



# **Cynulliad Cenedlaethol Cymru** **The National Assembly for Wales**

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

**Dydd Iau, 22 Mawrth 2012**  
**Thursday, 22 March 2012**

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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
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

**Eraill yn bresennol**  
**Others in attendance**

Yr Athro/Professor John Bolton	
Luisa Bridgman	Rheolwr Gwasanaeth, Cyngor Bwrdeistref Sirol Rhondda Cynon Taf Service Manager, Rhondda Cynon Taf County Borough Council
Parry Davies	Cyfarwyddwr y Gwasanaethau Cymdeithasol, Cyngor Sir Ceredigion Director of Social Services, Ceredigion County Council
Bob Gatis	Cyfarwyddwr Gwasanaeth Gofal Cymunedol, Cyngor Bwrdeistref Sirol Rhondda Cynon Taf Service Director Community Care, Rhondda Cynon Taf County Borough Council
Susie Lunt	Rheolwr Gwasanaeth, Cyngor Sir y Fflint Service Manager, Flintshire County Council
David Street	Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru Association of Directors of Social Services Cymru
Emily Warren	Cymdeithas Llywodraeth Leol Cymru Welsh Local Government Association

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

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

*Dechreuodd y cyfarfod am 9.29 a.m.  
The meeting began at 9.29 a.m.*

### **Cyflwyniad, Ymddiheuriadau a Dirprwyon Introduction, Apologies and Substitutions**

[1] **Mark Drakeford:** Bore da a chroeso **Mark Drakeford:** Good morning and i bawb i'r Pwyllgor Iechyd a Gofal welcome, everyone, to the Health and Social Cymdeithasol. Care Committee.

9.30 a.m.

### **Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Trafodaeth gyda'r Athro John Bolton Inquiry into Residential Care for Older People—Discussion with Professor John Bolton**

[2] **Mark Drakeford:** Ar gyfer yr ail **Mark Drakeford:** For the second item this eitem y bore yma, bydd gennym awr a hanner morning, we will have an hour and a half gyda'r Athro John Bolton. with Professor John Bolton.

[3] We will use it to work our way through the paper from the professor, which I know that all Members have. Good morning, John, and welcome again. I am keen to ensure that we cover all the different dimensions of your paper in this session. In rough terms, I am looking to spend about a quarter of an hour or 20 minutes on sections 2, 3, 4 and 5. If that works, it will leave us with a little time before 11 a.m. for Members who want to explore any items that are not directly covered in the paper or where you have other issues arising from the discussion that we need to cover. I think that that is the best way of working our way through it. Section 2 in the paper deals with councils and residential care. John, do you want to give us a minute at the start of each section, and then we will go straight into questions?

[4] **Professor Bolton:** First, the evidence is clear that the use of residential care paid for by the public purse has been falling, as indicated last time. It is falling faster in Wales than it is in England, where it is falling at about 3%, while in Wales it is about 5% per annum. I assume that that has a direct relationship with Welsh Government policy. There has been a strong emphasis in England and Wales on helping people to live in their own homes. In every survey, and every time anyone is asked—except for the people who have ended up in residential care—whether residential care is an option of choice, the answer is 'no'. The major survey on this suggests that only 10%, one in 10, of older people would at all consider residential care as an option. I suppose that councils have got increasingly better at thinking about how to support people in their own home. That is what the first part contains.

[5] My work in Wales would suggest that there is still scope in many councils to reduce demand further. The biggest area of concern that I have come across is direct admission from hospital to a residential care home without allowing a proper period of assessment to see whether the person is able to recover. So, there is still scope in parts of Wales, and I have been working with three Welsh authorities that are demonstrating, to different degrees, that that can be the case. That is probably a summary of the first part.

[6] **Rebecca Evans:** You say that only one in 10 older people would consider residential

care as an option. Are those figures available with a socioeconomic breakdown? If you were wealthier, your options would perhaps be more attractive in terms of what you could receive in a residential care setting.

[7] **Professor Bolton:** No, I do not have a socioeconomic breakdown for those figures; I am sorry. There is a strong view that people who have money enter residential care even earlier, when they do not have proper advice and help, than people who do not have money, who, at the least, are getting some advice from the local authority. We touched on this the last time I was here in terms of whether people who have money get their legal entitlement to the assessment that the local authority ought to provide them with. People often make their own decisions. There is a report, which is about five years old, from England that says that older people, using their own resources to enter residential care, get advice from either their lawyers or their GPs, neither of which are renowned for understanding the intricacies of the care market.

