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Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
22 September 2011

Meeting time:
09:30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda

1. Apologies and substitutions

2. Inquiry into Stroke Risk Reduction - Evidence from Atrial Fibrillation Association (09.30 - 10.30) (Pages 1 - 15)
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- Jo Jerrome, Assistant Director

3. Inquiry into Stroke Risk Reduction - Evidence from the Stroke Association (10.30 - 11.30) (Pages 16 - 22)
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- Ana Palazòn, Director Cymru
- Paul Underwood, Deputy Director Cymru
- Lowri Griffiths, Head of Communications and External Affairs

4. Scrutiny of Draft Budget 2012-13 - Consideration of approach (11.30 - 11.40) (Pages 23 - 25)
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5. Inquiry into Adult Residential Care - Scoping paper (11.40 - 11.50)
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6. Children and Young People Committee inquiry into children's oral health - Letter from Chair (11.50 - 11.55) (Pages 34 - 35)
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AFA submission to
Welsh Assembly Inquiry into Stroke Risk Reduction
8 September 2011

Atrial Fibrillation Association (AFA) is a registered charity.
Internationally, AFA works closely with patients, carers, medical professionals, service providers, service payers affiliated groups and allied professionals to:

- provide support and information
- advance the education of the medical professionals
- raise awareness amongst the general public
- promote research into the management of Atrial Fibrillation

In Wales, many thousands of preventable strokes occur every year leading to thousands of early deaths and a devastating burden on individuals, families and society in terms of disability, medical and social care costs, and loss of working hours and tax revenues.
Atrial fibrillation (AF) is a common heart rhythm disorder associated with deadly and debilitating consequences including heart failure, stroke, poor mental health, reduced quality of life and death.[i]

Key points of AFA evidence

1. AF patients suffer a disproportionate number of strokes which are, in turn, disproportionately fatal, debilitating, expensive and likely to recur.
2. AF detection and diagnosis is low, leaving an estimated 50% of patients undiagnosed. **Opportunistic screening**, has been shown to be both effective and cost efficient at finding AF patients, however it is not widely used.
3. **Guidance and guideline adherence** is poor and consequently leaves AF patients at risk of avoidable strokes.
4. The main current therapy option, warfarin, which can effectively prevent many of these strokes is actually effective in only 18-21% of AF patients, due to under prescribing especially in those at high risk of stroke.
5. Too often, those at most risk, frequently the elderly, are prescribed aspirin, which only reduces the risk of stroke by 22% and increases their risk of a bleed to equal that of warfarin.
6. For those who often fall out of therapeutic levels (> 60% outside of target therapeutic range), warfarin is of little or no benefit.
7. The Inquiry Committee may wish to consider seeking evidence from all relevant professionals, including heart rhythm specialists.

Supporting evidence
AFA is mindful that budgetary pressures are ever-present and inevitable, and as a result, cost effectiveness has to be a reasonable expectation when comparing guidance it is important to consider both cost and effectiveness. This difference is probably best summarised but the QIPP, Right Care programme, 'Commissioning for Value':

> *'…value must also be measured by outputs, not inputs. Hence it is patient health results that matter…'*

The AFA has amassed and documented many thousands of experiences that have been shared with us by patients, their caregivers and health care providers. These accounts are an excellent representation of the "health results" of patients suffering from AF in the UK today. In light of this amassed patient feedback and respected published data we have formulated the following response on behalf of patients suffering from AF.

1. AF is the most powerful independent risk factor for stroke and results in strokes that are more severe, more likely to disable, more likely to kill and more likely to recur.

Atrial Fibrillation (AF) is a common heart rhythm disorder associated with deadly and debilitating consequences including heart failure, stroke, poor mental health, reduced quality of life and death. [26] Today, more than 51,000 of the Welsh population have been diagnosed with AF, [28] yet experts suggest that up to half of all AF patients have not yet been detected. Among many damaging and debilitating consequences, AF increases an individual's risk of suffering a stroke by five times. [31] This effect alone results in considerable disability and death, [27,32] not to mention avoidable millions in healthcare expenditure [28] that NHS Wales cannot afford. For example, patients with primary or secondary diagnosis of AF occupied almost 308,000 bed days in 2008, at a cost to NHS Wales of £100 million [265]. Strokes kill about 1325 people in Wales each year. AF is known to be responsible for almost one quarter of these strokes, the health and social care costs of AF-related strokes in Wales are expected to reach £46.3 million per year [266]. These figures exclude the economic burden on NHS Wales and the Welsh economy.

Atrial Fibrillation is known to be responsible for 45% of all embolic strokes, resulting in more than 12,500 strokes per year in England and Wales. The strokes suffered by people with AF are also more severe, [82] they are more frequently fatal [83 84] and they are more likely to lead to disability, [83 85 86 82] increased healthcare costs [89] and extended hospital care than strokes in patients without AF. [82] Moreover, AF-related strokes are more likely to happen again [89], adding not just to the risk of future strokes, but also to the potential for increased patient anxiety and a further reduction in quality of life. AF-related strokes kill nearly twice as frequently as non-AF strokes. [82,83,84]

The medical cost of a stroke in first year is £9,500 - £14,000 per stroke. Embolic, and hence AF related, strokes are likely to be represented at the high end of this range. [93,98,100,103,104] These costs do not include continuing costs after first year, nor do they include costs associated with long term disability or the human cost, which is incalculable.

2. AF detection and diagnosis is low, leaving an estimated 50% of patients undiagnosed

Without effective detection and diagnosis of AF up to half the patients affected will never be identified. If a lack of detection and diagnosis continues, then many patients will be denied the opportunity to benefit from treatments that can dramatically reduce their risk of stroke. Existing research suggests that routine pulse screening has a role to play, as does public education on the need to investigate an irregular pulse.

Opportunistic screening, has been shown to be both effective and cost efficient at finding AF patients, however it is not widely used.

The role and value of screening programmes following the positive results of the SAFE study [266] illustrate the value of this in both finding patients with AF and reducing stroke risk, and ultimately stroke events. This has been more recently shown in Wrexham [268] where The Wrexham primary care AF model pilot launched on1st May 2007 in four general practice surgeries under the Local Health Boards and ran for six months with positive results and findings. The audit of the pilot evaluated the view of existing patients on the AF registers in the surgeries as well as those patients that were identified through the routine screening using the manual pulse check. Seven new AF patients were found during opportunistic checks as part of the pilot and 68 patients were found to be on inappropriate or no thromboprophylaxis, which prompted further review by the GPs. Four

years since the start of the pilot the team are still reaping the benefits of the work undertaken in primary care.

NICE also recommends that all patients with an irregular pulse receive an ECG to make a diagnosis. However, The SAFE study found that GP and practice nurse performance in interpreting ECGs was not encouraging, identifying another potential challenge to the effective diagnosis of AF in primary care.

The need for routine, opportunistic screening, especially amongst those at greater risk of developing AF is essential if lives are to be saved and costs due to stroke events, reduced.

3. Guidance adherence is poor and consequently leaves AF patients at risk of avoidable strokes

There remains poor adherence to authoritative and national guidelines. Even NICE's own data shows that of all those with AF who should be on warfarin, almost half are not. Yet, when asked, physicians demonstrate both awareness of the guidelines and agreement with them. One study documented the medications being taken by AF patients when they suffered an ischemic stroke. It found that only 10% of these patients had been taking an effective dose of an anticoagulant. Nearly a third were on no antithrombotic treatment at all (29%). A further 29% were on aspirin and another 29% were on a non-therapeutic dose of warfarin.

