidence of falls[36] [37].
For stroke survivors support workers to motivate, prompt and instruct exercises set by a Physiotherapist to improve limb function or tasks.	Low intensity home-based therapy can improve lower limb function more than one year after a stroke[38] Evidence that these approaches can improve rehabilitative outcomes[39]. Some studies have shown significant gains through occupational therapy intervention resulting in reduced hospital

[32] The Dietary Reference Values prepared by COMA (the Committee on the Medical Aspects of Food Policy) in 1991 should be used as the basis for the nutritional guidelines for food prepared for older people.
[33] Eating well for Older People: The Expert Group Report The Caroline Walker Trust, 1995 revised 2004.
[34] Just add water, Community Care October 2005.
[35] Interventions for preventing falls in older people living in the community; Gillespie LD, Robertson MC, Gillespie WJ, Lamb SE, Gates S, Cumming RG, Rowe BH (Online publication 2009
[36] National Institute for Clinical Excellence (2004) Clinical practice guideline for the assessment and prevention of falls in older people. National Collaborating Centre for Nursing and Supportive Care
[37] Kerse, N., Flicker, L., Pfaff, J.J., Draper, B., (2008), Falls, Depression and Antidepressants in Later Life: A Large Primary Care Appraisal. Public Library of Science. June 2008 Volume 3 Issue 6
[38] Lin, J.H., Hsieh, C.L., Lo, S.K., Chai, H.M., Liao, L.R., (2004), Preliminary study of the effective of low-intensity home-based physical therapy in chronic stroke patients. Kaohsiung Journal of Medical Science. 2004; 20:18-23
[39] Walker, M.F., (2007), Stroke rehabilitation: evidence-based or evidence-tinged. Journal of Rehabilitative Medicine 39 (3):193-197.

Intervention	Evidence
	admission and more appropriate aids and adaptations[40].
For stroke survivors, develop an action plan for support workers so that they can recognise and respond to TIAs or further strokes.	
Consider whether psychological support may be necessary for stroke survivors and if so ensure its delivery.	Evidence that there is high prevalence of depression following a Stroke but that this can be averted and is not an inevitable long term side effect if treated[41].
Continence	
Ensure particularly where person displays signs of incontinence or is in a high risk category, eg, women who have had multiple births that full continence assessment is completed, together with diagnosis and full treatment plan.	A diagnosis following comprehensive assessment increases likelihood that incontinence will be *pro-actively* treated[42] [43].
Supporting service users through the continence assessment process with bladder diaries, urinanaylsis to aid assessment process and information and support re: potential medical interventions. Ensuring service users are assisted and engaged in any continence plan increases the likelihood of successful outcome[44].	Older people benefit from taking control of their incontinence[45].
If appropriate assist to motivate,	Evidence that Pelvic floor exercises can

[40] Occupational therapy for stroke patients after hospital discharge — a randomized controlled trial (Corr and Bayer 1995)

[41] Kneebone, I. & Dunmore, E. (2000). Psychological management of post-stroke depression. *British Journal of Clinical Psychology, 39,* 53–66.

[42] Department of Health (DH)(2000) Good practice in continence services' and National Service Framework for Older People Outlines good practice in relation to managing incontinence

[43] National Audit of Continence Care For Older People – Royal College of Physicians
Peters. Tim J;et al.; (2004) Health and Social Care in the Community 12 (1), 53 – 62. Factors associated with variations in older peoples use of community-based continence services

[44] DH Good Practice in Continence Services (2001)

[45] (ibid)

Intervention	Evidence
prompt and instruct exercises set by a Physiotherapist to improve continence.	reduce both stress urinary incontinence (SUI) Urge Urinary Incontinence (UUI) and faecal incontinence[46] [47] [48] [49] [50] [51] [52]. Postural and breathing exercises help with some incontinence issues[53]. Correct toilet positions help with some incontinence issues[54]
Where peoples are incontinent, regular cleaning may help to ensure home is free from odour.	
Skin integrity needs to be checked as part of daily routine of care.	
Assistance to wash and dress and assist with helping service users to wear and feel comfortable in adapted clothing if required.	
Improve access to lighting at night. Good positioning of commodes may also help.	

[46] Tan TL (2003) Urinary incontinence in older persons: a simple approach to a complex problem

[47] Hay-Smith EJ Bo Berghmans LC Hendricks HJ de Bie RA Vab Waalwijk van Doorn ES (2003) Pelvic floor muscle training for urinary incontinence in women Cochrane Database of Systematic reviews issue1

[48] Berghmans L Hendricks H Bie RD Doorn EVWV Bo K Kerrebroeck PV (2000) Conservative treatment of urge incontinence in women: A systematic review. British Journal of Urology International

[49] Solomon MJ, Pager C, Rex J, Manning J, Roberts R. Randomised, controlled trial of biofeedback using anal manometry, transanal ultrasound or pelvic floor retraining with digital guidance alone in the treatment of mild to moderate fecal incontinence. *Diseases of the Colon & Rectum* 2003; 46: 703 – 710

[50] Newman D. *Managing and treating urinary incontinence*. Baltimore, MD: Health Professions Press; 2002

[51] Bowel and Bladder Foundation website

[52] Katherine Wilkinson MA, DN, RGN, FAE 730/7, non-medical prescriber. A guide to assessing bladder function and urinary incontinence in older people 9 October, 2009 Nursing times.net

[53] Grewer H, McLean L (2008) The integrated continence system: A manual therapy approach to the treatment of stress urinary incontinence. MANUAL THERAPY; 6: 5, 375-386.

