Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd a Gofal Cymdeithasol
The Health and Social Care Committee

Dydd Iau, 23 Chwefror 2012
Thursday, 23 February 2012

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mick Antoniw	Llafur Labour
Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour
Vaughan Gething	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Lindsay Whittle	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Yr Athro/Professor John Bolton	Y Sefydliad Gofal Cyhoeddus, Prifysgol Oxford Brookes Institute of Public Care, Oxford Brookes University
Julie Jones	Prif Weithredwr, y Sefydliad Gofal Cymdeithasol er Rhagoriaeth Chief Executive, Social Care Institute for Excellence
Ruth Marks	Comisiynydd Pobl Hŷn Cymru Commissioner for Older People in Wales
John Moore	Fy Mywyd mewn Cartref Cymru My Home Life Wales
Tom Owen	Cyfarwyddwr, Fy Mywyd mewn Cartref Director, My Home Life
Sarah Stone	Dirprwy Gomisiynydd Pobl Hŷn Cymru Deputy Commissioner for Older People in Wales
Alun Thomas	Pennaeth Adolygu, Archwilio a Pholisi Head of Review, Examination and Policy

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

Stephen Boyce	Y Gwasanaeth Ymchwil Research Service
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Meriel Singleton	Clerc Clerk

Dechreuodd y cyfarfod am 9.14 a.m.
The meeting began at 9.14 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Mark Drakeford:** Bore da. Croeso i aelodau'r Pwyllgor Iechyd a Gofal Cymdeithasol a chroeso hefyd i'n tystion y bore yma. Nid wyf yn mynd i wneud yr holl gyflwyniad. Mae pawb yn gwybod bod y cyfarfod yn gyhoeddus; mae'r meicroffonau yn barod ar ein cyfer, a phopeth felly.

Mark Drakeford: Good morning. I welcome members of the Health and Social Care Committee and welcome our witnesses this morning. I will not make the usual introductions. Everyone knows that we are in public session; the microphones will come on automatically, and so on.

Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Tystiolaeth gan Gomisiynydd Pobl Hŷn Cymru
Inquiry into Residential Care for Older People—Evidence from the Older People's Commissioner for Wales

[2] **Mark Drakeford:** Trown yn syth at eitem 2 a diwrnod cyntaf ffurfiol ein hymchwiliad i ofal preswyl i bobl hŷn. Croeso mawr i Ruth Marks, Comisiynydd Pobl Hŷn Cymru; Sarah Stone, dirprwy gomisiynydd pobl hŷn Cymru; ac i Alun Thomas, pennaeth adolygu, archwilio a pholisi.

Mark Drakeford: We will turn straight to item 2 and the first formal day of our inquiry into residential care for older people. A warm welcome to Ruth Marks, the Commissioner for Older People in Wales; Sarah Stone, deputy commissioner for older people in Wales; and Alun Thomas, head of review, examination and policy.

9.15 a.m.

[3] Fel arfer, Ruth, mae gennych chi gyfle i gyflwyno pethau inni. Rydym wedi cael cyfle i ddarllen eich tystiolaeth ysgrifenedig—a diolch am y dystiolaeth honno. Ar ôl eich sylwadau, byddwn yn troi at aelodau'r pwyllgor ac rwy'n siŵr y bydd gennym lawer o gwestiynau ichi.

As usual, Ruth, you have an opportunity to make a brief introduction. We have had an opportunity to read your written evidence—and thank you for that evidence. Following your remarks, we will turn to committee members, and I am sure that we will have many questions for you.

[4] **Ms Marks:** Diolch yn fawr, Mark. Good morning. We are delighted to have had the opportunity to submit evidence and to come to committee today. For practical purposes, depending on which one of us is best placed to answer the questions, we will go directly to Sarah, Alun or I, as opposed to each of us intervening or answering in any particular order. I also wanted to note that our comments and any suggestions we make this morning are based on concerns and information that has been brought to the commission by older people, their families and others across Wales during the course of our work and, also, that our comments are based on a set of core principles. I would like to recommend to the committee that the reference to the United Nations principles for older persons be taken very seriously as you take forward this inquiry, because we believe that the principles provide a strong basis for the provision of residential care services in Wales. It is important to remember in all our work, but particularly in this inquiry, that we are talking about someone's home, about a fundamental approach to human rights, about people being involved, and about their decisions to enter a home, whether in a planned way or in rushed and potentially challenging circumstances. It is absolutely imperative that people feel protected and safe, as well as happy, in their homes, and that residents' voices are heard at all stages of people's experience of living in their home, which happens to be either a residential care home or a nursing home. I wanted to set out those important points at the beginning.

[5] **Mark Drakeford:** Thank you. Who wants to ask the first question? People are not normally shy in this committee. I see that William will start.

[6] **William Graham:** Thank you for your presentation. A slightly smaller part of your report, but obviously one that you have taken great interest in, is to do with independent mental capacity advocates and the deprivation of liberty safeguards. That touches on what you were saying earlier, which is that, too often, sadly, admission to a home can be the result of a crisis or lack of mental capacity. Could you give us an idea how this committee could take forward the relevant concerns that you have stated in your paper?

[7] **Ms Marks:** Thank you for your question. I will make a couple of comments and then check with Sarah and Alun whether they have anything to add. I would like to refer the committee back to my first statutory review into older people's experiences in hospital, 'Dignified Care?', and to the points I made there with regard to leadership and training, and staff's understanding of the statutory tools available to them. The way in which support, advocacy and advice can be given to older people and their families is often not understood in the variety of different settings. Importantly, in terms of the interdependence between health, social care and housing, having all public services focusing on the needs of the individual, and making sure that they are safe and supported, is absolutely imperative. I will leave it there and check whether Sarah or Alun have anything to add to that for the inquiry to focus on.

[8] **Ms Stone:** This links with the wider issue of advocacy. The evidence we have is that there is a real misunderstanding in some quarters, for example, about the use of the Mental Capacity Act 2005 and people's right to a mental capacity advocate at a critical moment, as you have referred to. People do not have time to read books about it when that happens; they need to know that at the time and have access to the advocacy. That is an area for the committee to take seriously, because those decisions made during a crisis have a permanent effect on people's lives.

[9] The evidence that has come to us is very much about people not necessarily being aware of how they got to be in the residential home that they are in and about how much of it was their decision and how much of it was driven by others. There is a very important human rights issue there. In relation to the deprivation of liberty safeguards, a better way of recording those, looking at those and at what the thresholds are and how they are being applied, would be an improvement on the current situation. Again, it would be great if the committee were to look at those very practical sorts of things. Perhaps we will get a chance to talk about our wider advocacy review in a bit.

[10] **Mr Thomas:** I have a few comments to make on mental capacity, if I may. There are issues that we have highlighted with regard to the process for recording and reporting developments at an all-Wales level in relation to independent mental capacity advocates. There are processes that we are aware of in England that could be looked at as something that we could follow as regards reporting trends relating to mental capacity. One thing evident to us is that capacity can fluctuate. People's mental capacity can fluctuate from one day to the next and people will have capacity for certain decisions but not for others. So, there are gaps that are not necessarily covered by independent mental capacity advocates or independent mental health advocates. One of our real concerns with regard to the deprivation of liberty safeguards is their inconsistent use. We cite in our evidence the fact that, in one local authority area, there is a huge variation in the number deprivation of liberty safeguard procedures. That is just within one county, so we need to paint a coherent picture of what is going on and get an explanation as to why those differentials exist.

[11] **Ms Marks:** In conclusion, William, with regard to the inquiry's focus and the importance of the matters that you are considering now and for the future relating to the potential increased demand for service, increased awareness and understanding of dementia

support flows into the question that you have asked as well.

[12] **Mark Drakeford:** Mick is next, then Lynne.

[13] **Mick Antoniw:** I have two specific questions, which are very different—if you will indulge me, Chair. The first is on the evidence that you have given about the closure of homes. Is it your view or experience that what is actually happening with local authorities is that they are seeking to divest themselves of responsibility for homes and to become purely a funding mechanism or is something else behind what is happening with local authorities and the reduction in the number of homes that they run?

[14] **Ms Marks:** Thanks very much indeed for the question. I am going to make some comments, but I would like Sarah to come in on this in relation to other evidence and possibly to link that to the research on care home closures on which we have been a partner with Swansea University, if that is all right in widening out this issue. Local authorities are in a challenging place. We recognise that in relation to configuring and commissioning services and so on. Whether there is a grand plan with regard to divesting I am not so sure. However, I have certainly been very concerned about the way in which some local authorities have gone about either considering or running care home closures. I have had to intervene and remind public bodies of the need for genuine consultation and timely information and advice and advocacy support when appropriate. The focus on inspections, monitoring and decisions that look at only certain aspects of care home provision are not helpful in that regard. Again, we have some other comments that we would like to make about current guidance in relation to care homes. I will turn to Sarah to start and we will then widen this out.

[15] **Ms Stone:** I would like to make a couple of comments, one of which is about the move to extra care housing, which has been the driver for a number of care home closures around Wales. As a commission, we held a series of seminars last year, which were about extra care and the research that had been carried out into its adequacy, as the model currently stands, for people with cognitive impairment, for example, and its ability to substitute for residential care for people with higher levels of dependencies. There are some issues around that, and we need to be careful about a move to another model of housing that does not necessarily cover the needs of all people. The needs of people with dementia in particular are important, so there is an issue around planning there.

[16] The second point that I wanted to make, and which we make in our paper, is on the current guidance on care home closure, 'Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults'. Our view is that, although it is an improvement on the situation in other places that we have this guidance in place at all, the guidance needs reviewing. Its current applicability to, for example, the planned closure of care homes where there is not a financial crisis or an issue about quality is a real matter of concern. There is a lengthy chapter in the work that we partnered Swansea University on, which you have as part of your evidence, that sets out in some depth the evidence and the case for reviewing 'Escalating Concerns' so that it becomes more fit for purpose. Care home closures can be very protracted, causing immense uncertainty and anxiety over a long period for residents and relatives. That uncertainty and anxiety is an issue in itself.

[17] There is also the issue of good practice, and what constitutes a good process. We know that closure is not always avoidable. What does a good process look like? The engagement of advocates in that is terribly important. One concern that we have had is that the involvement of advocates in crisis is difficult, because a relationship is not built up. It is very hard for that to be effective when it is just being parachuted in quickly. There are some really important messages there. Reviewing the 'Escalating Concerns' guidance is certainly something that we wanted to recommend to you today.

[18] **Ms Marks:** With regard to your comment on local authorities divesting and just becoming funding routes, Mick, it is important for local authorities to work with others and learn from other models and have a mixed provision, because one size does not fit all. We do not have a huge amount of choice, and we certainly do not want to reduce and restrict choice, either now or for the future. That is another important dynamic in that debate.

[19] **Mick Antoniw:** Is the research that you have done into this area completed? If so, it could be helpful if we could see that. One thing that I would like to pursue relates to the fact that part of the remit of this inquiry is to look at such things as the balance and models of ownership and so on. In the evidence, could you see a particular trend of local authorities almost wanting to wash their hands of the responsibility of having that as part of their provision? Is that something that is emerging or is it rather that there is a move towards more mixed provision?

[20] **Mr Thomas:** One of the real emerging concerns is that care homes are not being closed now because of issues to do with quality of care as much as they are being closed because of concerns about funding and because of policy decisions. That is where the issue of the applicability of the current guidance comes into play. There needs to be a mixed economy of provision. People have real fears about transferring from local authority homes, for example, into joint-ownership arrangements with housing associations and about a wholesale movement into the independent and voluntary sector. Whether or not those fears are grounded, they are fears that older people in care homes have been communicating to us as we have been undertaking our visits throughout Wales.

9.30 a.m.

[21] The other element in this, coming back to the issues to do with the mixture of provision, with extra care and with dementia specialist provision, is that, effectively, local authorities might be pursuing where the finance might be for future developments. We have seen some excellent extra care housing initiatives throughout Wales, from Blackwood to Llanrwst, which we have visited. There are some real issues, particularly in relation to people with cognitive impairments—there is evidence that they are not being included from the outset in some schemes. There is also evidence that some schemes cope less well with deteriorating conditions, and there are issues with regard to the coverage of personal care within extra care facilities. Sometimes it is stated that 24-hour care support is covered when in fact that may not necessarily be the case.

