# APPCOG Parliamentary Inquiry:

# Carbon Monoxide Exposure in Health and Social Care, Risks and Solutions

## Session One Discussions & Outcomes

11 May, 2021 13:40 – 15:30, Chaired by Liz Twist MP

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The All Party Parliamentary Carbon Monoxide Group (APPCOG) is undertaking a parliamentary inquiry chaired by Liz Twist MP to explore the health and social care workforce's awareness levels of CO danger, and to establish how health and social care professionals (HSCPs) might be better protected from the risk of carbon monoxide exposure in domiciliary settings. Sponsorship has been kindly provided by all four of the UK's Gas Distribution Networks, the Gas Industry Safety Group and the Gas Safety Trust.

Session one will examine carbon monoxide as a risk in domiciliary settings, looking at how aware HSCPs are of carbon monoxide and what practices are currently in place across domiciliary health and social care to manage risks to health and safety.

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## Event Summary:

### 1. Why Health and Social Care? Unique opportunities, specifically in home domiciliary services

Liz Twist MP opened the inquiry session, thanked the expert speakers and attendees.

A short presentation from LF outlined the key facts underpinning the inquiry (please see 'Context of the meeting' section below for further details), and the proposed lines of inquiry.

- People at greater risk of carbon monoxide exposure are often also more vulnerable to the harm CO causes, compounding their liability in a vulnerability overlap. Such individuals, for example those in advanced years or with disability support needs, are more likely to be receiving domicilary services than non-vulnerable individuals.
- A study by Croxford et al. (2006) found that more than 1 in 8 homes (13%) contained levels of carbon monoxide which are dangerous after one hour of exposure [as measured against WHO guidelines].
- There were 1.52 million people working in health and social care in England in 2019/2020. Domiciliary care jobs, including personal assistants (43%) now account for more jobs in the sector than residential care (41%), and there are indications that domiciliary work is increasing across HSC (source: Skills for Care 2020).

Health and Social Care Professionals (HSCPs) have a unique opportunity to raise awareness and improve carbon monoxide safety; as they are contact points, with health care training, and often have access to

homes. People who are receiving domiciliary services are likely to be at greater risk of CO exposure and harm. Therefore, supporting health and social care professionals to practice carbon monoxide safety will provide a cost and time effective model for behaviour change: creating an umbrella of protection for people receiving services, and consequentially those they live with.

**Inquiry approach/Lines of inquiry:**

a) How are carbon monoxide risks in domiciliary settings managed by existing processes, and are HSCPs aware of the risks posed by carbon monoxide?
b) How can carbon monoxide safety processes be improved in HSC, are there examples of best practice in the sector to learn from?
c) What can regulatory bodies & industry leaders do to encourage better carbon monoxide safety in domiciliary health & social care?

## 2. Expert Panel: Understanding current levels of carbon monoxide awareness and safety practices in health and social care, inquiry considerations

Liz Twist MP introduced the expert panel to the attendees, and thanked the speakers.

Nadra Ahmed OBE, Executive Chairman of National Care Association

Nadra pointed out that although it might be unlikely for employers to be thinking about carbon monoxide, this poses a critical risk, with significant potential impact. HSCPs are looking after vulnerable people, and after all the care planning and health & safety work that goes into keeping them safe, it may well be that we are missing a serious safety component in relation to carbon monoxide.

The National Care Association's members have staff whom are often delivering services in a wide range of settings, these can be in deprived areas where there is a greater risk of carbon monoxide exposure; and involve clients with both physical and mental health needs. The National Care Association represents organisations that are delivering care in the community and those which run care homes. A further concern is the growing informal care, but progress must be taken step by step; and perhaps the more regulated services would be an appropriate starting point for the inquiry. It would be beneficial to engage with the regulator for England, the CQC, to look into this aspect more closely.

Direct payment personal assistant (PA) groups are increasing. PAs may not be registered with regulatory bodies, and as the employer is the person receiving the service, they may need support to act as a responsible, compliant employer and provide a safe working environment. RM noted that it may be possible to activate Policy Connect's existing connections with groups of disabled people, to help the inquiry to better understand the experience of direct payment recipients. LT notes that it will also be important for the inquiry to engage with local councils on this point.