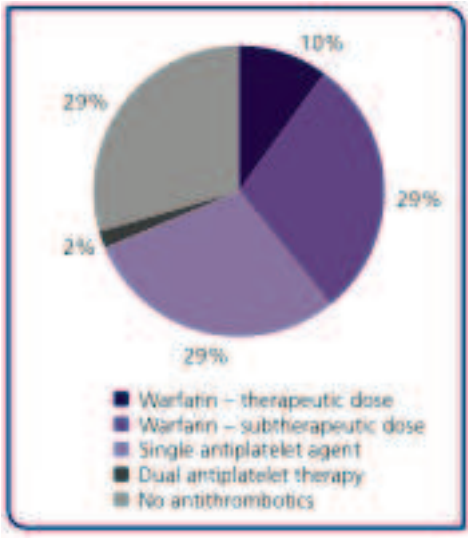

Figure 10. Medications received before admission to hospital by patients with known atrial fibrillation who suffered an acute ischaemic stroke: only 10% of patients had received warfarin at a therapeutic dose. Adapted with permission from Gladstone

Adherence to Guidelines for the prevention of stroke in patients with AF may be low for several reasons. These include difficulties in maintaining INR within the therapeutic range and physicians' concerns about bleeding risk, particularly in the elderly. [35]

Quality Outcomes Framework (QOF) was designed to reward GPs for the quality of the care that they provided, instead of for how many patients they treated. Currently, GPs can work to secure up to 1,000 QOF points by meeting predetermined performance targets in four broad areas: Clinical, Organisational, Patient Experience, and Additional Services. A total haul of 1,000 points represents an additional payment to GPs of over £13,000.

Specifically for AF, within the current QOF scheme, up to 12 points are available for GPs achieving a high percentage of 'patients with atrial fibrillation who are currently treated with anticoagulation drug therapy or antiplatelet therapy.'

It is reasonable to expect that many patients diagnosed with AF will already be taking aspirin for another condition. It is also relatively simple to start and manage a patient on aspirin (antiplatelet

therapy) compared to warfarin (anticoagulation therapy). Consequently, the way the target is written enables GPs to receive the maximum QOF reward just by having AF patients on aspirin, even if none of them is on warfarin.
Consequently, QOF today provides virtually no incentive for GPs to put patients on warfarin in accordance with the NICE 2006 or the ESC 2010 guidelines.
AFA would suggest that guidelines and rewards encourage

- An increase in the percentage of patients with Atrial Fibrillation in whom stroke risk has been assessed using the $CHADS_2$ risk stratification scoring system in the previous 15 months
- In those patients with Atrial Fibrillation in whom there is a record of a $CHADS_2$ score of ≥1, an increase the percentage of patients who are receiving anticoagulants

Adherence to agreed guidance is essential if AF patients are to be properly assessed and treated to reduce stroke.

4. Aversion to warfarin leaves thousands of patients at unnecessarily high risk of stroke

In clinical trials warfarin has been associated with a stroke risk reduction in AF patients of 50%-70%. However, this potential is not being realised in routine clinical practice, leaving thousands at risk of preventable strokes.
Warfarin is currently recommended in UK and European guidelines as first-line therapy in patients with AF and a moderate or high risk of developing stroke. [138 139] Despite evidence that following the guidelines results in improved patient outcomes, [166] there is significant under-use of warfarin. Thus, many patients with AF and a moderate-to- high risk of stroke do not receive anticoagulant therapy and therefore remain at high risk for stroke. [156 153]
NICE data shows that of all those with AF who should be on warfarin, almost half are not. [179]. In a study conducted in seven European countries, it was found that only 8.4% of patients with AF who had a stroke were receiving anticoagulants at the time of their stroke, and the proportion decreased by 4% per year with increasing age. [181] A review of the scientific literature from 2000 indicated that only 15–44% of eligible patients with AF were receiving warfarin.[180] Yet, when asked, physicians demonstrate both awareness of the guidelines and agreement with them, despite not treating patient in accordance with those guidelines. [182] This further highlights the discrepancy that is often found between trial results and what happens in clinical practice. Another study documented the medications being taken by AF patients when they suffered an ischemic stroke. It found that only 10% of these patients had been taking an effective dose of an anticoagulant. Nearly a third were on no antithrombotic treatment at all (29%). A further 29% were on aspirin and another 29% were on a non-therapeutic dose of warfarin. According to recent surveys in different parts of Europe, the proportion of patients with AF at high risk of stroke who are receiving adequate anticoagulation is most commonly around 54–61% [185,172]
Warfarin is under-prescribed for many reasons including the complexity of dosing and patient management as well as fear of the associated bleeding risks. Consequently, almost half the AF patients for whom warfarin is indicated are not on warfarin and remain at extremely high risk of severe, debilitating and expensive strokes.
Management of warfarin is complex and time-consuming for primary care physicians. It is also recognised that those at greatest risk, the elderly, are less likely to be given warfarin because of perceived fear of complications.

In centres where clinicians with a special interest in AF have set up clinics and outreach support, such as Prince Philip Hospital, Llanelli, commitment of a truly multidisciplinary team, has led to a

successful "one-stop service" service for those referred with AF. When started, only 22% of the patients referred to Dr Izzat with a CHADS2 of more than 1 were adequately anti-coagulated with warfarin, this has now improved to just over 40% and plans to improve this further are in hand. Knowledge of and adherence to current guidance, effective use of validated risk assessment schema and appropriate use of anticoagulation has lead to successful stroke prevention – and with no extra finance.

5. Too often, those at most risk, frequently the elderly, are prescribed aspirin, which only reduces the risk of stroke by 22% and increases their risk of bleed to equal that of warfarin.

Many physicians resist the use of warfarin in the elderly, largely on grounds of safety. Research has demonstrated repeatedly that physicians over-estimate the risk of bleeding associated with the use of warfarin and under-estimate its benefits in preventing thromboembolism and stroke; conversely, they have been shown to under-estimate the bleeding risk of aspirin therapy and over-estimate its benefits. [196,188,201] As a result, eligible patients are not receiving therapy that could prevent strokes. [18] For many physicians, bleeding risk is a particular concern in the elderly, who are more prone to falls, more likely to have suffered previous major bleeds, and who are subject to many additional problematic factors associated with old age. [202,204] While the bleeding risk with warfarin is no worse than that with aspirin, physician experience of major bleeding events associated with warfarin can profoundly reduce prescription of warfarin. [205] A study investigated the behaviour of physicians treating AF patients who had bleeds while on warfarin. Patients treated in the 90 days after the physician had encountered a bleeding event were significantly less likely to receive a prescription for warfarin than patients treated before the bleed. [205] In contrast, having a patient who experienced a Stroke while not receiving warfarin did not influence prescribing behaviour with subsequent patients. [205] In other words, a bleeding event may make a physician less likely to prescribe an anticoagulant but a stroke does not increase the likelihood that a physician will prescribe and anticoagulant.There are large numbers of younger patients who according guidance should be prescribed anticoagulants including 'those with a history of stroke and those aged 65 years or over with one of the following: diabetes, coronary artery disease, or hypertension', but who simply are not receiving it, whether this be through their choice or physician assessment. AFA would propose that guidelines recommending that patients be assessed for risk using the $CHADS_2$ and the $CHADS_2VASc_2$ system should be adopted.

