

Y Pwyllgor Iechyd, Lles a Llywodraeth Leol

The Health, Wellbeing and Local Government Committee

Dydd Iau, 11 Chwefror 2010
Thursday, 11 February 2010

Cynnwys

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Procedural Motion

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg. Mae hon yn fersiwn ddrafft o'r cofnod. Cyhoeddir fersiwn derfynol ymhen pum diwrnod gwaith.

" "

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. This is a draft version of the record. The final version will be published within five working days.

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
Helen Mary Jones	Plaid Cymru The Party of Wales
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Gareth Evans	Cyfarwyddwr Clinigol Rheoli Perfformiad a Gwella Gwasanaeth, y Grŵp Rhaglen Therapiau a Chymorth Clinigol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Clinical Director of Performance Management and Service Improvement, Therapies and Clinical Support Programme Group, Betsi Cadwaladr University Local Health Board
Helen Hortop	Pennaeth Therapi Galwedigaethol a'r Gwasanaeth Aelodau Artiffisial a Chyfarpar, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Head of Occupational Therapy and the Artificial Limb and Appliance Service, Cardiff and Vale University Local Health Board
Alison Ravenscroft	Rheolwr y Canolfan, Gwasanaeth Aelodau Artiffisial a Chyfarpar Wrecsam Centre Manager, Artificial Limb and Appliance Service Wrexham
Keith Roberts	Rheolwr Cynorthwyol, y Gwasanaeth Aelodau Artiffisial a Chyfarpar, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Assistant Manager, Artificial Limb and Appliance Service, Cardiff and Vale University Local Health Board
Clive Sparkes	Pennaeth Staff, y Grŵp Rhaglen Therapiau a Chymorth Clinigol, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Head of Staff, Therapies and Clinical Support Programme Group, Betsi Cadwaladr University Local Health Board
Mike Spencer	Rheolwr Grŵp Gwasanaeth, y Gwasanaethau Cyfleusterau a Chlinigol, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Service Group Manager, Facilities and Clinical Services, Cardiff and Vale University Local Health Board

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

Steve Boyce	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Marc Wyn Jones	Clerc Clerk
Sarita Marshall	Dirprwy Glerc Deputy Clerk

"Dechreuodd y cyfarfod am 9.13 a.m.
The meeting began at 9.13 a.m."

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

Darren Millar: I welcome Members to today's meeting of the Health, Wellbeing and Local Government Committee. I also welcome members of the public and remind them that headsets for both simultaneous translation and sound amplification are available in the public gallery. If anyone has any problems with using them, the ushers will be able to assist. Committee members and members of the public may wish to note that the simultaneous translation feed is on channel 1, and the language being spoken is on channel 0. I would be grateful if Members, members of the public and witnesses ensured that mobile phones, BlackBerrys and pagers are switched off so that they do not interfere with the broadcasting and other equipment. If it is necessary to evacuate the room or the public gallery in the event of an emergency, then everyone should follow the instructions of the ushers, who will be able to guide people to the appropriate exit. Finally, I remind Members and witnesses that the microphones are operated remotely, and therefore it should not be necessary to press any buttons to activate or deactivate them.

We have received apologies this morning from Irene James. I am not aware of any other apologies or substitutions. Are there any declarations of interest under Standing Order No. 31.6? I see that there are none, and so we move on to item 2 on our agenda.

9.15 a.m.

Ymchwiliad i Wasanaethau Cadeiriau Olwyn: Tystiolaeth gan Wasanaeth Aelodau Artiffisial a Chyfarpar Rookwood

Inquiry into Wheelchair Services: Evidence from Rookwood Artificial Limb and Appliance Centre

Darren Millar: I am delighted to welcome the following witnesses to today's committee meeting: Helen Hortop, head of occupational therapy and the Artificial Limb and Appliance Service in the Cardiff and Vale University Local Health Board; Keith Roberts, assistant manager of the artificial limb and appliance centre; and Mike Spencer, the service group manager of facilities and clinical services at the Cardiff and Vale university health board.

You have kindly sent us some information, and you hosted a visit for us a couple of weeks back, which we appreciate. For the record, could you outline for the committee the targets or quality indicators that your service is required to meet at present in relation to the assessment and provision of wheelchairs? Are these targets being achieved, and how relevant and effective are they? Helen, do you want to start?

Ms Hortop: Yes, thank you. The only formal targets that we have are set by Health Commission Wales: a 12-month cycle from referral to the delivery of wheelchairs for children, and a 15-month cycle for adults. Alongside that, there are the national service framework targets, with the one for children and young people set at 14 weeks. We were never resourced to achieve that target, but we still aspire to it. We do not see the 12-month cycle target as something to aim for, but we have never breached it. We deliver the chairs as fast as we can, as well as any other components, such as the cushions or the seating. Whatever it is, we do it as quickly as possible. We then have the 21-day cycle for standard chairs, and we do not breach that.

Darren Millar: You have made reference, as have other witnesses, to the national service framework target. We will come to the national service framework later on in our lines of questioning. Is there any explanation of why there is an inconsistency between the national service framework target on wheelchair delivery for children and the target that Health Commission Wales has set?

Ms Hortop: 'I do not know' is the honest answer. We were not consulted when the target was set for the NSF. We were just made aware of it when the NSF was established. So, we were not party to it. One problem, given the shortage of staffing and resources in the centre to deliver the target, is being able to get the chair or the seating component within the timeframe. However, we were not consulted.

Helen Mary Jones: That is interesting. You say that you are not resourced to meet the national service framework targets for children and young people, but have you made an assessment of what level of resource you would need to meet those targets? If so, have you made submissions to Health Commission Wales or to the Assembly Government about that?

Chair, I had a technical problem with my microphone, which did not come on then.

Darren Millar: Okay, we have noted that.

We will come to discuss the funding in more detail a little later, but perhaps you can answer that for us briefly, Ms Hortop.

Ms Hortop: Health Commission Wales is well aware of the resources that we have. As I was able to tell you when you came to the centre, we have fewer than four whole-time equivalent clinical assessors to deal with the needs of almost 3,000 children in our part of Wales. So, we have to contend with the number of children and the geography. That issue is flagged up continuously, but we have not put a formal bid in for additional staffing.

Helen Mary Jones: Do you know what that additional staffing need would be? Have you made an assessment of what you would need?

Mr Roberts: We do not know at present. We have been at full capacity, staffing-wise, only for the past 12 months. We would need to look at that and do a lot of work on it to know what our capacity is and how many people we can assess per year with the staffing complement that we have. We have had a stable staffing group for only the past 12 to 18 months, as it is quite difficult to recruit—or it has been in the past.

Mr Spencer: The annual commissioning process between HCW and the service has been based on a roll-forward against the targets set by HCW. Therefore, the year-on-year discussion has been based on that, as opposed to a separate discussion on the NSF. However, I am sure that, if challenged to do so, the service could estimate that gap.

9.20 a.m.

Ms Hortop: To add to that, we have an IT system for the whole of the service in Wales called BEST, which includes a mechanism that enables us to look at the time components for direct and indirect patient contact. In south Wales, that has been implemented in the past few months, so we are actively looking at how much time it takes to deal with an average patient. It is difficult to define an average patient, but we are trying to do that in a scientific way.

Val Lloyd: You mentioned standard and other wheelchairs. I wondered whether you could give us an indication—if not now, perhaps via a note at a later stage—of the percentage of standard and non-standard wheelchairs.

Ms Hortop: The ratio for new referrals is 20:80. Overall, however, because we get re-referrals as well, it is 50:50.

Darren Millar: Returning to targets, would you like to see further targets for your service and a requirement from Health Commission Wales, or whoever sets these targets, for improved standards?

Ms Hortop: I think that we would, yes. In fact, I more than think it—I know that we would. Anything that will improve the service for our clients is to be welcomed. We are constantly striving to make changes in the service that achieve better outcomes and realistic ways of measuring those outcomes. The way in which we manage the current waiting list is not particularly realistic, because there are some urgent cases that we need to see quickly. In response to that, Cardiff has appointed a rapid-response clinician, so that when we get a patient who is particularly at risk, we can send someone out, sometimes within days, but certainly within one or two weeks, to ensure that that person is not at risk of deterioration.

Those cases might involve motor neurone disease, or a child at risk, so we have at least one dedicated person who can respond quickly. Anything that we can do to improve the service is to be welcomed, but performance targets need to be realistic and need to take into account the needs of our group of clients, because they will be our clients for life. Many have chronic conditions, so their dealings with us are not a one-off, as with many other services with waiting lists. It is different for us, and we need to be responsive to that. The policies on patients who do not attend that are implemented in some other services are not right for us. If a child DNAs, for example, it is not their fault, but that of their carer or parent.

Darren Millar: You touched on how you manage some of your urgent priority cases. How do you manage the rest of your waiting list? As Assembly Members, both in committee and in our constituencies, the most frequent complaint that we hear about ALAS is the waiting times involved in assessment and the provision of equipment. How do you manage your waiting lists?

Ms Hortop: All referrals are triaged when they come into the service. If we can prescribe from the prescription that we get from a referrer—and we accept referrals from any registered health professional—that chair can go out on the prescription. That is the 21-day cycle. We then look at what that person needs. If they need a postural assessment, the referral goes to the clinical team. If it is a technical issue, it goes to the medical technical team. If it is something that we cannot provide off the shelf, a bespoke product, it goes on to the highest level of skilled group, namely the rehabilitation engineers. So, it is triaged to different needs across the range of skills that we have available.