This inquiry is very timely; the safety of staff is always paramount, but never before has there been such strong public awareness of the need to protect our HSCPs. Staff have been on the frontline of COVID, both in care homes and going into people's homes, and we all know how important it is that they are supported to work safely. It is of the utmost importance that this collaborative work facilitates positive practical change in the sector to increase safety for both HSC staff and recipients of services, and I look forward to helping drive this forward.

Gordon Lishman CBE FRSA, Executive Chair of the Gas Safe Charity

Gordon has spent his working life providing services for, representing, and advocating for older people. The Gas Safe Charity was set up over a decade ago and derives from a concession agreement between HSE and Gas Safe Register. To maximise impact and minimise expenses, GSC has no permanent staff, and works in partnership with other organisations, such as Safety Centres around the country which help to educate children about dangers inside and outside the home.

GSC undertook some original research, which found it to be entirely clear that there are people who are especially vulnerable, whether they may be poor, disabled, not speak English as their first language; are particularly vulnerable to long term low-level CO poisoning. The key insight GSC sought was how to communicate with those people, who are naturally harder to reach.

The research established the concept of "trusted intermediaries", and found that the best way to communicate with these individuals is through the professionals that they trust, whether that be HSCPs or the fire and rescue service, or volunteers. GSC sought partnership but found nothing was there, so set up Think CO to provide a wide range of services for trusted intermediaries. Hilary Bath and Simon Main lead on this work, and will now share some of their findings with the group.

Hilary Bath, Programme Manager, Think CO

Hilary began by sharing some insights and challenges from the Think CO program.
The Think CO programme was developed from scratch about 6.5 years ago, they have now completed around 80 face to face workshops and 34 online workshops, training a range of individuals in HSC including domiciliary carers, occupational therapists, smoking cessation officers, re-ablement officers, social workers, and midwives. The core audience of Think CO are domiciliary HSCPs, as they make up the majority of the trusted intermediaries and contact points that offer help and support, however the program is open to any home visitor.

Before engaging with the programme, HSCPs generally know very little, their understanding of CO is about the same as the general public. Most people know that carbon monoxide is a poisonous gas but that's all:

- HSCPs do not make the connection between carbon monoxide and their work
- Carbon monoxide is associated with mains gas and nothing else, there is no connection with solid fuel or blocked flues or LPG
- There is little or no knowledge of what danger signs to look for on an appliance
- It is generally assumed that all CO expsoure is an emergency
- HSCPs do not know where to go for help with CO within their own organisations
- How CO is formed is not known
- HSCPs have little to no knowledge of low level or sub-lethal exposure, so Think CO have developed a particular focus on this, through Sources, Signs and Symptoms

So usually some under lying knowledge is there, but it is not good, and it is not useful in their everyday work. Think CO increases knowledge, and makes the connection that being CO aware helps them, and helps their clients. After engaging, learners do know how CO is formed. They know the Sources, Signs and Symptoms of

CO, and crucially how to help prevent it from being formed in the first place. They understand what to do if someone they support has been exposed to CO.

The Think CO programme includes an e-learning package, which has been tailored into specific tools for the RCN members, and a suite of videos have been developed. The aim is to make the program as accessible as possible, so the resources are free, and the course strives to be as inclusive and understandable as possible. For example, to make the material relatable, one of the interactive exercises is based in a domiciliary care setting.

Other key information shared by Think CO is about the importance of carbon monoxide detectors, the types and correct placement. Think CO sign post to funding sources, as often people cannot afford an alarm let alone servicing. Follow up from the course includes free resources, and information about the Priority Services Register; which few people know about.

**Think CO's follow up research shows that 93% of the HSCPs that engaged with the program felt better able to offer help and support to their clients.**

Simon Main, Programme Manager, from Think CO

Simon Main presented some case examples. When Think CO were able to run face to face workshops participants would often talk about their own experiences, which really helps to demonstrate what is happening on the front line.

