

Health and Social Care Committee

Meeting Venue:
Committee Room 1 – Senedd

Meeting date:
28 February 2013

Meeting time:
09:00

Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales



For further information please contact:
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Agenda

1. Introductions, apologies and substitutions

2. Consideration of approach to Legislative Consent Memorandum: Children and Families Bill (09.00 – 09.15) (Pages 1 – 10)

3. Papers to note (09.15) (Pages 11 – 12)

**Letter from Minister for Health and Social Services to Chair – Human
Transplantation (Wales) Bill: Submission from Professor Fabre (Pages 13 – 16)**

**Letter from Minister for Health and Social Services to Chair – Human
Transplantation (Wales) Bill: Emerging issues (Pages 17 – 22)**

**Letter from the Wales Deanery – Actions arising from 10 January meeting
(Pages 23 – 40)**

**Letter from the Minister for Health and Social Services – Actions arising from 5
December meeting (Pages 41 – 42)**

4. Motion under Standing Order 17.42 to resolve to exclude the public (09.15)

Motion under Standing Order 17.42 to resolve to exclude the public from the
meeting for:

- the remainder of today's business;

- the meeting of 6 March;
- the meeting of 14 March; and
- item 1 of the meeting of 20 March.

**5. Recovery of Medical Costs for Asbestos Diseases (Wales) Bill:
Stage 1 – Consideration of final report (09.20 – 10.20)**

(Break 10.20 – 10.30)

**6. Human Transplantation (Wales) Bill: Stage 1 – Consideration of
key issues (10.30 – 15.00)**

Health and Social Care Committee

HSC(4)–07–13 paper 1

Legislative Consent Memorandum: Children and Families Bill

To: Health and Social Care Committee

From: Legislation Office

Meeting date: 28 February 2013

Purpose

1. To invite the Committee to consider its approach to a Legislative Consent Memorandum (LCM) for the Children and Families Bill.

Background

2. On 12 February 2013, the Minister for Health and Social Services laid a Legislative Consent Memorandum (Annexe 1) for the Children and Families Bill¹, which is currently before the UK Parliament.

3. On 19 February 2013, the Business Committee referred the Memorandum to both the Health and Social Care Committee and the Children and Young People Committee for consideration and agreed a reporting deadline of 11 April 2013 in order to allow a Legislative Consent Motion to be debated in plenary on 16 April 2013.

4. The reporting deadline of 16 April falls within the Easter recess. In practice, this means that the Committee will need to conclude its work and report by Friday 22 March.

¹ Legislative Consent Memorandum available via <http://services.parliament.uk/bills/2012-13/childrenandfamilies.html>

The Memorandum

5. The Memorandum was laid by the Minister for Health and Social Services in accordance with Standing Order 29.4.
6. Members will wish to consider in particular—
 - Paragraphs 6–10, which set out the relevant provisions in the Bill for which consent is sought,
 - Paragraphs 13–14, which set out the advantages of utilising the provisions within the Bill rather than including similar provisions in an Assembly Bill.

Legal Advice Note

7. A Legal Advice Note (attached at Annexe 2) from the Committee’s legal adviser:
 - provides further background on the Bill and the provisions for which consent is sought; and
 - confirms that the provisions outlined in the LCM fall within the National Assembly’s legislative competence and that consent is, therefore required
 - suggests some matters that the Committee may wish to consider and question (paragraphs 14 and 15).

Main effect of the provisions for which consent is sought

8. Consent is being sought in relation to two provisions in the Bill relating to—
 - i. the dis-application of the Adoption and Children Act Register to Wales (Part 1, clause 6 and Schedule 1); and
 - ii. the preparation of a care plan (clause 15(2)).
9. In relation to adoption, the Bill seeks to amend the Children Act 2002 so that the Secretary of State will no longer have the power to direct Welsh local authorities to provide information for the Adoption and Children Act Register.
10. In relation to the preparation of a care plan, the Bill seeks to amend the Children Act 1989 to provide that, in relation to Wales, the Welsh

Ministers, rather than the courts as is currently the case, will have the power to set time limits for the preparation of a care plan by a local authority. The Bill also seeks to clarify that Welsh Ministers will now have powers to 'prescribe' the content and form of the care plan.

Consideration of the Memorandum

11. Given the timeframe within which the Committee must consider and report on the Memorandum, the options available are somewhat limited:

- i. note the Memorandum – the Committee may consider that it is content with the memorandum and report to this effect;
- ii. write to the Minister seeking clarification, prior to the plenary debate, on the points raised in paragraphs 14 and 15 of the legal advice note;
- ii. invite the Minister to attend a meeting of the Committee to answer questions about the Memorandum (given the Committee's work commitments, this is likely to be difficult within the time available and may mean having to ask the Business Committee for additional time to consider the Memorandum).

12. The Committee will also wish to consider how to work with the Children and Young People Committee in order to avoid unnecessary duplication.

Action

13. The Committee is invited to consider and agree its approach.

LEGISLATIVE CONSENT MEMORANDUM

CHILDREN AND FAMILIES BILL

Legislative Consent Motion

1. "To propose that the National Assembly for Wales, in accordance with Standing Order 29.6, agrees that provisions of the Children and Families Bill, relating to amendments to the Children Act 1989 (section 31A (4A)) and sections 125 to 131 of the Adoption and Children Act 2002 in so far as they fall within the legislative competence of the National Assembly for Wales should be considered by the UK Parliament."

Background

2. The Legislative Consent Motion at paragraph 1 above has been tabled by Lesley Griffiths, Minister for Health and Social Services, under Standing Order 29.6 of the Standing Orders ("SO") of the National Assembly for Wales (the "National Assembly"). This Legislative Consent Memorandum is laid under SO29.2. SO29 prescribes that a Legislative Consent Motion must be tabled, and a Legislative Consent Memorandum laid, before the National Assembly if a UK Parliamentary Bill makes provision in relation to Wales for a purpose that falls within the legislative competence of the National Assembly or has a negative impact on that competence.

3. The Children and Families Bill (the "Bill") was introduced into the House of Commons on the 4 February 2013. The Bill can be found at:
<http://services.parliament.uk/bills/2012-13/childrenandfamilies.html>

Summary of the Bill and its Policy Objectives

4. The Bill is sponsored by the Department for Education (DfE) to make legislative changes to reform support to children and families. The first half of the Bill seeks to improve services for children and young people by reforming the systems for adoptions, Looked after Children, family justice and Special Education Needs. The second half seeks to encourage growth in the childcare sector, shared parental leave and ensuring children in England have strong advocates for their rights. The Bill includes provisions relating to;

- (a) Reform of the family justice system in England and Wales¹ to tackle delays in public law cases;
- by implementing a 26 week time-limit for care and supervision cases; reduce the excessive use of experts' reports; remove unnecessary duplication; and ensure the impact of the child is considered when timetabling decisions are made, and
 - in private family law - by requiring parents to attend a family mediation and assessment meeting before applying to court; send a clear signal to separated parents that courts will take account of the principle that both

¹ FJR review of the family justice system for England and Wales and written statement
<http://wales.gov.uk/topics/childrenyoungpeople/parenting/help/justice/;jsessionid=F5E2D1B1C006F79F4176E6D249D006D4?lang=en>
<http://wales.gov.uk/about/cabinet/cabinetstatements/2012/familyjusticereviewupdate/?lang=en> ,

Annexe 1

should continue to be actively involved in their children's lives where that is safe and consistent with the child's welfare; and introduce a new "child arrangements order" so that the courts can make full use of powers to direct parents to undertake activities aimed at helping them to make child arrangements work; and streamline divorce processes for the courts.