6. For those patients on warfarin large numbers of patients are difficult to control and spend >60% outside the target therapeutic range – rendering warfarin of no benefit.

Research has shown that AF patients in routine clinical care were able to maintain a target INR for over half the time (56%). Of the considerable remaining time, patients were above the target range for 30%, and below the target range for 14%. [184]. If around half of all patients in need of anticoagulation aren't prescribed warfarin [179] and if those who are have either ineffective or unsafe blood levels of warfarin for nearly half of the time, [184] then perhaps only a quarter of patients at any one time receive the therapy they need to safely lower their risk of stroke. This becomes ever more worrisome when considering experts' estimates that only about half of all AF patients are actually diagnosed. The vast majority of these undiagnosed patients would be expected to be at moderate or high risk of stroke, [190] and, hence, in need of warfarin therapy according to

the ESC 2010 guidelines. Yet perhaps only a fifth of patients in need of warfarin to reduce risk of stroke are actually receiving safe and effective anticoagulation treatment at any time.

-Effective monitoring is essential if at risk AF patients are to be protected.

-An education programme, in line with recommended guidance is required to increase awareness and understanding of the importance of appropriate anticoagulation therapy in AF patients.

7. **The Inquiry Committee may wish to consider seeking evidence from all relevant professionals, including heart rhythm arrhythmia specialists.**

AF is largely managed in primary care, but cardiologist who are arrhythmia specialists also play a key role in local training, referrals and care of more challenging AF patients. Cardiac Networks and cardiology arrhythmia specialists are also instrumental in informing and supporting local guideline adherence in order to PREVENT stroke in AF patients.

AFA has worked with the Cardiac Networks and Arrhythmia specialist in Wales, and suggests that the Inquiry would benefit from seeking expert advice from these sources. AFA would be very happy to highlight Welsh centres where specialist clinicians are working to reduce both the burden of AF and the risk of stroke amongst the AF population.

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Atrial fibrillation—so what? Changing clinical practice

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The arrhythmia nurse practitioner's role has many different titles, from specialist nurse to arrhythmia care co coordinator, with the different titles comes the diverse yet rewarding workload. The role of the British Heart Foundation (BHF) arrhythmia nurse is underpinned with three key elements

- Ensuring that all patients with arrhythmias receive an effective and holistic assessment and a package of care, to ensure that all the patients' medical and emotional needs are discussed.
- All those who are included in the care pathways including patients, families and carers receive education and support as needed.
- Ongoing monitoring and auditing of the arrhythmia service takes place. These elements ensure that the quality requirements of chapter 8 of the National Service Framework (NSF) for Coronary Heart Disease (CHD) (Department of Health, 2005) and the Welsh equivalent standard 5 of the Welsh NSF (Welsh Assembly Government, 2008) are met.

Arrhythmia nurse practitioners service

In October 2006 two experienced cardiac nurses were appointed to the arrhythmia nurse practitioners (ANPs) service based in a district general hospital, one with additional experience in primary care with knowledge of the local area. These roles had been created to develop a service that would bridge the gap between primary, secondary and tertiary care for patients who suffer from arrhythmias.

The day-to-day work load now is very varied and can include answering telephone enquires from the advice line, pre-assessing patients for procedures such as elective direct current cardioversion, permanent pacemaker implants, educating other health professionals about the management of patients with arrhythmias, visiting patients, families or carers at home or in hospital to discuss arrhythmias and their management, liaising with other health professionals to improve patient care, audit, and developing patient pathways to improve access to services. Nevertheless the majority of our work load centres around the management of patients with atrial fibrillation (AF).

Atrial fibrillation

Atrial fibrillation (AF) is the most common sustained cardiac arrhythmia, if left untreated it is a significant risk factor for stroke and other morbidities (National Collaborating Centre for Chronic Conditions (NCC-CC), 2006). The annual risk of stroke increases by around 4-5% for patients with atrial fibrillation, however this is not relative and the risk increases with age and other co-morbidities. This risk can be reduced with appropriate and timely thromboprophylaxis (NCC-CC, 2006). The effects of AF on the patient can range from none to many side effects such as reduced quality of life, breathlessness, fatigue, palpitations, and angina. The screening for atrial fibrillation in the elderly (SAFE) study (Hobbs et al, 2005) identified that when GPs record manual pulses during routine consultations the incidence of AF diagnosis is significantly increased, ultimately leading to a reduction in the incidence of stroke.

Based on experience as a practice nurse prior to taking the post as an arrhythmia nurse practitioner, it was felt that GP surgeries and practice nurses play a vital role in the care of patients with chronic diseases and are therefore

ABSTRACT

Atrial fibrillation (AF) is the most common sustained cardiac arrhythmia, if left untreated it is a significant risk factor for stroke and other morbidities. Approximately 12 500 strokes each year are sttributable to AF and the annual cost to the NHS and personal social services budget is estimated to be around £148 million. The SAFE study identified that when GPs record manual pulses during routine consultations the incidence of AF diagnosis is significantly increased, ultimately leading to a reduction in the incidence of stroke.

On 1 May 2007 the Wrexham primary care AF model pilot was launched. Working in partnership across organizational boundaries, changes were made to existing templates in some GP surgeries. A manual pulse check was added to all chronic disease management templates, and a stroke risk stratification tool was added to AF templates to ensure patients are correctly stratified for appropriate use of a thromboprophylactic agent, which in turn would reduce the incidence of stroke. Seven new AF patients were found by opportunistic checks during the pilot and 68 patients found to be on inappropriate or no thromboprophylaxis, which prompted further review by the GPs.

KEY WORDS

- Manual pulse checks
- Atrial fibrillation
- Screening
- Stroke risk assessment

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ideally situated to initiate a screening service for atrial fibrillation within local primary care settings.

The hospital is based on the borders of Wales and England, serving patients from both countries, and the same region is also served by two other hospitals. To reduce inequalities in services between the different hospital that serve the local area, we chose to facilitate other health care professionals in the community to undertake screening for AF by integrating manual pulse checks into routine clinical assessments i.e. chronic disease management in GP surgeries, district nurse assessments, community matron or long-term condition nurse assessments.

Facilitating AF screening in GP surgeries

The model for screening is not complex, nor ingenious, quite the opposite. It is simple, requires no funding, and can be adapted into any general practice setting that conducts chronic disease management reviews. The model aims for each individual to be assessed, to create a treatment plan that is centred on their own exclusive needs.

Before piloting the model we delivered several educational workshops for local practitioners (including GPs, practice nurses and district nurses) to reach as many health professionals in primary care as possible in order to highlight the implications of AF. Emphasis was placed on the need for manual pulse and blood pressures monitoring, as the use of automated machines can give inaccurate readings for patients with irregular pulses.

The arrhythmia nurse practitioner service worked in partnership across organizational boundaries and made changes to existing templates in some GP surgeries (who volunteered to take part). These included the addition of a manual pulse check to all chronic disease management templates, which instigates opportunistic and routine screening not only for those who are at high risk for AF but also for the wider population.