[22] When people enter into extra care, they need clarity about what can be anticipated, not just now but, in the future, as their condition deteriorates. Our particular concern is that we are finding examples around Wales of couples being separated in care. This is a real human rights issue, and, if we have future models that are, on the one hand, dependent on extra care and, on the other, on dementia specialism, there is a real danger that couples will increasingly be separated within care. There is an important dimension with regard to prevention here and the ability to continue care within people's own homes to prevent that sort of thing from happening. However, it is happening in Wales today.

[23] **Mark Drakeford:** Vaughan and Lindsay have detailed points on this that they want a raise. I ask them to do that now and then we will have one more go—

[24] **Lynne Neagle:** I had points on 'Escalating Concerns' as well.

[25] **Mark Drakeford:** Okay, let us take those three now; this is an important topic that we are covering. We will then have one more go before we have to move on. So, those three Members will ask their questions in turn. Vaughan is first.

[26] **Vaughan Gething:** I have a brief point. In your evidence, you provided us with the exchange of letters between yourselves and the Government. The final letter from the Government is dated 13 April last year. It seemed from what you were saying that there has been no further progress on that, so could you confirm whether that is or is not the case, given that, in the final paragraph, the Government asks you to give it advice on specific issues, which it will then raise with the Care and Social Services Inspectorate Wales? Has anything happened, either in discussion or in any further correspondence, to move the matter further forward, because we have all heard what you have said and you have provided in written evidence about the guidance and whether it was adequate?

[27] **Ms Marks:** Would it be better to answer all three questions from Members together?

[28] **Mark Drakeford:** That is a very specific question, so I suggest that you take it now. Has there been further progress since the letters?

[29] **Ms Stone** Yes, there have been further discussions. The publication of the research that you have been provided with in evidence, which we partnered Swansea University on, is a major step. That has happened very recently. We are minded as a commission to take further actions and make strong statements directly to the Welsh Government on this matter.

[30] **Lindsay Whittle:** I am desperately trying to write down my questions—I have about 25, so I must be brief, because I know that the Chair will not allow that, which I understand. [*Laughter*.] I have been a housing professional, and it will be of no surprise to you to hear that when you move older people from a property that is totally unsuitable to one that is perfect for them, it has an effect on their health and wellbeing, because they are leaving their old home and going to somewhere new, which they are clearly unsure about. That worries me. First, would you encourage joint working and for local authorities to work with registered social landlords? I am not too worried about the small-scale private residential homes, although I have real concerns about the large scale private residential homes.

[31] Secondly, shame on any housing or any social services professional who separates a couple. They should not be in their job. If I were the chief executive of an organisation, I would not allow it; I would leave my job rather than do that. That message should go out loud and clear. When I was leader of Caerphilly County Borough Council, I was involved in the closure of a residential home, and it is extremely tough. What can you do to alleviate the worries not only of the residents, but of their relatives? Could you give any encouragement and hope to the sector?

[32] **Ms Marks:** The simple answer to the question of whether we would encourage joint working is ‘yes’, and we would encourage joint working by all partners in housing and social care, and link that to health and the provision of information and advice. That leads into the second point, namely that clear information and advice should be available from whomever. People often say to me, ‘I don’t mind who gives me the information, as long as it’s the correct information, in the right format, at the right time’. So, that message is very important. The final point that I would like to make is that when someone leaves home 1, which might have been their home forever, or certainly for 50 or 60 years, and moves in a planned way to a state-of-the-art facility providing all sorts of services, activities, support and so on, that is one scenario, but another, linked to the context of care home closures, is that when a home is closed for whatever reason and someone is moved, whether to a similar type of setting or a different setting that is deemed to be better, and there is evidence of this, the impact of that transfer can cause significant trauma and negative effects on individuals and their families. So, that is another context that it is important to mention, but I am getting the feeling that Alun wants to come in and possibly Sarah.

[33] **Mr Thomas:** On the issue of local authorities and registered social landlords, yes, we

would encourage their working together. There have been a number of pieces of research that it would be helpful for the committee to be aware of, one of which is another report undertaken on extra care housing and issues around fit and frail people by Swansea University. Among the issues raised in that research is whether the new provisions in extra care could be registered as domiciliary care settings, because, at the moment, there seems to be a dichotomy between housing provision and needs on the one hand and personal care needs on the other. So, that may well be a solution. A piece of research has also been undertaken by the Kafka Brigade on behalf of Community Housing Cymru that looks at the interrelationship between housing needs and health within new home settings for older people. Again, there are some practical solutions for the committee to be aware of.

[34] **Lynne Neagle:** You refer to escalating concerns related to planned closures in your paper. Are you satisfied with the guidance, as it was presumably intended to deal with situations where there are concerns about quality and safety, and are you satisfied that all local authorities are implementing that guidance properly across Wales?

[35] **Ms Stone:** A lot of the detail on that is contained in the evidence that you have received in the full report, but we have some concerns about how it applies in any case in which it is planned to be applied, so I will list those. On the length of the consultation process, we have seen processes strung out over several months, if not years. Also, when a home is under threat of closure, referrals will stop being made to it, which undermines its financial viability, so, whatever the result of the consultation process, that home's ability to continue is damaged and people are not placed there and so forth.

[36] The other area of real concern relates to the question of the support for the decisions that need to be made about where to next. It is important for any of us to feel that we have some control over what happens to us, and one of the most stressful things is to feel that you cannot affect where you are going. That is why advocacy matters and should not just be a tick-box exercise. It is about the information and advice that Ruth spoke about earlier, and a voice that is not that of the local authority, but of someone without a vested interest, supporting individual older people, asking, 'Where next?', and, 'How do we manage this?'. That need is not being adequately met under the current arrangements, even where it is clear that escalating concerns apply. So, there should be a real opportunity to review that guidance and make it much better. It could be made much better.

[37] **Mark Drakeford:** That is useful. Do you have a follow-up question, Lynne?

[38] **Lynne Neagle:** No; I was just reminding you that I was going to come in with another question later on.

[39] **Mark Drakeford:** That is fine. I know that you have another question. I had not forgotten about you. I will go to Darren next and then Rebecca, and I know that other Members have questions besides the follow-up ones they have just asked.

[40] **Darren Millar:** Thank you for your evidence paper. I just want to go back to your opening remarks in your presentation about the UN principles for older people. I know that you have been at the forefront of trying to encourage the UK Government to press for a convention at the UN on the rights of older people, but do you have any recommendations that you would like the committee to make to the Welsh Government on its role in recognising those principles more widely, perhaps through regulation or legislation, in the same way that children's and young people's rights had been recognised? You did emphasise that in your opening remarks. That is one question, and I have two more, if I may.

[41] The second question is about whistleblowing, which you refer to in your paper. You will be aware that the Royal College of Nursing has been encouraging and promoting the

need for regulation on whistleblowing, to force its own members to blow the whistle on bad practice and so on, so that they do not feel that they can be ostracised by their employer because of the legal obligation that they might have. Everybody knows that it is best practice to blow the whistle and the professional thing to do, but it is clear that there are difficulties that some members of staff can face. I wonder whether you might point us in the direction of a specific recommendation on that issue that we might want to make as a committee.

[42] Thirdly, in terms of the regulation of care homes, there has been a lot of emphasis on the financial viability of homes, because of increasing cost pressures, local authority cash difficulties and all sorts of other different reasons. We have seen the collapse of a large care home group. Do you think that the regulation by the Care and Social Services Inspectorate Wales and other regulators is sufficient to keep an ongoing watch over the finances of individual care homes? Given the complexity of being able to look at the finances of one home when it is part of a much wider group, in that the home could be doing fantastically well in terms of its own financial performance while the group could be on the brink of collapse, how can those things be effectively regulated here in Wales? I am sorry, but there were three questions there.

[43] **Mark Drakeford:** They are three big and important questions. I must say that I have a lot of people around the table who want to ask you questions, so please be as brief as you can.

[44] **Ms Marks:** We will be brief, and we can possibly supply other information afterwards.

[45] On the UN principles, the rights-based approach, as I mentioned earlier, is incredibly important for all older people, but particularly for people who might find themselves in vulnerable situations, which some older people in some care homes will from time to time, though not necessarily all of the time. Wales is already leading the way in including the UN principles in the single equality scheme. Yes, a recommendation to anybody in Wales to commend to the UK Government that it should sign up to the idea of a convention is something that I, as commissioner, would support.

[46] On whistleblowing, we are currently undertaking two pieces of work. One is on the culture of whistleblowing in health and social care settings, and the other involves data mining on whistleblowing incidents. That material will be with us shortly and, as soon as it is and we are happy with it, we will be happy to share it. I would certainly like to come back on that issue, if we get the opportunity later on, to talk about advocacy.

[47] With regard to financial viability, I would just make one comment about the onus being on local authorities or others involved in commissioning services to check. There are difficulties around the different financial models and I have also heard people involved in the inspection world say that some forensic financial analysis tools are needed and there is a question as to whether everybody who is working in this field has the skills, or sees it as their job, to investigate financial viability. It is an interesting conundrum. I will just check if Sarah or Alun have anything to add.

[48] **Ms Stone:** I will just make a supplementary remark on the UN principles. Some of the evidence that you have had from older people and their relatives for your work concerns the lack of mental stimulation in care homes. One of the UN principles talks about the right to social and mental stimulation. Where that is clearly not happening, that could be a powerful guide and lever to change things. It is very clear that some places could not meet that principle as it stands.

9.45 a.m.

[49] **Darren Millar:** I would like to make two points, one of which may be for the committee. It would be useful if we could perhaps write to the UK Government to ask where it is at in terms of pressing for a convention. Secondly, on the issue of financial viability, how regularly should local authorities consider these things? To put the onus on a local authority to consider it every time it places an individual in a care home would be a pretty significant responsibility. How practical would that be?

[50] **Ms Marks:** Perhaps there should be discussions between local authorities, registered social landlords and the inspectorate as regards the most appropriate time to check. I would have thought that it should certainly be undertaken on an annual basis, when the annual accounts are submitted, for example. That would seem sensible.

[51] **Mr Thomas:** Short of us having a convention, there are other United Nations activities that we need to utilise to report to. For example, the UK, as a state party, will be quizzed this year as part of a four-year cycle on human rights issues. Once again, the United Nations convention on economic, social and cultural issues is one on which we would rely on, short of a convention. I attended a meeting between the Ministry of Justice and Welsh Government officials to look at Welsh input into the UK state party report. The quizzing will take place in Geneva in May.

[52] **Mark Drakeford:** Thank you very much. I am sure that, as a committee, we will want to take up Darren's suggestion of writing to reinforce the case for a convention. Ruth, as a committee, we have struggled to obtain expert advice on the financial side of the care system. We have received a very interesting paper from our final witness today, Professor Bolton, which we can share with you and which provides the background to this, but it has not been easy to find people who have genuine expertise in understanding the financial side of care home operations. So, I am not surprised to find that at a local authority level—

[53] **Ms Marks:** No, it speaks volumes. There is also a quick link to the debate on paying for care. If there were another opportunity for the committee or colleagues in Wales to impress upon the UK Government the fact that this is a chance in a lifetime, or certainly a chance in a decade, to ensure that Dilnot is not allowed to disappear, that is something that we would be very keen to see.

[54] **Rebecca Evans:** I have two questions. First, could you tell us more about the views of older people and, perhaps, their families and what they expect from residential care? You give us a really sad example on pages 2 and 3 of your evidence, in which a gentleman aged 90 said that he was assisted with getting dressed, had his meals prepared and bed made, and that was all that he could expect at this stage in his life. I thought that that was very sad. Could you tell us a little more about that? Secondly, what lessons can the residential care sector learn from your 'Dignified Care?' report?

[55] **Ms Marks:** I will answer briefly and Sarah or Alun may want to come in on this point as well. The example that you have just quoted, Rebecca, sums it up, in a way. There is a link there to the 'Dignified Care?' report in terms of people's incredibly low expectations of what service or life might look like. It is incredibly important that all of us here, who are considering current services and planning ahead for the future, consider what our expectations would be should the choice or the need arise for us not to live where we currently live but to live in a care setting. Our expectations are likely to be different and they are likely to change as we age. Keeping in touch and engaging with older people and their family members is incredibly important in terms of ensuring that the care that is provided meets your needs, my needs, and those of Alun and Sarah. Those lessons from 'Dignified Care?' link back to caring and understanding, and finding out what people's experiences have been. If it has not been good enough, then we need to hear their ideas about how to improve it. I will leave it there

and hand over to Sarah and Alun to answer briefly.