- (b) Adoption to deliver on reforms to; reduce delays in the adoption system; widen the use of 'Fostering for Adoption'; improve the support available to adopters and the arrangements for the recruitment and assessment of prospective adopters and to make the Adoption and Children Act Register on a statutory register in its application to England.
- (c) Looked after children: the need to reform the contact arrangements between a child in the care of the local authority and their birth family and certain other people, and to require every local authority in England to designate an officer to act as its 'Virtual School Head' (VSH) for the children it looks after.
- (d) To reform the Special Educational Needs (SEN) system in England to; improve support for 16-25 year olds, offer a personal budget to children and families, require better collaboration between services; clearer information about the support available; streamline assessment processes and plans.
- (e) Shared Parental Leave and Flexible Working; to introduce a system for shared parental leave and shared statutory parental pay as well as reform the system that gives individuals the right to request flexible working.
- (f) Childcare, to increase flexibilities for childminders by the introduction of childminder agencies.
- (g) Office of the Children's Commissioner for England – to enhance the commissioner powers in promoting and protecting children's rights and greater independence from UK Government. The changes will apply to the Commissioner's role in promoting and protecting the rights of children in the devolved administrations, but only in relation to non-devolved matters.

5. With the exception of 4 (b) (c) (d) and (f) above provisions in the Bill extend to Wales.

Provisions in the Bill for which consent is sought

6. The provisions for which consent is sought are contained within Part 1, clause 6 and Schedule 1, and Part 2, clause 15 (2) of the Children and Families Bill, and relate to:

- (i) the dis-application of the Adoption and Children Act Register to Wales;

Provisions in relation to the Adoption and Children Act Register amend sections 125 – 131 of the Adoption and Children Act 2002 so that the Secretary of State will not have the power to direct Welsh local authorities to provide information for the register, and the Order in Council provision (which is the current secondary legislation vehicle) is to be removed and replaced with a regulation making power on the Secretary of State.

The provisions relate to the issues that are within the legislative competence of the Assembly, in that they concern adoption. Adoption is a matter within subject heading 15 of Schedule 7, Government of Wales Act 2006.

- (ii) the preparation of a care plan;

Annexe 1

This provision prescribes that, in relation to Wales, the Welsh Ministers have the regulation making powers in respect of setting time limits for the preparation of a care plan by a local authority (a power that is currently vested in the courts).

7. The proposed new section 31A reads as follows:

- (1) *Where an application is made on which a care order might be made with respect to a child, the appropriate local authority must, within such time as may be prescribed prepare a plan (“a care plan”) for the future care of the child.*
- (2) *While the application is pending, the authority must keep any care plan prepared by them under review and, if they are of the opinion some change is required, revise the plan, or make a new plan, accordingly.*
- (3) *A care plan must give any prescribed information and do so in the prescribed manner.*
- (4) *For the purposes of this section, the appropriate local authority, in relation to a child in respect of whom a care order might be made, is the local authority proposed to be designated in the order.*
- (4A) *In this section prescribed*
 - (a) *in relation to a care plan whose preparation is the responsibility of a local authority for an area in England, means prescribed by the Secretary of State: and*
 - (b) *in relation to a care plan whose preparation is the responsibility of a local authority in Wales, means prescribed by the Welsh Ministers.*
- (5) *In section 31(3A) and this section, references to a care order do not include an interim care order.*
- (6) *A plan prepared, or treated as prepared, under this section is referred to in this Act as a “section 31A plan”.*

8. There are 2 elements of Section 31A that are to be amended and they are underlined above:

- Firstly, under the current provision the time limit for the preparation of the care plan is determined by the court. However, the new provision will amend section 31A(1) and will remove the power of the court to set the time limit and instead impose a regulation making power upon Welsh Ministers (in relation to Wales) to set such a time limit.
- Secondly, the clause creates a new provision, section 31A(4A) which is intended to supplement the current section 31A(3) which states:

“A care plan must give any prescribed information and do so in the prescribed manner.”

9. The word “prescribed” was never defined when the original and subsequent amendments have been made to this provision. The new section 31A(4A) clarifies the position by prescribing that the Secretary of State has the function in relation to England and the Welsh Ministers in relation to Wales.

10. Both of the proposed amendments to section 31A fall within the legislative competence of the Assembly in that they concern care planning – a subject which falls

Annexe 1

within Schedule 7 , Subject 15 (social welfare)and is concerned with social services, protection and well being of children and the care of children.

Interdependency with the Social Services & Wellbeing (Wales) Bill

11. Local authorities duties to provide a plan for children with care and support needs, including looked after children, is contained within the Social Services and Well-being (Wales) Bill. This is a holistic plan that sets out the health, education, physical, emotional and social development of a child including with whom and where the child lives etc. It is intended that the section 31A plan (court plan) required under the Children Act 1989 will be a component part of the holistic plan local authorities will be required to prepare under Part 4 (section 38-39) of the Social Services and Well-being (Wales) Bill. Therefore in practice a child will have one integrated plan.

12. The Social Services and Well-being (Wales) Bill (Part 9, section 151) provides for Welsh Ministers to direct local authorities to enter into joint arrangements in relation to their functions for the maintenance of adoption services. It enables the Welsh Ministers to deliver on the national adoption support service that will also consider the future development of a national adoption register for Wales.

Advantages of utilising this Bill

13. Family law and proceedings are not devolved and it is the Welsh Government's view that this UK Bill represents the most appropriate and proportionate vehicle to enable the provisions on family justice reforms to apply in relation to public bodies in Wales. It will also ensure there is a consistent approach across England and Wales in the family justice courts handling of family law cases, and local authorities and Welsh Family Proceeding Officers (Cafcass Cymru) handling of cases in relation to public and private law proceedings

14. Local authorities' functions for adoption of children are devolved. The new provisions in the Children and Families Bill provided a timely opportunity to legislate to dis-apply the pre-existing provisions in relation to Wales.

Financial implications

15. There are no anticipated financial implications for the Welsh Government associated with the provisions discussed in this memorandum. Local authorities will as they do now be required to make a care plan for a child who they are looking after. Changes under the SS&W Bill also provide for integration of plans for children with care and support needs – including the requirements under Section 31 (Children Act 1989) a court plan. Similarly provisions to make the Adoption and Children Act Register a “*statutory register*” do not extend to Wales, and therefore there are no financial burdens anticipated.

Lesley Griffiths
Minister for Health and Social Services

Paratowyd y ddogfen hon gan gyfreithwyr Cynulliad Cenedlaethol Cymru er mwyn rhoi gwybodaeth a chyngor i Aelodau'r Cynulliad a'u cynorthwywyr ynghylch materion dan ystyriaeth gan y Cynulliad a'i bwyllgorau ac nid at unrhyw ddiben arall. Gwnaed pob ymdrech i sicrhau bod y wybodaeth a'r cyngor a gynhwysir ynddi yn gywir, ond ni dderbynnir cyfrifoldeb am unrhyw ddibyniaeth a roddir arnynt gan drydydd partïon.

This document has been prepared by National Assembly for Wales lawyers in order to provide information and advice to Assembly Members and their staff in relation to matters under consideration by the Assembly and its committees and for no other purpose. Every effort has been made to ensure that the information and advice contained in it are accurate, but no responsibility is accepted for any reliance placed on them by third parties

Legal Advice Note

LEGISLATIVE CONSENT MEMORANDUM CHILDREN AND FAMILIES BILL

Background

1. On the 12th February 2013, Lesley Griffiths AM, Minister for Health and Social Services gave notice of a motion in the following terms –

“To propose that the National Assembly for Wales, in accordance with Standing Order 29.6, agrees that provisions of the Children and Families Bill, relating to amendments to the Children Act 1989 (section 31A (4A)) and sections 125 to 131 of the Adoption and Children Act 2002 in so far as they fall within the legislative competence of the National Assembly for Wales should be considered by the UK Parliament.”
2. The Legislative Consent Memorandum (“LCM”) was considered on the 19th February 2013 by the Business Committee, who agreed that the LCM could be considered by both the Children and Young Persons Committee (“the CYP Committee”) and the Health and Social Care Committee (“the HSC Committee”) because the provisions in the Bill for which consent was sought related to sections in the Social Services and Well-being Bill that were being scrutinised by both Committees. The Legislative Consent Motion is due to be debated in plenary on Tuesday 16 April 2013. This Note is intended to inform that consideration.