In addition, the model used a stroke risk stratification tool—CHADS2 (Valentin et al, 2006)—and recorded the results using the read code 388I in an AF template to ensure patients were correctly stratified for the appropriate thromboprophylactic agent, which in turn would reduce the incidence of stroke.

The $CHADS_2$ stroke risk stratification is a clinical prediction tool used for estimating the risk of stroke in patients with nonrheumatic, or nonvalvular, AF. Points are assigned for chronic heart failure (C), hypertension (H), age 75 years or over (A), diabetes mellitus (D) and history of stroke or transient ischaemic attack (S—2 points). The higher a person's $CHADS_2$ score, the greater the risk of stroke.

An annual diary date was created to prompt annual review, which is a component missing from the clinical indicators of the quality outcome framework (QOF) for atrial fibrillation (British Medical Association/NHS Employers 2006).

Implementing the tool and annual check was supported by the development of internet-based guidelines and cardiac network guidelines that GPs can access.

AF primary care pilot

The Wrexham primary care AF model pilot launched on 1st May 2007 in four general practice surgeries under the local health boards, and ran for six months with positive results and findings. The audit of the pilot evaluated the review of existing patient on the AF registers in the surgeries as well as those patients that where identified through the routine screening using the manual pulse check. Seven new AF patients were found during opportunistic checks as part of the pilot and 68 patients were found to be on inappropriate or no thromboprophylaxis, which prompted further review by the GPs.

Nearly two years since the start of the pilot the team are still reaping the benefits of the work undertaken in primary care. Although four practices were initially recruited into the pilot, the arrhythmia nurse practioners wrote to every practice in the catchment area and asked to set up a meeting to discuss the basis of the pilot.

It seems a key reason that practices were not keen to take part in the pilot was that the pilot scheme used paper audit forms, whereas most GP surgeries operate a paperless policy. This appeared to be an obstacle that could not be overcome at the time, and the additional time needed to complete the form was seen to be problematic.

In one surgery one of the ANPs personally performed an audit of all the patients on the AF register, highlighting any patients that appeared to be on inappropriate therapy or thromboprophylaxis. This allowed her to gain a better understanding of the extent of problems that could be discovered, and appreciate the time it took to perform this audit and the impact it would have on GP and practice nurses' workload. This method of auditing patients was also used in other surgeries by GPs and practice nurses, whereas some practices chose to invite all patients on the AF register in for a review.

The ANP service now see on many referral letters that the patient was found to be in AF during a routine blood pressure check or during an annual chronic disease management review. Hopefully, this is a direct effect of the educational events the service continues to provide and also a result of those surgeries that made the changes to their chronic disease management templates.

Award winning service.

In April 2008 the team's work in this area was recognized nationally with an award at the Cardiac Nursing Awards in London for 'Excellence or innovation in arrhythmia management'. This award would not have been possible if it were not for the continued support of our manager, consultants, GPs, practice nurses, cardiac lead nurses in the community and last but not least the BHF. Our idea was simple but has proved to be effective.

The future

Other initiatives undertaken by the team include a collaboration with the local health board lead nurse for cardiovascular disease on developing part of a cardiology local enhanced service (LES) for GPs (DH, 2008)).

The option in the LES relating to AF included raising awareness of AF, the significance of taking a manual pulse and the importance of using the stroke risk stratification tool to identify those who needed interventions to reduce the risk of stroke. GP practices agreeing to take part in this option were asked to attend an ECG study day on arrhythmias and an AF study session provided by the two ANPs. The session included the importance of the stroke risk stratification tool and thromboprophylaxis. Following this, the practices involved were encouraged to adapt all their chronic disease management computer templates to include taking a manual pulse.

It is recognized that ongoing education is required in primary care and working closely with local health boards the ANP service aims to provide further education.

In addition, the service is in the process of organizing a 'Know your Pulse' educational event for Arrhythmia Awareness Week 2009. The event is to be hosted with the support of the occupational health department of a large local employer who has approximately 8500 permanent and contract staff. The event will start with an internal television campaign highlighting the importance of 'know your pulse' followed by site tours educating staff on how to check their own pulse and the importance of seeking medical advice if an abnormal pulse is found. Due to the enormity of the site three days have been scheduled for this event over the summer months, alongside night visits to ensure night staff benefit from this event.

Key Points

- Atrial fibrillation is the most common arrhythmia and if left untreated can lead to an increased risk of stroke
- Undetected AF cannot be treated, making screening important
- Studies have shown that when GPs record manual pulses during routine consultations the incidence of AF diagnosis is significantly increased
- By providing education and support to primary care colleagues to assist them in identifying and appropriately treating patients with AF, future complications may be reduced

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Health and Social Care Committee

HSC(4)-03-11 paper 2

Inquiry into Stroke Risk Reduction - Evidence from the Stroke Association in Wales

Y GYMDEITHAS STRÔC

The Stroke Association

The Stroke Association in Wales welcomes the opportunity to provide written evidence to the Health, and Social Care Committee on the Inquiry into Stroke Risk Reduction.

The Stroke Association in Wales is the leading third sector provider of Life After Stroke Services. We aim to reach at least nine out of ten stroke survivors and their families within two weeks of the stroke. We are at the forefront of raising awareness of stroke and promoting the right of stroke survivors. We help people to reduce their risk of having a stroke and lobby for improvements in stroke services across the whole care pathway.

1. What is the current provision of stroke risk reduction services and how effective are the Welsh Government policies in addressing any weaknesses in these services?

1.1 Around 11,000 people in Wales have a stroke each year. However, stroke is both preventable and treatable. Preventing a stroke from happening in the first place should be at the forefront of health promotion policy. Smoking, excessive intake of alcohol, obesity, poor diet and lack of exercise are all conclusively linked to stroke.

1.2 The Welsh Government has funded a number of stroke prevention campaigns including Weigh up your Risk of Stroke, the F.A.S.T campaign and most recently with the Stroke Association; Ask First – to help prevent a stroke later campaign which focussed on the risks of having a stroke associated with having a condition called AF and / or high blood pressure.

1.3 As well as ensuring continued awareness about healthy lifestyles, The Welsh Assembly Government must aim to tackle the inequalities in health which continue to lead to less favourable health outcomes for those with a lower socio – economic background.

1.4 The Welsh Assembly Government needs to take a wider view to implementing successful health promotion campaigns and integrate thinking

with the social inequalities that come about as a result of the wider determinants of ill health which exist across parts of Wales.

1.5 The Stroke Association welcomes its continued partnership with the Welsh Government in delivering stroke prevention campaigns. However, these should be delivered more strategically. This can be achieved by allowing longer planning periods and more collaboration across organisations and functionalities, as well as ensuring that adequate levels of funding are available to deliver integrated campaigns.

2. What are your views on the implementation of the Welsh Government's Stroke Risk Reduction Action Plan and whether action to raise public awareness of the risk factors for stroke has succeeded?

2.1 Whilst the Stroke Association cannot comment on the implementation on some of the actions attributed to other organisations, we can offer comment on how we see the overall implementation. Last year the Stroke Association welcomed the Health, Wellbeing and Local Government's Inquiry into Stroke and the resulting publication of "Promoting Cardiovascular Health: the Stroke Risk Reduction Action Plan". However, following publication, we have not had any further correspondence regarding implementation despite being attributed as an organisation to deliver key actions in partnership with others.