[56] **Ms Stone:** Low expectations were something that we found in the hospital review. It has a practical impact, because if not much is expected it becomes pervasive in the culture. So, part of our hospital review recommended having a clear statement of what hospitals should be expected to deliver, and that is something important to listen to.

[57] One of the other important things to emerge from the hospital review was that this is not all about money. The hospital review found that, despite similar resources, good care was being delivered in some places and poor care in others, even on different wards in the same hospital, and that it is essential to learn from what is being done well. Culture and attitude are terribly important, as is training for everyone, particularly with regard to dementia.

[58] I could pick up on a number of other things, but I will just say that, with regard to the patient experience, we felt that there was an ongoing promise of lasting improvement. In the hospital review, we wanted an all-Wales comparison and tool for capturing the outcomes for patients—how they felt about how they had been treated—looping that back to the way that the system is run, and getting board members out on the wards. There is a lot for care homes to learn from that with regard to patient experience in a meaningful way, by capturing how older people and their relatives feel about where they are living.

[59] **Mick Antoniw:** That point very much leads into your comments on activity, which is to do with quality. As anyone whose parents have gone through this will know, this seems to be the most depressing part of the whole regulatory regime, in that it often seems to be tokenistic and there is no engagement—it is almost as though you are left sitting in a chair having been medicated, or whatever. The whole regulatory regime does not seem to encompass that. If it was an Estyn inspection, many schools would be way down the bottom in terms of what Estyn reported, as opposed to what happened in practice. How can that be massively improved or raised up the agenda, as far as regulation is concerned?

[60] **Mr Thomas:** There is a surprising variation in the approach to activity rates at the moment. Activity levels are determined by one or two individuals pulling out the stops within care homes. As a consequence, if those individuals move on or are not in work for a period of time, there is danger of some slippage. We see marvellous examples of a range of activities being undertaken, but we also see situations where there is a degree of over-caution, for example, where a home might assume that they would go on a visit to another comparable home because of fears about the lack of facilities in the community, which seems to be a very limited approach. We are aware of some research that has been done—not in Wales, unfortunately—which looks at the amount of time people spend in organised activities within care homes; it made a comparison between England and another European country in that sense.

[61] **Ms Marks:** The chief inspector's last report was issued earlier this week, and I sense from that that there is an appetite for change in relation to engagement and people's experience of residential care. So there is work to build on. The final comment is that entry into residential care should not be a situation of last resort. There are some fantastic residential care homes in Wales, and some of the people to whom we talked are very happy, while others are not.

[62] **Lynne Neagle:** My points are on dignity in care. I know that, as a result of that important report and through the transforming care agenda, there are changes starting to be made in hospital settings in the way that nurses interact with patients with dementia. I wonder whether there have been any attempts to import some of that good practice into residential care settings, either from Government or from local authorities.

[63] **Ms Marks:** Yes, or from us. The fact that the Minister has made dignity a top priority for the NHS is to be noted, and the fact that unannounced spot checks have been rolled out across the country is important. I am about to embark on a series of meetings with the chief executives of all the health boards in March, to hold them to account in relation to the detail in their action plans regarding changes that they said that they would take on board. We are keen to transfer lessons from 'Dignified Care?' to other areas of work, especially across to social care. That has certainly been at the back of our minds in relation to our advocacy review, and in work that we are currently doing on domiciliary care and people's experience of receiving their care at home. Making people's voices and experiences heard is fundamental through all of that. There was one other point that I wanted to make, but it has slipped my mind for a minute, Lynne; sorry, it is not coming back.

[64] **Mr Thomas:** A very brief example is that we have been involved in providing much support for the only dignity in care network that has been established in Wales. It is in north Wales, and it brings together co-ordinators, the health board and so on, to look at how we learn across sectors. Some marvellous work has been done in north Wales, asking older people about the one thing that can be done to enhance dignity. We will continue to support that network in all that it does and encourage other types of approaches. We are also minded to hold a conference later in the year, which will enable us to extend the learning beyond the health setting to other settings, too.

[65] **Ms Marks:** I have remembered my point, and it links to sharing across not only health but also social care. We convened a round table meeting a while ago with all the inspectorates—Health Inspectorate Wales, community health councils, the Wales Audit Office, the Welsh Government and the National Leadership and Innovation Agency for Healthcare. We are meeting again in April to share information, to make sure that we are not duplicating or wasting resources and to make sure that lessons from any inspection programmes or any concerns or trends are spotted and shared among that group. There is no reason why we could not consider links of that type with the Care and Social Services Inspectorate for Wales and the Care Council for Wales.

[66] **Rebecca Evans:** Lynne mentioned training earlier, and I do not think that we have talked much about that. People may come into residential care with all sorts of pre-existing conditions, such as autism or diabetes, or they may develop conditions such as mental ill health when they are there. What is your assessment of how staff are trained and experienced in identifying conditions, dealing with them and supporting people who have them?

[67] **Ms Marks:** I will ask Sarah and Alun about links with the advocacy review, which would be the most relevant issue, Rebecca.

[68] **Ms Stone:** The advocacy review has allowed us to visit care homes all over Wales to interview a wide range of older people. We will be reporting on that work in June, and we hope that we can bring you the evidence and recommendations from it. We are currently analysing the evidence, and I am sure that there will be robust evidence that we can bring to you that will be relevant to your question about training. In a broader answer to your question, the evidence that we have is that training is patchy; some places are much better than others, and it is an important area for you to be looking at as a committee.

[69] **Ms Marks:** There is a link there to the image and status of the workforce. People are not encouraged to consider a career in care, and people's aspirations are not necessarily aimed at looking at different experiences or accessing any training that might be available, whether on the job or in any other format. We will share any initiatives that we hear about. I agree with Sarah's point about looking at this.

10.00 a.m.

[70] **Mark Drakeford:** There was very clear evidence in the Southern Cross Healthcare case that, as the company began to run into trouble, training was one of the very first things that it sacrificed in order to try to stabilise its financial position. So, I am sure that you are right about the patchy nature of this.

[71] Commissioner, this is the first major session of our inquiry. It is a scene-setting session. We have had a large number of very important issues rehearsed, albeit very briefly, this morning, but I want to ensure, in the few minutes that we have left, that you have a chance to catch up on some issues that we have not raised. I noticed that, once or twice, you mentioned having the chance to come back to something; maybe we have come back to them, but if not, now is the chance to do so. Also, this is an opportunity for all of the witnesses to tell us, as we proceed with more detailed work over the next few months, which issues they believe are important to keep at the forefront of our minds.

[72] **Ms Marks:** Sarah will cover the advocacy review, Alun will pick up the issues that he wants to cover and I have a couple of things that I would like to leave you with.

[73] **Ms Stone:** We are conducting a review of the adequacy of advocacy arrangements for older people in care homes. It is not just about ticking a box that says that these people have access to advocacy. It is about the choice and control that people have in care. We will be doing significant work on that over the coming year. It is our intention to make recommendations to the Welsh Government and others. That is something that we are considering as we sift all of the evidence. So, this is a chance to raise people's expectations of the degree of self-determination that they can have when they are in a care home. Before coming to this committee meeting, we spoke about the big picture and what is at stake in getting residential care right in Wales. The issue of self-determination for older people was something that we really wanted to impress upon the committee. I really believe that there is absolutely unacceptable variation in the quality of care at the moment. There is very good care, but there is also care that we hear about that is absolutely not so. It is not necessarily the case that this care is failing inspections. However, it is about stimulation, the ability of a human being to have a meaningful life, wherever they are and whatever their level of dependency or need. We have the opportunity to make that so much better, and I hope that the committee's inquiry can play a significant part in that. We are hoping that our advocacy review recommendations will play a part in driving that kind of change.

[74] **Mr Thomas:** I want to reflect on some of the issues around the notion that one size does not fit all, and the importance of recognising diverse needs. First, in relation to Welsh speakers sometimes being lost in care settings, there are particular concerns where people have to travel a distance for specialist provision. Sometimes, people have to move from Welsh-speaking communities and travel long distances to the place where the provision is provided. In this context, journeys through to the north Wales coast are particularly relevant. There are also real fears that we have picked up from Welsh speakers who are living in local authority homes that are under threat. The language mix of those homes may well be changed in terms of having to transfer to the independent or voluntary sector, and we need to be aware of that. Research is being undertaken by the University of Glamorgan that is looking at dignity and respect for older people from black and minority ethnic communities. Certainly, there is a distinct danger that people are being lost in care at the moment. There is also research that will be reported next year by Swansea University that is looking at the experiences of older lesbian, gay, bisexual and transgender people within residential care settings. Our knowledge at the moment is that people are more dependent on formal care and more likely to be isolated in later life, with their sexual orientation. Again, it will be very interesting to follow the course of that research.

[75] **Ms Marks:** I would just like to make some closing remarks on information and

advice services, and the importance of information sharing across agencies. It picks up on Lindsay's point earlier about the importance of joint working across health, housing and social care, not only for older people in residential care now who might be considering residential care in the short-term, but for planning ahead and spotting trends and needs as they are going to change and emerge during the next five, 10 or 20 years. Do not forget the Dilnot commission, and always remember that we are talking about someone's home.

[76] **Mark Drakeford:** Diolch yn fawr i chi i gyd am ddod i'r cyfarfod y bore yma ac am dystiolaeth ddiddorol dros ben. Bydd trawsgrifiad o'r cyfarfod yn cael ei anfon atoch, fel arfer, i gywiro unrhyw gamgymeriadau ffeithiol. Fodd bynnag, diolch i chi am ddod yma'r bore yma; bu'n ddefnyddiol iawn i ni.

Mark Drakeford: Thank you all very much for coming to this meeting this morning and for the extremely interesting evidence. A transcript of the meeting will be sent to you, as usual, for you to correct any factual errors. However, thank you for coming here this morning; it has been very useful.

[77] Cyn i ni droi at eitem 3, hoffwn nodi'n ffurfiol ein bod wedi cael ymddiheuriadau gan Kirsty Williams. Bu farw ei thad brynhawn ddoe, ac, ar ran y pwyllgor, nodaf ein cydymdeimlad â hi yn ei cholled.

Before we turn to item 3, I would like to note formally that we have received apologies from Kirsty Williams. Her father died yesterday afternoon, and, on behalf of the committee, I extend our sympathies to her in her bereavement.

10.06 a.m.

Ymchwiliad i Ofal Preswyl i Bobl Hŷn: Tystiolaeth gan raglen Fy Mywyd mewn Cartref
Inquiry into Residential Care for Older People: Evidence from the My Home Life programme

[78] **Mark Drakeford:** Symudwn ymlaen at eitem 3. Mae tystion eraill yn ymuno â ni.

Mark Drakeford: We will move on to item 3, for which other witnesses will join us.

[79] Bore da a chroeso. Diolch yn fawr am ddod i'r pwyllgor y bore yma. Rydym yn troi at eitem 3, sef tystiolaeth gan raglen Fy Mywyd mewn Cartref ar gyfer ein hymchwiliad i ofal preswyl i bobl hŷn. Hoffwn groesawu Tom Owen, cyfarwyddwr My Home Life UK, a John Moore, rheolwr rhaglen Fy Mywyd mewn Cartref Cymru. Diolch am eich tystiolaeth ysgrifenedig. Rydym i gyd wedi cael cyfle i'w darllen. Mae cyfle i chi wneud unrhyw ddatganiadau agoriadol byr yn awr, cyn imi droi at aelodau'r pwyllgor i'ch holi.

Welcome and good morning. Thank you very much for coming to the committee this morning. We turn to item 3, which is evidence from the My Home Life programme for our inquiry into residential care for older people. I welcome Tom Owen, director of My Home Life UK, and John Moore, manager of the My Home Life Wales programme. Thank you for your written evidence. We have all had an opportunity to read it. There is now an opportunity for you to give brief opening statements, before I turn to committee members for questions.

[80] Thank you for being with us today and for helping us on the first main day of our inquiry into residential care services for older people. Thank you for your written evidence. I invite you to begin with a few brief remarks, highlighting any points you think are particularly important for us to grasp. We will start that way, and then it will be over to members of the committee for questions. At the end, I hope that there will be a chance for me to come back to you, either for you to highlight any points that have not emerged in the evidence, or to leave us with any key messages you think are particularly important for us to

have at the forefront of our minds as we pursue this inquiry during the coming months.