The Bill

3. The Bill was introduced in the House of Commons on the 4th February 2013. The Bill can be found at -
<http://services.parliament.uk/bills/2012-13/childrenandfamilies.html>

4. The main purpose of the Bill (according to the Explanatory Note) is to make legislative changes to reform support to children and families. The first half of the Bill seeks to improve services for children and young people by reforming the systems for adoptions, Looked after Children, family justice and Special Educational Needs. The second half seeks to encourage growth in the childcare sector, shared parental leave and ensuring children in England have strong advocates for their rights.

Legislative Competence

5. The LCM identifies the Assembly's legislative competence under 'Adoption' and 'Social Welfare' under Schedule 7, subject 15 of the Government of Wales Act 2006 ("GOWA 2006") as being relevant.

Provisions in the Bill for which consent is sought

6. Paragraph 6 of the LCM lists the provisions for which consent are sought. They are contained within Part 1, clause 6 and Schedule 1, and Part 2, clause 15(2) of the Children and Families Bill.

Adoption register

7. Part 1, clause 6 and Schedule 1 makes changes in relation to the law on adoption. The provisions amend sections 125 to 131 of the Adoption and Children Act 2002 so that the Secretary of State will no longer have the power to direct Welsh local authorities to provide information for the Adoption and Children Act Register.
8. This change has been made with the foresight that the Welsh Ministers will make plans of their own in relation to a Welsh adoption register. Section 151 of the proposed Social Services and Well-being Bill provides for Welsh Ministers to direct local authorities to enter into joint arrangements in relation to their function for the maintenance of adoption services. The LCM states that this will allow the Welsh Ministers to deliver on the national adoption support service that will also consider the future development of a national adoption register for Wales.

The preparation of care plans

9. Clause 15(2) of Part 2 of the Children and Families Bill amends the Children Act 1989 and inserts a new section 31A. The new section provides that in relation to Wales, the Welsh Ministers will have the regulation making powers in respect of setting time limits for the preparation of a care plan by a local authority, a power that is currently vested in the courts.

10. The new provision inserted into the Children Act 1989 will also state that “a care plan must give any prescribed information and do so in the prescribed manner.” The word “prescribed” was never defined in the original enactment or in any of the subsequent amendments. However, the new section 31A(4A) clarifies the position by stating that the Secretary of State will have the function in relation to England and the Welsh Ministers in relation to Wales.
11. The Social Services and Well-being Bill also sets out provisions by placing duties on local authorities to provide a plan for children with care and support needs, including looked after children. The care plans are intended to set out in detail the health, education, physical, emotional and social development of a child including with whom and where a child lives. It is intended that the section 31A plan (court plan) required under the Children Act 1989 will be a component part of the holistic plan local authorities will be required to prepare under Part 4 (section 38-39) of the Social Services and Well-being Bill. Therefore, in practice a child will have one integrated plan.

Conclusion

12. It is the view of Legal Services that the Bill will make provision in relation to Wales, for a purpose within the Assembly’s legislative competence.
13. Standing Order 29.7 provides that the Assembly must consider a legislative consent motion which has been tabled.
14. The Committee may wish to consider and question why these provisions were not included within the Welsh Government’s Social Services and Well-being Bill, as they do inter-relate with provisions contained within it and this would have complemented the Welsh Government’s intention to consolidate legislation wherever possible. Although the provision in relation to care plans does remove a power vested in the Court, and family law and proceedings are not devolved, if these provision were planned in any event, timely inter-governmental discussions might have allowed these provisions to be contained in the Social Services and Well-being Bill.
15. The Committee may also consider asking the Minister what transitional measures, if any, are being put into place in relation to the dis-application of the Adoption and Children Act register to Wales and whether or not Welsh Ministers have considered a timeframe for introducing a new national adoption register for Wales.

Health and Social Care Committee

Meeting Venue: **Committee Room 1 - Senedd**

Meeting date: **Wednesday, 20 February 2013**

Meeting time: **09:01 - 12:28**

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http://www.senedd.tv/archiveplayer.jsf?v=en_200000_20_02_2013&t=0&l=en

Concise Minutes:

Assembly Members:

Mark Drakeford (Chair)
Mick Antoniw
Rebecca Evans
William Graham
Elin Jones
Darren Millar
Lynne Neagle
Gwyn R Price
Jenny Rathbone
Lindsay Whittle
Kirsty Williams

Witnesses:

Lesley Griffiths, Minister for Health and Social Services
Pat Vernon, Welsh Government
Grant Duncan, Welsh Government
Sarah Wakeling, Welsh Government
Phil Walton, NHS Blood and Transplant

Committee Staff:

Sarah Beasley (Clerk)
Sarah Sargent (Deputy Clerk)
Steve George (Clerk)
Victoria Paris (Researcher)
Joanest Jackson (Legal Advisor)
Robin Wilkinson (Researcher)
Gwyn Griffiths (Legal Advisor)

TRANSCRIPT

View the [meeting transcript](#).

1. Introductions, apologies and substitutions

1.1 Apologies were received from Vaughan Gething.

2. Human Transplantation (Wales) Bill: Stage 1 – Evidence session 11

2.1 The Committee heard evidence from Lesley Griffiths AM, the Minister for Health and Social Services; Dr Grant Duncan, Deputy Director Medical Directorate, Welsh Government; Pat Vernon, Policy Lead for the Bill; and Sarah Wakeling, Legal Services, Welsh Government.

3. Human Transplantation (Wales) Bill: Stage 1 – Evidence session 12

3.1 The Committee heard evidence from Phil Walton, Team Manager (South Wales SNODs), Donor Care and Co-ordination, NHS Blood and Transplant.

4. Papers to note

4.1 The Committee noted the minutes of the previous meeting, the Committee's forward work programme, and the supplementary evidence from both Professor Vivienne Harwood and the Kidney Wales Foundation in relation to the Human Transplantation (Wales) Bill.

5. Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business: Consideration of the Draft Report

5.1 The Committee resolved, in accordance with Standing Order 17.42(vi), to meet in private for item 6.

6. Recovery of Medical Costs for Asbestos Diseases (Wales) Bill: Consideration of the Draft Report

6.1 The Committee considered this item in private session.

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



Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref LF/LG/0071/13

Mark Drakeford AM
Chair, Health and Social Care Committee
National Assembly for Wales

7

February 2013

Dear Mark,

Human Transplantation (Wales) Bill: Consultation submission from Professor John Fabre

Thank you for your letter of 30 January 2013 drawing my attention to the submission you received from Professor John Fabre of Kings College, University of London. I feel it is important to respond to the serious suggestions our Explanatory Memorandum is incorrect and our case for the Human Transplantation (Wales) Bill is not justified by the international evidence.

I have been provided with an overview of the robust international research attached, developed by our Social Research officials. This illustrates the wide consensus in research papers which consistently categorise Spain as a country with an opt-out system of legislation. It reiterates the conclusion of the research we published in December, that is opt-out laws are associated with increased organ donation rates and increased willingness to donate. I hope this analysis is helpful in considering Professor Fabre's comments.

We stand by the text of the Explanatory Memorandum. The Spanish Government's website points to the adoption of appropriate legislation as one element of the success of the "Spanish Model" for organ donation. We have always said while the law is just one part of the framework for a successful organ donation system, opt-out legislation influences societal behaviours leading to it being a norm across society. Clearly this is alongside the commitment for a comprehensive communication package.