Darren Millar: There are different waiting lists according to those different categories, are there?

Ms Hortop: Yes.

Val Lloyd: In your written evidence, you note that the maintenance, repair and refurbishment of powered chairs has now been brought in-house. How will that service be managed, what improvements do you expect to see as a result, and what targets do you have for those improvements?

Ms Hortop: We brought the approved repairers' service in-house on 1 February. By bringing our two teams of skilled personnel together, we feel that we have a better pool of expertise and so we can be more responsive in providing the service. The target that we are in the process of delivering is a three-day repair target, based on the percentage achieved in the first fix. So, we want to be able to go out and do that first fix immediately. That was not always the case for the service. So, we try to ensure that the engineer who goes out knows as much as possible about what is wrong with the chair, and we are in the process of setting up well equipped vans so that the engineer has sufficient equipment on board to enable him to do the fix at the home and not inconvenience the person any more. We are aware that if someone is dependent on their chair and it breaks, that person's lifestyle is completely wrecked while they are not in the chair. So, we are trying to set sensible and realistic targets.

Ms Spencer: You mentioned the complaints that you get as Members, and the complaints that we were getting were consistently about the performance of the maintenance and repair service. As Helen indicated, another driver for bringing the service in-house was to improve that. It was also to bring together two groups of staff under one management team, leading to smoother ways of working. We will be looking at streamlining how we process paper, requests and repairs. Some of the innovations that Helen touched on, such as the rapid-response individual, will be easier to achieve within the existing budget and will allow us to test solutions before making bids for additional funding, if required. So, the streamlining of the service is a key part of that.

Darren Millar: Could you not have seen those improvements through better contract management, rather than having to bring the service in-house? We have heard evidence from other parts of the country, and a few of us have visited Sefton, for example. There does not seem to be any issues with its repair service, which is also contracted out privately. Was it a contract management issue?

Mr Spencer: You are probably aware that the scale of the service in Wales is significantly different from that of most services in the UK, never mind just England. Running two call centres and two organisations had its issues, so bringing those two together into one would not have been possible with a contracted-out service. There were issues with the scale of the service and the geography of Wales, as well as a number of others that led to the drive to unify the service.

Ann Jones: I want to talk about funding. You have already indicated that you felt that you were never resourced to hit the national service framework target for children, and, in your written evidence, you state that you strive to make the best use of your scarce resource. So, if I asked you whether you had sufficient funding, I could probably guess the answer. What mechanisms are in place to ensure that the resources that you receive are used effectively?

Ms Hortop: As a result of the five-year plan that was implemented about six years ago, we funded a training officer for Wales, and she set up three levels of training. We are the only country that has a training officer, and other countries are now interested in looking at our training pack. The reason for that is that, if we can get better and more accurate information on the prescriptions as they come in, we can try to issue from those prescriptions. That is one way in which we are doing it. We are also investigating the concept of trusted assessors in different areas, namely people who have worked closely with the service and so we are confident that they have the skills to assess patients and assist us with that fast flow. So, those are two of the ways in which we are trying to use our resources effectively.

9.30 a.m.

Ann Jones: What specific improvement could you provide as a service as a priority if you had the funding? What would be the priority?

Ms Hortop: We would address waiting times and use the additional funding for reviews. The rehabilitation engineering service is able to review adults on an annual basis and children twice yearly. That is what we need to do. We need a structure for reviewing children in particular, along with anyone else in the service that needs a review. Apart from addressing the needs of a child, we would also be providing a much more cost-effective service, because we would identify issues earlier in the cycle and be able to stop the child from deteriorating. One thing we are looking into at the moment is the use of Lycra for children. If we could position children better in Lycra suits we could probably reduce the prescription in the chair. We are trying to look at issues that are wider than wheelchairs themselves.

Ann Jones: So, are you saying that the way that you provide a service at the moment, with the funding that you have, is very costly and that, if you had a little bit more, you could make it cheaper?

Ms Hortop: Yes, I think so. If we could look at the wider lifestyle needs—

Ann Jones: So, it is a case of invest to save?

Ms Hortop: Yes, I think so.

Ann Jones: I think I am right in saying that you manage the contract for the supply of wheelchairs and equipment.

Mr Spencer: The tendering process is run through the Cardiff and Vale University Local Health Board. We see the wheelchair service as one service that delivers in two parts.

Ann Jones: How do you drive down the prices in the contract? How effective are you at getting a good deal?

Mr Roberts: The last wheelchair supply contract was let in 2006, so we are coming to the end of that now. We are looking to roll that on for the final year, which will conclude in November 2011. Companies come back to us yearly for price increases on the equipment, and we negotiate quite hard to ensure that they do not increase them. Twelve to 18 months ago, because of the state of the economy, many of the companies came back with requests for increases of between 5 per cent and 20 per cent on some of their equipment. We have requested to roll this contract on for another year, as I said. So far, all but one of the companies have agreed to that with no cost increases, which is good. We are in the middle of negotiating with that one company. The contracting process takes a great deal of time and effort, because we try to get the best range that we can for our clients. The contracting process in 2006 took the best part of a month's worth of the clinical team's time and effort categorising and evaluating the products. The contracting process is very well done.

Ann Jones: Why do you want to extend the contract for another 12 months? Is it purely on an administrative basis or is it because you think that it might be easier to negotiate a better contract?

Mr Roberts: I think that if we went back out to contract at the moment, prices would increase. At the moment, it makes economic sense to extend for a further year.

Ann Jones: If your prices are going to increase as a result of coming out of the contract, which is basically what I think you are saying, why do you intend to hang on for just 12 months? Why do you not hang on for longer if you can get a better deal?

Mr Roberts: The contract was awarded for two years in 2006, with the option to roll over for three years.

Ann Jones: So, that takes you to 2011. Do you feel that—

Darren Millar: Sorry, Ann, but Mr Spencer wants to come in on this.

Mr Spencer: I wanted to elaborate on the point that the clinical time that goes into the contract evaluation is quite significant, as is the user involvement. It is a very big process for very good reasons, and the judgment was balanced between investing that clinical time now and the knowledge that prices would almost inevitably increase. So, we took the view that we should recommend that the contract be rolled forward for another year. That means that we can do it again at the right time with the right clinical involvement and the right user group involvement.

Ann Jones: Do you think that there would be any merit in going for a UK-wide contract, so that you would have a bigger pull? Would you join with another consortium to see whether you could get a better deal?

Mr Spencer: I think that you have seen from the evidence that the range of wheelchairs available in Wales is larger than, or as large as, the range available anywhere else in the UK. So, there are issues around us in Wales having a broader range. The concept of UK procurement is in place for many things, if appropriate.

Mr Roberts: We do go out of range for equipment, but we can also purchase through the NHS supply chain. There are separate contracts.

Ann Jones: Therefore, you have the two.

Mr Roberts: Yes.

Ann Jones: Which would be the best option? If you could only have one option, which one would you choose?

Ms Hortop: I think that it would be the one offering the better prices and the system that we have—"Inaudible."

Mr Roberts: We have better prices.

Ann Jones: So, you can get better prices—"Inaudible."

Mr Roberts: Yes.

Ann Jones: So, should we be stopping the NHS contract, and should we be letting everyone just do their own?

Mr Roberts: I believe that the NHS supply chain prices were only finalised last year.

Ann Jones: Are they still higher than the ones that you have in the contract that is about to run out?

Mr Roberts: Yes, for some of the products, I am sure.

Ann Jones: That is interesting. Thank you.

Andrew R.T. Davies: In an earlier response to Ann, and in the evidence that you have provided, you talked about the five-year plan for wheelchair services, but, by and large, the bulk of this was never commissioned. As we are dealing with funding in this section, I assume that it was never commissioned due to lack of funding, or was it the case that you did not really think that there was a need to commission those services?

Ms Hortop: The money was never provided. There was an agreement that it would go forward. It was before I was in post, but I remember it from my involvement as head of occupational therapy. The money was just not there for the whole of the plan. We have the training officer for Wales, and we have a transport officer for Wales, who is based in the north Wales service. Both those officers have been huge assets. However, there are other aspects that have not been funded.

Andrew R.T. Davies: Was a reason ever given as to why the money was not forthcoming? The plan was there, and I presume that the recommendations in that plan were consensually agreed and that everyone thought that it was a sound plan. Was there a logical reason as to why a deaf ear, perhaps, was turned to supplying that money?

Ms Hortop: I believe that the money was just not available. Is that right? I was not—

Andrew R.T. Davies: Therefore, it was not seen as a priority.

Ms Hortop: I guess so.

Mr Spencer: As part of the commissioning process, Health Commission Wales would annually talk to the service about what it wished it to deliver in the subsequent year. That would have been the process for agreeing the incremental increases to meet the—

Andrew R.T. Davies: In reality though, it was not a priority.

Mr Spencer: I cannot speak on HCW's behalf, but no additional funding was provided for many aspects of the plan. As a commissioner, it would have taken the view as to how it would approach the annual commissioning round. As a service, we respond to the commissioner in that sense. We make best use of the funding that we have, as Helen has indicated, but the actual commissioning intent is set by the commissioner in the annual discussions.