[81] **Mr Owen:** I am Tom Owen, the national director of My Home Life UK, which is a programme all about trying to support the quality of life in care homes, led by Age UK and Age Cymru in partnership with City University London and the Joseph Rowntree Foundation. It is important for me to tell you a bit about how My Home Life works. Rather than identifying problems and blaming practitioners in the care home sector for those problems, our starting point is very much about exploring what residents want and what works well in care homes. We try to work in collaboration with a bottom-up approach with care homes to try to grow that good practice.

[82] The key message for us, and the main message to you, is that care homes, if properly supported and properly invested in, can deliver a very positive choice for older people, and particularly those with high support needs. They can deliver really good care for those people who, if they are living on their own and receiving limited domiciliary care packages, may not be getting the kind of choices people get in care homes, particularly relating to very basic needs, such as the need to use the toilet, the need for food and the need for reassurance, particularly for those who are mentally and psychologically frail.

[83] However, we have not seen the support and investment needed in care homes in many years. I can talk mainly from the UK perspective, although John can come in on this in a minute. Remembering that this is 24-hour professional specialised care for people who are increasingly frail, the typical public funding for this is around £2.50 per hour. That is what it works out as. Beyond that, the sector has not had the sort of investment needed in terms of leadership and professional capacity to meet the needs of older people who are highly frail. A great deal of our work is about getting into care homes and really understanding the day-to-day challenges but also the opportunities for managers and staff in trying to deliver quality of life. Another message is to do with how managers need that ongoing independent professional support to cope with the huge amount of anxiety and stress, so that they can share that and support their staff. They also need the support of the health and social care system to help them to deliver that care. That is the main message from us.

[84] **Mr Moore:** Thank you for inviting me today; I appreciate the opportunity very much. It is my great privilege to have been working on this programme since the beginning of March 2009 and to have been able to go into people's homes, the care home they live in, and chat to lots and lots of residents, their families as visitors, managers and all the different levels of staff in care homes to see exactly what quality of life looks like now in lots of different environments. We have worked with lots of care homes, and I have worked with 38 homes intensively over the past three years. They are all very different with different approaches. What they do comes in different shapes and sizes in different services. However, they are dealing with similar groups of people—older people who are physically and mentally frail. The staff members and staff teams look very similar as well. The pressures that homes are under are obviously very similar across Wales as are the expectations from CSSIW, local authorities and others that have an impact on what care homes do.

[85] It has been a great privilege to be able to go in to see that, how things are working out in different parts of the country and to hear the messages of those different groups of individuals—the residents, the families and staff—about the things that really affect quality of life of the residents, most importantly, and the things that affect the staff and the family members visiting the homes.

[86] **Mark Drakeford:** Indeed. Capturing the experience of people who live and work in residential care is one of the key themes of our inquiry, so we are very glad to have a chance to learn from your experience of that so far.

[87] **Mick Antoniw:** I have two points, one of which is on community engagement. First, with regard to your research messages, on page 22 of your paper, one of the things you are looking at is the amount of time homes have spent looking after people and dealing with things such as quality of life. Of course, no-one wants to promote unnecessary bureaucracy and wasting time on that, but what is your thinking when, for example, you refer to the burden of bureaucracy relating to things such as fire prevention and health and safety. What sort of examples do you have of where people have been overburdened by the amount of time needed to spend on these areas, because these are areas that we would see as being of fundamental importance with regard to the security and safety of people in residential care?

[88] **Mr Owen:** I think it is an almost unanimous view among managers that paperwork has increased hugely over the past 10 or 15 years. It depends what we want from the role of a manager. If their role is to work with the staff towards the primary aim of supporting quality by building relationships and engaging with and understanding the needs of individuals, you need managers on the floor modelling good practice, supporting their staff and helping them to reflect on what they are doing and really thinking about the work.

10.15 a.m.

[89] Many of them will say that they spend a large proportion of their time sat behind a desk. Yes, there is a vital need for regulation, for health and safety, but then there is the additional paperwork. There is often a double regulation, with commissioners developing their own quality indicators that people need to measure themselves against. There is a lack of clarity about the fact that you might have key policies, but, in terms of their operation, there may be a difference of opinion between a commissioner and a monitoring officer in the local authority and a regulator. Many care home managers said they have to constantly cover their backs in any decisions they make. They want to support older people to take informed risks that benefit them and their identity, but they constantly use reams of paper in writing about any potential risks involved. If things go wrong—and they do in care homes because of the complexity of the health and social care needs of the population—a tsunami of agencies come on them. They start from a position of mistrust and suspicion and expect them to demonstrate evidence of everything. For example, a manager wanted a greenhouse in the care home garden because they had a gentleman resident who loved gardening and they wanted to support his identity. However, there was a risk assessment process because of the glass, and the regulator raised many concerns about the glass of the greenhouse, as well as the compost. They had to go through all the chemicals in the compost to check whether it was appropriate to have in the greenhouse. She might have been taking that over the top, but the perception is that whatever managers do, they are going to be hit on the head by the outside world. Some of that is about the paperwork that comes directly from agencies and the ongoing need to comply with things. However, some of it is about managers' desperate need to somehow cover their backs.

[90] **Mick Antoniw:** Is it an issue to do with the quality of management? Is that the perception? Those of us who have been involved in some of these areas would say that some of the things are serious issues, but if they are handled with common sense, they are not an issue. Is this about perception, relating to the experience and quality of the management, rather than the fact that you need to ensure a quality environment?

[91] **Mr Owen:** It is a mixture of both. There is a sense that care homes have a fear of the outside world, because many behaviours and attitudes towards care homes come from that starting point. Even the community comes in and connects with the care homes from a position of suspicion. We have very specific examples. I have done a lot of work with monitoring officers—the people in local authorities who oversee care homes—and they will admit that they start from a position of suspicion. One person said, 'I will start by expecting to look for problems, even if the manager says that they do not exist'. There is that fear and

anxiety. There was an example of a lady who had a fall, a lady who the care home knew well. She was lying on the floor and they had not put a blanket over her because they knew that she did not like too much interference from other people. She was an isolated, lone woman who did not like interference. The ambulance people came—this was not in Wales, by the way—and referred the case because they had not put a blanket over the woman, even though they did it for the right reasons. That led to a major long-term investigation. It was a lengthy investigation because the police and others did not visit and deal with it quickly. During that investigation, they were not allowed to take any more local authority residents and they had to tell all the relatives that an investigation was happening. Again, that amplified the mistrust that already existed in the community. There is a perception, but there is also a reality to it. John, do you have anything else to add?

[92] **Mr Moore:** Your point about the different levels and areas of responsibility that the manager has is interesting. The manager is the head of a community. A care home is a small community within the wider community. The manager has responsibility for everything that goes on in that community—health, wellbeing, delivery of the service, health and safety, and so on. That is a huge challenge within the care home for most managers, and I do not know whether every manager is really prepared for that.

[93] **Mick Antoniw:** Do you think that there is a problem with management being up to the task and the responsibility? Is that an issue that exists within residential homes?

[94] **Mr Moore:** Yes, in some cases. Up until now, when managers came into the role, they had to go through a fit person interview with CSSIW to register. Is that enough? You must take into account the whole role to see whether the person is right for that role, given the level and range of responsibility.

[95] Going back to the pressures on managers, there tends to be an awful lot of duplication in the questions that are asked of care homes. There is CSSIW and its inspection regimes, which we know are undergoing change. It is not a great stretch of the imagination to say that the local authority contract compliance officer could come in the next week and ask exactly the same questions. The fire regulators or Healthcare Inspectorate Wales could then come in during the following weeks and ask some of the same questions. Sometimes, they are answering the same questions over and over.

[96] **Lindsay Whittle:** Having been involved with care homes for some time, I do not regard the role of care home managers and workers as a job. Anyone who regards that role as a job should not be there. I regard it as a vocation that should be as highly regarded within our society as the role of doctors and nurses in hospitals. Did you find any evidence that they are as highly regarded?

[97] **Mr Owen:** No, not at all. A Skills for Care survey in England showed that most care workers felt that they were not valued by society. There is a sense that care assistants can be slightly embarrassed about telling their friends that they work in an older people's home or a care home. However, those who work with animals as veterinary assistants or who work as hospice assistants are happy to say so. Managers are not valued by the other professionals within the health and social care system. We often find that nurses do not listen to managers, even though managers should be, and often are, the experts in relation to the care that is being delivered in the care home. Similarly, in England, we have experience—John, please nudge me if you do not feel that this is relevant to Wales—of out-of-hours general practitioners completely ignoring the recommendations of the manager, particularly when a resident is near to the end of their life and wants to stay in the care home, because it is their home, but the out-of-hours GP wants to get them into hospital as soon as possible, which is clearly not positive for the resident. Do you have anything to add on that, John?

[98] **Mr Moore:** We have lots of anecdotal evidence from across the board over the past few years from nurses who feel that they are treated as second or third-class nurses because they work in a care home setting and not in an NHS health facility setting. We have examples of nurses not being listened to when they go onto wards to do an assessment prior to an admission to a care home. We have many examples of that. There are lots of examples of residents valuing the support that they get from the home, from the individual workers who they have built up good relationships with, and of families who greatly appreciate that. I have received lots of comments, from families especially, about care workers not being valued. I am told, 'These people are just not paid enough for what they do'.

[99] The role of care workers is not just to look after people; that is not their job. It is about supporting older people to get the best out of their lives. That is what those workers are there to do, but we do not really value some of the great work that is going on. You mentioned people having a vocation to work in this area. We rely a great deal on people giving of themselves and of their qualities. When we see good care and support in action, we rely on people's sense of caring, kindness, consideration, compassion, understanding and empathy, and rely on people giving those things freely. Those are not trained qualities—you cannot train someone to do that. We rely on people to give those things freely, and, when they do that, you see some excellent care and fantastic examples of good practice in care homes.

[100] **Lindsay Whittle:** Thank you for that; I knew when I asked the question that that would be your answer. I have had examples in the past of residents saying about their carer, 'This is the daughter or son I never had'. If we do nothing else today except highlight the fact that these people are doing a superb job, by and large, we will have done a great service. So, thank you for that.

[101] **Mr Moore:** The other side of that is that we sometimes get older people not being valued by those who are in the position of caring for them and supporting them. A resident in a care home just outside of Cardiff said that, shortly after she moved in, she realised that the workers in the home were there to care for her, not to care about her. That tells me everything about what a care home should not be, but it also tells me everything that a care home should be. This person felt that she was not being valued as an individual, and was just being supported in the way that she had to be supported.

[102] **Lindsay Whittle:** We often read in newspapers and hear on television about poor carers, and that obviously has to be highlighted, but we are missing a whole army of people who are doing a superb job.

[103] **Vaughan Gething:** I want to come back partly to some of the points that Mick made and then go on to talk about the quality of care. Earlier, we were talking about approaches to regulation and paperwork, and I think that you were saying that we needed a smarter way to do the same sort of regulation, rather than removing the areas of regulation or not requiring care homes to evidence what they do in writing. It would be helpful if you could clarify that.

[104] I also want to talk about quality and the points in your written evidence on pages 17, 18 and 19 in particular. Looking at practice in other areas of life, I tend to find that good managers run good institutions. You tend not to find good managers running poor institutions, whether it is a school or a care home. On page 17, you note that the care home sector in Wales is mostly made up of small independent sector providers and note the problems in terms of peer support. I want to link that to the point about quality that you make on page 19. In your evidence you say that many people are now happier in their care home than they were but that their previous experience of residential care, if they had one, had been poor in the main, and a lot of that was to do with the people and approach taken. Is there a link between smaller care homes, where managers have less support, and the quality of care provided, or do you not find a link between those larger institutions and the premium that they place on peer

support and training for staff?

[105] **Mr Owen:** It is probably quite a complex picture. We find that there are some care home providers that are quite autocratic in the way that they organise themselves, so that is about a bit of support, but also very much about telling the manager what to do, which in some ways does not support the manager to be able to try things out and take the initiative, take ownership and work with their team. Then, there are other providers where the organisation is completely set up to support the manager. We have great examples of providers that provide ongoing leadership support to their managers, they lean forward into complaints and welcome them as a way of learning and sharing, and they do not start from a position of blame, which helps the ethos. It helps people to feel free and not feel anxious. If you do not feel anxious as a manager, then anxiety does not pervade the culture of the home; you do not then have anxious staff, residents and relatives.