2.2 However, The Stroke Association has worked with the Health Improvement Division of the Welsh Government to implement action point 37: Conduct an awareness raising campaign 'know your blood pressure, know your pulse; including targeted action for BME groups at greater risk.

2.3 At the Stroke Association our focus turned to AF in September 2010 when we were in the process of developing our UK wide Stroke Association AF campaign. In Wales we were given the opportunity to jointly launch "Keeping our Finger on the Pulse: why Wales must address the personal, clinical and economic impact of Atrial Fibrillation" funded through an educational grant by Sanofi Aventis and in partnership with the Atrial Fibrillation Association. This document outlined a case for action and offered analysis on the devastation that AF causes in Wales each year.

2.4 At the same time, The Welsh Government was launching "Promoting Cardiovascular Health: the Stroke Risk Reduction Action Plan" and one of the actions was to carry out an awareness raising campaign around both high blood pressure and irregular heartbeat. This coincided with our UK wide strategic drive to raise awareness of AF as a risk factor for stroke.

2.5 We decided to form a partnership to deliver a joint campaign. Ours was an AF specific campaign at UK level; however the Welsh Health Minister wanted a dual purpose approach to include high blood pressure. We set to work to integrate the requirements of The Welsh Government with our own strategic priorities and we planned and implemented a successful campaign called Ask First: to help prevent a stroke later, in March this year.

2.6 The partnership has been hugely successful and we hope to be able to work with the Welsh Government to deliver further awareness and prevention campaigns along these lines in the future.

2.7 With regard to delivery of the remaining actions, we would welcome a report on progress and an open dialogue to ensure that the actions are implemented. A review and refresh of this action plan is needed to ensure the best possible outcome for promoting good cardiovascular health and therefore a reduction of strokes in Wales.

3. What are the particular problems in the implementation and delivery of stroke risk reduction actions?

3.1 We believe the main problem with the implementation has been ownership. Despite being attributed actions, no further communication has been forthcoming to facilitate these actions to ensure delivery.

3.2 With a focus on working to remedy the failure of Wales to meet standards set out in the RCP National Stroke Audit which has been critical of Wales in terms of its delivery of stroke services within the acute setting; the work around stroke prevention has had less focus and resource, and yet it is vitally important if we are to prevent some of the 11,000 strokes which happen in Wales each year.

3.3 Whilst it is right and proper that stroke patients are given good quality interventions within hospital to ensure the best possible outcome, the whole stroke pathway needs to be taken into consideration. This pathway should not start with the onset of stroke symptoms; rather stroke prevention should carry equal weight. This is why the Stroke Association in Wales continues to call for an overarching All Wales Stroke Strategy which would incorporate prevention, acute intervention and life after stroke rehabilitation and reablement services placing the citizen and his or her carer at the very centre of the stroke journey.

3.4 The work being done by the 1000 Lives+ initiative and supported by the NHS Delivery and Support Unit to drive up standards in stroke services has been fundamental in improving the performance of acute stroke care across Wales. The Stroke Association wholeheartedly welcomes the development of

Intelligent Targets for acute, TIA, early rehabilitation stages of the stroke pathway. The implementation of these targets has been hugely successful and praise needs to be given to clinicians in the stroke community across Wales for their determination to implement this programme.

3.5 The Stroke Association is pleased to be able to support this programme and is looking forward to the work being developed on the Life After Stroke Intelligent Target and in particular any work that is going to be done to develop a Stroke Prevention Target.

3.6 Vital to implementing a successful programme of stroke improvement is the engagement of all strategic partners. The work around improving stroke services has to date centred on the clinical intervention of stroke and is firmly embedded within health. Yet, acute intervention is one part (though crucial) of the journey of a stroke survivor and the role of Local Authorities in ensuring that effective prevention strategies are embedded into local strategic planning is all too often missing as stroke is seen as a "medical" problem and not a social problem with opportunity for improvement through solutions that lie within social care.

3.7 Whilst this is an issue which affects Life After Stroke Services more so than prevention services, we would like it stated as part of this inquiry that the role of Local Government as a strategic partner in promoting preventative and early intervention programmes is vital and we would expect to see the role of Local Authorities being bolstered in a renewed and invigorated action plan for stroke prevention and risk reduction.

4. What evidence exists in favour of an atrial fibrillation screening programme being launched in Wales?

4.1 AF affects about 750,000 people in the UK and is more common in older people. AF is the most common heart rhythm disorder in Wales and it is said that AF related strokes cost in the region of £46.3 million a year.

4.2 AF means the heart is not pumping as well as it should do. The upper chambers of the heart contract and relax in an uncoordinated and irregular way because of erratic electrical activity. Irregular and fast heartbeats mean the heart does not have a chance to relax and empty properly before filling up with blood again. Blood can collect and pool and this increases the risk of blood clots forming in the blood. As a result, blood clots are more likely to form in the heart. If a clot dislodges itself from the heart it can then travel through the blood stream to the brain and can cause a stroke.

4.3 The risk of stroke is five times greater in people with AF than in people with normal heart rhythm, and one of every six strokes occurs in a person

with AF. Strokes due to AF are twice as likely to be fatal as non-AF stroke, more severe and have a greater need for long-term care.

4.4 AF can cause symptoms such as palpitations, breathlessness, chest pain or fatigue, but can also have no obvious symptoms.

4.5 The Stroke Association is actively campaigning to improve awareness of AF and its link to stroke. We believe that routine screening for AF should be introduced across Wales. This should not be onerous and the following existing opportunities should be considered as a way of identifying more people with AF:

- Flu clinics. Since older people are routinely called in each year for the annual flu vaccination, a simple pulse check would identify new cases of AF.
- Chronic disease clinics. The people who attend for monitoring of chronic cardiovascular conditions, diabetes etc. are at a higher risk of developing AF and will also carry a higher stroke risk. The addition of a routine pulse check to the assessment would increase the identification of AF.
- Flagging applied to records of all patients over 65 known not known to have AF would prompt routine checking of pulse.

4.6 The role nurses can play in detecting AF is crucial. The Stroke Association recently ran an event with the Royal College of Nursing to raise awareness regarding the role of the nurses in identifying AF. By ensuring that each local health board establishes a nurse who champions AF and its link to stroke, AF would be seen as a risk factor for stroke, not merely as a heart rhythm disorder. Primary Care nurses also have a role to play in detecting people who have AF and promptly referring for treatment. Many options are available to increase the role of nursing in this area, and training to carry out manual pulse checks could easily be integrated into the clinics listed above at little or no extra cost to the NHS.

4.7 The existing Quality and Outcomes Framework (QOF) indicators may be one possible reason why fewer than expected AF patients are identified as they do not adequately encourage the detection of unrecognised AF. The Stroke Association recommends that pulse checks are introduced into an overall Health Check programme and we support the call for the inclusion of a new QOF indicator ‘the percentage of patients aged 65 or over who have undergone pulse assessment in the last 15 months.’

4.8 As blood clots are more likely to form in the heart in AF, stroke may occur if a clot travels to the brain. While not everyone who has AF will have a stroke, some are at more risk than others. Some simple tools have been

validated that help health professionals identify those most at risk of stroke, and a tool has been developed in England called GRASP-AF for the easy use in GP practices. The Stroke Association would like to see the use of this tool or a similar tool in GP practices in Wales.