Darren Millar: I assume that you had to bid for a pot of money that you felt would be appropriate in terms of the level of resource that you would require to meet the demand for your service.

Mr Spencer: The commissioning is more on a mutual basis. There are regular meetings between the commissioner and the service, and the plans for the subsequent year emerge from that process. Again, I cannot speak for some of the earlier times, but I cannot recall a specific request to cost some of the issues in the five-year plan, although I may be mistaken.

Darren Miller: I suppose that the question that I am asking is: if you roughly knew what the demand for your services would be, and you could estimate the resource required to meet that demand, what is the difference in terms of what you receive from Health Commission Wales and what you feel you require for the service?

Mr Spencer: I think that reviews were part of the five-year plan, and we have already touched on the fact that we are not able to deliver a review for children in particular. The number of occupational therapists supporting 3,000 children in the service is fewer than four. You can see that to bring children in on a regular basis with that number of occupational therapists, and deal with the new cases, would require an investment in capacity. Therefore, the service could certainly—as it has indicated, based on the information that it has—estimate what that gap is and what the additional funding requirement would be. So, the service is more than capable of doing that.

Darren Millar: I find it difficult to believe that if you have been petitioning Health Commission Wales for resources for your organisation to be able to meet the demand of service users, you have not quantified the resource that you might need. That seems astonishing, frankly. Can you explain why you have not been able to estimate the resource that you require to date? Surely, if you are going to HCW on an annual basis asking for extra cash for your service, which I assume has been the case, then you must go to it with a figure. It is not surprising that you do not get what you want if you are not able to say what you want.

9.40 a.m.

Mr Spencer: That goes to the heart of the commissioning process. HCW is commissioning a wide range of services from the organisation, and the discussion that would go on between the commissioner and the service is at the heart of that. The commissioner will indicate clearly the type of service development that it wishes to see coming forward. Some of those cases have been put forward in the past. Whether they are funded or not is part of the commissioning process.

Darren Millar: However, you have made a business case, with an estimate of the cost of funding those extra parts of the service.

Ms Hortop: In reality, we are told what the percentage increase for the year will be. We have a very good relationship with our commissioner, but he has a finite budget. So, we have been trying to reconfigure the service so that we make better use of what we have and try to go forward in that way. We have had limited-waiting-list initiatives, so we have been able to do some work in that regard. As you know, a waiting-list initiative is not recurring, so, although you take people from the front of the list, you are left with more people who need to be fitted for their wheelchairs. That is a balancing act. It is a short-term fix and not a long-term solution. One reason why we have brought the approved repair service in-house is that we feel that we can use that resource better, to do more.

Peter Black: What is the policy of Cardiff ALAS on allowing patients to top up or use joint funding with a charity to purchase a wheelchair and equipment? What is the policy on the repair and maintenance of equipment that has been purchased in this way?

Ms Hortop: Keith has been more actively involved in those sorts of cases.

Mr Roberts: We carry out joint funding actively with charities such as Whizz-Kidz. We met it this week to agree a process on an all-Wales basis, and that was a positive meeting. We have worked with it in north and south Wales on a more separate basis. So, as I said, we fund jointly, and we have done that with other charities. Many people request riser seats, which we are not able to provide within our current budget. The second part of the question was on maintenance, was it?

Peter Black: Yes. If you purchase equipment through joint funding, how is that maintained?

Mr Roberts: When we fund jointly with Whizz-Kidz and others, we take ownership of the equipment, and we will maintain it thereafter.

Peter Black: You say in your evidence—and you have just said this—that you will fund jointly with charities such as Whizz-Kidz, but not with individual patients. Why is it that you have a different rule for an individual patient from the rule that you have for a charity?

Mr Roberts: We have undertaken joint funding with individuals for riser seats, but not for anything more than that. It comes down to the ongoing maintenance of equipment. As you have heard, we brought the service in-house, and we will strive to carry out a set percentage of first fixes, and the fitters turn up at people's doors. Having a wider range of equipment will make that work more difficult because of the spare parts that we would have to carry. We have negotiated the supply of a wide range of consignment spares with Invacare in Bridgend, and others. We have over 140 of that company's products on the shelves. We are only into week 2 of the contract, but I would like to think that that, along with training the people in the vans that visit people's homes, is the way forward.

Peter Black: Your written evidence says:

'We are not able to joint fund with individual patients although we are willing to joint fund components. For example if a client wants to purchase their own riser seat to go on our wheelchair.'

You do not talk about funding the riser seat jointly; you talk about the client purchasing their own.

Mr Roberts: The client will purchase their own riser seat

Peter Black: So, you do not fund jointly with clients.

Mr Roberts: We would purchase the chair, and they would fund the riser seat.

<p>Peter Black: You have just said that you would fund the riser seat jointly.</p>
<p>Mr Roberts: I apologise for that. I meant that we would purchase the chair and they would fund the riser seat.</p>
<p>Peter Black: Why would you fund jointly with a charity but not with individual patients?</p>
<p>Mr Roberts: We would fund the equipment jointly with Whizz-Kidz and others, and take on the maintenance and ownership of the equipment. It also comes down to lifestyle needs. They would go for riser seats and sitting-to-standing elements.</p>
<p>Peter Black: Why is an individual patient treated differently if they do not go through a charity?</p>
<p>Mr Roberts: The Minister for Health and Social Services did not want us to joint fund with individuals.</p>
<p>Peter Black: So you have had a directive from the Minister not to joint fund with individuals, is that right?</p>
<p>Mr Roberts: Yes.</p>
<p>Helen Mary Jones: You said that you joint fund with charities, but do you joint fund with other public bodies, particularly in relation to children? It has been put to us that there will sometimes be a situation where education services have to make available a high-quality chair for a child to use when in school, but the chair at home does not have a riser seat, for example, whereas the one at school might. Would you be prepared to give consideration to joint funding with educational services, particularly for children and young people?</p>
<p>Ms Hortop: That would be a very sensible way forward and is something that we want to investigate and progress. It makes perfect sense, as you say, to provide a riser seat for a child in order to enable them to access their whole school life; we would and do want to look at that.</p>
<p>Helen Mary Jones: What barriers have prevented you from doing that so far? There are more complicated issues when it comes to allowing individuals to purchase whatever they want and then you are responsible for the maintenance, but when it comes to working across two public services, clearly, it seems like a good idea, so what have been the difficulties?</p>
<p>Ms Hortop: I think that it is a time issue in terms of Keith and I working together to take the service forward. We have prioritised—our first priority was to bring the approved repairer in-house and there is a list of other things. Talking about lifestyle, to be able to better accommodate a person's entire lifestyle is obviously an aim, but doing so requires funding.</p>
<p>Andrew R.T. Davies: Going back to what Keith said, that was a powerful remark that you made, that the Minister for Health and Social Services did not want joint funding. However, you have indicated, along with your colleague, that there is no operational reason why joint funding could not happen. That, to me, suggests—we have talked about priorities on funding and the implementation of the five-year plan—that the Minister has taken a political decision on joint funding, but does not become involved in the prioritisation of funding this service. Would that be correct?</p>
<p>Ms Hortop: Sorry?</p>
<p>Andrew R.T. Davies: The point that I am trying to make is that, from what Keith said, the Minister has said that joint funding should not be allowed, but when it comes to funding the five-year plan, you go to Health Commission Wales, and it is not deemed sufficiently important for the Minister to determine in that instance.</p>

Mr Spencer: Whizz-Kidz as a service is in the wheelchair business and works specifically with children; it can work closely in a technical and other nature with the service on what is purchased and on how we can help to support and maintain it. The challenge with individuals, as has been indicated, is that fitting anything different to a wheelchair will cause potential maintenance difficulties. As we have indicated, what we strive to do—and what HCW and the Minister would support—is to provide the widest possible range of services. That range would certainly be as wide as anywhere else in the UK and it would be customised, where possible, through rehabilitation engineering and so on so that, from a clinical needs perspective, each person is assessed and a solution is offered to meet their clinical needs; that is the main driver of the service. Clearly, some individuals would feel that they needed more than that and I think that that is the issue here, namely whether it is appropriate to go beyond clinical need for which the service is funded in a joint way. Public bodies and charities, as you have indicated, are certainly the way forward on that.

Darren Millar: I think that you have answered the question. Helen Mary is next.

Helen Mary Jones: I think that my question on reviews has been answered, but my next question on provision beyond clinical need follows on neatly from what Mr Spencer has already told us. The committee has heard a lot of evidence that wheelchair services should take into account all of the user's needs. You have already touched on this point and have said that, particularly in the case of children and young people, it should include their social needs and their ability to participate in the community. However, you are funded to meet clinical need and nothing else. Would that be fair to say? I see that you agree that it would. How do you determine the level of clinical need? Would you like to be able to go beyond that? I think that you indicated that you do not think that it is adequate just to fund the basic clinical need.

9.50 a.m.

Ms Hortop: No, it is not. Professionally, as an occupational therapist, I look at all of the person's occupational needs. We are assessing people's mobility and posture needs, so we are comfortable that we achieve that. However, I can cite the case of a child who comes to our service whose family has an active lifestyle, but we can only go so far when it comes to providing the chair that would allow that child able to interact fully with the family. You have mentioned schools; we would like to be able to provide riser chairs so that the child can be at the same level as everyone else and get a book from a shelf. Those are things that we take for granted, but we are not able to provide those things. So, yes, we would love to be able to go wider than that.