I would add we are not seeking to emulate the law or practice of any particular nation. Some have reservations about the practice in Spain of approaching families repeatedly and

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with persistence. We are developing an organ donation system which is right for Wales, taking full account of international law, practice and evidence of outcomes.

Please let me or my officials know if we can be of any further assistance in considering the international evidence.

Your later letter of 5 February is receiving attention.

Regards
Lesley

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

Academic literature and the organ donation system in Spain

The following papers – all judged to be methodologically robust by Rithalia et al (2008) and/or Welsh Government (2012) – found that opt-out systems for organ donation are associated with increased organ donation rates or increased reported willingness to donate:

Author(s)	Findings	Data
Gimbel et al (2003)	Countries that practiced presumed consent had, on average, and extra 6.14 donors PMP compared to countries that practiced informed consent.	Data from 28 countries from the years 1995-1999.
Healey et al (2005)	Organ donation rates were greater by 2.7 donors PMP in countries with presumed consent legislation compared to informed consent countries.	Data from 17 countries over period 1990-2002.
Abadie & Gay (2006)	Countries with presumed consent legislation had 25-30% higher organ donation rates than informed consent countries.	Data from 22 countries over the period 1993-2002.
Neto et al (2007)	Presumed consent countries produced 21-26% higher organ donation rates compared to countries with informed consent legislation.	Data from 34 countries over a five year period.
Mossialos et al (2008)	Individuals living in presumed consent countries were between 17-29% more likely to report willingness to donate their own organs and 27-56% more likely to report that they would be willing to consent to the donation of their relatives' organs, compared to respondents living in explicit consent countries.	Individual-level survey data from participants living in 15 European countries.
Bilgel (2012)	Countries with presumed consent legislation have on average 13-18% higher organ donation rates than countries with informed consent legislation.	Data from 24 countries over the period 1993-2006.

Of the papers, only Gimbel et al (2003) classify Spain as an informed consent country 'in practice'. However, Spain is omitted from the analysis as it is treated as an outlier. All of the other papers listed above classify Spain as a presumed consent country.

The Gimbel paper is notable for classifying other countries as informed consent in practice (including France, Italy and Norway) that other studies have classified as presumed consent. As noted by Rithalia et al (2008: 28), there is a difference between the legislation itself and how it is implemented in practice – and Gimbel classified countries according to their methods of implementation.

The study by Rithalia et al is a summary of the evidence on the impact of opt-out systems at the time, and noted that Spain's legislation was based on "presumed consent".

Rithalia et al provide further explanation of how organ donation consent laws function in practice in different countries, including Spain, which is defined as having a weak/soft version of presumed consent:

"In practice, the ways in which these laws function differ between countries and even regions. It is rare that a country will have a 'pure' informed or presumed consent system and it is common for there to be provision for the involvement of relatives within each legal system. The importance placed on relatives' opinions varies. The terms hard/strong and weak/soft have been used to describe the extent of emphasis placed on relatives' views. For example, though both Spain and Austria have a presumed consent law, in Spain the law is considered 'weak/soft' as doctors take active measures to ascertain that the next of kin does not object. In Austria the law is relatively 'strong/hard' in that organ recovery proceeds unless it is known that the deceased objected prior to death, and the views of relatives are not actively sought."

Rithalia et al (2008: 14)

References

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



Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref LF/LG/0089/13

Mark Drakeford AM
Chair
Health and Social Care Committee
National Assembly for Wales

14 February 2013

Dear Mark,

Human Transplantation (Wales) Bill: emerging issues

Thank you for your letter of 5 February setting out a number of issues and questions arising from the evidence you have been gathering on the Human Transplantation (Wales) Bill.

I deal with each of your points in turn at Annex 1. There is one key point I wish to emphasise. The international evidence continues to make an association between improved rates of consent and countries which have introduced an opt-out system. I aspire for Wales to be amongst these best performing countries, on a sustainable basis.

The evidence you have taken highlights the complexity and the variety of issues and opinions which are involved with organ donation. What gives me confidence is the success others continue to have. With vision and determination all these issues have practical solutions. The core principle is simple: improving our consent system to help save and improve lives. I note with interest the announcement from Northern Ireland that they will also be consulting on a soft opt-out system for consent to deceased organ donation.

I look forward to attending Committee again on 20 February for my final evidence session.

Regards

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
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Annex 1

Human Transplantation (Wales) Bill: response on some of the emerging issues

1. Practical difficulties in determining whether consent can be deemed to have been given, and whether this could lead to fewer donors

The international evidence does not support this. It rather indicates the exact opposite. Countries with opt-out systems are associated with higher rates of donation. In Wales we will have a two-year communication campaign which will highlight the subject of organ donation and encourage discussion within families. Unlike now, people will be able to register a clear yes or no to donation. Where they do neither, it will be in the knowledge their consent will be deemed; but qualifying relations can provide information about whether the deceased would have objected. I believe this will provide a framework for greater clarity of individual wishes, which in turn will provide comfort to families who will be much clearer about their loved one's wishes

I agree the new arrangements will of course result in some change in practice in terms of the consent process. We are working with NHS Blood and Transplant and the Human Tissue Authority on the practicalities of adapting the current consent process in order to deal with the requirements of the new legislation. The existing questionnaire for donor families already contains a number of substantive questions, and I do not believe the new system will add to this significantly. In most cases, questions about residency and mental capacity will be straightforward to determine as part of the process.

The type of questions asked of families, even today, may seem intrusive and unnecessary to those of us not involved in the organ donation process. However, the skill and training of the Specialist Nurses means they are approached sensitively and with care. I believe the requirements of the new system can be carefully woven into the conversation and will not cause significant difficulty for staff or families. Other countries manage it well and so can we.

2. Donation after Brain Death (DBD) and Donation after Circulatory Death (DCD)

You have asked for an explanation of the terms DBD and DCD and how the Bill applies in relation to them.

Donation after Brain Death (DBD) may take place where death is confirmed following neurological tests to establish whether the patient has any remaining brain function. Patients declared brain dead may have suffered head trauma, for example in a car accident, or a massive stroke. These patients are sometimes also called “heart-beating donors” because the circulatory system is maintained through a ventilator whilst consent is established and until the donation takes place.

Donation after Circulatory Death (DCD) may take place following diagnosis of death by cardio-respiratory criteria. These patients are called “non heart-beating donors” because death follows the cessation of the body's cardio-respiratory functions. DCD may be either “controlled” which describes organ retrieval which follows the planned limitation or withdrawal of treatment at the end of a critical illness from which the person will not recover; or “uncontrolled” which occurs following a sudden, irreversible cardiac arrest. Uncontrolled DCD is rare in the UK at present.

In either DBD or DCD, it is important to separate decisions about the care and treatment of the patient from decisions about organ donation and you have heard evidence in Committee to that effect. The provision in the Bill and the introduction of a system of deemed consent do not alter this in any way. The Bill, as in the current Human Tissue Act, makes it lawful to take steps to preserve part of a body for potential transplantation, including in those situations where it is still being established if a decision on consent has been or will be made. Having a system of deemed consent does not somehow make it “easier” to retrieve organs or exert undue influence over decisions around the care and treatment of a patient. It merely indicates the deceased individual may have had no objection to the idea of organ donation and informs the conversation with family members which may then ensue.

The Bill deals with consent to donation and does not alter *any* current practice in terms of the diagnosis of death. I am aware of Professor Harpwood’s evidence to the Committee but, with respect, I do not agree that we should define these terms in the legislation. There is no current statutory definition of death/deceased person, but rather a duty exists in the Human Tissue Act 2004 and as amended by our Bill to empower the HTA to issue guidance on the matter. There have also been a number of documents issued by the Academy of Royal Colleges and the UK Donation Ethics Committee to guide medical and ethical practice in this area, providing the necessary consistency across the UK. Whilst I appreciate Professor Harpwood’s view that we could start with a clean slate in Wales and choose to define these matters, I do not think this is something which we should be seeking to include in our legislation.