**Case Study:**

A re-ablement officer had been to a property to fit a shower, when he noticed yellow flames and marks on the fire. He recalled that this was an indication of CO exposure, so he spoke to the owner, who said she had been suffering from headaches and not feeling well. Knowing that these could be symtoms of carbon monoxide exposure, the re-ablement officer arranged for an engineer to come and check the appliances. Once the engineer attended, the fire was immediately condemned and removed, and it was deemed there was definite CO exposure. If this re-ablement officer had not been on the training, he might well have just attended to install the shower and then left.

In the program there is a strong emphasis on talking to people, asking them how they are is key.

Of those who attend the course, the vast majority say that there is no mention of carbon monoxide in any policy or procedure at their place of work. Think CO follow up afterwards to see if the organisation will now include CO in future policies:

- **45%** say they will definitely be implementing carbon monoxide safety practices, and
- close to **40%** say they hope to do so.

A frequent response from frontline staff who attend the course is that all they can do is pass on the information to their manager, in the hope that it is acted on. Frontline staff are not often in a position where they are able to make changes to safety practices and processes or influence company policies. Managers do

generally understand their duty of care to their staff, and once they have engaged with the program quickly pick up on this aspect of carbon monoxide safety practices. For example, one particular council has now sent 45 people from their social care team on the course.

In fact, promoting the courses is the main challenge that Think CO faces. Despite being free of charge, both Hilary and Simon spend a significant amount of time calling relevant organisations to try and encourage them to tell their staff about the Think CO program, so they can benefit from the free training and resources available. Think CO is frequently featured in national newsletters and e-bulletins; however these have a short shelf life.

Getting organisations to understand the relevance of carbon monoxide awareness to their frontline staff can be difficult. Some organisations have feedback that accreditation of the course would encourage them to send staff. Think CO currently provide a certificate of achievement, but there is nothing formal in place, and critically no obligation for employers to offer carbon monoxide safety training to their staff.

### 3. Round Table Discussion

LT thanked speakers for a fascinating presentation.

Getting the message out

NA: Noticing the symptoms of CO poisoning is so important, as if staff are unaware of the signs they will not look for carbon monoxide as a cause of behavioural change in clients. This awareness could help us to keep people at home safely for longer, so it is really important to get the messaging out there to ensure we are not missing a trick. The Care Provider Alliance (CPS) is an alliance of ten national bodies, which represents all care provision. The National Care Association represent small to medium sized providers; but within the CPA the voluntary sector, the larger corporate providers, learning disability providers and the domiciliary care providers are all represented, so we can draw together to really make a difference here.

Councils

An area for the inquiry to consider is how to work with councils to support them to engage on carbon monoxide effectively, as they have a key role in the delivery and oversight of health and social care. HB shares that Think CO have made attempts to engage with council groups such as those mentioned, however unfortunately the programme has been met with a mixed reception. SM adds that often when approaching local authorities in particular, or the learning and development and training teams, there is often a sense that “we’ve got this covered”. There is a set of skills they believe the front line worker needs and their department knows how to deliver those skills – carbon monoxide is not on that list, so it doesn’t get considered.

When council employees do attend the training, they often respond very well, as mentioned one lcal authority has now sent their entire HSC team, and another has purchased 2000 CO detectors to distribute. . NA may be ablw to assist with engagement of the LGA and Adass. LT commits to taking this matter up with the local authority in her constituency.

Public services – a postcode lottery?

LT was previously on LA select committee, and examined housing for older people. Some of these people cannot afford regular servicing, which puts them at greater risk of carbon monoxide exposure. HB shares

there is a bit of a post code lottery, when it comes to support from local authorities. Some will provide alarms, some will not, some may offer safey support services, but many do not. Benevolent funds do help, e.g. in the Midlands there is one linked to the car industry and these can be engaged to offer a pool of money. Age UK has recruited some engineers who offer limited pro-bono gas checks, but again this is a postcode lottery, so there is great inconsistency across the UK.
SM states that safe and well checks from the Fire and Rescue Services also vary, some will install a CO detector; however, often there is not the capacity to do this in the service as budgets vary, and many have been squeezed. In some areas, alarms for elderly and vulnerable people are 'hived in' to local services and care provision, enabling live monitoring of smoke, heat and CO. Think CO always encourages those attending the course to explore what support is available, and make the most of what is on offer locally, as this can vary widely in different areas.