Helen Mary Jones: So that, once again, comes down to the commissioning process and what you are commissioned to do.

Ms Hortop: Yes.

Helen Mary Jones: I would like to move on to discuss communication with service users and feedback. What feedback, if any, has Cardiff ALAS received from patients concerning the service provided? Are there systems that allow you to seek proactively feedback about the quality of the service? How do you respond when you receive that feedback?

Ms Hortop: We have a website that we keep updated, not only with our own information, but information from other organisations, such as Disability Wales, which is regularly in touch with us. We have screens in the centre in Cardiff through which we pass on that information. We are currently in the process of reviewing a newsletter to send out to users. We are doing that in conjunction with the posture mobility steering group, which, as we discussed before, is a mixture of commissioners, managers, service users and representatives. We are looking at that in order to be able to interact as closely as possible.

A customer satisfaction survey used to be sent out regularly either by phone or by post by Serco, the ex-approved repairer. The response rate was appallingly low. Therefore, we have to look at better ways of collecting information. I do not think that just sending a letter to someone is the way to do it. In the past, we have gone out to meet groups of service users and groups of clinicians. We regularly go to Newport and Swansea to meet paediatric occupational therapists and physiotherapists to talk about their issues and to look at ways in which we can improve the service. We recently made an offer to a group of people who use wheelchairs in the Llanelli area, but have not had any feedback yet. We never turn down an opportunity to talk to people. We also do it on a one-to-one basis. We have a complaints procedure and a complaints manager. We are trying to look at different levels and different ways to communicate with individuals and groups of people.

Helen Mary Jones: Evidence given to the committee has highlighted a lack of communication once referrals are made to ALAS. For example, no written reports are given to parents or local therapists following assessment. How do you ensure that there is effective communication at that stage with service users and, in the case of children, their families, and with local clinicians and therapists?

Ms Hortop: I agree that there is a gap. We are addressing it at the moment. What we intend to do, when we receive a referral, is to send a letter to the client to tell the client the length of the relevant waiting list. In conjunction with our IT department, we are looking at ways to share the assessment with the client. One problem with giving information on the day of the assessment is that, while the clinician might be assessing the person, he or she does not know what the solution is until all aspects have been considered. That is part of it. However, there is nothing to stop us from sending that information on afterwards. I agree that it is a gap that has to be filled.

Helen Mary Jones: I am glad to hear you say that, because that is a serious gap. Do you have a timescale by which you would expect to be able to address that—roughly, obviously; I would not expect you to say that it would be by 1 May or something like that. How long do you think that it will take to sort that out?

Ms Hortop: Those are the sorts of timescales that we are looking at. Having the approved repairer come in-house has been an 18-month cycle. Although we have had a lot of support from the trust to do that, we have done it from within our existing resources, so things have gone on the back burner while we focused on that, and that is one of those things. We have talked about it to our IT department this week, obviously, and we have seen the evidence put forward by others, and we are taking on board the things that we are being made aware of that are particularly important to people. We are trying to respond as soon as possible. That will be done in the next few months or so—I know that 1 May was just a date that you plucked out of the air, but we are talking about some time now.

Darren Millar: I am conscious of the time. We are running slightly over, but I think that it is important that we ask all the questions today. With Members' permission, we will continue with our lines of questioning. I ask the witnesses to be to the point in their answers, and I ask Members to do the same in asking their questions.

Andrew R.T. Davies: Thank you for your evidence this morning, and thank you for the tour two weeks ago that you kindly afforded Members of your Rookwood premises.

In your paper, you talk about training and the various levels of training—1, 2, and 3. You have touched on that periodically throughout the evidence this morning. At the moment, you are in the process of developing level 2 training, because level 1 is in place for most of your assessors and level 3 is in place. What is the timeframe to get the level 2 training completed so that your operatives are up to speed? With local therapists playing a significant role in the assessment of wheelchairs, how important is it for them to have the training so that the whole package is in place?

Ms Hortop: So far, we have trained almost 1,000 people to level 1. All of our staff are trained to level 3. We are in the process of identifying trusted assessors who will make up the level 2 group. When the post was created, there was no training programme, so the post holder had to create it from scratch, and, as I said, no other country has that, and we are talking about sharing that.

I do not have a defined timescale for implementing the training right across the board. At the moment, we are trying to get district nurses on board with level 1, because they are one of the categories of referrers. However, for as many people who tell us that they want training, we also have people who say, 'I'm not doing your job for you'. You are hearing about the people who want training, and they are the people who we are trying to reach at the moment. There is no waiting list for training; if someone were to ring up today and say that he or she has a group of people in that area, anywhere in Wales, we would be able to provide that training within the next month to six weeks. That is the programme that we are going through, but we will not be ready to roll out level 2 until we are confident that the level 1 training has bedded in and we are getting prescriptions that show us that they have taken that initial training on board. So, there is that post training assessment period, after which we will go on to trusted assessors.

Andrew R.T. Davies: Was the training plan part of the five-year wheelchair assessment? Was there a defined timeline for when this training should have been in place? Are you on target? It is good to hear that there is no waiting time for people who wish to have the training, but to have a successful plan you need to have all the component parts in place, do you not? By not having the level 2 and a backline on it, was the original plan for this level of training for it to be completed by a given date?

Ms Hortop: It was a roll-out process.

Helen Mary Jones: I will understand if you do not want to answer this, but who is telling you, 'We don't want to do your job for you'? I do not think that this is just your job.

Ms Hortop: Neither do I. For therapists out in the community, it was put into the five-year plan originally because so many people were saying that they wanted the training. We then went out to say that we had the training officer and the packages, and there were people who responded, 'I have my day job; how can I fit that in as well?' I understand that; they have their day jobs, and it is an extra, but when people understand the training and see that they can complete the prescription forms more easily and more effectively, and their patients get their chairs more quickly, that is the message going forward. However, there are still people who do not feel that they have the time to do the training or take on that role.

10.00 a.m.

Lorraine Barrett: What systems are in place to encourage joint working between you and health and social care services and the voluntary sector, in particular the British Red Cross, from which we have taken evidence? Could improvements be made to the joint working, and if so, what practical actions could be carried out?

Ms Hortop: In terms of the British Red Cross, I met with the lead—I cannot remember his name—in the autumn of last year, and we talked about how we could work more closely together to deliver the chairs. My response to him then was that we needed to bring the approved repairer in-house, and then we would go back and look at how we could work closer together if possible. If you are talking about the provision of short-term chairs, we are not commissioned for that, but we recognise that there is a huge gap in the services that needs to be filled.

On joint working with other organisations, as Keith described, we do it when we can with organisations such as Whizz-Kidz.

Lorraine Barrett: We probably do not have time, Chair, but the British Red Cross raised some issues where there was a bit of frustration on its part. Perhaps we can compare the record on that when we put the report together, because it felt that it could do more with you. Will you take away that message, because you have a willing partner who wants to offer a bit more? From this side, we feel that that could plug the gap in some areas, particularly with regard to the short-term or temporary loans of chairs.

Ms Hortop: That is the conversation that I had with him, but it would not have been possible while we were in the process of bringing the approved repairer in-house.

Darren Millar: There is a final question for you before we bring this part of our session to a close. We have had all sorts of different evidence about how wheelchair services should be organised in Wales. Some people have suggested that it should be on an all-Wales basis, some have said it should be on a regional basis and others have said that it should be on a local health board basis. What is your opinion on how wheelchair services should be organised?

Ms Hortop: I think that it works as it is. We are an all-Wales service, but delivered out of two centres. That is how I feel at the moment because we share so much with the north Wales service. So, I am comfortable that we are making the best use of that. The worst option would be to be broken up according to health boards. If four occupational therapists or less were working across several LHBs looking after children, it would be a case of a bit of each. We would have problems with governance, duplication and peer support, and so on, which would be an absolute disaster.

Darren Millar: Okay, thank you for those comments. If Members have no further questions, I thank our witnesses for joining us. We will send you a copy of the transcript so that you can make any corrections if needed. Thank you for your time, and for hosting our recent visit to the centre.

We are running a little behind time, but I think that it was important to take evidence on all of those areas.

10.03 a.m.

Ymchwiliad i wasanaethau cadeiriau olwyn: tystiolaeth gan Wasanaeth Aelodau Artiffisial a Chyfarpar Wrecsam
Inquiry into Wheelchair Services: Evidence from Wrexham ALAC

Darren Millar: I welcome to this part of our meeting Clive Sparkes, chief of staff, therapies and clinical support programme group from the Betsi Cadwaladr University Local Health Board; Gareth Evans, the clinical director of performance management and service improvement, in that group at the Betsi Cadwaladr University Local Health Board; and Alison Ravenscroft, the manager of the Wrexham ALAC. I also take this opportunity to thank you, on behalf of the committee, for our recent visit to the centre in Wrexham, which you hosted, Alison. We appreciated the opportunity to take some informal evidence at that time. You have provided us with a paper, which has been very helpful, therefore we will go straight to the questions. In your written evidence to the committee, you say that the longest wait for a complex assessment for a wheelchair at the moment is 22 months—at the time of the visit, it had gone up to 24 months—with an average wait of 15 months. What are the respective waiting times for complex assessments for children and adults and what exactly is causing delays in getting people through the assessment process?