[8] **Mark Drakeford:** Just to pursue that, I think that later in your paper you argue that there is a public interest in getting advice to self-funders early, because they very often turn into state-paid residents.

[9] **Professor Bolton:** What we say in this paper is that, in Wales, 70% of the older population own their properties, and under current rules, that means that they would be self-funders, by definition. The average length of stay in a residential care home is three years, but if someone has entered too early, then the money from the sale of a property for around £100,000 could quickly run out, and then they would become the responsibility of the state. It is a matter of best practice, so that everybody is aware of the options open to them and can make a rational choice rather than feeling that they have no choice.

[10] **Mick Antoniw:** It is implicit in what you are saying that there is considerable variability across Wales. Looking through some of the other papers at the approaches of the various councils, Rhondda Cynon Taf has 84% in the community as opposed to care homes. I was wondering if there was any particular reason why there is that degree of variability, and whether that is an area of potential influence. Secondly, where you have that higher proportion of people being looked after in the community as opposed to in residential care, is there any evidence that that indicates a better working or practical relationship with the NHS in terms of reablement of people, and so on? Is there any link between those two things?

[11] **Professor Bolton:** First of all, some of the patterns that you describe are quite long term. You will be aware, I hope, of the major report that I did in Wales almost two years ago now. I was interested to see that, if you go back to look at the old county boundaries for Wales and the new unitary authorities, you will find that some of the patterns have been there for 10 years and have not significantly changed. Some of the practices are quite long term. Therefore, concepts like reablement, which are relatively recent, might change those patterns, but they have not set those patterns. So, there are traditions in areas about how people have worked and seen their resources. A study in England—but not in Wales—did suggest that social workers tend to fill the supply that is available, so there may be an issue there. I have the data here for RCT, so let us have a look at it. If you have a small, tight supply, are you more likely to use that well? In Ynys Môn and Gwynedd, there is an oversupply of residential care homes, in my view, so does that mean that people will use that supply because it is available? That is the kind of question to ask. There is no doubt, however, that the solution around residential care does in part relate to the work with health. All of our evidence on public care is that the health of an older person plays a big part in their decision about whether to enter residential care. I made reference last time to a paper that we did for your civil servants on health and admissions to residential care; I apologise, because I was hoping to be able to get that for you, but I do not yet have approval. I do intend to get that for you, Chair.

[12] The particular issues are dementia care, incontinence, falls, strokes, foot care and dental care—and, with incontinence, urinary tract infections. They are seen as the big drivers that trigger the decision to go into residential care for an older person. One or more of those conditions is likely to lead to the ‘Oh dear’ trigger decision. Health performance in those areas could therefore be critical, and our report indicates that, in Wales, health does not generally perform very well in those areas. So, again, you probably have scope for further improved healthcare, which is likely to reduce the use of residential care.

[13] In a sense, reablement fits into all of that, because it is part of how we help someone to get the right treatment and the right recovery, so that they can get back on their feet and go back to living in their community, caring for themselves and being cared for in the community. I genuinely believe that part of the scope of that would suggest that you are likely to see a further decrease in the use of residential care, because that will improve.

[14] I have one last point to make on that. You may have noted that I make a pretty strong statement in the report about the arrangements for being discharged from hospital. The information given to me by the health board for the Vale of Glamorgan was that, in the three years prior to this study, it had saved £1 million by speeding up hospital discharges. However, when it looked further into its accounts, I discovered that, during the same period, it had spent £4 million on extra nursing and residential care beds. So, what appeared to be a good saving was actually costing. I can only hypothesise that there is enormous scope for looking again at that process and whether it could have been managed better in the health/social care interface. In fairness to the people I talked to there, they accepted that and were very keen—that was two years ago—to look hard at that process and to improve it.

[15] **William Graham:** On that point in particular and on your introductory point about what is really a crisis in how people are currently discharged, there is enormous pressure from politicians and the press on the issue of delayed transfers of care, how that is wrong and all the rest of it. Are you, therefore, suggesting that more resources should be put into that? Do you think that the GP should be more involved in that?