Carbon monoxide alarms and user knowledge

OM reflects HB's findings that most people in HSC are unaware of the chronic harm that sub-lethal levels of carbon monoxide can cause, there appear to be arguments for vulnerable people to have the more sensitive alarms that can detect sub-lethal and lower levels of carbon monoxide.
GL shares that between eight and fifteen years ago, there appeared to be a push across the Fire and Rescue Services where quite a few CO alarms were installed. Unfortunately, no list or record was kept of the houses where alarms were installed, and many of these are likely to require new batteries or replacement by now. It is not just having the alarm, but crucially knowing how to use and maintain it, and understanding how to respond when it triggers which is necessary. Education is key, otherwise an alarm is redundant. IMy shared an anecdote where a client's CO alarm sounded, the client complained to her health visitor that the beeping sound was annoying and so the HSCP took the alarm outside and shook it, then brought it back in when she had finished her visit.

Cementing change: both top down and bottom up approaches are required

OM states that in order to establish proper processes to manage carbon monoxide risks in HSC, it will be necessary to engage with the managerial team and the decision makers within care providers and the HSC sector. We have heard from HB and SM that often individual HSCPs are not in a position to influence company policy, despite knowing the dangers they and their clients may be exposed to, and drawing the managements' attention to these risks. So although awareness of frontline staff is one part of the puzzle, to cement change the inquiry will also consider how best to engage with care providers, employers and professional bodies. Getting through to the heart of these organisations will help us to deliver successful solutions. LT agrees, there are two sides that must be brought together, the employer and the individual. In order to best effect change, the inquiry will explore opportunities for both top down (practices) and bottom up (awareness) approaches.
NA agrees that there are two elements to improving CO safety, and safety generally in HSC; there is the responsibility of the employer at the 'heart of the organisation', and also the personal responsibility of the individual to assimilate the practices. One of the hurdles for provider organisations is knowing how to embed learning. Particularly with e-learning, people may tick the box to say they have completed a training module, but it can be tricky to know how much of that information has been well absorbed. However, clearly organisational support is key for such a training module to even be offered.

Sector leaders

JS and NA referenced the Care Quality Commission and Skills for Care as key influencers to encourage best practice and improve policy in the sector. There are many relevant parties which should have an interest in developing a better approach to CO safety, protecting workers, and ultimately saving lives. This inquiry will make a bold first step into improving knowledge and policy across the sector.
Home Carer magazine featured an article from IMy on carbon monoxide, so there is some history with UKHCA and these matters have been referenced in the sector before. It is likely to be more comprehensive to focus on the individual receiving services, and how their behaviour or symptoms might indicate exposure, as this is the core of the HSCP's responsibility. HB supports that listening to clients is very important, and this is emphasised on the Think CO courses.

Managing risk in a range of situations

LT reflects that it is not just the elderly who are at risk, but also disabled people. Many of these people live at home and have full time carers, or receive services around the clock from different individuals. There are different risk profiles, depending on the circumstance, we should be sensitive to that in this inquiry. Informal carers may perhaps be spending longer periods of time in the homes of those they support, and are therefore could be at greater risk.
IMy highlights that an area for the inquiry to consider might be the point of discharge from hospital, where people often have their domiciliary network set up. It is key to design schemes that are going to fit the circumstance and be effective, for example with occupational therapists.
OM draws a parallel between safety practices in the nuclear industry, where individuals have personal alarms that are all 'hived in' to a central system which monitors their exposure. It is possible that there is a greater volume of workplace harm incurred by workers in HSC being exposed to CO than there is of workers in the nuclear industry being exposed to radiation. Understandably, there are cost implications here, however there could be significant benefits with personal monitors, as a HSCP would be able to see their own exposure levels throughout the working day, and monitor exposure in the homes of those they care for. This could be an interesting solution to explore. CB may be able to support this, as he knows of a product in development where an ID badge incorporates a personal monitor.
**Action:** SciTech group to consider personal CO monitors – how can they be made cost effective and user friendly?