Ms Ravenscroft: The longest waiting time for paediatric cases, as of yesterday morning, is 23 months. That is expected to be 18 months by the end of February if everyone attends their appointments, because the tail is long, but there are small numbers in that tail. The adult waiting time for powered wheelchairs is 18 months and the waiting time for a complex wheelchair posture and ability assessment is 15 months. There is a legacy of long waiting lists in north Wales. A significant amount of work has been done on that over the past two to two and a half years, so there has been a great deal of improvement, but we are working towards more because we recognise that those are unacceptably long waiting times.

Darren Millar: You say that it is a relatively small number. How many people are waiting in excess of 12 months, for example, across these particular parts of the service?

Ms Ravenscroft: Twenty-six.

Darren Millar: Just 26 individuals.

Ms Ravenscroft: However, that includes the adult and paediatric lists.

Darren Millar: How many children are waiting over 12 months for an assessment?

Ms Ravenscroft: I would have to check my figures to give you an exact number, but it is approximately 18.

Darren Millar: What is the reason for the delay in getting those children through the assessment process?

Ms Ravenscroft: Resources. It is the capacity and the demand that the service has the opportunity to—

Mr Sparkes: May I take a second to make a statement on the waiting times and the quality of the service in Betsi Cadwaladr health board? It is important that the committee is aware that BCU local health board has been focusing on this for some time, because we also realise that the waiting time is unacceptable and the quality of the service is unacceptable. In that regard, the chief executive commissioned some recommendations for this service in June 2009, and a turnaround team was appointed in October 2009, which is currently working through a number of recommendations around waiting times and the quality of service. You will know that I have received a number of complaints from members of this committee about the waiting times and the quality of that service. That turnaround team is reporting directly to me and to the chief executive, and a number of processes have been put in place around the waiting list, particularly looking at that tail of the waiting list, which, as Alison mentioned, is extremely long. We are focusing resources on that at present, but the bottom line is that there is a commissioning gap between the services that we need to provide and those for which we have funding. It is a fragile service at the moment because, as you can imagine, there is an intense spotlight on it and staff are working extremely hard and are very dedicated. They, too, find it difficult to work in an environment of constantly long waiting lists. We are hoping that the turnaround team and the result of your committee's investigations will help us towards a more sustainable service, the aspiration for which would be to meet the children's national service framework on waiting times.

Darren Millar: I call on Ann Jones.

Ann Jones: Have you finished, Chair?

Darren Millar: Yes.

Ann Jones: Alison, you said that there is a legacy of long waits in north Wales and, to me, it seemed as though you were almost citing that as some sort of excuse. However, you received an additional £0.5 million in 2007 and another £85,000 in 2009 to further reduce that number of children about which you are unsure. Why do you still have this legacy if you have had that additional help, which the other services have not had? Why are you still lagging behind?

10.10 a.m.

Ms Ravenscroft: I should explain that the £525,000 was directed to the total waiting times, which includes adults. It disheartens me to say that, at that time, the waiting time was over 50 months, so we have made a significant change to bring it down to the current waiting times. We have been able to use the investment from the last 12 months since just before Christmas 2009, when recruitment took place. So, we have been able to direct that funding over the last few months.

Mr Sparkes: It is important to realise that the waiting list money was around to remove some of the tail. It is not enough to sustain a steady state where that waiting time is down to the level to which we would aspire.

Ann Jones: I understand that, but an additional £500,000 went in in 2007. All you seem to have done is to reduce the waiting time rather than clearing your list. In my view, you have had the money, you have done that little bit, and now you have just gone back to the way that you used to work before.

Mr Sparkes: That is not the case. The waiting list has constantly gone down since October 2008. We can provide you with the statistics on that. It is continuing to go down and we are striving to bring that down further. I do not think that we will be able to get to the national service framework level, I am sorry to say. The resources are not there for that. However, we will certainly make big inroads into the waiting time.

Darren Millar: Mr Evans, you wanted to come in on this point.

Mr Evans: The £525,000 that was invested in the service on a non-recurring basis was to deliver a maximum wait of 22 months in north Wales; that was the agreed use of the money. We have continued to state that to maintain and to improve that time requires further recurring investment.

Ann Jones: Okay, but the wait is 23 months now. So, you are even failing the target of 22 months. If I had been a part of the negotiations on that, I would have wanted you to reach it a lot sooner. We are talking about months, but we are also talking about people's lives. There are 18 children waiting now. It almost makes me feel that we are making them wait so that we can miss out a section. That is, if they need a wheelchair now, then they have to wait 18 months or nearly two years, then they miss out on a stage. So, in a way, it is a case of thinking that they will wait anyway, so you can cut out a stage that means that instead of their having to have four chairs over their lifetime, they have only three because they are waiting every time. Is that a fair analysis, or is it cynical?

Ms Ravenscroft: I cannot see that it is a fair analysis.

Ann Jones: So, it is cynical. I am a cynic.

Ms Ravenscroft: I would not accuse you of that.

Ann Jones: No, I have said that I am a cynic.

Darren Millar: Let the witnesses answer the question.

Ann Jones: Sorry.

Ms Ravenscroft: We have tried to put several initiatives in with non-recurring funding to try to ensure that we see people with extremely urgent need as quickly as we can. However, that is challenging. We triage people when they come onto the waiting list so that they are not waiting an undue length of time when they do not need qualified staff to be involved; we have competently trained support workers who can help in that. That has managed to keep 30 per cent of our complex referrals from staying on a waiting list. We then do as much as we can to target the resources towards bringing those waiting times down.

Ann Jones: In the next 12 months, what will you do to bring waiting times down? I would like to see them coming down so that no-one waits longer than around 6 weeks for a wheelchair. What will you do to bring this poor service up to standard?

Mr Sparkes: We have a turnaround team, as I have already mentioned. That turnaround team has a specific set of targets relating to this service and a number of recommendations that we are prepared to share with this committee. Those relate to both an internal review of the service in terms of getting better value for money—and there are a number of recommendations around efficiencies, which we hope will deliver a change—and quantifying the gap in commissioning terms to meet the service need. As you mentioned earlier, we are already starting to look at the business case that would define what that quantum is. We think that around £1.8 million would bring to that service a waiting time that was sustainable at the NSF. However, the difficulty, which I think you have alluded to, is that the longer children wait—because it is a continuing healthcare condition and not an intervention that is finished—the greater the delay the next time that they access that service. What we are not yet able to do is look at the quantum around the review process so that we do not get into the situation where they are constantly reaccessing the waiting list. Our aspiration would be to maintain those children for life and for there to be no such concept as a review because they would be constantly accessing those services whenever they needed a change.

Darren Millar: Of course, there are knock-on costs elsewhere within the health service if you do not see a child within a reasonable timescale.

Mr Sparkes: Absolutely.

Peter Black: I have a couple of quick questions. You said that you were not resourced to meet the children's NSF, but presumably you have agreed targets with Health Commission Wales that fall short of the children's NSF. Are you resourced to meet those targets?

Mr Sparkes: Yes, we are resourced to meet the latest target relating to the waiting list and we will meet that target.

Peter Black: That is the HCW target.

Mr Sparkes: Yes, it is. In reality, there is no specific target from HCW because the commissioning guidelines of September 2008 state that there is no specified maximum time for access to these services. That is the commissioning guidance. Clearly, we have an aspiration to get to the children's NSF. That trumps everything and is what we should be working towards. However, the question now is: what resources are required to get to that NSF and are those resources available?

Peter Black: So, what you are saying is that HCW is not commissioning specifically to meet the requirements of the children's NSF.

Mr Sparkes: No, it is not in the guidance.

Helen Mary Jones: I want to come back to the issue of resources and what resources are needed. Forgive me, Chair, because I may have misunderstood, but I thought that I had heard Mr Evans say that representations had been made on the resources that you need to deal with this. However, I thought that I heard Mr Sparkes say later that the work was only now being done to identify the resources needed to deal with this. Could we have some clarity on that? If representations were made, I want to know who ignored those, but how could representations be made, if you did not know how much you needed?

Mr Sparkes: I should have made that clear. The representations were on the waiting list and not the review. The review component is what we would like to put in and we have not put in resources for that yet.

Helen Mary Jones: Leaving the review aside for a minute, do you know how many extra members of staff you would need and how much it would cost to reduce the length of the waiting lists? Let us leave the children's NSF to one side for a minute, although I think that that should be a target, and get the waiting lists down to what the targets are.

Mr Evans: When we undertook work a couple of years ago on the use of non-recurring money, we looked at what it would take to reach a sustainable position, excluding reviews, as Mr Sparkes has pointed out, and that is when we arrived at the figure of £1.8 million.

Helen Mary Jones: Did Health Commission Wales tell you that you could not have that?

Mr Evans: Health Commission Wales has informed us consistently that there is no recurring money available.

Darren Millar: Did you put a bid in for £1.8 million at that time to Health Commission Wales?

Mr Evans: Yes. There have been several iterations based on questions that were asked by Health Commission Wales. That was the singular piece of work that we did on what we felt that it would take to reach a sustainable situation based on the NSF target for children. We used a six-month or 26-week proxy for adults.

Darren Millar: So, effectively, the extra cash that was allocated to you was to clear the backlog, as it were, and then you wanted to sustain that position going forward. You made a bid for £1.8 million, based on what you knew at the time, and that was dismissed on the basis of HCW telling you that it could not afford to commission those extra services.