4.9 NICE guidelines already exist for the stratification of patients with AF for risk of stroke, using validated tools. However, adherence to these guidelines is low and we recommend that a risk assessment for stroke, using a recognised tool recommended in the ESC guidelines, to be carried out on all patients with AF, and that this is reviewed at regular intervals. We call for a new QOF indicator that states 'the percentage of patients with AF in whom stroke risk has been assessed using a validated tool'.

4.10 Anti-coagulant treatments are available for at-risk individuals. Despite the existence of NICE guidelines, and the availability of treatments to reduce the risk of stroke, many AF patients at risk of stroke are not treated in accordance with the guidelines.

4.11 The Stroke Association calls for NICE guidelines to be urgently updated, and for clinicians to adhere to the most recent guidance on the treatment of AF and reduce the risk of stroke by appropriate treatment. We also want to see the inclusion of a new QOF indicator 'The percentage of patients at high risk of stroke who are receiving anticoagulants (unless a contra-indication or side-effects are recorded)'.

5. Final Remarks

5.1 The Stroke Association in Wales wholeheartedly welcomes this Inquiry into Stroke Risk Reduction and in particular the focus on Atrial Fibrillation as a risk factor for stroke. Mitigating the devastation that stroke can have on people's lives is the basis of our work and we wholeheartedly support further attention being given to raise the awareness of the importance of stroke prevention and risk reduction.

5.2 Prevention work need not be resource heavy as we have demonstrated. Including simple pulse checks into already existing clinics and introducing new QOF indicators will help save lives and prevent people falling into disability as a result of stroke.

For further information please contact Lowri Griffiths, Head of Communications and External Affairs at the Stroke Association in Wales lowri.griffiths@stroke.org.uk or ring 029 20524400

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Health and Social Care Committee

HSC(4)-03-11 paper 3

BUDGET SCRUTINY 2012/13

Purpose

1. One of the Health and Social Care Committee's ("the Committee's") roles is to scrutinise the Welsh Government's annual budget. The Committee's portfolio covers three budget areas: health, mental health and social services.

2. This paper seeks the Committee's view on the proposed approach to budget scrutiny.

Budget scrutiny process

3. The Finance Committee is the only committee which can recommend changes to the Government's budget.[1] However, any other committee can consider and report to the Finance Committee on the draft budget.[2] This is usually done through a committee report or a letter to the Finance Committee.

4. The Finance Committee launched a public consultation over the summer on the budget. The call for evidence[3] was broad and went to a wide range of stakeholders, including health, mental health and social services organisations.

5. The committee time available for budget scrutiny is limited:

4 October	Government lays draft budget
12 October 20 October	Committee meetings available for evidence to be taken on the budget.

[1] Standing Order 20.11
[2] Standing Order 20.10
[3] http://senedd.assemblywales.org/documents/s2247/Consultation%20letter%20-%20Welsh%20Government%20draft%20budget%20proposals%20for%202012-13.pdf

26 October	Date by which committee reports must be laid in order for the Finance Committee to take any committee views into consideration in their report on the draft budget.
8 November	Deadline for the Finance Committee's report on the draft budget.

Ministerial Scrutiny

6. The Minister for Health and Social Services and Deputy Minister for Children and Social Services are available to attend the Committee's meeting on 20 October for budget scrutiny.

Roundtable

7. The Committee is asked to consider a proposal to hold a 'roundtable' session with representatives from each of the three budget areas. This would be a short (1 hour) session on 12 October. The purpose of the discussion would be to identify key issues to consider when scrutinising the draft budget and to inform scrutiny of the Minister and Deputy Minister the following week.

8. As the purpose of this session would be to gather information, a detailed briefing would not be provided. Members would be encouraged to explore with the witnesses those areas which warrant further investigation with the Minister and Deputy Minister.

9. Due to the nature of the session, Members may feel that umbrella organisations would be best placed to provide an overview of the key issues which require further exploration with the Minister and Deputy Minister. In addition to umbrella organisations, the Committee may wish to consider inviting a witness who can provide a general overview on the financial situation facing the sector, such as a health economist or academic.

10. Possible witnesses could include:

    - NHS Confederation

- Association of Directors of Social Services
- National Programme Board for Adult Mental Health
- Academic

Future budget scrutiny

11. Budget scrutiny is an on-going responsibility for the Committee and further work can be undertaken throughout the year. To aid the Committee's ability to undertake future budget scrutiny, Members may wish to consider identifying 'expert advisers' who could help with future budget scrutiny.[4] This would help mitigate the difficulty in recruiting witnesses who have the right balance of expertise in finance and policy and who are not already providing support within Wales.

12. Members are asked to suggest potential candidates to assist with budget scrutiny in the future. These could be academics/experts from outside Wales, who would agree to provide advice to the Committee for the 2013-14 budget round.

Action for the Committee

13. The Committee is invited to:

- agree the approach to financial scrutiny for 2012-13 (paragraphs 6 – 10); and
- give further consideration to the approach for future budget scrutiny (paragraphs 11 and 12).

[4] Standing Order 17.55 permits committees to appoint advisers for the purposes of providing expert advice.

Members' Research Service
Gwasanaeth Ymchwil yr Aelodau

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

HSC(4)-03-11 paper 4

Health and Social Care Committee

Adult Residential Care

Scoping paper for an inquiry into adult residential care in Wales

Date of meeting:	**22 September 2011**

This briefing has been produced by the Research Service for use by the Health and Social Care Committee.

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Members' Research Service

1. Introduction

The Committee agreed to undertake an inquiry into residential care in Wales at its meeting on 13 July 2011, and that Members would consider a scoping paper at its meeting on 22 September 2011. This paper sets out the possible scope of such an inquiry.

Background

For some time social care services have been the subject of scrutiny, particularly around the issue of funding services for an ageing population. In addition, recent events at Southern Cross have focused attention on the stability and sustainability of the residential care sector.

Earlier this year the Welsh Government published a policy paper[1] setting out its plans for social care for the next ten years, which include the publication of a Social Care Bill in the Fourth Assembly.

The Deputy Minister for Children and Social Services is setting up a Task and Finish Group to examine issues around the care and accommodation needs of older people. Its membership is to be announced in autumn 2011.

The Committee may wish to agree to undertake an Inquiry into the capacity and sustainability of the residential care sector in terms of meeting the current and future needs of older people in Wales, and alternative models for providing such care.

This would consider the needs of older people only, but could be extended to include younger adults.

The Inquiry could address the following aspects of residential care.

2. Pathways into residential care

For some time the emphasis in social care policy has been away from institutional care and towards provision that helps to maintain independence and autonomy. This focus continues to inform current policy: the Welsh Government's social services policy paper[2] envisages a 'transformation' of services for older people driven by wider provision of re-ablement schemes and innovative community-based support services.

The high costs of residential care, together with the negative outcomes associated with institutionalisation have led to increasing numbers of people with high levels of need receiving care services at home. New approaches to care, such as the Gwent Frailty Programme, and developments in technology, such as Telecare, have expanded the possibilities for non-institutional care. Nevertheless the pace of change from institutional

[1] Welsh Government *Sustainable Social Services for Wales: A Framework for Action* (2011) [accessed 5 September 2011]
[2] Ibid

to community-based forms of care has been slow[3] and the balance between the commissioning of residential and non-residential care is variable across local authorities[4].