Levels of CO in homes

PH undertook a study looking at carbon monoxide levels in homes, but this was some years ago. PH also sat on the committee for the NICE guidelines, the same issue arose: how do you get people to work together? It may assist the inquiry to review that report. There are an increasing number of 'smart' meters which are always powered and online, so if these were centrally linked that would be an excellent source of data on CO levels in homes across the UK.

LF rounded up the session, thanking attendees for their excellent contributions and outlining the next steps that the inquiry will take, as below.

LT closed the session, expressing her gratitude for the contributions and to the sponsors for enabling this inquiry to be held. This has been a very productive scoping session, allowing us to learn from each other's experience and expertise. The aim of this work is to achieve some change and improvement on the ground and in people's homes. Once the data collection is complete, the secretariat will be in touch with details of the next evidence session for the inquiry, which all here are welcome to attend.

## Findings & Outcomes

In the experience of the group and expert panel, health and social care professional's (HSCPs) awareness of the risks posed by carbon monoxide is generally very low. The vast majority of people and professionals associate carbon monoxide exposure only with fatality, and are not aware that sub-lethal carbon monoxide poisoning can have chronic, long term health effects. In addition, many in the sector only associate CO risk with mains gas, and not solid fuel or Liquid Petroleum gas (LPG).

When HSCPs do become aware of the risks posed by carbon monoxide via online training, they quickly understand the potential for undetected harm, and the majority will attempt to change their internal working practices to better protect themselves and their patients. However, feedback indicates that these changes are implemented with mixed success, as individuals may not hold decision making power or be able to influence their employer to include carbon monoxide within their current safety practices.

Opportunities exist in HSC for improving carbon monoxide safety; for example through staff training, risk assessments and response procedures. However, these opportunities are not universally or even commonly embraced, even when training is offered free of charge.

To effectively improve carbon monoxide safety in HSC, both a 'top-down' and a 'bottom-up' approach will be required. The top down approach will involve employers, agencies and care providers implementing carbon monoxide safety practices throughout their organisation, making staff aware of these practices, and providing training opportunities. The 'bottom-up' approach will involve staff and HSCPs under taking training, incorporating the new carbon monoxide safety practices into their work, and educating those receiving services about how best to reduce and monitor the risks of carbon monoxide exposure.

## Next Steps

- The steering group for the inquiry will meet in June. The steering group is chaired by Liz Twist MP, Baroness Finlay is a peer member, sector membership includes Nadra Ahmed of National Care Association, Dr Nichola Ashby of the Royal College of Nursing and Lia Brigante of the Royal College of Midwives; in addition sponsoring organisations and industry stakeholders.
- We will conduct a short survey for health and social care professionals, to gauge awareness of carbon monoxide and experience of CO safety practices in health and social care. Assistance with circulation of the survey has kindly been offered by relevant organisations.
- We will seek further primary data via structured interviews with industry leaders and sector stakeholders, to gather intelligence on current regulatory obligations and compliance, considerations for practice change and effective messaging.
- The inquiry will also reach out to service providers to identify examples of best practice in current employment for analysis.
- The findings from the above steps will be reviewed by the steering group on 14 September 2021.
- A second parliamentary session is likely to be held in October 2021 (date TBC). Attendees will be informed of the details of the next session via email from the APPCOG secretariat.

## Background

**Carbon Monoxide**

Carbon Monoxide is a poisonous gas that has no taste, colour, or odour. It is produced by the incomplete combustion of carbon-based fuels such a gas, oil, biomass and wood. Each year, accidental CO poisoning is responsible for the deaths of approximately 60 people in England and Wales.[1]

However, exposure to carbon monoxide does not always result in fatality. Lower concentrations of carbon monoxide (CO) cause common symptoms such as headaches, tiredness, nausea and feeling dizzy, which are often missed, or attributed to other factors such as stress and lifestyle.