Mr Evans: Yes, effectively. We were asked what it would take to make sustainable improvements in the service and that is the figure that we provided. Unfortunately, the only answer that we have had so far is that there is no recurrent investment for the service.

Darren Millar: Mr Sparkes, you have mentioned this internal review and have identified that £1.8 million is needed to bring down waiting times to an acceptable standard. Ann Jones asked you what you expect to do over the next 12 months to address the issues in the service. What if you do not get that money? What will happen?

Mr Sparkes: The waiting times will increase and be challenging. I do not know if you are aware, but Betsi Cadwaladr University Local Health Board has put in its own resources in this regard. Our chief executive is particularly concerned about this service and we have put in our own internal resources, but it is a commissioned service by Health Commission Wales and that is where the funding should come from.

10.20 p.m.

Darren Millar: You indicated earlier, Alison, that a small number of children were waiting more than 12 months. What is preventing your service from putting on just a few extra Saturday clinics, for example, to clear that backlog? If it is a small number of people, you could presumably get through them pretty quickly, with only a tiny amount of extra resource in the form of an assessment.

Ms Ravenscroft: The health board has supported us recently with a locum, and that has helped tremendously. We have done some weekend overtime working, flexible hours and extra hours. There is a limit to the extra work that a dedicated group of staff can do within tolerances linked to stress and reasonable working hours. We are fortunate that we now have a locum who is dedicated to working with the paediatric team. That is what will make a significant difference over the next two to three months.

Mr Sparkes: In addition, the tail is not a static thing, and as referrals continue to come in, unfortunately, next week comes along, and more children enter that tail. With initiatives, you find yourself constantly fighting a tail; what we need is a sustainable resource that will get us to a steady state. No amount of initiatives will get you to a steady state; you need a properly resourced service to get there.

Val Lloyd: Very appropriately, I want to focus on the performance and quality indicators, and how they are used in particular. You tell us in your evidence that the formally agreed service standards, or key performance indicators, for the provision of wheelchair services has meant that the performance management focus on the service is not as clear as it is for other specialties. Why are those specifications not in place? How, in your view, should standards and performance indicators be used to improve the service? I really want you to focus on why they are not there.

Ms Ravenscroft: The service standards reports are done by the commissioner, and they are what we would work towards. The specific service standards are not there. We are cognisant of standards for other areas, particularly in relation to Access 2009, for example, and so we have tried hard to shadow what those expectations would be. We can report against those, but it remains difficult to achieve them when the resources are not there in the long term.

Mr Sparkes: That is right, in that there is not a standard set of metrics for the performance indicators in this service. We have developed some internally, and we feed a couple of those through to Health Commission Wales, but there is not a defined set, whereas for other services that I manage, there is a very specific set of indicators, targets and performance measures for us to work towards. Clearly, where targets are set for services, there is a focus of resources around those services. This service that does not have that sort of focus, however, and that is a shame.

Val Lloyd: May I ask why it does not? That is what I was trying to get at: why are they not there?

Mr Sparkes: I do not know. We are the provider of the service. That is an issue for the commissioner.

Val Lloyd: Right; thanks.

Darren Millar: Is it not a bit of a cop-out to say, 'Because there aren't any targets, we effectively haven't aimed at them or focused our resources on achieving targets'? Is that not something of a cop-out, Mr Sparkes?

Mr Sparkes: You could say that, but I do not think that it is. We have indicated to you that we are very serious about this service, and we are putting in processes to achieve our aspiration, which is the delivery of this service, hopefully, to meet the children's national standards framework. So, you might say that, but I personally think that the service is very dedicated to trying to achieve some standards; it is just that there is no agreed set of standards. Even on reporting waiting times, do you take medians or do you take the longest waits? It is complex stuff and it is better to have a set of agreed metrics so that we all know what we are delivering. I would aspire to that, and I hope that that will be in some service commissioning in the future.

Darren Millar: So, it is the fact that the priority is elsewhere that is preventing you from delivering, because you are just not getting enough resources.

Mr Sparkes: That happens quite often. It is about the focus of resources, and where there are specific targets, we work hard towards them. That is how we work.

Lorraine Barrett: I am looking at urgent cases and routine cases and how they are prioritised. You say in your evidence that cases are prioritised as urgent and routine, and that individuals with rapidly deteriorating conditions, or who are awaiting hospital discharge, are seen as very urgent or are even seen immediately. How quickly do those patients with urgent or very urgent conditions receive wheelchairs, and are you satisfied that the system is effective at prioritising cases?

Ms Ravenscroft: The prioritisation of cases is particularly challenging because we are aware that, to an individual, the provision of their essential posture and mobility is very important. So, there is a fine balance to be struck. We try to keep to the guidelines that are in front of you. We try to see urgent cases within a couple of weeks, but it is not always possible to do that. Sometimes we can see them in much less time, depending on the circumstances. However, it can be challenging to meet that target. The definition of 'urgent' is very subjective, and that can be difficult to pinpoint for the individual, but we do our best to respond as quickly as we can in those circumstances. However, that must be balanced against the numbers of referrals that the service sees and the other people that they have to—

Lorraine Barrett: I appreciate that. From the experience that I have had with constituents, if it is very urgent, I think of the target as being days, if not immediately, and not having to wait for weeks. Do you have any data that shows whether routine cases have become urgent because of delays and because of priority changes?

Ms Ravenscroft: We do not have specific data on that, but anyone who is on a waiting list can send information to the service and the information is reviewed. They can become an urgent case if their circumstances have changed from the initial information that was given to us. So, we are very clear and open about the fact that people should get back to us if things change, and it can be reviewed.

Darren Millar: Before Lorraine continues, are children always regarded as urgent cases, or do they just slot into one of the categories? Given that children are constantly growing and developing, I would have thought that children would be generally prioritised. Is that the case?

Mr Sparkes: No, it is not. There is a single waiting list. Part of the turnaround team's recommendations is to look at whether children should be prioritised. Personally, I think that they should be, but the team is looking at that now and there will be a recommendation around that.

Lorraine Barrett: I think that we received evidence at some point that suggested that if a client's priority changed, they had to go back to the beginning of the process or they would at least be waiting awhile. Would the date of the original referral always be kept so that no-one would have to start again from the beginning of the waiting list? I am not sure if that was to do with repairs, but I know that there was an issue about having to go back to the beginning.

Ms Ravenscroft: No, we maintain the date of referral as the date of entry onto the waiting list, regardless of what happens with that individual. Repairs are generally not to do with the waiting list, as they are done through an approved repairer process. The waiting lists are for assessments for provision—they are nothing to do with repairs.

Lorraine Barrett: Okay. I think that there was an issue to do with repairs and having to be re-referred, and I may have got that mixed up.

Ms Ravenscroft: If you need a repair to your equipment, you can contact the approved repairer directly, or you can contact us and we will let you know.

Ann Jones: On repairs, how satisfied are you that the contract that is negotiated for repairs delivers for the person? If you have a wheelchair and something goes wrong with it, it can be just as devastating as having to wait for 23 months to get your wheelchair in the first place. How confident are you that that system works?

Ms Ravenscroft: We are very pleased with the contract that we currently have. We have had very good performance from that contract, and very good working relationships and local monitoring on a very regular basis. The repairers consistently meet their key performance indicators and we have not had any formal complaints about our approved repairers for well over 12 months. We have received very good customer satisfaction surveys about them and some very good compliments.

Ann Jones: So, if a person with a wheelchair loses a wheel from the wheelchair or one of the wheels becomes defective, they will not have to wait nearly six months to get that repaired?

Ms Ravenscroft: No, not to my knowledge. A huge amount of work has been done on improving the response rate, which is extremely good. I do not deny that there can be a wait for some specialist spares. Our approved repairer keeps an extensive range of spares for the more commonly used wheelchairs, but many of our wheelchairs are bespoke and are specially built for an individual so it might not be possible to keep every single spare part needed, but, generally, the response is extremely good and we have good feedback from—

10.30 a.m.