However, in light of both Professor Harpwood and Sally Johnson’s comments, officials are reviewing the use of the word “deceased” in section 12 of the Bill in the context of taking steps for preservation for transplantation.

3. Registration of wishes

Under the new arrangements, people will have a choice to either register a wish to be a donor (opt in); register a wish not to be a donor (opt out) or do nothing, in which case their consent may be deemed to have been given. The register will not record people whose consent will be deemed.

Our policy preference is for a single UK register which will contain any recorded wish because this is the solution which poses least risk when it comes to identification. We are in discussion with the other UK Health Departments about whether we should use this opportunity of a change in the law in Wales to redevelop the existing Organ Donor register (ODR) for the whole of the UK. This would future-proof the register, and is the most cost effective proposal. We have received positive responses from all the UK Governments and will be setting up an all-country meeting shortly. One of the key issues is to ensure a decision to opt out taken by a Welsh resident is available to clinicians in other parts of the UK, since any recorded decision of the deceased will have to be taken into account under the Human Tissue Act 2004 and the Human Tissue (Scotland) Act 2006. Having a single register for the whole of the UK, capable of showing these details, will resolve this situation.

In terms of people who have currently opted-in to the ODR in Wales, our intention is they will be contacted and asked to confirm their decision in light of the new legislation. It would certainly be possible for someone to remove themselves from the opt-in register and choose to be classified as having their consent deemed. However, I think this unlikely to happen in most cases, since I can think of no advantage to doing so. We will be encouraging people who have already made a formal decision to be a donor to keep that decision on record. It is of course possible for someone to change their recorded opt-in wish to an opt-out wish

but the intention of doing so by large numbers of people is not supported by the results of our public attitudes survey.

4. Appointed representatives (section 7)

The ability to appoint a representative to make the decision about organ donation is something which exists under the existing Human Tissue Act 2004 and which will continue under our new legislation. Even now, there exists a small risk of the appointed representative not being present at the time donation is discussed, and other family members being unaware of the appointment. Under the current law, it is possible that family members would be asked to take the decision about donation if no-one knew about the existence of an appointed representative.

Under the new system, I understand concerns have been raised in Committee that in a situation as described above, where the appointed representative is not known about, the person's consent could then go on to be deemed. We intend to allow for further clarification and safeguards of the deceased's wishes by providing for the recording of the appointed representative on the register, something which does not happen now.

However, it could be possible for an appointment to be made either orally, or in writing, and for the person not to have recorded the appointment on the register. Therefore, the communications campaign will encourage people who decide to appoint a representative to tell other family members about their decision.

Where more than one representative has been appointed, only one of them needs to give consent, unless the terms of the appointment state they must act jointly. This is in line with guidance set out in the current Human Tissue Authority Code of Practice.

5. Coroners (section 13)

The Bill makes no changes regarding the role of the Coroner – section 13 of the Bill on Coroners replicates the effect of section 11 of the Human Tissue Act 2004. In some cases the person's death may come under the jurisdiction of the Coroner and so donation cannot go ahead without his or her agreement. This could include the steps necessary to preserve part of a body for transplantation as I have mentioned above. The Bill does not change the timescales involved in this process and hospitals will already have local arrangements in place with their Coroner, which I expect to continue.

6. Codes of Practice (section 14)

I intend to make available to the Committee a briefing on the likely content of the Code of Practice in time for Stage 3. We will continue to liaise with the HTA about the overall timescales for the actual draft Code as well as its content, and seek to accelerate this if possible.

7. Relevant material (section 16)

It is our clear policy intention that deemed consent will not apply to so-called "novel" forms of transplantation. The types of transplant being discussed (i.e. hand, face) are known as composite tissue transplants and even under the current system, they are dealt with differently. Current practice, which has been endorsed by the Human Tissue Authority, is to require the express consent of family members even if the deceased person is on the ODR.

However, I understand the concerns being raised and I am currently considering this issue.

8. Interpretation (section 17)

I am aware there has been discussion in Committee about the ranking of relationships, how disagreements between families will be resolved, etc. and some confusion about the lists and why one is ranked and the other is not. Briefly, the difference in the list is predicated on the actions being required of the qualifying relations, as I will explain below. Effectively there are two lists of qualifying relationships in the Bill, each with the same people on them, each there for different purposes.

The first *unranked* list exists for the purposes of deemed consent. Any person on the list at section 17(2) may provide information as to whether the deceased may have objected to their consent being deemed. The reason this list is not ranked is because those people are not being asked to make a *decision* on donation, but rather to provide *information*. This is because the deceased has already made a decision to have their consent deemed and the law will recognise this as a valid consent, unless a person on that list can say otherwise. In practice, this does not mean every person on the list has to be contacted; clearly that would be unworkable. However, it provides the opportunity for those people present to say whether they know or think anyone else might know, if the deceased would have objected. As indicated above, in practical terms this will be worked into the conversation so as to encourage the people present to think about the question and whether anyone else should be contacted and asked if they have any information. This is an important additional safeguard in relation to deemed consent: ranking the list would reduce the opportunity to say whether the deceased would have objected.

The second *ranked* list only applies to people who do not fall within the deemed consent arrangements, i.e. excepted adults and children. For these deceased individuals, if they have not expressed a wish themselves, the decision on donation passes to the person at the top of the hierarchy of qualifying relationships. The list is ranked because when a decision is called for, it would be impossible to give everyone on the list equal ranking as this would run the risk of no decision ever being taken. Therefore, in relation to express consent, we are not changing the current system and have retained the ranked relationships as provided for in the Human Tissue Act 2004.

It is not the case that an objection by someone in a qualifying relationship would be enough to prevent donation taking place. As happens now, disagreements amongst family members have to be carefully handled with emphasis being placed on open and sensitive discussions. The focus should be on the deceased person's wishes wherever possible, but healthcare professionals are not there to traumatise family members by insisting on donation. Each case has to be dealt with individually and in accordance with best practice which will be set out in the Code.

I have covered your query about the definition of death/deceased under answer number 2 above.

9. Costs

You have asked for my observations on evidence put to the Committee that we have not taken account of costs to the NHS in Wales in removing organs for donation which are then used in transplants elsewhere in the UK. The Explanatory Notes contains a very thorough financial impact assessment on the legislation and show the financial benefits an increased number of donated organs could bring, including an analysis based on an assumption that only 30% of the organs are used in Wales.

I do appreciate the point which is being made however. The allocation and use of organs has always been done on a UK-wide basis and for very good reason this will continue under our new soft opt-out system. The cross border nature of the transplantation programme means it is not always a simple matter to directly attribute costs and savings to particular organisations – there is nothing particularly new in that – however the NHS in the UK and society as a whole benefits. I do not dismiss the point being made, but I feel these are relatively minor considerations in the overall scheme of things, and can detract from the wider aim of the legislation.



Ref: DDG/jld

25 January 2013

Mark Drakeford AC AM
Chair
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Dear Mr Drakeford

Re: Health and Social Care Committee Consideration of LHB Service Reconfiguration Plans

Ysgol Addysg
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Neuadd Meirionnydd
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Thank you again for the opportunity to meet with members of the Health and Social Care Committee to discuss service reconfiguration plans.

Further to your letter dated 14 January please below and attached further information addressing the questions raised which should hopefully provide the necessary clarification.

1. The number of training posts available in each specialism in each of the past 3 years.

Appendix 1 details the number of training posts managed by the Wales Deanery in August 2010, 2011 and 2012. As you will see there is a slight overall variation in the number of posts. These changes are due to strategic shifts, for example The Wales Deanery has invested in new emerging specialties such as Acute Medicine and Community Sexual and Reproductive Health. Any reductions in posts have been made for a number of reasons, for example in Paediatrics fixed term unattractive posts were converted to substantive long term training programmes leading to the certificate of completion of training (CCT). For General Practice variations in posts numbers are due to recruitment difficulties and a pilot extension to the training scheme in 2010.