10.30 a.m.

[106] With regard to the smaller homes, some get great support from their owners; others get very poor support—sometimes there is a real detachment between owners and managers. We had an example the other day of a manager who was in all kind of trouble to do with care, and the owner completely backed away and said, 'You are on your own', so it is very variable, and it is very much about whether owners are in there because they love the work, they want to be part of it, and they are coming from a position of confidence, or whether they are coming from a position of, 'My goodness, we have to make sure that we tick every box, and that we cover our backs all the time—anything that could potentially go wrong, we have to sort out'. I have just one last point on that, which is that, if we want quality, a controlling organisation will stifle that. An organisation that controls from the top will feed down to managers who will then do what they can to control the staff, which means telling them what to do rather than helping them to engage with the work, and with their relationships with their residents and relatives, which is at the heart of good quality. The ones that are more enabling are the ones where you get better quality, in my view.

[107] **Mr Moore:** Obviously, the tapestry is very mixed in Wales. There is a great difference and variety in the homes that you have mentioned there. In the smaller homes the relationships and the freedom to pursue new things and to go down new avenues and investigate new things, are obviously stronger. Every home has its own unique personality, and that is made up of the manager, their ethos, their leadership, and where they are going with the home, the resident community and the impact that it has and what it wants from the home, the families that visit the home, and the staff team. They all impact upon and shape the individual identity of that home. When the home is bigger, that can be difficult to handle. If you have 70, 80, 90 or 100 residents, then things can become a wee bit detached and fragmented in some cases. In my experience, working with an array of different types and sizes of home, the smaller homes are better suited to having a handle on what the personality of the home is, and how best to react to the needs of that shared personality, make changes, and investigate new developments. They are more in touch with how they are able to do that. Sometimes in a home that is part of a larger organisation, for example a local authority, or of a large group, if the manager wants to go down a certain road with a new initiative, there would be certain layers of management and hoops that they would have to go through to get permission to do that. That might take time, and six months later an answer might come back, and it might be 'no'. That time will have passed with nothing happening on the new initiative that they were excited about. Sometimes in the smaller organisations, it is not like that. Things are able to be looked at much more quickly, and things can be acted upon, if that is the right thing to do. That is a benefit sometimes in a smaller environment.

[108] **Vaughan Gething:** I have one small, follow-up question. I understand the point that you are making about the variation in small and large organisations, and obviously that is not

in itself a determining factor in the quality of care provided. Just to pick up the point that you made about the size of the individual home, or residential centre, do you have a view about an optimum size? If you are saying that 70, 80, 90 or 100 residents is too big, do you have a view on what is manageable and sensible? Equally, do you have a view on care homes that are too small?

[109] **Mr Owen:** I do not think that there is any very clear research evidence about the link between care quality and the size of the home. That is not there at the moment—it is too complicated. The potential to deliver quality is perhaps greater in the smaller homes, but that is from our experience rather than research evidence.

[110] **Vaughan Gething:** What is a 'smaller home'? You are referring to smaller homes: is that one with 10 residents or 20 or 30?

[111] **Mr Owen:** There are homes that work with five or six residents, and they can provide wonderful care, but, at the same time, they sometimes become less able to reflect, because they are so small that there are usually just one or two staff members, or one manager and a member of staff, so sometimes there are challenges around that too. I am sorry not to be able to give you a concrete answer on that—it is just kind of complicated.

[112] **Mr Moore:** The homes that I have been working with over the past three years range from a home with seven residents in Carmarthenshire to a home that I have recently been working with in Swansea, which has 100 residents, and is looking to enlarge its capacity to 120. You go from a very small situation in a home with seven residents, which feels very much like a large family and has that kind of atmosphere, and the home itself is just a large house. I do not think that it is impossible for larger homes to recreate that atmosphere or that feeling of closeness, but the way in which they do it has to be managed very closely. Many homes have gone down the avenue of having small wings or small units, especially in dementia care, with up to nine or 10 residents in small units. That pattern is then recreated throughout the whole home, which may have many more residents. However, the approach of the manager and the staff and the way in which the staffing regime is set up within the home need to be looked at. So, I do not think that we can say that there is an optimum number or a perfect size for a home.

[113] **Mark Drakeford:** We will move on to Darren next and then Rebecca. I then want to give you a chance to offer the committee a couple of examples where the work of the My Home Life project, in going into residential care homes and providing the sort of input that you do, has been able to improve the quality of life of residents. It would be very useful for us to hear a couple of practical examples where you can tell us that something that is not as good as it could be could be turned into something much better with the sort of interventions that you are able to bring. I do not want us to miss the chance to hear a little of that.

[114] **Darren Millar:** You will have to forgive my ignorance, but I had no idea that your organisation existed and I had no idea as to what you did, other than the information provided in the papers and the little bit more that you have offered this morning. Thirty eight care homes are working with you at the moment, which is a very small number given that there are around 700 in Wales. How do homes access your programme and the support that you can give them?

[115] **Mr Moore:** The 38 that we are working with represents 5% of the sector in Wales at the moment. When we started at the end of 2008-09, we invited homes to come to work with us. We were charged by our funder, Health Challenge Wales, to work with small groups of homes over a period of time during the introductory part of our work. So, we worked with seven or eight homes through three separate phases. We worked with 22 at first, and then we brought some more homes on board. Homes volunteered to work with us. They were self-

electing, really. That told me something straight away about the type of homes that we were working with. Having worked in the care sector for a number of years in different guises, and having previously worked in local authorities such as Powys in mid Wales, my experience was that care homes that are looking to develop and are interested in developing quality, homes that are looking to do the right thing and to build quality earnestly, will volunteer for projects and pilot projects, they will come to the local provider fora that are organised by the local authority, and they will go to conferences and attend workshops. They look for opportunities to engage with the wider sector to improve their practice and their service. We do not hear from the homes that we may be worried about and which may not be providing the services that they should. They do not come to provider fora or conferences and they do not volunteer for projects; they are not there. So, I knew that when these homes came forward and said that they were interested in working with us, we were looking at homes that already probably had at least quite good services and were towards the good end of the market. So, I knew that, with those homes, we would find some very good practice, because they are looking to improve. They were probably already doing some quite good stuff.

[116] **Darren Millar:** In terms of the geography, are those homes located across the length and breadth of Wales? They are not confined to the south, west or east, are they?

[117] **Mr Moore:** No, we have 38 homes across 18 local authority areas.

[118] **Darren Millar:** That is a good spread.

[119] **Mr Moore:** We have tried to build up that representation from the population-heavy areas as well. We are looking to work with them nationally to establish a national network, but also on a regional basis. We have split the 38 into four regions: north Wales, the south-west, central and south-east Wales. There are nine or 10 homes in each of those regions. Apart from the 38 homes that we have been working with intensively so far, over 220 homes have approached us and have wanted to be involved, but we have had to turn them down—and these are homes that have attended conferences and some of our training events. So, that means that the number of homes that have actively come to us represents about a third of the sector.

[120] **Darren Millar:** May I clarify that? You are saying that you do not have the capacity to support the number of homes that are coming to you, asking for support at the moment. Is that because of your funding or the size of the organisation within Wales?

[121] **Mr Owen:** It is funding.

[122] **Darren Millar:** So, where does all of your funding come from? Forgive my ignorance, but it was not in your paper. You said that you were funded by some voluntary sector small grants from HCW. Is that all of the funding that you receive or do you also get funding from other sources?

[123] **Mr Moore:** In Wales, it is 100% funding from the voluntary sector small grant, which is facilitated by Health Challenge Wales.

[124] **Darren Millar:** How much is that funding?

[125] **Mr Moore:** It is roughly £103,000 per annum.

[126] **Darren Millar:** Thank you for that; it has helped to clarify some issues in my mind. Turning to the quality of care, you have made what seem to be very reasonable recommendations about care home managers who might feel isolated because they are not part of a wider group, and who might be so busy and rushed off their feet that they are not

able to get to the meetings that you might put on to encourage and promote quality of care. You have talked about trying to create networks of individual care home managers so that they can come together to support and encourage each other, and talk through some of the problems related to the job. How do you see those networks being built up? Do you think that it is something that will evolve naturally or will it take an organisation such as yours to build that capacity? I suppose that once the pendulum starts swinging, it keeps on swinging, but starting these things off can be quite difficult.

[127] **Mr Owen:** England has a slightly different model to Wales. In England, the networks we develop are around supporting small groups of managers and having an independent, highly skilled facilitator to help them to process some of the serious challenges that they face. That has produced remarkable outcomes, and I shall mention some of them after these questions. When you take away that independent facilitator, groups of managers sometimes come together, but it does not have the same kind of value and impact as having someone there to support and hold that group so that managers can be completely open and honest about sharing some of the real challenges that they face.

[128] In England, and I think in Wales too, there is a real and increasing desire for managers to have that type of support. Managers typically see themselves as competitors with one another as their starting point, and they are also very worried about sharing some of their problems because there is a sense of, 'Oh, I thought it was just me that had those problems'. It is great when they find out that it is not just them, and that others also have them. So, it is about allowing these networks to evolve naturally on their own. The evidence is that they did not exist in the past, so why would they exist without someone coming in to try to support them to happen?

[129] **Darren Millar:** I appreciate that you are producing many documents containing best practice—you have listed many of them in your paper. However, in terms of seeing the end result, given that you are an organisation that is trying to promote best practice, how are you able to identify and track the difference that that information is making to those that are participating? Are there fewer recommendations in their inspectorate reports, for example, and those types of things? Are the improvements measurable?

[130] **Mr Owen:** We are tracking that in England at the moment; the Care Quality Commission is doing some work for us on that. Rather than starting from a position of saying, 'Right, we need to be measuring you as managers', we recognise that the world is measuring managers, because every agency is doing so, and we are there to offer support. Over the journey—I think that it is the same in Wales—they tell us what they have done and what their changes have been. They have never been able to do that before. So, we have qualitative data, which is being written up as we speak, on some of the fundamental changes in terms of managers' ability to develop their confidence, to challenge inappropriate staff behaviour, to engage staff better in their work, to challenge outside agencies and to work better with relatives. We have countless examples of those types of outcomes. They also complete a survey at the end which asks how it has improved things after 12 months. It is a self-report for managers, but they all say that it has improved the quality of life of their residents, their relatives and staff.

[131] **Darren Millar:** I have one final question, which will be very brief. There does not seem to have been a great deal of work done on spiritual care in residential care home settings. I know that you are working with some faith-based care homes. How good, in your opinion, is the spiritual care in the other care home settings that you are working with? Are there any recommendations that the committee might want to consider as part of our work in order to promote good spiritual care?

10.45 a.m.

[132] **Mr Owen:** Do you have an idea on that?

[133] **Mr Moore:** There are two sides to that. There is the spiritual aspect to people's needs and also the religious aspect to people's needs. Those areas, as you know, are quite different sometimes. For the older population, the religious needs are quite great. There is great variety and there is a patchiness about how people are supported in that way. We are seeing great changes in that, because of the changes in the care home population, as new generations come into care settings. We are now getting people coming into care settings who are in their early 70s, who lived through and were the life and soul of the 1960s, for example. So, we are seeing a great change in the lifestyles that people bring with them, the belief systems that people have and what makes up their personal identity. We also need to react to that. However, the religious needs of people are met in a patchy way. We know that, in general, in terms of the religious needs of the population at large, things have changed greatly so that, in some areas, services are not available locally or they may be available only once a week, once a fortnight or once a month. Obviously, on the needs that people have for a visiting minister or clergymen to come in, those needs may not be met as much as they would have expected 30 or 40 years ago when they were attending church every day. The landscape of religious needs has changed.

[134] On the spiritual aspect and the spiritual wellbeing of an individual, that is wrapped in with the My Home Life approach to quality of life and wellbeing, in which people are able and are supported to be at peace with themselves, to enjoy their lives and to have goals to attain. That is part of the whole approach.