<p>Ann Jones: However, you admit that it was poor previously.</p>
<p>Darren Millar: If I may help, Ann, the evidence that we received as a committee was about wheelchair repairs in south Wales.</p>
<p>Ann Jones: But it is as bad in the north, I have to say.</p>
<p>Darren Millar: As a committee, we have not taken a great deal of evidence on repairs in the north, but the individuals who have given us evidence have complained about the situation in the south. We will discuss repairs in a little more detail in a short while.</p>
<p>Lorraine Barrett: We received some powerful evidence and a strong presentation from the British Red Cross, which was keen to work with ALAS. It made the case that it could help quite a bit with the provision of temporary solutions for people with non-complex needs—that is, for more standard wheelchairs. Do you work with the British Red Cross? Do you see that it could make a contribution and help you to provide the service?</p>
<p>Ms Ravenscroft: We certainly have good contact with the Red Cross in north Wales. We met recently and agreed a process, moving forward, to look at where the potential exists and what, if anything, could be done. So, we have a good working relationship with it. It recently implemented an agreed strategy to look at where, if anywhere, there are gaps and how we can work together to look at them.</p>
<p>Lorraine Barrett: Do you work with it or use its services now?</p>
<p>Ms Ravenscroft: Not specifically in our service, because its service is directed at providing short-term loans, which is not in the remit of the Artificial Limb and Appliance Service.</p>
<p>Peter Black: Ann has asked my second question, so I will start with my follow-up question, which is on the repair and maintenance of wheelchairs. In your evidence, you say that the maintenance and repair of wheelchairs issued by ALAS is a subcontracted service, the contract having been negotiated by Cardiff and Vale. Cardiff and Vale University Local Health Board has now taken that in-house, but you have not. Is that right?</p>
<p>Ms Ravenscroft: That is right. As I have indicated, our performance indicators for that arrangement are very good, so it has not been the high priority for us that it has been in south Wales. We are currently in the final year of the extension of that contract, so we will have to advertise in 2011 and we will be going through the "Official Journal of the European Union" for that.</p>
<p>Mr Sparkes: We will learn from whatever happens in Cardiff and the Vale, but, at present, it is not an issue that has been identified in north Wales.</p>
<p>Peter Black: Are you receiving any complaints about the repair service? One of the reasons that we were given for the decision to take it in-house—we may have heard this on one of the visits—was that, sometimes, a technician would make multiple visits, first to assess the need before ordering the part, and there was a bare minimum of parts in stock, which caused delays in repairing the chairs. Is that your experience in the north?</p>
<p>Ms Ravenscroft: No, we have not had such an experience in the north. We have a close working relationship with contractors, and there is close monitoring. In the past, we have challenged contractors about stock levels and how they are managed. I have indicated that multiple visits might be needed, but that is for where a need for very bespoke and specific parts has been identified. We are currently looking at some initiatives to improve that further.</p>
<p>Peter Black: You state in your written evidence that, given current resources, it is not possible to offer routine reviews for every client. To what extent could that lead to more serious problems for users in the future, particularly children?</p>

Ms Ravenscroft: We are very aware, and we have received feedback from individuals, that holding reviews would have a beneficial effect. Unfortunately, given current resources, we are not able to do that routinely. We are cognisant of the fact that that would be a positive step forward.

Peter Black: So, will the review that you have initiated look at that particular issue?

Mr Sparkes: Yes, there is a recommendation.

Peter Black: Presumably, you will need to find resources to do that.

Darren Millar: Is that within the £1.8 million that you mentioned before?

Mr Sparkes: No.

Darren Millar: It is not?

Mr Sparkes: No.

Darren Millar: So, you need resources in addition to that.

Mr Sparkes: Yes.

Darren Millar: I want to clarify this £1.8 million. Is the £1.8 million simply to maintain the improvements that you saw after the one-off, non-recurring investment from HCW?

Mr Sparkes: No, it is not to maintain that. It is related to a capacity-demand analysis, so it is about having the right capacity for the demand. That demand, as we know, has gone up, so maintenance of the status quo will mean more patients coming on to the list. So, the £1.8 million is to provide a service that is sufficient to meet the needs of the current referral rates that are coming into that service, to get to a steady state and to a waiting list that is acceptable. It is not around reviews. That piece of work has not been done, and we are commissioning that piece of work as part of the review process.

Peter Black: So, will you be seeking additional finance from HCW for that or looking to fund it within Betsi Cadwaladr University Local Health Board?

Mr Sparkes: Until the review is finished and we have looked at the internal review of the service, I cannot really comment on that. However, we will be in a position fairly soon to know the answer to that.

Andrew R.T. Davies: The evidence that you have given on the back-up service for spare parts is very different from the evidence from the south. In reply to Ann's question, you said that the company—and I presume that it is the same company that used to hold a contract in the south—carries an extensive range of spare parts. Therefore, its technicians obviously have that provision. Would it be your understanding that you manage the contract differently in the north, which is why virtually everything that you have said has contradicted what we heard in evidence from the south? I am just trying to get a feel of whether that part or aspect of the service was managed differently in the north and in the south, hence why you have not had the problems. I think that you identified that you have not had an official complaint for 12 months.

Ms Ravenscroft: I do not think that it is appropriate for me to comment. The majority of these services are in south Wales and, of course, I am not part of that.

Andrew R.T. Davies: You are bound to have an understanding of how it is managed, are you not?

Ms Ravenscroft: Yes. There has been a consistency of personnel in the depot across the last two or three contracts. Although the company managing the contract has changed, the personnel has been consistent in that depot and, therefore have built, over a long period of time, a good working relationship across the contract with us. Although we have had a change in the management of the contract—that is, the company—we have had consistency in the personnel and have developed working relationships that have included a broad-ranging discussion on how services can be improved, and on the training and so forth, so that individuals in that depot have had the time to grow—

Andrew R.T. Davies: Therefore, you do not monitor the contract any differently to how it would be monitored in the south.

Ms Ravenscroft: No. We have joint review meetings with the companies, and then we have local meetings face to face. Nationally, we would have a joint meeting.

Andrew R.T. Davies: Therefore you have good practice, but they do not.

Helen Mary Jones: Coming back to reviews, your evidence states that it is not possible to offer routine reviews for every client. Does that mean that there are reviews for some clients and not others, and, if there are, how do you decide who are the ones that get reviewed and when?

Ms Ravenscroft: To explain, the individual clinician has the autonomy to decide whether it is absolutely imperative that a piece of equipment or an assessment is repeated. It would not be possible to tell an individual clinician that they are not allowed to do that; it would be very difficult to do. However, where there are specific issues related to someone with a serious illness and where they are deteriorating rapidly, the individual clinician would be able to say, 'I will see you in x number of months'. There is a particular issue for the rehabilitation engineering unit, where specific equipment is modified. Under the MHRA rules, such units have to review the equipment; they would not be allowed to not do that. So, they have the ability to do those reviews. If, within the Artificial Limb and Appliance Services we have also done some modification, which has ended up being quite extensive, we will also review that equipment for safety.

Darren Millar: The experience of many Assembly Members arising from their casework is that, very often, adjustments to wheelchairs and existing equipment can take an inordinate amount of time to arrange. That is one area that we have not covered so far. Why do people have to wait such a long time for what might be a very minor adjustment that makes a huge improvement in the quality of life for the individual service user?

Mr Sparkes: We share that concern. As you know, a number of complaints that I have had have been around that particular subject. One of the recommendations of the review was that we look at that and find out how we can put in a more streamlined service around that. One of the advantages that we clearly now have in Betsi Cadwaladr University Local Health Board is that all of those services are now under the same management structure. Therefore, the therapeutic referral service to this service, rehabilitation engineering and ALAS are all in the same clinical programme group.

10.40 a.m.

Mr Sparkes: So, part of the review team's work is to go around assessing the management structures so that there is no problem in having different avenues for maintenance reviews, and so on. It should be a seamless single service so that we do not end up having to refer them on to rehabilitation engineering or to the approved repairer or to the services that ALAS can provide itself. We want to make the service seamless. I do not want to predicate the review because it is a recommendation that it considers that, but it would be obvious that you could have a more seamless service if that was in one structure.

David Lloyd: On the general issue of access to wheelchair services in north Wales, you state in your evidence that wheelchair services are organised on a hub-and-spoke model. For the purposes of the record, can you explain how that works in practice and how do you ensure an equitable service for all who need it over such a large and rural area?

Ms Ravenscroft: The hub-and-spoke model was recommended in the Audit Commission's documentation around 2000-01 as a positive way forward in north Wales. We have had an opportunity to consider that model in working with specific referrers, who refer a lot to the service as 'spokes' rather than to actual buildings around north Wales. Having buildings and a satellite service in north Wales is part of the current review, to see how they would potentially benefit the service. So, it would not be appropriate to make a definitive comment on that now. However, in north Wales, we have been able to take the gatekeeper concept forward to a certain degree, which is about working with individuals who refer to the service and helping them develop their knowledge and their product knowledge so that their prescriptions can be more specific. Those gatekeepers are in various parts of north Wales, and we are currently working with another four. That is helping us to look at the capacity issue around what is coming into the service, as well managing what is there.

Mr Sparkes: There is a specific recommendation around setting up a satellite service in north-west Wales. As you know, ALAS is based in Wrexham, which is at one end of north Wales, so one of the recommendations that the team is currently considering is how to set up a unit in north-west Wales to serve the population there, which, as you are aware, is very rural. The travel costs are high, so it also makes economic sense to have a service based in north-west Wales.

Darren Millar: Members who visited the South Sefton and Kirkby wheelchair service will know that it organises its hub-and-spoke model by having individual rooms to hold clinics in a relatively small urban area. It is easy for people to travel to the centre, but there is still a hub-and-spoke model. The more complex work is done at the centre, but the 'spokes' deliver assessments and the less complex stuff at five centres around the urban conurbation. Why is it that you have not, to date, in spite of the difficulties with the service over a number of years, considered having permanent bases elsewhere, for example in the district general hospitals in north Wales?

Ms Sparkes: I do not know the answer to that, although I wish I did. I have asked the team to look at the Sefton model to see what is being done there. I cannot answer that question.

Darren Millar: The area that you cover is huge and we recognise that that poses challenges. Is it too large an area to cover from a single service point of view?

Mr Sparkes: It would be if it was a single service, but if it is a hub-and-spoke model, then it is not. It is one of the aspirations of the turnaround team to look at how we can provide services to a very rural area, and I have given you one of the specific recommendations. So, the team will be looking at that issue.