2. The number of training post vacancies in each specialism in each of the past 3 years.

The basic salary for the majority of training posts is 50% funded by the Deanery and 50% funded by the Health Board. The Deanery would like to stress that in the event that a post is vacant the 50% funding provided by the Deanery to the Health Board continues to enable a service appointment to be made and funded without extra cost to the Health Board. Due to the fluid nature of vacancies it is difficult to provide meaningful information to the question; therefore please find attached copies of the Vacancy Matrix Reports provided to the Medical Directors at their meeting of the Medical Directors Executive Group. Appendices 2a, 2b and 2c provide a snapshot of the number of training vacancies in each of the Health Boards for the main specialties in August 2010, 2011 and 2012 respectively.

3. The underspend forced by the inability to fill these trainee posts in each of the past 3 years.

As discussed above the Deanery continues to provide the Health boards with funding if a post remains vacant and as a result there is no underspend. Where posts remain vacant for 12 months or more a strategic review will be undertaken of the posts to determine whether funding should be invested in the future. The Deanery would only reduce the funding to the Health Boards when Training posts are fully dis-established for training purposes

Yours sincerely

A handwritten signature in black ink, appearing to read 'Derek Gallen', with a long horizontal flourish extending to the right.

Professor Derek Gallen
Postgraduate Dean and Head of School

Training Grade Post Summary August 2010 to August 2012			
Specialty	Aug-10 Number of posts	Aug-11 Number of posts	Aug-12 Number of posts
Foundation Training Programme	678	678	678
Acute medicine		9	11
Anaesthetics (Core Training)	133	118	118
Anaesthetics (Higher Training)	130	129	129
Audiovestibular medicine	1	1	1
Cardiology	43	43	43
Cardio-thoracic surgery	12	12	12
Chemical pathology	5	5	5
Child & Adolescent Psychiatry	12	12	13
Clinical genetics	9	7	8
Clinical immunology and allergy	1	1	1
Clinical Neurophysiology	1	1	1
Clinical Oncology	18	19	18
Clinical pharmacology and therapeutics	3	3	3
Clinical Radiology	44	44	44
Core Medical Training	222	223	229
Core Psychiatry Training	93	97	90
Cor Surgical Training	172	171	147
Community Sexual & Reproductive Health			2
Dermatology	12	13	13
Emergency Medicine	59	57	56
Endocrinology and diabetes mellitus	27	28	28
Forensic psychiatry	8	8	8
Gastroenterology	23	23	23
General Adult Psychiatry	36	36	37
General medicine	9		
General Practice	259	225	233
General surgery	62	62	62
Genito-Urinary Medicine	4	4	4
Geriatric medicine	44	43	47
Haematology	21	21	21
Histopathology	20	21	21
Infectious diseases	3	3	3
Intensive Care Medicine	18	20	21
Medical microbiology and Virology	10	10	10
Medical oncology	4	4	4
Neurology	11	12	12
Neuropathology	1	1	1
Neurosurgery	5	5	5
Nuclear medicine	1	1	1
Obstetrics & gynaecology	117	116	115
Occupational Medicine	9	8	9
Old age psychiatry	8	8	8
Ophthalmology	21	21	22
Oral and maxillofacial surgery	11	11	11
Otolaryngology	16	16	16
Paediatric neurology	1	1	1
Paediatric surgery	2	2	2
Paediatrics	177	181	174
Palliative medicine	17	17	17
Plastic surgery	11	12	12
Psychiatry of Learning Disability	9	9	9
Psychotherapy	1	1	1
Public health medicine	36	36	36
Rehabilitation Medicine	1	1	1
Renal medicine	16	16	16
Respiratory medicine	31	31	31
Rheumatology	10	10	10
Sports and Exercise Medicine	1	1	1
Trauma & Orthopaedic Surgery	52	52	52
Urology	14	16	16
Total	2775	2736	2723

The Wales Deanery – Vacancy Matrix (accurate 28th July 2010)

Health Board	Hospital	Medicine	Paediatrics	Emergency Medicine	Anaesthetics	Surgery	Obstetrics & Gynaecology
Aneurin Bevan	Gwent	2/34	2/17	0/7	1/13	0/25	0/12
	Nevill Hall	0/13	1/9	0/6	1/12	0/9	1/7
	Caerphilly	0/9					
Cardiff and Vale	UHW	0/45	4/32	0/13	4/12	0/30	0/15
	Llandough	0/13				0/10	
	Rookwood	0/3					
Velindre	Velindre	0/7					
	Holme Towers	0/2					
Cwm Taf	Royal Glam	0/16	2/14	0/6	1/7	0/14	0/4
	Prince Charles	4/20	0/9	1 GP/3	2/7	2/11	1/6
ABM	POW	2 (1 CT, 1 GP)/23	0/12	1 CT/9	2/10	1/11	0/5
	Neath	2/21					
	Morrison	0/28		0/12	5/28	4/38	
	Singleton	1/17	1/20			1/10	0/9
Hywel Dda	Prince Philip	2/16		0/5		0/3	
	West Wales	0/14	1/7	0/4	1/5	1/16	0/5
	Withybush	2/10	1/7	0/5	0/4	0/5	0/6
	Bronglais	3(2 CT, 1 F2) /9	1/4	1 GP/6		0/6	0/1
Betsi Cadwaladr	Bangor	2(1 CT, 1 GP) /17	1/9	1 GP/7	0/5	3/7	0/5
	Llandudno	0/9					
	Glan Clwyd	3(2 CT, 1 F2)/25	2/13	0/6	0/6	6/17	0/6
	Wrexham	1 GP/22	1/10	2 CT /6	0/6	2/20	0/5
	TOTALS	24 (19 CT + 2 F2 +3GP)	17 ST	6 (3 CT + 3 GP)	15 CT	20 CT	2 ST

Risk Table Key:

Green – currently no vacant posts, Amber – vacancies range between 1% and 25%, Red – number of vacancies exceeds 25%

The number given in each box corresponds to the number of vacancies as of 28th July 2010 at the Core/Lower years levels (i.e. formerly SHO) out of the total number of training posts in that specialty and hospital (includes Specialty Training, F2 and General Practice posts).

This table does not include data on the higher specialty training positions.

Risk Analysis: Core Surgical Training Grade Rotas – August 2011	Wales Deanery 							
	Key to risk rating <table border="1" style="width: 100%;"> <tr> <td>High</td> <td>Gaps>25%</td> </tr> <tr> <td>Medium</td> <td>11%>Gaps>24%</td> </tr> <tr> <td>Low</td> <td>Gaps<10%</td> </tr> <tr> <td>No risk</td> <td>No gaps</td> </tr> </table>	High	Gaps>25%	Medium	11%>Gaps>24%	Low	Gaps<10%	No risk
High	Gaps>25%							
Medium	11%>Gaps>24%							
Low	Gaps<10%							
No risk	No gaps							

Health Board	Site	Number of trainees on rotation (intended)	Actual Number of trainees confirmed on rotation in August 2011	Predicted Number of Training gaps (as of 28/6/10)	Training risk and comments
Cardiff and Vale	UHW	19	18	1	Gap in T&O
	Llandough	3	3	0	
Cwm Taf	Merthyr	6	5	1	Gaps in T&O
	RGH	13	13	0	
Betsi Cadwaladr	Wrexham	14	10	4	Gaps in General Surgery x2, ENT, T&O
	Bangor	13	7	6	Gaps in General Surgery x3, ENT, T&Ox2
	Glan Clwyd	12	9	3	Gaps in T&Ox2, EM
Aneurin Bevan	Royal Gwent	16	16	0	
	Nevill Hall	5	3	2	Gaps in General Surgeryx2
ABMU	Morrison	27	25	2	Gaps in T&Ox2 Existing quality concerns likely to be exacerbated by gaps
	Singleton	2	2	0	
	POW	6	3	3	Gaps in T&Ox3
Hywel Dda	West Wales General	4	4	0	
	Prince Phillip	1	1	0	
	Withybush	5	1	4	Gaps in T&Ox2, General Surgery x2