[135] **Mr Owen:** We know that when care homes work well, you are more likely to have a better spiritual and religious input from the care home. It is often the case that in care homes where there is a certain amount of disengagement or emotional detachment between staff and residents, there is no way to gather intelligence about what is meaningful to a resident. When we work with care homes and their managers, they get a greater strength of connection between residents and staff. So, it is not about the tasks—you get some staff who get very excited about the fact that they have got five people up in an hour. Being able to get rid of that great focus on tasks, so that they realise that it is about human beings and working and living together in a community, means that there is much more emotional engagement, and, from that, huge things flow out. That is where we have seen real outcomes. There is one home that never had any engagement from churches, partly because it did not feel that it had the time or the confidence to go out and get it, but also because the staff were not taking the initiative to suggest that it might be a good thing to do. Now, it has three different churches coming in on a weekly basis. So, it can work in care homes. It is important for you to understand that there is some fairly ordinary care out there, but that is partly because of the lack of support and investment to make it flourish and thrive.

[136] **Mark Drakeford:** One or two of us here remember the 1960s.

[137] **Rebecca Evans:** I do not.

[138] **Mark Drakeford:** As you do not, Rebecca, we will go to you next—I am sorry, but Lynne had a specific question on that point.

[139] **Lynne Neagle:** You say that you cover 18 local authorities. In which local authorities are you not operating?

[140] **Mr Moore:** The four local authorities in which we are not working with homes presently are Anglesey—Ynys Môn—Blaenau Gwent, Denbighshire and Ceredigion.

[141] **Lynne Neagle:** Will you be taking steps to try to engage with homes in—

[142] **Mr Moore:** Very much so. We have a quarterly newsletter that started in early 2009, which goes out to every single care home for older people in Wales and has done since that period of time. It contains information about what we are doing, news from the sector and new things that we want to get managers and homes involved with. So, every single care home at least gets that from us on a quarterly basis. We also signpost to our webpages, which have resources and news reports on all the different things that are happening. We are publishing new resources. We are developing hard resources and trainee events for homes, and we publicise those to the whole sector. We work very closely with Care Forum Wales to get the sector engaged. We also have working relationships with the Care Council for Wales and with the CSSIW, which have representatives on our advisory group, which meets bi-monthly, to make sure that we are trying to reach the whole sector.

[143] **Rebecca Evans:** I have just one question. Could you expand on your comments in the paper on what makes a good, managed and planned transition into care in the first place and then between care homes? Do you have examples of good practice, and how prevalent is that? What are your major concerns, insofar as transition is concerned?

[144] **Mr Owen:** We have done quite a lot of work on this. Clearly, the transition into a care home is probably the biggest life change in our time on this planet. It is a huge emotional upheaval, because you will have lost your health, and it often involves the loss of a loved one who has been looking after you. You are losing your home and being told that you have to go into a care home, and perhaps all you know about care homes is what you have read in the newspapers, which is not always great news. So, it can be a very frightening thing for older people. On top of that, there is the use of policy in trying to move people out of hospitals as quickly as possible, and that kind of goes against the policy of wanting to support choice and control for older people. You could be at your most vulnerable—you do feel very vulnerable in hospital, and you might also have significant health and mental frailties—when you are asked to think through this transition, and you and your relatives are being asked to do it very quickly. There is a lot of pressure on relatives to find a home, sort it all out and work out all the finances, and they start from a position of being really very ignorant. It can work well, and we have been doing some work in England to bring along the hospital staff, social workers and care homes, simply to get to know each other—I think that things are a bit better in Wales, but certainly, in England, these groups are really divorced from each other. We get them together to work out what works well and how they can better support care homes through this process.

[145] Advocacy is a great way of supporting them. Slowing things down so that they have time to process what is happening is very important. There is a sense that, when somebody comes into a care home, they are not given the opportunity to communicate and express their distress or anger at what has happened to them. We are therefore working with care homes to see how fundamental it is, particularly in those first few months, so that they allow such people the space and safety to process what on earth has happened to them. If you do not do that, they cannot move forward and think about what they want from the care home in terms of their quality of life. So, for care homes, having an induction process for residents and relatives, as you might have for staff, is crucial.

[146] There is also the issue of nurses' better understanding of the roles of care homes and what they can and cannot deliver in the timescales, so that care homes are not receiving older people at 10 p.m. or 11 p.m.—it is ridiculous that that happens. There is a fundamental structural issue, however, to do with the time given to this. You can tell me whether this is happening in Wales, but in England, there is more of a move towards having intermediate care—a place where you will receive rehab and you can have a bit of time out of hospital to think through your options. Sometimes, that rehab happens in a care home, but you recognise

that that is a temporary placing for you to consider things. However, that is still not very common; it is quite limited across England.

[147] **Mark Drakeford:** We are very much running out of time now, so you will have to be brief, I am afraid. We will let you have the last word.

[148] **Mr Moore:** I think that the population at large has quite a negative image of care homes, so when people move into one, they come from a very negative perspective, and so do their families. That is a very vulnerable position for them to be in. Time needs to be taken with the families and the individual. There are also problems with being discharged from hospital, which have been mentioned. Anecdotal examples from the sector suggest that hospitals discharge people to a care home only at weekends because they know that the manager of the care home is not on shift, so they know that they will not have anyone difficult to deal with. So, they will discharge someone at the weekend when the manager is not there. There are a lot of anecdotal examples of that sort of thing happening.

[149] The approach of the home in building up a real partnership with the individual resident and their families is important. We know that that is difficult sometimes, because it might be an emergency admission, which is difficult to prepare for in advance. We encourage managers to look at this as a partnership approach. Families are pushed to having to choose a home from a list of three, with 10 days to make a choice. Families do not know what they are looking for or how to tell a good home from a bad one. They need much advice and information. We are looking at developing a resource for individuals and their families around their journey into care homes and what guidance we can give them to help them along that journey, especially if that journey has to happen quickly.

[150] **Mark Drakeford:** Thank you. I am sorry to have to guillotine the session, but we have a heavy agenda today, and other people are waiting to give evidence to us, so I am afraid that we cannot afford to run on. Thank you both very much for the evidence that we have had. I invite you to suggest to us on paper any key issues that you think that we must make sure that we keep in the forefront of our minds as the inquiry goes on. We have some opportunities in our timetable for members of the committee to go out and about in Wales, visiting different aspects of residential care. There may be an opportunity for one or two of us to see some of the work of My Home Life out there on the ground. A transcript of the meeting will be sent to you in case there are any factual issues in it that you need to clarify. We are grateful for your time this morning.

[151] Rydym yn mynd i gael egwyl fer a byddwn yn ailymgynnull am 11.05 a.m..

We will take a short break and reconvene at 11.05 a.m..

Gohiriwyd y cyfarfod rhwng 10.57 a.m. a 11.07 a.m.
The meeting adjourned between 10.57 a.m. and 11.07 a.m.

Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Tystiolaeth gan y Sefydliad Gofal Cymdeithasol er Rhagoriaeth a'r Sefydliad Gofal Cyhoeddus
Inquiry into Residential Care for Older People—Evidence from the Social Care Institute for Excellence and the Institute of Public Care

[152] **Mark Drakeford:** Welcome to you both to the Health and Social Care Committee, and thank you for coming here this morning. We will offer you a few minutes at the beginning to highlight any point that you particularly want to draw attention to in your evidence. Thank you for your written evidence, which we have received. There will then be a chance for committee members to ask questions—there are lots of questions. We have been under a lot of pressure with time this morning with previous witnesses, so I appeal to

committee members and witnesses to keep questions and answers as focused as possible. It is not easy, because this is our first substantive session and we are looking at big-picture issues. So, there is often quite a lot of meat behind the issues that we will be raising with you.

[153] First, I will ensure that we all know who everyone is. Julie Jones is the chief executive of the Social Care Institute for Excellence, and Professor John Bolton is an associate of the Institute of Public Care. Julie, would you like to go first?

[154] **Ms Jones:** Thank you for the invitation and the opportunity to provide some written evidence and then to follow that up this morning. The Social Care Institute for Excellence is a UK-wide knowledge-transfer body. We try to collect evidence about what works in social care, with a particular focus on practice. Our remit covers England, Wales and Northern Ireland. We cover children services as well as adult services, including older people services, which is a very broad range.

[155] I was fortunate to be on the independent commission in Wales in 2010, and spent most of 2010 moving around Wales listening very hard, which led to that independent commission report. I did that in a personal capacity, but SCIE also has a relationship with Wales and the improvement agenda in Wales, which goes back 10 or 11 years now.

[156] In the evidence that we have given on older people and residential care, we have focused specifically on information and advice, and the very difficult circumstances in which people are often asked to make what are very significant life-changing decisions. We have also focused on the quality agenda, with a particular emphasis on what in England is called personalisation, but in truth is person and family-centred care, and how to make whatever setting social care is delivered in a personal experience for the people who are using the services and their families. We have focused on dementia care, which is so significant now for residential care home providers across the UK, and we have focused on the dignity agenda, which is a very serious agenda in Wales. So, we focused on those issues, rather than try to cover what is an extremely broad remit for your committee.

[157] **Mark Drakeford:** Thank you very much. I would just like to clarify for our information: the independent commission will be known as the Pearson review, will it not?

[158] **Ms Jones:** Yes, that is right.

[159] **Mark Drakeford:** I just wanted to make sure that everyone had that information.

[160] John, would you like to make some introductory remarks?

[161] **Professor Bolton:** Yes. I hope that my late submission has been received by you. I apologise that it was late; that was partly because your officials encouraged us to do a particular piece of work around the market, which we were only able to do at a later stage. The original request for me to attend was because I also spent 2010 in Wales. I visited every local authority in Wales, looking at how councils were achieving efficiency savings in their social care budgets. I had been commissioned by the Social Services Improvement Agency to do that. It produced a report, 'Better Support at Lower Cost', to which I will refer.

[162] I will now give you a few of the headlines. First, it states that admissions of older people to residential care funded by councils have been falling for over a decade. In fact, it is interesting to note that, in Wales, this number has been falling faster than it has in other parts of the UK. In part, that is related to Welsh Government policies, which have a very strong emphasis on preventive measures and helping people to live in their own homes. There is still variance between Welsh authorities as to how far they have made progress in delivering that agenda. However, all Welsh authorities have made some progress. During this piece of work,

I cannot recall reading—I think that is the best way to put it—any strategic commissioning plan that did not have a further reduction of admissions to residential care for older people as part of the council's agenda.

[163] I am working with three Welsh authorities directly at present, including the two highest users of residential care. Based on my work in Wales and in England, I would say that it is still possible to reduce state-supported admissions by a third through a number of measures. I think that people should be aware of that context. There is no correlation between the demographics of the population and admissions to residential care. I want to say that because that mistake is sometimes made by people. On the other side, I know that the evidence given by the Social Care Institute for Excellence shows that there are self-funders, and that they are becoming a larger proportion of the people who are occupying residential care homes in Wales. That is a particular issue in Wales. I do not know whether the following fact is known to you, as I only found it out after I had written this report: Wales has among its older people the highest proportion of owner-occupiers. Therefore, an older person in Wales is much more likely to be a self-funder in relation to the current rules governing admissions to residential care. That is a challenge for the principality.

[164] Regarding the preventive agenda, there is quite a lot that one would want to say about health and housing. One piece of evidence I came across while doing this work for you is a piece of work that one of my colleagues at the Institute of Public Care, Professor Andrew Kerslake, did for civil servants at the Assembly. I have not quite got permission yet to share that work with you, but I intend to do so. That work looks in particular at our evidence on the health triggers that link to admissions to residential care, and how Welsh health authorities are dealing with those triggers.

11.15 a.m.

[165] In case you do not know, the triggers are, not surprisingly, dementia care; not very far behind that, and sometimes equal to it, incontinence; falls; stroke recovery; and then podiatry and dental care as slightly lower triggers. So, those are the main triggers. Without going into a great deal of detail—I will submit the report to you—the general indication is that the Welsh health services are not performing particularly well in those areas. Therefore, that will be contributing to admissions to residential care. So, if we are looking at the preventive agenda, I would like to draw your attention to that.

[166] In the same vein, the Welsh Government has done a great deal of excellent work helping Welsh local authorities look at extra care housing as opposed to a housing offer and a care offer for older people. Unfortunately, the way that particular local authorities have interpreted that has been to offer a tenanted model of housing. Again, the wealth in the population suggests that you might also need to be thinking about an extra care housing model that relates to owner-occupation within the housing schemes. I brought with me today a recent publication by us as the Institute of Public Care called 'Strategic Housing for Older People', which I think is a very good document that spells out the sort of options for housing there are in this care environment.