[16] **Professor Bolton:** A piece of work that I have been doing over the last year suggests that the model of assessment used for social care for the last couple of decades may well be wrong. What we have tended to do—and we have tended to have the performance regime to support this both in England and in Wales—is to say that we need to assess somebody quickly and get them the services that they need very quickly. That has been our mantra, as it were. Despite the short period that people may spend there, I consider residential care to be a serious and long-term decision, so we should not make those assessments in haste, and we should definitely not make them from a hospital bed.

[17] With regard to intermediate care, I perfectly understand the logic of someone who does not need treatment not taking up a hospital bed. However, having a period of proper assessment of the intermediary period, during which time people can look at their recovery and see how they are going to do—they may get a good diet, get some exercise and see what the physiotherapist can do—and monitor their recovery before the long-term decision is made, is, I would argue, a financial saving. It is probably better for most people to have that option. For me, that has been the missing piece of the jigsaw, and you can see that in some Welsh authorities—going back to the earlier question—that are beginning to develop that kind of service. I was working in Bridgend last year and that was absolutely what the authority there was looking to do. It had gone through all of the case files for the last 100 admissions to residential care, and on its own assessment, it thought that a third might have been avoidable had they been given that better time. When they got into residential care, those people had started to recover, but it was too late by then to make a further decision because they had given up their previous home, broken their ties and settled in. I hasten to add that it

is not a criticism of residential care, but more about people's real choice and whether we are supporting them in the most appropriate way.

9.45 a.m.

[18] **William Graham:** I asked you about GPs; do you think that they have a greater part to play?

[19] **Professor Bolton:** No, not particularly.

[20] **William Graham:** Should they not know their patient to be able to—

[21] **Professor Bolton:** They may know their patient or they may not. GPs generally tend to be risk-averse in their practice. They tend generally, in my view, to be pushing residential care. This is a generalisation. I cannot speak for all GPs. I recently had a very constructive discussion with a GP who absolutely got it. So, GPs vary. In the same way, many GPs will say to me, 'If in doubt, I will go for a hospital admission, just to be safe'. From my experience, that is the predominant culture with GPs. I know that it is my profession, but I would like to see a good social care assessment that works alongside that older person and is clear about what is right for them; it is about having confidence about what can be provided and having the right resources in place, like intermediate care, to help that. That is what I think the solution is.

[22] **William Graham:** Within that assessment, you are emphasising that there should be a major health element to the criteria.

[23] **Professor Bolton:** Yes. In a way, the role of the GP and the health community is to absolutely make sure that the health treatment that the person is getting is of the highest quality and the best standard and that it is delivering. There is some evidence in Wales that you have not quite got that right yet. I am sure that everyone is striving to make it better. Do not get me wrong; there are similar challenges in England. As we read in the newspapers every day, there is a real issue about whether the health service has caught up with what is happening to older people now with the kinds of health conditions and challenges that they bring to us.

[24] **Elin Jones:** In relation to hospital discharge, is that intermediate care provided in an institution or a home, or can it be in the domestic home as well? That was not meant to be my question. My question goes back to the earlier points that you made about the variation. In your table, there is variation between the spend from the social services budget on residential care, with Gwynedd at 61% and Monmouthshire at 39%. You have mentioned that it may be the supply of residential care that may be driving that variation. Is that supply in the form of council-owned and council-run homes, so that there is a tendency in those local authorities that have a high spend on residential care to spend that in their own homes? In addition to that, where you have this differentiation in spend—61% compared with 39%—have you analysed what the rest of the budget is spent on? Is Monmouthshire, for example, which is spending only 39% of its budget on residential care, spending a higher proportion on care in the community and care at home—domiciliary care—so that there is an inverse relationship?

[25] **Professor Bolton:** To answer the last question first, the graph that is shown in the middle of page 2 is one of three graphs that shows how much they are spending on the assessment and care management staff, how much they are spending on supporting people who live at home and what proportion of their spend is spent on residential care. So, the other two variables are what they spend on social care assessment staff and what they spend on support in the community. There is a reasonable correlation between a high spend on residential care and a low spend on community care, and vice versa.