The assessment process undertaken by local authorities (soon to be the subject of a Welsh Government review) and, particularly for private fee payers, the information and advice service users and their families receive, impact on decisions about the type of care they receive.

The Committee may wish to consider the process by which people enter residential care and the availability and accessibility of alternative services

3. Resources and commissioning

Most care homes for older people in Wales (87 per cent) are operated by the private and voluntary sectors[5], although local authorities are the largest purchasers of residential care services. The planning and commissioning activities of local authorities therefore strongly influences the shape of local care markets. The Welsh Government is planning to introduce a national outline contract for residential care.

Disputes[6] over fees for residential care between providers and local authorities in Wales have highlighted the difficulties facing commissioners and providers in times of public spending constraint[7]. A memorandum of understanding promoting cooperative working between social care providers and the Welsh Local Government Association has recently been under pressure following court action against local authorities by care providers in some parts of Wales, and there is evidence[8] of an increasing number of care providers going into administration.

Lower average occupancy levels in care homes in Wales have contributed to the financial pressures on care providers[9], although the long term prospects for demand appear to be more positive, and there is significant demand from private fee payers who purchase 40% of residential care.

Local authorities have a role in providing advice and information to self-funding care home residents, some of whom may later become eligible for public funding as their financial resources diminish.

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[3] Care and Social Services Inspectorate Wales *Chief Inspector's Annual Report 2009-10* p17 [accessed 7 September 2011]

[4] See Welsh Government Statistical Release SDR 155/2011 ***Assessments and Social Services for Adults 2010-11*** September 2011, Table A1 [accessed 7 September 2011]

[5] Welsh Government *Residential care: a briefing paper for the health and social care scrutiny committee meeting 28 July 2011* paragraph 4 [accessed 2 September 2011.

[6] Community Care *Welsh Government bids to cool social care fee row* 22 June 2011 [accessed 5 September 2011]

[7] See Guardian.co.uk *Firms going bust in social care sector up by 50% amid spending cuts* 4 July 2011 [accessed 10 July 2011]

[8] Community Care ***More care homes on the brink of closure as fees fall*** 14 July 2011 [accessed 2 September 2011]

[9] See Welsh Government *Residential care: a briefing paper for the health and social care scrutiny committee meeting 28 July 2011* paragraph 5 [accessed 2 September 2011.

There has been a considerable amount of consultation and discussion around the issue of paying for social care both in Wales and at the UK level in recent years. Most recently, the publication of the *Dilnot report*[10] on funding social care in England has contributed to the debate on future arrangements on both sides of the border.

The Committee may wish to consider the process of commissioning places in residential care by local authorities and the ability of the sector to meet demand in the context of constraints on resources.

The Committee may wish to consider the support provided by local authorities to privately funded residents.

4. Capacity of the residential care sector

The development of more community-based health and care services in recent years means that people entering residential care tend to have higher levels of need than was the case in the past. Research evidence[11] suggests that investment in improved staff training is required to meet this need, and that better staff training leads to improved quality of life for residents.

The Care and Social Services Inspectorate Wales[12] has identified incidences of the admission of people with dementia to care homes lacking capacity and staff competence to meet their needs. A summary[13] of Directors of Social Services Annual Reports identified a need to develop more services for people with dementia, and its *Preliminary Analysis of Dementia in Wales* report stated that:

> A significant finding of the preliminary analysis is that there are wide variations in what is available across Wales and that this variability doesn't seem to be related to need. Crucial gaps have also been identified. This means that the needs of people with dementia and their families and carers are not being adequately or equitably met by social care and social services (p.3)[14].

The Committee may wish to consider the capacity of the residential care sector to meet the demand for services for people with increasingly high needs, including those with dementia, in terms of number of places and facilities and staff knowledge and skills.

[10] Commission on Funding of Care and Support *Fairer Care Funding. The Report of the Commission on Funding of Care and Support* July 2011 [accessed 5 July 2011]
[11] Joseph Rowntree Foundation ***Residential care home workforce development: the rhetoric and reality of meeting older residents' future care needs*** (2010) {accessed 2 September 2011]
[12] Care and Social Services Inspectorate Wales *Chief Inspector's Annual Report 2009-10* p17 [accessed 5 September 2011]
[13] Social Services Improvement Agency *Annual Reports by 22 Statutory Directors of Social Services in Wales - An Analysis of the Achievements and Challenges* (2011) p10 [accessed 5 September 2011]
[14] Care and Social Services Inspectorate Wales *Preliminary Analysis of Dementia in Wales* July 2010 [accessed 5 September 2011]

5. Quality of services in residential care home

The experiences and views of care home residents and their families provide a measure of the quality of service provision in the sector. Research studies[15] have identified a range of factors that influence residents' satisfaction with care including staffing levels, staff turnover, family involvement, meal-time experience, personal control, recreational activities and residential environment. The research also indicates that family and peer support enhances quality of life, as do choice and the empowerment of residents. Regulation and inspection arrangements, resources and staff training also determine service quality.

The effectiveness of services in meeting the needs of specific groups of older people, such as Welsh speakers and those from BME groups also fundamentally affects the experiences of those users of residential care.

Given the current volatility of the residential care market, continuity of services may be threatened when providers transfer or close care homes, causing distress to service users and their families. The Older People's Commissioner for Wales has expressed concerns[16] about the impact of care home closures on older people. The Commissioner is currently considering utilising her powers in relation to the adequacy of advocacy provision for older people in residential care.

Recent reports have highlighted a need for improved healthcare for older people in residential care homes[17], including those needing palliative care or mental health care[18].

The Welsh Government is reforming the arrangements for promoting service improvement in social care to meet objectives in a new National Outcomes Framework. Progress will be measured through a "revised set of high level indicators"[19].

The Committee may wish to consider the quality of residential care services and the experiences of service users and their families, including the effectiveness of services at meeting the diversity of need amongst older people.

The Committee may also wish to consider the arrangements for ensuring continuity of care for older people when care homes close.

6. Regulation and inspection

The regulation and inspection regime for care homes is intended to ensure consistent standards of provision across the large and diverse residential care sector. The current

[15] Joseph Rowntree ***Foundation Improving care in residential care homes: a literature review*** (2008) [accessed 2 September 2011]
[16] Older People's Commissioner for Wales *Statement on Care Home Closure* 1 December 2010 [accessed 10 July 2011]
[17] British Geriatrics Society ***Quest for Quality. British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Quality Improvement*** (June 2011) [accessed 2 September 2011]
[18] Joseph Rowntree ***Foundation Improving care in residential care homes: a literature review*** (2008) p3 [accessed 2 September 2011]
[19] Welsh Government *Sustainable Social Services for Wales: A Framework for Action* (2011) paragraph 3.14 [accessed 5 September 2011]

arrangements have been in place since the implementation of the *Care Standards Act 2000*, since when changing demands and new models of care have emerged.

Recently, the financial difficulties experienced by Southern Cross Healthcare have focused attention both on this large provider of care homes (thirty four of which are in Wales) and on the residential care sector generally. It has been suggested that an economic regulator is needed to monitor the finances of larger private care providers[20].