[167] The last bit of work we did for you was trying to look at the care sector. There are a few headlines. There is a reputable organisation called Laing and Buisson, which is seen as an organisation of experts that is sometimes viewed as representing the private sector in an analysis of what is happening in the care market, although we use it quite widely as it certainly has a strong base. It has a mechanism it uses, supported by the Joseph Rowntree Foundation, for looking at what the cost of care ought to be. If you look at its formula and then look at what I discovered local authorities are paying for care—and I have evidence for the same time period only from north Wales authorities—you will find that they are paying below that cost threshold. As you will probably know because of the Pembrokeshire

judgment, that is a tension between providers in Wales and local authorities. That might also mean that those private funders may be funding some of that gap and there is an issue of equity between the two.

[168] Laing and Buisson is very confident that there is sufficient supply in Wales of residential care via a formula it uses to look at what supply ought to look like. Actually, based on my work, that might suggest that, if we got the preventive agenda right, there may be an oversupply. However, I would not want to go too far in making that assertion. I will stop there to deal with questions. I think I have covered the essence of the points we wanted to make.

[169] **Mark Drakeford:** There was some fascinating information there and in your paper. Lynne has the first questions.

[170] **Lynne Neagle:** Thank you for your evidence. First, I want to ask about provision for people with dementia, because you highlight the fact that there is a shortfall of homes for people with dementia. You say that this is a serious problem. You have also told us that providers say that this reflects a lack of incentives. Do you think that that is an accurate assessment of the problem and, if not, in what other way should that be addressed? On the section on self-funding, you said that the concerns about the performance of a home are likely to be picked up at a local level by commissioning authorities. Obviously, that is for people who are not self-funding. How confident are you that local mechanisms are sufficiently robust? You used the word 'likely', but are there any situations where commissioning authorities are missing those sorts of concerns? In relation to self-funders, you said that there is a gap that needs to be addressed. How do you suggest we do that in Wales?

[171] **Professor Bolton:** I am just trying to look back, but I am not sure quite how seriously I suggested that there is a shortfall of homes for people with dementia. In fact, I think I would take you more to the dementia strategy developed by the Department of Health in England. That may not always be a popular thing to do, but the evidence it presented, which is what I wish to draw to your attention, was that the way in which you can intervene, early intervention and early diagnosis of dementia are critical features. It suggests that early diagnosis, helping the person and their carers to live with dementia, using technology, and managing medication can make a variable difference of 22% within the dementia population in terms of whether people need residential care at the outset. My work has always focused on getting it right at the start. You should get the community option right before you build your residential care. Residential care should not be the default position that it tends to be at times, but a clear part of a coherent strategy that started with the community as its essence. Those would be my comments on dementia care.

[172] **Ms Jones:** Whether we like it or not, the largest proportion of people in residential care suffers with dementia, which is true in England as well as in Wales. The statistic I saw from the chief inspector's report was that the figure is probably in excess of 60% of people in residential care in Wales. In publicly funded care homes across the UK, it is significantly higher. The challenge presented, once the residential care service is chosen, is how to ensure very good quality care and ensure that front-line staff and, in particular, the manager of the care home are well serviced with information, advice, knowledge and evidence about what good care looks like. We must make that available in a way that families can also understand, so that they know what to expect. Families are often in a strong position to challenge if they think that the quality of the care is not good enough.

[173] My organisation over the last few years has spent a lot of time and effort putting evidence together in ways that are accessible for front-line staff, as well as for informal carers and families. For example, if you went to the Social Care Institute for Excellence's website and looked at dementia care in residential settings, you would find material including filmed evidence and hear, through the voices of service users, carers, and front-line staff, about how

to minimise the use of restraint—whether that is medication or physical restraint— and how to not find yourself in a position where that is a problem for the older person as well as the staff.

[174] I am not sure if I understand the question on incentive, because, in a sense, it is about having no excuse for not knowing what good care looks like and that the care home manager takes responsibility for ensuring that staff also know. It is also about finding ways of making that material and information accessible to families. The whole system around the older person will ensure a better quality of life for them.

[175] **Lynne Neagle:** The issue of incentives comes from the report, where it says:

[176] 'The providers argue that this reflects a lack of incentives for expanding dementia care'.

[177] From what you say, I take it that you do not agree with that.

[178] **Ms Jones:** They may well experience it as a lack of incentive, but the people for whom they are responsible and whom they care for are likely to have dementia. To offer a residential care service that does not provide a good enough level of knowledge about what good dementia care looks like is not supportable.

[179] **Darren Millar:** I have some other questions on dementia that I will come to later, but, given that the prevalence of dementia in the care home population is so high, to what extent do we not need a specialist dementia care home these days, because, at the moment, people in the sector are saying that there is insufficient demand for specialist care homes or insufficient incentives? Is it not the case, therefore, that all care homes ought to be specialists in dementia?

[180] **Ms Jones:** I agree. All care homes need sufficient knowledge and experience to manage dementia care well. That is also true of people in healthcare settings and of acute hospitals. The prevalence of dementia in our older population as it currently stands means that anybody in those front-line jobs has a responsibility to know what good dementia care looks like and we need to make that easier for front-line staff and their managers.

[181] **Darren Millar:** Does that mean that we ought to step back from the separate registration for EMI residential care settings and concentrate on widening and expanding the provision for dementia care within all care homes?

[182] **Ms Jones:** That is worth considering.

[183] **Professor Bolton:** There was also the question about self-funding.

[184] **Lynne Neagle:** Yes, there was a question about self-funding.

[185] **Professor Bolton:** There is a problem with the system here; it is about the role of local authorities as commissioners and assessors. Unfortunately, in history, despite what the legislation states, local authorities have focused their role on commissioning for the people for whom they think that they are responsible—those who are eligible either in terms of eligibility or financial criteria. Many local authorities have not extended that service—the right to an assessment, which is in the statute—to people who are not eligible. They have confused the two in both their commissioning and assessment roles. There is evidence now of councils, particularly those with wealthier populations, beginning to recognise that they do that at their peril. If they are not offering that same quality of assessment and preventive options to their self-funders, then there could be a long-term cost to the local authority. For

example, if someone entered residential care too early and ran out of money, they will have to pick up the cost.

[186] So, there is a challenge and a real issue; we should ensure that the means test, if that is the right term, is not applied until after we are clear about which service and interventions are appropriate for that person, as opposed to the current system practice—it is nothing more than that—which has tended to lend itself to the means test almost being applied at the first stage. For example, if people own their own homes, the response is, 'Here is a list of residential care homes' or 'Here is a list of domiciliary care agencies', rather than, 'Let's talk things through and look at the options'. I think that we probably all agree on that.

[187] **Ms Jones:** That has become the default practice, but it is not what the Act requires.

[188] **Mark Drakeford:** I want to ask you to what extent you think that the Dilnot proposals will have an impact on that in Wales, but I will park that question to one side for the moment, because it is too big a question and will get in the way of other people who I have promised to bring in next. So, Mick is first and then Darren.

[189] **Mick Antoniw:** I have some questions for Professor Bolton in particular. I found the information that you provided helpful and interesting, although it poses more questions than we have time to ask. So, I will focus on one or two of the important areas. One point that you made at the beginning was about the decrease in provision—the way in which local authorities are changing their approach to residential care—which is demonstrated in your graphs and the other chart relating to local authority spend, which show a decrease from 30,000 to around 22,000 persons in residential care. So, it seems that that provision is already decreasing. Is there any empirical evidence that shows that, at a time when the older population is increasing, there is an equivalent or comparative increase in spend on reablement and domiciliary support? Are we losing money from one area and it is being replaced on the domiciliary side, or is it just that money is going out of the pot?

[190] **Professor Bolton:** The answer is that the money is the money in the system. Although, in the previous 10 years until 2010, there was something like a 50% increase in real terms in the spend on social care, and therefore the spending on residential care was decreasing during that period, some of that money was being spent on other services. Since that period, we have been hit by the recession and therefore there has been lower spend by local authorities on social care, although the spending fall in Wales is not as high as it is in the majority of English authorities. So, there has been some protection for social care in Wales.

11.30 a.m.

[191] There is a combination of factors with regard to what has happened in social care, and there is no simple answer. One is that demography is, in part, linked to wealth, so there is a wealthier set of people living longer. That is the generation that we are part of, who will have wealth and who are expected to live long into our old age. That is part of the problem, which is allied to a whole set of interventions, which, in a sense, my report in Wales tried to highlight. I do not think that any one council was doing all of the things that it could do, but several councils were doing quite a lot of interesting things in how they were thinking through dealing with their population and trying to ensure new investment in reablement. So, there were good examples of that in Wales, and I thought it had been well supported by the infrastructure in Wales, because it is new. I am still working in one authority in Wales that is still just introducing reablement, but, generally, the Welsh authorities have a good domiciliary care reablement scheme. They still have work to do with what I would call intermediate care, which is the reablement that might sometimes need to be in a residential setting to help someone to get back on their feet, but Welsh authorities are grappling with that and looking at that, and trying to talk to health partners about how they should do that together, because that

would be the ideal answer.

[192] So, there is evidence that reablement is having an overall impact. Reablement's biggest impact, of course, ought to see a decline in use of domiciliary care, but it seems to have some impact on residential care as well. Overall, there are a number of factors happening. I am a massive fan of reablement, and I would suggest that it is one of the solutions that we ought to have in our armoury to help people. It is the kind of sense that we have discovered in social care that, when older people get ill, they can get better, and we ought to be supporting that rather than assuming that the illness is the downward trend for that person.

[193] **Ms Jones:** If you look at the spend patterns across the UK, there is a reducing demand for residential care, and home and domiciliary care is picking up some of that, but it is servicing fewer people, so more is being spent on each person, because the cost per head of someone being supported at home who is very frail is quite high. So, there is a variety of ways of looking at the numbers to get a grip on the whole story. One challenge is that fewer people now, because the eligibility access threshold is rising, have access to public funds. When they do, they have access to quite significant public funds.

[194] **Professor Bolton:** It varies significantly from one authority to the next, which is part of the challenge. Very different patterns emerge from different authorities, as a result of their histories, their work with health, their housing and their preventive agenda. There are variations in Wales, but they are not as extreme as the variations in England.

[195] **Mick Antoniw:** Is there research that shows the increase in spend and how it is being spent with regard to the domiciliary side? If so, that would be helpful.

[196] **Ms Jones:** Yes. Your Government officials will have that and would publish the data.

[197] **Mick Antoniw:** It would be helpful to have that. I would like to move to another aspect of the finance side. You provide information about analysing the way in which residential homes operate financially and some of the difficulties that have existed in evaluating their financial background, particularly some of the big corporate homes, but, I presume that there is a similar issue with some of the smaller homes. In your view, is there sufficient forensic analysis of the interlink between the way in which these homes operate financially, from large to small and the way in which that spend, for example profit levels, spending on staff, ratios on staff, impact on the quality and provision of residential care? Is this an area that should be more closely examined with regard to the regulation and inspection of residential care?

[198] **Professor Bolton:** Given the way that residential care is regulated, issues such as staffing levels are set, so it is hard to play with them whatever your financial basis, because of the nature of the regulator. What staff are paid will vary from one provider to another. The only analysis that I have seen is UK-wide, and that suggests that, on average, workers in the residential care sector are paid about £1 above the minimum wage. That is a fairly round figure from the data that we have looked at. We have always found in social care that there is no correlation between investment and outcome in relation to the quality of care. Some people can make fantastic use of tight resources, and others can waste large amounts of money.

[199] On your point regarding financial viability, I suppose that this was one of the issues that impacted in Wales—I was working in Bridgend at the time when Southern Cross was in difficulty, and there were some signs that they were looking to cut corners in some of the service delivery. That was picked up by local authority monitoring officers, but no-one had the big picture at that point in time, so in Bridgend they knew that the Southern Cross homes were in difficulty, but they had not realised that it was part of a bigger problem with the

company; they were just dealing with a local home and the regional organiser. There is an issue, and I know that the Department of Health in England is equally concerned about that, as to whether we should have a better understanding of the financial security of all homes, because residents may be put at risk if the finances become risky. There is a real issue there. Julie might know more about this, but I thought that I was informed that the current regulations allow that to happen, but it has not operated as robustly as some may now think is necessary.