At lower concentrations, 'chronic' CO poisoning can cause significant, adverse short-term health effects. This occurs where victims are exposed to sub-acute levels of CO over a longer period of time spanning weeks, months or even years. Evidence has been found that chronic CO poisoning can produce adverse effects on the cardiovascular system, postnatal outcomes (where the mother is poisoned during pregnancy) and neuropsychological symptoms such as changes in memory, sleep, anxiety levels and sensory capacity[2].

**The Croxford study found that ore than 1 in 8 homes contained levels of carbon monoxide which are dangerous after just one hour of exposure.**

In the largest study of its kind, Croxford et al (2006) targeted 270 households with old and faulty appliances, as identified by the Warm Zone pilot study in East London, in the winter of 2004-05. The study found 18% of homes had CO concentrations that regularly exceeded 8-hour WHO guideline levels, including 9.4% exceeding the 1-hour level and 3.6% exceeding the 30-minute level. [3]

Health and social care professionals could be harmed if present in the home for an hour or more, and residents in those homes are being continually exposed to levels of carbon monoxide that are likely to be having a damaging impact on their health.

This means there may be unrealised opportunities for health and social care workers going into homes to improve both public awareness and reduce CO risks (e.g. through the promotion of alarms, encouraging appliance servicing, ventilation and gas safety checks).

**Health and Social Care in Domiciliary settings**

Domiciliary care is defined as the range of services put in place to support an individual in their own home. Services may involve routine household tasks within or outside the home, personal care of the client and other associated domestic services necessary to maintain an individual in an acceptable level of health, hygiene, dignity, safety and ease in their home.

**The adult social care sector was estimated to contribute £41.2 billion per annum to the economy in England in 2019/20.**

There were 1.52 million people working in adult social care in England during 2019/20. Of those, approximately 560,000 work in domiciliary care. Domiciliary care jobs in England have increased at a faster

[1] NHS: Carbon Monoxide Poisoning. Available here: https://www.nhs.uk/conditions/carbon-monoxide-poisoning/
[2] Townsend and Maynard (2002) https://oem.bmj.com/content/oemed/59/10/708.full.pdf
[3] Croxford et al 2006 - https://discovery.ucl.ac.uk/id/eprint/5017/1/5017.pdf

rate (by 95,000, or 15%) than residential care jobs (by 25,000, or 4%) since 2012/13. Domiciliary care jobs, including personal assistants (43%) now account for more jobs in the sector than residential care (41%).[4]

There are a wide range of health and social care professionals (HSCPs) who deliver services in domiciliary or home settings, such as occupational therapists, social workers, midwives, nurses and HCPs. These HSCPs have an ideal combination of resources: both access to the individuals home, and their own healthcare knowledge. By being able to see the home environment and the person, HSCPs can identify signs of CO exposure in the property, as well as monitoring symptoms in the person, giving them a broad overview of the potential risks. In addition, HSCPs can help to prevent carbon monoxide exposure by advising individuals on practical steps they can take, such as servicing appliances and installing a carbon monoxide alarm.

However, at present it is unclear if many HSCPs are aware of the risks of carbon monoxide in the home, or if there are any standard practices and procedures for addressing carbon monoxide risk in place with independent or council care providers.

**The APPCOG believes there may be a significant opportunity for increasing CO safety practices through the health and social care sector, which would in turn benefit those receiving domiciliary care.**

**About the APPCOG**

The All-Party Parliamentary Carbon Monoxide Group (APPCOG) is the leading forum for parliamentarians from both the Houses of Commons and Lords to work together to address carbon monoxide (CO) poisoning. Through its busy programme of events and research, the Group seeks to push the vital issue of carbon monoxide safety up the political agenda, to improve government policy, to support research and to raise public awareness of the threat posed by carbon monoxide.

The APPCOG draws on a wide range of stakeholders; working closely with leading figures in academia, the scientific and medical community, the civil service, Ofgem, industrial public bodies, gas distribution networks and those with direct experience, such as CO survivors, campaigners and charities. Policy Connect provides the secretariat for the APPCOG, which was formed in 2012.