[26] In terms of the intermediate care provision, it could be either setting. Often, in this rather risk-averse system, people like to have someone in a place, in a bed. Physiotherapists and other therapists tell me that it is much more likely that you will be successful in getting the programme working if the person is back at home. So, the ideal is to get the person back home with the right support. Failing that, they should be in a residential bed. Sorry, I am providing a lot of detail here, Chair. There is evidence to suggest that the local authority and the primary care trust—or the health authority here—must be very careful that they have absolutely procured those beds for that purpose. There is some evidence that, if you say to a residential care home, ‘Could you take this person for six weeks and we’ll see whether they get better?’, and it is not geared up and its staff are not trained to help with a recovery programme, the staff will do what they are very good at, which is settling the person in. Again, they need to be very clear about what is procured and how it is procured with either of those options.

[27] As you will no doubt have become aware, the most expensive forms of residential care are those run by the local authority. Local authorities that are strapped for cash may well consider whether they ought to be continuing to supply residential care, and a number of councils—I see that you have some of those known to me giving evidence later—have closed their own residential care homes, as is the case with Flintshire, which is giving evidence today, and replaced those with extra-care housing, which is a much more modern version of that. Again, the issue varies. Of course, you are encouraged to do that, but, for example, Gwynedd, where I have done some work, has the largest number of council-run residential care homes in Wales and has relatively low occupancy, so it is costing the council even more than it should. They are politically, and as officers, really challenged with regard to whether they can sustain the supply that they are currently running, particularly as there is also a relatively high number of private and voluntary sector care homes in Gwynedd, to the extent that, even if the authority was not running any of its 16 care homes, there would probably still be sufficient supply for the overall market. That is a real challenge for a local authority that, of course, wants to do the best for its citizens, including in the employment and community sense, which are elements that its residential care homes can provide. That is a real dilemma for councils.

[28] **Lindsay Whittle:** Good morning. I thought that page 3 of your report was interesting. We know that people who move to Wales from outside the country have families that live far away. In other parts of Wales, the families of the indigenous population are also, sadly, moving away because of the lack of employment. I read something about the bullying of parents in the *Western Mail* this week. Is there any evidence to suggest that families that live outside Wales put undue pressure on elderly relatives to go into residential care so that they feel that they have done their bit and that their relative is safe as they cannot visit them as often as they would have liked to?

[29] **Professor Bolton:** I am not aware of any formal studies of that. However, anecdotal evidence would strongly suggest that that is a feature. It would strongly suggest that the decision to go into residential care is very commonly made on the basis of health professionals working with the person and their family.

[30] **Lindsay Whittle:** At the top of page 3 of your paper, you say that there is pressure from health professionals as well. That flies in the face of some of the other things you have said. I thought that health professionals were trying to encourage people to remain in their homes as long as they could. I would hope that they were doing that—

[31] **Professor Bolton:** I do not think that I said that. I said that the risk-averse nature of the health culture may lead—not every time—to an admission that, in some circumstances, you might argue could have been avoided.

[32] **Lindsay Whittle:** Do you think that health professionals should work more with the social work professionals?

[33] **Professor Bolton:** My view is that everyone needs to do their job properly and do it well. Social care professionals have a very important role to understand older people, their circumstances and their longer term potential, to work with them to make those decisions and to ensure that they have had the right advice, help and support. They should also engage with the family in that process and, in making those decisions, be really aware of the best health information about the prognosis, the condition and the opportunity for recovery that will be available. The role of the health professionals is to ensure that they have offered the best-quality healthcare and have made a good assessment of what the prognosis is, particularly with regard to recovery. We have learnt a lot in the last 10 years. Unlike 50 years ago, when people had a relatively short period of old age and died, we now have longevity, and people get ill and get better again in old age in a way that we did not perceive old age to be when I was training 40 years ago.

[34] **Kirsty Williams:** I am interested in the interface between health and social care. I absolutely recognise what you say about risk-averse healthcare professionals. I would agree with you wholeheartedly that that is the temperament of that particular group of people. It also seems to me that another thing that they are worried about is swiftly moving the cost to another organisation. Is there any evidence that they trying to move people into residential care not only because it is less risky, but because it is potentially a quicker way of getting someone out of your hospital bed if they can go into residential care than if you have to wait for complex home care or domiciliary care support packages to be put in place?