Risk Analysis: Emergency Medicine Higher Training Grade Rotas (ST4+) – September 2011



Key to risk rating

High	Gaps > 25%
Medium	11% > Gaps > 24%
Low	Gaps < 10%
No risk	No gaps

Health Board	Site	Number of trainees on rotation (intended)	Actual Number of trainees confirmed on rotation in September 2011	Number of Training gaps (as of 28/6/10)	Training risk and comments
Cardiff and Vale	UHW	4	3	1	High
Cwm Taf	Merthyr	2	2*	0	Low
	RGH	1	0	1	High
Betsi Cadwaladr	Wrexham	1	0	1	High
	Bangor	1	1	0	Low
	Glan Clwyd	1	0	1	High
Aneurin Bevan	Royal Gwent	6	2	4	High
	Nevill Hall	1	1	0	Low
ABMU	Swansea	4	1	3	High
	POW	3	2	1	High
Hywel Dda	West Wales General	No higher grade EM trainees in Hywel Dda			
	Prince Phillip				
	Withybush				

Risk Analysis: Middle Grade Rotas and Paediatric Training September 2011	Wales Deanery 							
	Key to risk rating <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>High</td> <td>Gaps>25%</td> </tr> <tr> <td>Medium</td> <td>11%>Gaps>24%</td> </tr> <tr> <td>Low</td> <td>Gaps<10%</td> </tr> <tr> <td>No risk</td> <td>No gaps</td> </tr> </table>	High	Gaps>25%	Medium	11%>Gaps>24%	Low	Gaps<10%	No risk
High	Gaps>25%							
Medium	11%>Gaps>24%							
Low	Gaps<10%							
No risk	No gaps							

Health Board	Site	Number of trainees on rotation (intended)	Actual Number of trainees on rotation in Sept 2011	Number of Training gaps (as of 28/6/10)	Training risk and comments
Cardiff and Vale	UHW PICU	2	2	0	
	UHW general	8	7.8	0.2	
	UHW special	10	9.6	0.4	
	UHW neonates	8	5.6	2.4	
Cwm Taf	Merthyr	5	3.6	1.4	
	RGH	7	5	2	
Betsi Cadwaladr	Wrexham	3	1	2	
	Bangor	4	1.6	2.4	
	Glan Clwyd	3	2	1	
Aneurin Bevan	Royal Gwent	7	6.6	0.4	
	Royal Gwent neonates	6	6	0	
	Nevill Hall	5	4.6	0.4	
ABMU	Swansea General	10	9	1	
	Swansea Neonates	4	3.6	0.4	
	POW	6	3.8	1.2	
Hywel Dda	No middle grade rotations				

Risk Analysis: Psychiatry Core Training Grade Rotas (CT1 – CT3) – August 2011



Key to risk rating

High	Gaps>25%
Medium	11%>Gaps>24%
Low	Gaps<10%
No risk	No gaps

Health Board	Site	Number of trainees on rotation (intended)	Actual Number of trainees confirmed on rotation in August 2011	Number of Training gaps (as of 28/6/10)	Training risk and comments
Cardiff and Vale	Cardiff	13	13	0	NB existing quality concerns
Cwm Taf	Merthyr	7	7	0	
	RGH	8	8	0	
Betsi Cadwaladr	Wrexham	3	2	1	
	Bangor	7	6	1	
	Rhyl	4	4	0	
Aneurin Bevan	Gwent	18	16	2	Existing serious quality concerns related to out of hours cover. Likely to be exacerbated by gaps
ABMU	Swansea	8	7	1	
	Bridgend	9	9	0	
Hywel Dda	Carmarthen	4	3	1	
	Prince Phillip	2	2	0	
	Haverfordwest	2	2	0	

Wales Postgraduate Deanery
Recruitment Risk Analysis

The number given in each box corresponds to the number of vacancies as of 30th July 2012 for the August 2012 intake at the Core/Lower years levels out of the total number of training posts in that specialty and hospital. Please note that this table does not include data on F2 and General Practice posts and also higher specialty training positions.

Risk Table Key:

Green – number of vacancies are less than 11%

Amber – vacancies range between 11% and 24%

Red – number of vacancies exceeds 24%

Health Board	Hospital	Medicine (CMT)	Paediatrics	Anaesthetics	Surgery	Obstetrics & Gynaecology
Aneurin Bevan	Gwent	1 (4)	+0.1 (9)	0 (12)	1 (14)	0 (8)
	Nevill Hall	3 (9)	0 (2)	0 (11)	0 (4)	0 (5)
	Caerphilly	1 (4)	n/a	n/a	n/a	n/a
Cardiff and Vale	UHW	1 (22)	3 (23)	1 (11)	6 (19)	+0.1 (9)
	Llandough	1 (6)	n/a	n/a	0 (2)	n/a
	Rookwood	0 (3)	n/a	n/a	n/a	n/a
Velindre	Velindre	0 (4)	n/a	n/a	n/a	n/a
	Holme Towers	0 (2)	n/a	n/a	n/a	n/a
Cwm Taf	Royal Glam	0 (10)	+0.1 (6)	0 (7)	3 (9)	0 (1)
	Prince Charles	0 (15)	0 (2)	1 (4)	0 (5)	0 (2)
ABM	Princess Of Wales	3 (7)	0 (1)	1 (9)	1 (6)	0 (1)
	Neath	1 (6)	n/a	n/a	n/a	n/a
	Morriston	1 (22)	0 (2)	5 (23)	9 (27)	n/a
	Singleton	1 (7)	1.5 (7)	n/a	1 (2)	0 (1)
Hywel Dda	Prince Philip	1 (7)	n/a	n/a	0 (1)	n/a
	West Wales	3 (9)	0 (2)	1 (4)	2 (4)	0 (2)
	Withybush	2 (10)	1 (4)	0 (3)	2 (5)	1 (3)
	Bronglais	0 (4)	n/a	n/a	n/a	n/a

Betsi Cadwaladr	Bangor	4 (20)	0 (2)	0 (4)	1 (10)	0 (2)
	Llandudno	0 (4)	n/a	n/a	n/a	n/a
	Glan Clwyd	3 (15)	0.9 (9)	0 (6)	3 (9)	0 (3)
	Wrexham	3 (13)	1 (4)	0 (5)	2 (11)	0 (2)

Figures in brackets = no. of posts

Additional Information:

CMT

Figures for CMT – Do not include mat leave vacancies.

There are currently 29 vacancies for CMT out of a total of 203 posts.

All Medical personnel departments advised at each site (and royal college tutors) to try and fill their gaps with LAS's or trust grades for 12 months (if they wish to).

Note: There may be further vacancies, as existing CT2 trainees, whom we have offered additional training time and reserved posts for, obtain PACES and resign from CMT before August 2012.

Anaesthetics

Figures for Anaesthetics do not include vacancies arising from maternity leave or include posts which form ACCS rotations

All 26 CT1 advertised posts have been filled during Round 1.