In a Cabinet Written Statement[21] on 25 July 2011 the Deputy Minister for Children and Social Services Gwenda Thomas AM stated, in reference to the problems experienced by Southern Cross:

> I have been asked whether I am considering measures needed to prevent similar situations from arising again. Options for financial regulation or other measures will be considered as part of the development of the forthcoming Social Services Bill.

The Welsh Government has outlined plans to reform arrangements for regulation and inspection in social services. Its policy paper on social services signals a shift in emphasis from inspection of individual care settings to a focus on the registration requirements of organisations providing services; a 'licence to operate'. It states:

> The time is now right to shift the balance of regulation and inspection from the point of service delivery to the organisation which provides the service and to specific professional roles in the work force. This will enable us to reduce the burden and the quantity of regulation.

The Welsh Government has also decided not to pursue plans to register social care staff beyond social workers and care managers.

The Committee may wish to consider the effectiveness of the regulation and inspection arrangements for residential care, including scope for increased scrutiny of service providers' financial viability.

7. Coordination and integration of residential care and other health and social care services.

Residential care is one element of the range of interdependent health and social care services; therefore it does not operate in isolation from them. Services such as re-ablement that aim to maintain the independence of older people interact closely with, and impact on demand for, residential care services. Effective coordination between services affects both the experiences of service users and the efficiency at which interdependent services operate. For example, poor social care provision can increase the rate of delayed transfers of care from acute healthcare settings.

[20] Community Care *Southern Cross crisis prompts call for regulator* 2 June 2011 [accessed 10 July 2011].
[21] Welsh Government, Gwenda Thomas AM Deputy Minister for Children and Social Services ***Southern Cross – Update on Restructuring*** Cabinet Written Statement, 25 July 2011 [accessed 1 September 2011]

Better integration of services, especially health and social care, has long been a policy objective of the Welsh Government; its recent social care policy paper reinforces that aim[22].

The Committee may wish to consider arrangements for the co-ordination and/or integration of residential care with other health and social care services.

8. Future provision

A continuing emphasis on developing service models that promote independence, further changes to the demographic profile of the older population in Wales, and higher expectations of service quality are likely to require new approaches to the provision of care for people with the highest levels of need.

Models of care that are sufficiently flexible to meet the changing needs of older people without necessitating disruptive changes to accommodation may be needed in future. Extracare housing, for example, offers care with housing, allowing residents to retain their independence, as do retirement villages on a larger scale.

The Committee may wish to examine the role of new and emerging models of care provision, such as Extracare, care villages and others that promote independence and offer flexible care.

There has been a significant shift in residential care away from local authority to private sector provision since the 1980s so that 84 per cent of care homes are now in private ownership.

However, given the recent financial problems experienced by Southern Cross Healthcare, alternative models of funding and ownership may be explored. Not for profit organisations such as Registered Social Landlords, for example, may help to diversify the care economy by expanding their involvement in provision. In some countries, such as Canada, the cooperative sector is a major player in housing and care provision.

The Welsh Government states in its social services policy paper[23] that "social care is ripe for the development of social enterprises". The previous Welsh Government (2007-11) made a commitment to developing 'not for profit' nursing homes[24].

The Committee may wish to consider the opportunities available for developing alternative funding and ownership models such as those offered by the cooperative and mutual sector.

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[22] Welsh Government *Sustainable Social Services for Wales: A Framework for Action* (2011) paragraph 3.21 [accessed 5 September 2011]
[23] Welsh Government *Sustainable Social Services for Wales: A Framework for Action* (2011) paragraph 3.18 [accessed 5 September July 2011]
[24] Welsh Government *One Wales, A Progressive Agenda for the Government of Wales* (2007) p12 [accessed 7 September 2011

Health and Social Care Committee

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Children and Young People Committee Inquiry into Children's Oral Health – Letter from Chair

Attached as an annex to this paper is a letter from the Chair of the Children and Young People Committee regarding its Inquiry into Children's Oral Health.

Committee Service

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Y Pwyllgor Plant a Phobl Ifanc
Children and Young People Committee

Mark Drakeford AM
Chair, Health and Social Care Committee

21 July 2011

Dear Mark

Children and Young People Committee – Inquiry into Children's Oral Health

I am writing to inform you that, at its last meeting, the Children and Young People's Committee agreed to launch a short inquiry into children's oral health. Full details of the inquiry will be published on the Committee's website in due course—

http://www.senedd.assemblywales.org/mgCommitteeDetails.aspx?ID=224

Whilst the subject matter of the inquiry falls within the remit of the Children and Young People's Committee, I appreciate it is something that members of the Health and Social Care Committee may be interested in. With that in mind, I am happy to share any evidence we receive with your Committee, and would welcome any members of your Committee who would like to participate in our oral evidence sessions early in the autumn term. Do get in touch with me, or with the Clerk, Sarah Beasley, if you would like to discuss further.

Yours sincerely

Christine Chapman
Chair

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Croesewir gohebiaeth yn y Gymraeg a'r Saesneg / We welcome correspondence in both English and Welsh

Health and Social Care Committee

HSC(4)-03-11: Paper 6

Health and Social Care Committee Forward Work Programme – Autumn 2011

Purpose

1. This paper invites Members to note the Health & Social Care Committee timetable attached at Annex A.

Background

2. Attached at annex A is a copy of the Health & Social Care Committee's timetable until the October 2011 recess.

3. It is published as an aid to Assembly Members and any members of the public who may wish to be aware of the Committee's forward work programme. A document of this kind will be published by the Committee at regular intervals.

4. The timetable is subject to change and may be amended at the Committee's discretion as and when relevant business arises.

Recommendation

5. The Committee is invited to note the work programme at Annex A.

Committee Service

ANNEX A

Thursday 22 September (morning only)

Inquiry into Stroke risk reduction
Oral evidence session
- Atrial Fibrillation Association
- Stroke Association

Forward Work Programme
Inquiry into Adult Residential Care: scoping paper
Budget scrutiny: consideration of approach
Children and Young People Committee inquiry into children's oral health: letter from Chair, Christine Chapman AM

Wednesday 28 September (morning only)

Inquiry into Community pharmacy
Oral evidence session
- Royal Pharmaceutical Society
- Community Pharmacy Wales

Thursday 6 October (morning and afternoon)

Inquiry into Stroke risk reduction (morning)
Oral evidence session
- Public Health Wales
- NHS representatives
- Royal College of Nursing
- British Medical Association / Association of Stroke Physicians

Scrutiny of the Older People's Commissioner for Wales Annual Report (afternoon)
Oral evidence session
- Ruth Marks MBE, Older People's Commissioner for Wales

Wednesday 12 October (morning only)

Inquiry into Community pharmacy
Oral evidence session

Budget scrutiny
Public roundtable on budget (to be confirmed subject to Committee consideration on 22 September)

ANNEX A

Thursday 20 October (morning only)

Budget scrutiny
Oral evidence session

- Lesley Griffiths AM, Minister for Health and Social Services
- Gwenda Thomas AM, Deputy Minister for Children and Social Services

Monday 24 October – Friday 28 October: Half term recess

Additional information

- The Minister for Health and Social Services will attend committee on 2 November to conclude the evidence gathering process for the Stroke Risk Reduction Inquiry.

- It is anticipated that the evidence sessions for the community pharmacy inquiry will conclude before the Christmas recess.