Andrew R.T. Davies: Thank you for giving evidence this morning and for the informative visit that you kindly hosted last March. We touched on staffing issues during that visit. You state in your paper that waiting times have increased due to the increase in demand, and you state that there are staffing issues. Can you inform the committee what the staffing issues have been? Has it been a lack of resources to fill vacancies as they arise? When I visited, someone was going on maternity leave, I believe, and that post could not be filled. Or is it because the level of demand has been unpredictable, and so staff have been unable to cope with the increase?

Ms Ravenscroft: There are a multitude of reasons. The team in north Wales was very small, with just three qualified staff for many years. That situation was made worse when people moved on from the service to other posts, and recruitment is difficult—finding individuals with experience in the posture and mobility speciality is difficult, and that is why such strong training programmes have been developed within the service itself. Yes, we have had staff go on maternity leave, and we have had others on long periods of sick leave, and we have tried to maintain our impetus through those times. The team has gradually increased in number due to several initiatives, and support from the health board. However, as with any group of staff, there will always be difficulty in maintaining recruitment and retention at the optimum level.

Andrew R.T. Davies: From what I am hearing, it is perhaps an inability to source the necessary experience in north Wales that has precluded appointments that would have helped with the capacity of the team overall, rather than an issue about resources to fund those appointments.

Ms Ravenscroft: It is both, actually, but this is not just a north Wales issue—recruitment to these types of post is a global issue, because it is such a speciality. It is difficult to recruit, although we currently have a locum with relevant experience, and that has made a great difference. The resources have been there to recruit to the posts that we have been able to maintain, but the relationship between the number of posts and capacity and demand is still subject to scrutiny.

Mr Sparkes: It may be helpful for me to say that there have been recent requests for funding for additional posts in ALAS to the CPD management board. Not all have been successful, but a number of them have been. Again, one of the recommendations around the service is that we stabilise the financial situation because, as you are aware, we all have constant cost-improvement targets, and we are trying to protect the service at the moment so that we can make the changes that we need, particularly around capacity. A couple of posts recently have gone through what is called the vacancy panel, so we are hoping to address that, but you are right—there will be maternity leaves, and staff leaving for other reasons. With qualified staff in particular, it is not so much that you cannot get them, but that it is a long time before you get them in post. You are fishing in a small pond, and you need to create opportunities for people who want to move to a certain area, or perhaps the spouse moves; that sort of thing gets people to move in.

Andrew R.T. Davies: Could I ask you about the financial aspect to this? The Chair tried to tease out the financial wish list, shall we say, for the service, and we have this figure of £1.8 million, but we heard from you, Mr Sparkes, that that is not the complete picture. I appreciate that you are not in possession of the complete data because the work of the review group is ongoing, but when are you likely to be in a position to state what we need to deliver a viable, sustainable service in north Wales?

Mr Sparkes: Just to remind myself, the turnaround team was appointed in December 2009, and I have asked for the delivery of all the recommendations within six months, so they have that period to produce them. A number of things are happening now under the review, but by the end of the six-month period the team will have produced its final report, and I am hoping that it will lead to a resource. It is basically a capacity-demand analysis, so we will then be able to cost that. Within four or five months, we should be in that position.

Darren Millar: It never ceases to amaze me that turnaround teams are appointed at the time that we start inquiries in this committee.

Mr Sparkes: It was purely coincidental.

Darren Millar: One of the differences in the staffing arrangements in Wrexham compared to the very successful service over the border in Sefton was that Sefton has a specialist posture-mobility consultant embedded in the team, available to do assessments quickly when necessary and whole clinics at the spoke and hub, if you like. Is that something that your turnaround team is considering as a possibility with the new model?

10.50 a.m.

Mr Sparkes: No, it is not something that they have specifically been asked to consider, but they have been asked to look at the Sefton service as part of their work, so if that is a successful model, I presume that we will get some feedback on it.

Darren Millar: The service seemed to indicate that that was one of the keys to its success in being able to keep waiting times down and hit the targets for the short timescales. The maximum wait over the past three or four years was 22 weeks, from referral to delivery of equipment, which is quite impressive. We will move on. I ask Members and witnesses to be to the point with their questions and answers.

Helen Mary Jones: They are damned expensive things, consultants. Turning to the issue of structures, you tell us in your evidence that the way that the service is currently commissioned, by Health Commission Wales, and delivered by you, as the Betsi Cadwaladr University Local Health Board, should become part of the core activities of the health board. That means taking Health Commission Wales out of the picture. Could you tell us a bit about the benefits to service users of such a change? Do you have any other thoughts about how the service should be structured across Wales?

Mr Sparkes: We believe that this service is an integral part of disability services, and sometimes, the fact that it has been seen as a separate service has been part of the difficulty. It should work seamlessly with local clinical professionals and it should be part of their service. My chief executive is convinced that this should be part of our standard provision in the healthcare community for north Wales. There are opportunities around integrating it with existing OT and physiotherapy services. It should be part of that service and not seen as some separate entity. Again, it is our aspiration that, in the hub-and-spoke model, we should be able to deliver the service with local professionals. That is why I am wedded to the idea that it should be integrated with our existing services. The second point around children in particular is that there is a strong role for consultant community paediatricians in looking at the whole child. I think that that is part of that service, so it should all be integrated.

Helen Mary Jones: I can see that being effective, but you provide services outside the Betsi Cadwaladr local health board, do you not? Within the local health board, it is easy to integrate this with the other services, because as the health board you are deciding the priorities, where the resources go and so on. One thing that has been suggested to us is that the service should go back to all local health boards, perhaps with some national pulling together on very complex cases. What is the advantage of Betsi Cadwaladr local health board keeping the service and providing services to parts of other health board areas as you do now, as opposed to handing it all back to the local health boards?

Mr Sparkes: You would probably need to ask our chief executive that question. From my perspective, I accept that we provide some services outside the health board area. However, that is a very small group in comparison to the vast service delivery that is part of BCU local health board. The way that I have done this in the past has been around a service level agreement so that, although they are not contracts, you have agreements on a quality standard and a service specification. I run a number of those for services at the moment, medical physics being one of them. So, we are used to doing that, and that would be the vehicle I would use to ensure that the quality and the service delivery were agreed and understood.

Helen Mary Jones: Okay, that makes sense.

Val Lloyd: I think that everyone around the table would subscribe to the importance of good communication, but we have heard from service users about problems that they have encountered with communication, particularly when they have rung up to find out about their progress on the waiting list. I also note from your evidence that you had a review of external communications in 2009. So, could you tell us what systems you currently have in place and whether you are making, or have made, any changes following the review?

Mr Evans: The review was undertaken in April or May last year, I believe. We did that because we were undertaking ongoing analysis of complaints. We received some powerful feedback from a local resolution meeting that was held via the complaints process, and we received many letters from you and colleagues. We identified that communication was an obvious and key issue that we needed to improve, which included communication with our service users and our referrers. So, the review focused on that. We found a number of key themes, which were formalised into a series of recommendations and then agreed with the stakeholders that had become involved in the review. We formed a project group, and it is currently implementing the recommendations. We have made some changes already, for example having a service policy to return calls within a maximum of five working days in respect of enquiries from referrers and service users. At the moment we are working on information for clients who have been newly referred to the service, which sets out the expectations that they should have of the service as well as giving a lot of background information about the service upon referral. We are building a database of referrers so that we can acknowledge referrals from them as they come in, by e-mail if possible. We are undertaking more routine communication with referred clients about their position on the waiting list and are maintaining contact with them. We are also developing a website at the moment as a vehicle for several aspects of improving communication.

The key piece of work, which we have just started, relates to sharing information with clients and referrers, in particular local community therapists, with regard to the post-assessment prescription and care plan. We have had a meeting this week with some of our referrers to get a firm idea of what their requirements are. Our key task now will be to work out how we do that technically, that is, how we share that information.

Andrew R.T. Davies: On the benchmark of responding within five working days, if you ring on the Thursday, you will not get a response until the next Wednesday because of the weekend. In effect, that is a week. I rang our local council and I am still waiting for it to call me back—that was four months ago. How many calls are you returning in that five days?

Mr Evans: I do not have those data, as the policy has just been implemented. We will put a performance measure in place for it and then look at that. I am afraid I cannot answer that at the moment.

Andrew R.T. Davies: Can you provide us with the data?

Mr Evans: Yes, as soon as the data become available and the policy has been—

Andrew R.T. Davies: That would be just to see whether it is being implemented. It is a fat lot of good having a policy if it is not implemented. The national service framework is a document, but it is not being met, as it were. Health Commission Wales has a target, but that is not being met.

Mr Evans: As I say, it has only happened this side of Christmas.

Andrew R.T. Davies: That is six weeks' worth of data.

Ann Jones: A lot of what we have heard today has related to Mr Sparkes's internal review. Could we have a copy of your findings, when they are published? That might help us to move forward.

Darren Millar: Absolutely. That would be helpful.

Mr Sparkes: I report monthly to the board. That report is available and I can provide you with a copy.

Darren Millar: That brings us to the end of this part of our meeting. Thank you for attending today, for your oral and written evidence and the way in which you have helped our inquiry in respect of the visits to Wrexham. We really appreciated that. We will send you a copy of the transcript. If any corrections need to be made, please let us know.

Cynnig Trefniadol

Procedural Motion

Darren Millar: 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 11.17 a.m.
The public part of the meeting ended at 11.17 a.m."