[54] Bowel and Bladder Foundation website

Y Pwyllgor Iechyd a Gofal Cymdiethasol

HSC(4)-12-12 papur 6

Llythyr gan y Pwyllgor Deisebau: Deiseb P-04-329 rheoli sŵn o dyrbinau gwynt sy'n peri diflastod

Ynghlwm fel atodiad i'r papur hon, ceir llythyr gan y Pwyllgor Deisebau ynghylch Deiseb P-04-329 rheoli sŵn o dyrbinau gwynt sy'n peri diflastod.

Gwasanaeth y Pwyllgorau

Y Pwyllgor Deisebau
Petitions Committee

Mark Drakeford AM
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
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Bae Caerdydd / Cardiff Bay
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Our ref: P-04-329

19 March 2012

Petition: P-04-329 control of noise from wind turbines

At its meeting on 28 February, the Petitions Committee gave further consideration to a petition calling for the control of noise from wind turbines. At the meeting in Carmarthen, members of the public were invited to speak and share their experiences with the Committee. A transcript of that meeting is enclosed, for information.

The Committee also visited two wind farms the day before the meeting, in order to meet with wind turbine operators and see the turbines first hand.

Wind farm operators Statkraft told the Committee that although they had initially had issues with the wind turbines located in Atwallis, all turbines were now operating within the ETSU-R-97 guidelines for maximum noise emissions.

However, residents living close to the wind turbines told the Committee that the noise from the wind turbines is still causing them significant problems and they have asked that the ETSU-R-97 guidelines be reviewed or replaced.

As you will see from the transcript enclosed, the noise nuisance has in some cases affected residents' quality of life and health. The Petitions Committee will be following up petitioners concerns regarding the way complaints were dealt with by Statkraft, but the issue of noise emissions that are within the ETSU-R-97 guidelines and yet problematic for residents is on-going.

I will be writing to the Minister for Environment and Sustainable Development, and the Minister for Health and Social Services to make them aware of these concerns, but the Committee also wanted to make you aware of the issue for your future reference.

Yours sincerely

William Powell
Committee Chair
Enc: 28 February Petitions Committee transcript
http://www.senedd.cynulliadcymru.org/mgIssueHistoryHome.aspx?IId=1310

Y Pwyllgor Iechyd a Gofal Cymdiethasol

HSC(4)-12-12 papur 7

Llythyr gan y Pwyllgor Deisebau: Deiseb P-04-375 rhoi terfyn ar system eithrio ar gyfer rhoi organnau

Ynghlwm fel atodiad i'r papur hon, ceir llythyr gan y Pwyllgor Deisebau ynghylch Deiseb P-04-375 rhoi terfyn ar system eithrio ar gyfer rhoi organnau.

Gwasanaeth y Pwyllgorau

Y Pwyllgor Deisebau
Petitions Committee

Mark Drakeford AM
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Our ref: P-04-375

15 March 2012

Petition: Stop Opt-out Donation

The Petitions Committee has received the following petition, which collected 71 signatures:

'We call on the Welsh Government to stop proposals for its opt-out organ donation system. I think it is completely unethical for the Welsh Government to be pushing through an opt-out system for organ donation. This system should not be implemented, particularly if it does not consider the views of relatives. Whilst appreciating the need to donate organs in order to prevent unnecessary deaths, I still strongly believe it should be a decision that each individual takes and not something that is forced on them by the state. Archbishop of Wales Dr Morgan said: organ donation surely ought to be a matter of gift and not of duty" and I agree with his statement. This is violating individual rights and is an unfair system. Please sign this petition should you feel the same and want to stop this legislation being passed.'

As you know, the Welsh Government has issued a White Paper setting out its proposals for legislation on organ and tissue donation. At its meeting of 13 March, the Petitions Committee agreed to refer this petition to the Health and Social Care Committee, as the Committee that will be charged with scrutinising the future Bill on the subject.

The petitioner has informed the Committee that she is unhappy with the level of consultation undertaken by the Welsh Government on its legislative

proposals. A written statement by the Minister for Health and Social Services, issued on 8 March (attached), stated:

'the White Paper posed questions relating to the how the arrangements should work and did not explicitly invite respondents to state whether they supported the proposals.'

The Petitions Committee would like to request that whilst scrutinising the Bill, the Health and Social Care Committee explores the level of consultation undertaken and whether the questions posed as part of the process were explicit enough.

Thank you for your consideration of this matter.

Yours sincerely,

William Powell
Petitions Committee Chair

Encs: Written Statement by Minister for Health and Social Services: Proposals for organ and tissue donation legislation – publication of analysis report following the consultation;
Summary of Welsh Government Consultation Responses
http://wales.gov.uk/about/cabinet/cabinetstatements/2012/organdonation/?skip=1&lang=cy