Any unfilled CT2 posts which remain unfilled after the clearing process have now been released back to the Health Boards for LAS appointments

Paeds. and O&G

Some gaps due to maternity leave and, therefore will not be vacant for full 12 months

Figures with a + are where there is over a 100% fill rate as a result of slot-shares

All recruitment is now complete and all vacant posts have been returned to HBs

Risk Analysis: Core Surgical Training Grade Rotas – August 2012

Key to risk rating

High	Gaps > 25%
Medium	11% > Gaps > 24%
Low	Gaps < 10%
No risk	No gaps

Health Board	Site	Number of trainees on rotation (intended)	Actual Number of trainees confirmed on rotation in August 2012	Predicted Number of Training gaps (as of 30/07/12)	Training risk and comments
Cardiff and Vale	UHW	19	13	6	Gaps = 1x Transplant / 2x cardiothoracic / 3x T&O
	Llandough	2	2	0	
Cwm Taf	Merthyr	5	5	0	
	RGH	9	6	3	Gaps = 1 x general / 2 x T&O
Betsi Cadwaladr	Wrexham	11	9	2	Gaps = 1x general / 1 x T&O
	Bangor	10	9	1	Gap = 1x T&O
	Glan Clwyd	9	6	3	Gaps = 2x T&O / 1x ENT
Aneurin Bevan	Royal Gwent	14	13	1	Gap = 1 x ENT
	Nevill Hall	4	4	0	
ABMU	Morrison	27	18	9	Gaps = 2x plastic / 5x T&O / 1x cardiothoracic / 1x general
	Singleton	2	1	1	Gap = 1x ENT
	POW	6	5	1	Gap = 1x general
Hywel Dda	West Wales General	4	2	2	Gaps = 1x ENT and 1x general
	Prince Phillip	1	1	0	
	Withybush	5	3	2	Gaps = 2x general

Risk Analysis: Middle Grade Rotas and Paediatric Training September 2012

Key to risk rating

High	Gaps > 25%
Medium	11% > Gaps > 24%
Low	Gaps < 10%
No risk	No gaps

Health Board	Site	Number of trainees on rotation (intended)	Actual Number of trainees on rotation in Sept 2012 (as of 30/08/12)	Number of Training gaps (as of 30/07/12)	Training risk and comments
Cardiff and Vale	UHW PICU	5	4.6	0.4	
	UHW general	9	8.4	0.6	
	UHW special	10	10.2	0	+0.2 due to slot share
	UHW neonates	8	6.2	1.8	
Cwm Taf	Merthyr	5	5	0	
	RGH	7	6.6	0.4	
Betsi Cadwaladr	Wrexham	3	2	1	
	Bangor	4	2.6	1.4	
	Glan Clwyd	3	3	0	
Aneurin Bevan	Royal Gwent	7	7	0	
	Royal Gwent neonates	6	5.4	0.6	
	Nevill Hall	5	4	1	
ABMU	Swansea General	10	9	1	
	Swansea Neonates	4	3.8	0.2	
	POW	5	4	1	
Hywel Dda	No middle grade rotations				

Risk Analysis: Emergency Medicine Higher Training Grade Rotas (ST4+) – September 2012

Key to risk rating

High	Gaps>25%
Medium	11%>Gaps>24%
Low	Gaps<10%
No risk	No gaps

Health Board	Site	Number of trainees on rotation (intended)	Actual Number of trainees confirmed on rotation in September 2012	Number of Training gaps (as of 30/07/12)	Training risk and comments
Cardiff and Vale	UHW	4	3	1	
Cwm Taf	Merthyr – Prince Charles	2	2	0	
	RGH	1	0	1	
Betsi Cadwaladr	Wrexham	1	1	0	
	Bangor	1	0	1	
	Glan Clwyd	1	0	1	
Aneurin Bevan	Royal Gwent	6	2	4	
	Nevill Hall	1	1	0	
ABMU	Swansea - Morriston	3	2	1	
	POW	3	2	1	
Hywel Dda	West Wales General	No higher grade EM trainees in Hywel Dda			
	Prince Phillip				
	Withybush				

Risk Analysis: Psychiatry Core Training Grade Rotas (CT1 – CT3) – August 2012

Key to risk rating

High	Gaps > 25%
Medium	11% > Gaps > 24%
Low	Gaps < 10%
No risk	No gaps

Health Board	Site	Number of trainees on rotation (intended)	Actual Number of trainees confirmed on rotation in August 2012	Number of Training gaps (as of 30/07/12)	Training risk and comments
Cardiff and Vale	Cardiff	13	12	1	2 x less than full times trainees
Cwm Taf	Merthyr	5	5	0	
	RGH	8	7.5	.5	1 x less than full time trainee
Betsi Cadwaladr	Wrexham	4	4	0	
	Bangor	5	4.5	.5	1 X less than full time
	Rhyl	4	4	0	
Aneurin Bevan	Gwent	17	14.5	2.5	
ABMU	Swansea	6	3.5	2.5	One of the 3.5 may be taking up a staff grade post. + 1 LTFT
	Bridgend inc Hensol and Caswell	9	8.5	.5	
Hywel Dda	Carmarthen inc Caswell	8	6.5	1	
	Prince Phillip	2	2	0	
	Haverfordwest	2	0	2	

Total number of trainees on rotation – 83

Actual numbers confirmed on rotation – 72.5

Number of training gaps – 10.5

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



Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: SF/LG/3553/12

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

Mark.Drakeford@wales.gov.uk

20 February 2013

Dear Mark,

Following the General Scrutiny Session of the Health and Social Care Committee of 5 December, you wrote to me requesting updates on:

- the provision of neuroscience services in Wales, including a response to a letter you provided from David Maggs, Wales Development Manager, Headway, and;
- the Welsh Government's review of capital expenditure.

The Adult Neuroscience Review includes recommendations relating to the neuro-rehabilitation issues raised by David Maggs. These are being taken forward by Health Boards through their local mechanisms. Overall, progress in implementing the recommendations relating to neuro-rehabilitation has been slower than most of the other recommendations. However, I am assured, by both Betsi Cadwaladr University Health Board and the Directors of Planning Group for Mid and South Wales, progress is being made as set out below.

The North Wales Neurosciences Network has recently established a Rehabilitation Workstream. The aim is to co-ordinate and provide patients with the appropriate level of rehabilitation provision, support and care within the community in which they live and, therefore, the Health Board has established a rehabilitation referral bureau.

Work has been completed in Mid and South Wales to deliver recommended service models for neuro-rehabilitation services and Health Boards are now working to implement them. Improvements so far include better access to in-patient rehabilitation in Mid and South Wales.

Steps have also been taken to ensure the Wales Neurological Alliance is kept fully informed of progress. These arrangements have been strengthened with the Alliance being invited to attend the Health Boards' Directors of Planning meeting next month.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
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In addition, Cardiff and Vale University Health Board has recently submitted an Outline Business Case, seeking investment to support the long term future delivery of specialist neuro and spinal rehabilitation for Mid and South Wales. This is currently being considered.

Finally, I have decided it is appropriate to develop a Delivery Plan for Neurological Conditions. This will clearly set out the Welsh Government's expectations for the future delivery of services.

As we discussed at Committee in December, one of the recommendations of the mid year review is to reconsider the NHS capital programme to ensure it is clearly aligned and supports the vision of healthcare set out in "Together for Health."

This work is currently being undertaken. However, our ability to progress this review is driven by the need to take account of emerging Health Board service change plans. Given NHS organisations are at different stages of their engagement and consultation processes, the review needs to be structured and phased appropriately. Betsi Cadwaladr University Health Board and Hywel Dda Health Board both announced their responses to their consultation exercises in recent weeks. We are now in a position to work with the Health Boards to identify and consider their priorities for strategic investment and to ensure the schemes we are being asked to support will deliver in terms of providing safe, accessible and sustainable services.

The four organisations in the South Wales Programme have completed their engagement exercises and the health boards are currently planning to commence the formal consultation in early May. Powys Teaching Health Board is currently considering the responses to its consultation for services in South East Powys. It would not be appropriate to pre-empt the outcomes to these consultations. However, we are continuing to work closely with organisations so we are well placed to move forwards once the consultation responses are announced.

Regards



Lesley Griffiths AC/AM

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