[200] **Ms Jones:** I think that that is right, and the other thing that we learned from the Southern Cross experience was just how complicated the financing arrangements are for some of the large corporates. There is a lack of understanding, both in local government in England, certainly, and perhaps among people who are responsible for regulation and contract monitoring, about just how difficult it is to understand some of the financing arrangements that have developed over time. Perhaps one of the consequences of that Southern Cross experience is that everybody learned an enormous amount from the unravelling of that and from the attempts to resolve and ensure a safe future for residents, but they also understood a lot more about the financing arrangements sitting behind that. That bodes well for understanding what it is that should be going on by way of understanding financial viability, and how can we help both the regulator and the local authorities to get early warning of circumstances that are beginning to deteriorate.

[201] **Professor Bolton:** I have here, for example, a detailed analysis of Four Seasons. If anybody here reads *The Daily Telegraph*, you may have seen a report in the financial section on Monday about the significant difficulties that Four Seasons was getting into. This is a really detailed analysis of its financial base that was commissioned by local authorities in England for local authorities in England. They can rest assured that the base is more secure than the alarmist headlines might suggest. You can see that it is quite a detailed analysis, and goes into all the holding companies, the investment, where the banks are, who is looking for what credit, and so on—it is complicated and difficult. It is an excellent piece of work, I have to say.

[202] **Mark Drakeford:** As I think you say in your evidence, an awful lot of the information necessary to understand the financial circumstances of some of the larger corporates, although not just them, is not easily available in the public domain, and, even when you can track it, what is on the tin does not always give you a clear indication of what you will find inside.

[203] **Professor Bolton:** Southern Cross was publicly quoted on the stock exchange, and, if anybody had been interested, the fall in its share price was probably the first big indicator that it was in difficulty. It took quite a bit longer before the social care system picked that up.

[204] **Mick Antoniw:** We could look at the Four Seasons report as an example.

[205] **Mark Drakeford:** Is it available?

[206] **Professor Bolton:** I am pretty certain that this was produced by the Association of Directors of Social Services in England for its members. I do not think that it would take anything more than a quick e-mail to release that to you.

[207] **Lindsay Whittle:** You mentioned earlier that admissions to residential homes are going down in Wales—which, incidentally, I regard as a country and not a principality, but that is another issue.

[208] **Professor Bolton:** I am sorry.

[209] **Lindsay Whittle:** That is okay.

[210] We have heard today about cost and it is a shame that we are always talking about costs. Are you suggesting that local authorities should have a standard charge across Wales? I have a second question, but as a lead up to that question, I will just say that we should not forget that we are talking about a generation that still thinks in pounds, shillings and pence—I sometimes find myself slipping into that. I know that we should not, but it is happening. Many people of that generation in Wales are homeowners. They are homeowners because the main breadwinner was traditionally in a dangerous occupation and, should anything happen to them, they wanted to ensure that their families were not made homeless, and I think that that is a good thing. There are many people, me included, who do not want to work all my life to leave my home to the British state—or even, with respect, the Welsh state; I want to leave my home and its financial benefits to my children. I do not have any grandchildren yet. That is what we want, is it not, as a generation? What is your opinion on whether care homes should be free?

[211] **Professor Bolton:** I think that you are wandering into politics rather than an area on which I would want to claim to have personal views. I would not want to give the views of my institution on that. My personal view is that I have always believed in means testing. If you have the ability to pay, you should pay. That is a personal view. That view is not always shared by all of my contemporaries. Generally, in social care, you would probably get a majority of people arguing that it should be a part of the welfare state. I often find myself in public meetings with older people who do not understand that, when the welfare state was created by Aneurin Bevan, social care was not part of the settlement. Benefits and health were in the settlement, but social care was outside it. That is not understood by the wider population, and people want to change that. In England, it would cost the Government about £5 billion to do that.

[212] **Lindsay Whittle:** However, it happens in Scotland.

[213] **Professor Bolton:** Yes, but problems have arisen in relation to that.

[214] **Ms Jones:** Residential care in Scotland is not free, but access to personal care is free.

[215] **Mark Drakeford:** Social care is not free, but personal care is free.

[216] **Ms Jones:** There is nowhere in the western world that provides free social residential care for older people that I know of. It is a serious dilemma.

[217] **Lindsay Whittle:** Yes, it is.

[218] **Mark Drakeford:** Just for the record, I will note that the additional paper that we have from Professor Bolton, on which many of the questions that we have been asking are based, will be published on the website later this week, so the information that we have been reflecting on today will be available to members of the public and organisations that are taking an interest in the inquiry.

[219] **Darren Millar:** I found the section of your paper on calculating the cost fascinating, particularly in looking at fair market pricing, which obviously concludes that the fees that have been paid by local authorities in Wales are much lower than that required by the market as a fair price in order to maintain their homes, invest in staff and so on. How do you think that that gap can be closed? Do you think that increasing the ability of families to support their loved ones and expanding the role of direct payments might be one way to free up some cash to be able to invest in closing that gap?

[220] **Professor Bolton:** There are two issues, are there not? This relates in part to the previous question. The moral that has been developed through local authorities—the procurement mechanism—has been a simple market mechanism, whereby in a negotiation about price, local authorities have said, 'This is the price that we'll pay', and providers have said. 'Okay, we'll let you have care at that price'.

11.45 a.m.

[221] Within that, I make the point—it is a grossly under-researched matter—about the level at which citizens, having been assessed as to what they could afford to pay, have to use a third party to top up any gap. If the care home manager says 'If the local authority in Conwy will only pay a maximum of £437 and it costs me £463 to run my care home, I want that difference', then a third party, which could be a family member or a charity, is going to have to make up that difference. There has not been sufficient research done on this. As you look to see what information might help with that, I have discovered that it has not been fully investigated, because it is all done very privately. No-one knows about negotiations with care home owners. The local authority will not know, because it will only know that it is paying £437. So, there is a challenge there, but, on the other hand, local authorities have done a procurement deal. Sometimes they procure in blocks, although less so in residential care; generally, local authorities do what is called 'spot purchase'—they purchase one by one.

[222] When you read some of the business cases that some providers draw up, they assume that they will be operating in a local authority market. However, that has changed, and that is part of the message. You made the comment that admissions are falling. Admissions funded by the local authority are falling. Admissions are fairly static overall, and self-funders are, in a sense, meeting that gap. That presents a different set of challenges, and we are moving into a new world, in which we have to better recognise that challenge. One of our recommendations is that we have to look at this holistically as a total system, and local authorities have to accept their responsibility in law to undertake those assessments.

[223] So, to deal with your question, I am not sure that direct payments are the answer, because they will only have the same element to them, in that the local authority will say 'Your direct payment is £437'.

[224] **Darren Millar:** I was asking whether supporting direct payments for domiciliary care might be an avenue for releasing savings, which could be invested in helping to close the gap between the fair market price and the actual price currently being paid by local authorities.

[225] **Professor Bolton:** I am not sure. I think that direct payments are a very useful function for people who want to buy their domiciliary care, and, of course, domiciliary care could be a critical part of a package that avoids admission to residential care. So, in that sense, direct payments are directly related to that part of the preventative agenda. If you have had a chance to look at the work that I did on better support at lower costs, the whole message there is that a whole range of preventive measures can be brought into a system that will work to reduce the overall costs in the system significantly by reducing admissions to residential care. That is the difficulty for the residential care market, because it could increase the costs of residential care homes. When I was a director of social care, a while back, the authority that I worked for halved the number of people going into residential care by creating a set of options. We subsequently paid more for residential care, but because we paid more for fewer places, I was content. I was genuinely pleased that we could pay a proper premium for a smaller number of people whom I thought needed residential care. I was generally satisfied that I had a good infrastructure in place as alternatives for the majority of population.

[226] **Mick Antoniw:** Can you clarify what you mean when you talk about 'local authority care'? For many people on benefits who go into care in conjuncture with social services and

local authorities, all that they are effectively doing is signing over their benefits for the cost of care. Would you regard that as local authority care or as privately funded care?

[227] **Professor Bolton:** That is local-authority-funded care. People lose an element of their benefit, which does not cover the cost of the care. It is a contribution towards the cost.

[228] **Mick Antoniw:** However, it can be very close to the cost of their care.

[229] **Professor Bolton:** That is very rare for older people.

[230] **Mick Antoniw:** We will not go into personal examples. So, you regard that as local authority care. Would that not be part-funded care?

[231] **Professor Bolton:** I know the point that you are making—

[232] **Mick Antoniw:** It is a division between the funding mechanisms.

[233] **Professor Bolton:** A better term is probably state-funded care. Whatever route the money has come from, it has come out of state contributions, as opposed to coming entirely from the person's own savings, assets or wealth.

[234] **Mick Antoniw:** Are there implications for how that whole funding mechanism operates from the potential changes to the benefits system?

[235] **Professor Bolton:** Many of the changes to the benefits system relate to people on disability benefits. Older people are eligible for some of those benefits but not for others. So, there is an element there. I do not think that I have seen any work done on whether there are any cost implications for local authorities having to pay more because they will be recouping less. It is not an issue that has come to my attention, nor have I seen any work on it that would make me think that it is an issue. I am pretty certain that I would have seen that if it had been done.

[236] **Mark Drakeford:** I think that there has been some work done, particularly in relation to the differences between the retail price index and the consumer price index. We will take the last question from Rebecca and then I will have to wrap up this part of the meeting.

[237] **Rebecca Evans:** I would like to move on to a different issue. In paragraph 14 of the Social Care Institute for Excellence's paper, you say that

[238] 'more than one third of those subject to abuse live in care homes'.

[239] That was so alarming that I had to read it twice to make sure that I had read it right. Could you say more on the challenges in safeguarding and how they should be addressed?

[240] **Ms Jones:** That statistic came from you chief inspector's report, which looked at the statistics on safeguarding issues that have been raised with them and where those concerns have been raised. It is not surprising, because safeguarding issues are now more readily reported from care home settings. I never assume that an increase of that sort is necessarily a bad thing. It can be that people are now much more aware of safeguarding issues and much more ready to draw attention to them in order to resolve them. So, I do not think that that is necessarily bad news. The statistic came from your published material.

[241] **Rebecca Evans:** We have heard from the Commissioner for Older People in Wales that people have low expectations of what they should expect from care. It could be suggested that, with those low expectations, there would be less whistleblowing and reporting and so on.

Do you imagine that those figures might increase in the future?

[242] **Ms Jones:** Yes, I think that public expectations of any service provided through the public sector are going up. We are pleased about that. Those numbers are likely to rise in the future, as public expectations increase, as well as people's knowledge about what good care ought to be. It is not just the people using the services, but their families' expectations are rising, too, in terms of what good quality care should look like. We should encourage people to be more ready to say when it is not good enough. For all those reasons, I would not be at all surprised if those numbers went up.

[243] **Mark Drakeford:** Thank you both. I feel that we have barely scratched the surface of what we could have asked both of you in relation to the evidence that we have heard. That is something that the committee will want to reflect on after the session. We are grateful to you, both for the evidence that you supplied to us in advance, and for the chance to explore some of those issues with you in person.

11.54 a.m.

Papurau i'w Nodi
Papers to Note

[244] **Mark Drakeford:** There are three papers to note. Are you happy to confirm the minutes of the last two meetings? I see that you are. There is a paper on the forward work programme, which you have on the table in front of you. It is pretty firm between now and Easter. As you see, it divides witnesses into the groups that we identified earlier when we were looking at our plan. It becomes slightly more flexible after that, but it is there for people to be able to organise their diaries accordingly.

[245] We also have a letter from the Minister for Health and Social Services in relation to the community pharmacy inquiry, which is worth reading. It has interesting things to say in relation to the issue of capitation payments. My reading of it suggests that, in the Minister's view, it will be possible to move to a capitation-based payment in community pharmacy without needing a contractual renegotiation. That is one point that we explored, and you will see her view in the letter.

11.55 a.m.

Cynnig o dan Reol Sefydlog Rhif 17.42(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod
Motion under Standing Order No. 17.42(vi) to resolve to exclude the public from the meeting

[246] **Mark Drakeford:** Cynigiaf fod	**Mark Drakeford:** I move that
y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog Rhif 17.42(vi).	*the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 17.42(vi).*
[247] Gwelaf fod y pwyllgor yn gytûn.	I see that the committee is in agreement.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11.56 a.m.
The public part of the meeting ended at 11.56 a.m.