**About Policy Connect**

Policy Connect is a membership-based, not-for-profit, cross-party think tank. We bring together parliamentarians and government in collaboration with academia, business and civil society to inform, influence and improve UK public policy through debate, research and innovative thinking, so as to improve peoples' lives. We lead and manage an extensive network of parliamentary groups, research commissions, forums and campaigns. We are a London living wage employer and a Member of Social Enterprise UK, and have been operating since 1995. Our work focuses on key policy areas including health and accessibility; education & skills; industry, technology & innovation; and sustainability. We shape policy in Westminster through meetings, events, research and impact work.

[4] The state of the adult social care sector and workforce in England, October 2020; Skills for Care. Available here: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf

# Expert Speaker Bios

**Nadra Ahmed OBE, Executive Chairman of National Care Association**

Nadra has been involved in the field of social care for over 30 years. Her background is in training and education, which has been the passion that drives her towards a quality service, underpinned and provided by a skilled workforce. Since 2001, Nadra has been Chairman of NCA, and is also a trustee of SCIE and Parkinson's UK. In 2006 she was awarded the OBE for her services to Social Care. Nadra has been a member of a number of advisory committees in the DoH, including a number at Ministerial level and served on government Taskforces. She is a regular contributor to journals and conferences and is frequently called upon by major media networks to represent the views of social care providers.

**Gordon Lishman CBE FRSA, Executive Chair of the Gas Safe Charity**

The Charity does not have paid staff, so Gordon manages the Charity's work and major programmes, including ThinkCO and the Hardship Fund, which works with Foundations Independent Living Trust. Until retirement, Gordon was the Director General of Age Concern and the Chief Executive of the Age Concern Group (now Age UK). He made a major contribution to building the national Age Concern movement and led the Charity's effective influencing and campaigning work during the first decade of the century, including on pensions, social care and health issues. He was an officer of EU and global organisations concerned with ageing and older people. He is a councillor in Burnley and has been active in local, national and international politics for over 50 years.

**Simon Main, Programme Manager & Hilary Bath, Programme Manager, Think CO**

Hilary Bath and Simon Main are the Programme Managers for the Think CO Programme run by the Gas Safe Charity. Both have been involved since the inception of the Programme, developing it from an idea on paper to an established UK-wide programme of activity reaching many thousands of people. Activities include face to face and online workshops, e-learning courses, videos, and general guidance and support for any organisation interested in enabling its staff and volunteers to become more CO aware. Both their backgrounds are as programme and people managers in the voluntary and community sectors, particularly organisations working with older people and addressing the issues of our ageing society.

## Attendees:

Liz Twist MP, Inquiry Chair
Nadra Ahmed OBE, National Care Association
Gordon Lishman CBE FRSA, Gas Safe Charity
Hilary Bath, Think CO
Simon Main, Think CO
Chris Bielby, Stakeholder Forum Chair
Issie Myers, COMed Chair
David Goodall, SciTech Chair
Lia Brigante, Royal College of Midwives
Scott Darroch, Gas Safe Register
Steve Dacre, Northern Gas Network
Carys Hudd, Wales & West Utilities
Dan Edwards, SGN

## Apologies:

Barry Sheerman MP
Baroness Finlay
Sir Peter Bottomley
Rt. Hon. Maria Miller MP
Stephanie Peacock MP
Luke Pollard MP
Jason McCartney MP
Ian Byrne MP
Kerry Potter, SGN
Sally Thomas, Wales & West Utilities
Elizabeth Warwick, Wales & West Utilities
Dr Gill Jackson, NPIS
Dr Simon Clarke

Ian McCluskey, IGEM
Andy Curtis, CoGDEM
Ian Palmer-Smith, Domestic and General
Daniela Gentile, NPIS
Paul Harrison, COMed member
Jonathan Shaw, Policy Connect
Oona Muirhead, Policy Connect
Mohamed Ali, Policy Connect
Laura Fatah, Policy Connect
Phil Burrows, Cadent

## Secretariat Contact

Laura Fatah, Policy Manager - laura.fatah@policyconnect.org.uk