[35] **Professor Bolton:** Making that assessment would be a big step. Going back to the information that I saw in the Vale of Glamorgan, in fact, most of those costs had to be met by the health authority. If I am allowed comment, I like the Welsh system because the health authority is responsible for what happens in the hospital and for the post-hospital care. However, all of those costs were falling on that authority. So, the risk was that they were moving people into nursing homes, which they were paying the cost of, and not just into residential care homes. The £4 million that I saw was spent on their budget, not on the local authority's budget, albeit they were trying to work in partnership to look at how they could change that.

[36] There is evidence that about 25% of the admissions to nursing homes are avoidable. Decisions are made too quickly: a person was ill at one point but was going to recover, and that person gets into a nursing home and gets a bit better. In nursing care, about half the residents are there for palliative care and are likely to die within six months. Of the half that live for longer than six months, half will continue to need nursing care and half will not. There is whole issue about the assessment and how we make the assessment. Many of those people who do not need nursing care could be in a local authority home at the cost of a local authority needing to provide social care support, so it is not that they do not need the care environment, they just do not need the nursing element. In a way, if I was in the health profession, I might look quite strongly at that but, for humane reasons, it is very rare—I have probably come across a handful of cases in recent years—when someone moves from a nursing home to a residential care home. Once someone settles into a residential or nursing home, the general practice is that that is a home for life.

[37] **Kirsty Williams:** Given the crucial nature of the interface between health and social care, what could this committee recommend to make that work better? I still bear the scars of an abortive attempt to get Powys Teaching Local Health Board and Powys County Council into a single organisation. The health board basically runs community-based services, and it does not have to worry about high-end provision. If we cannot overcome the barriers to



getting those two organisations to be a single organisation, then we have little hope of it happening in other parts of Wales, where the LHBs are looking at acute medicine. So, what could we practically recommend that would get county councils and the health service working more closely together to overcome some of these problems?

10.00 a.m.

[38] **Professor Bolton:** My contention is that there are some key health conditions that I want to ensure the health boards are aware of. The Assembly Government needs to ensure that it has some priorities—with all the priorities that health has, I realise the challenge of that—and that there is proper recognition of the health conditions that older people will have, because that is what will determine the kind of care needs that they have. So, in the first place is this simplistic comment of mine: ‘Let us get every professional doing their job properly’—

[39] **Kirsty Williams:** And not worry about structures?

[40] **Professor Bolton:** That is my view. Quite a lot of research has been done on structures, and, despite the feeling, which I share, that if we created one structure and everyone had a single pathway, it would all work better, the evidence does not support that. There is a good study by the University of Bath on this. Around 10 years ago, half of Wiltshire was a joint trust and half was not. The study demonstrated that older people got better outcomes in the non-joint system than in the joint system. What is the hypothesis? It is possibly risk-averse practices and the health-dominant culture taking over from the social care culture. It is difficult.

[41] When I worked at the Department of Health, I did some work for the then Secretary of State in which I looked at the then 13 care trusts in England. Twelve of the 13 were, overall, getting worse outcomes for older people than their ordinary counterparts were. I used to compare Milton Keynes as a very good system—where health and social care worked well together and did some joint commissioning, but did not have an integrated system—with near neighbour Solihull, which really struggled to run a care trust. There are many caveats. For example, when we looked at care trusts, we discovered that many of them were formed in adversity. The health side was not working well—perhaps it was a little small for the district that it was covering in England, and the local authority was struggling a bit, so someone thought, ‘Let’s throw them together to see whether that makes things better’, but it did not: two failures do not make a success.

[42] So, it is not as simple as that. Just so you know, the success story that everyone talks about in England is Torbay. However, I have just been commissioned to do some work in Torbay, because it is beginning to struggle again with some new challenges. I do not know what those are, but, since I was last with you, I have had an e-mail correspondence asking me to do some work there. So, it is a real difficulty. Whatever you do, do not believe that the structure alone is the solution. The outcomes, the framework and what you require from that structure are as important. So, even if you wanted to recommend a joint health and social care structure, for goodness’ sake, please ensure that you get those health issues on that agenda, because if you have a great structure but you are not addressing those health issues, you have just created a structure.

[43] **Darren Millar:** In Northern Ireland, there are joint health and social services boards. What evidence do you have from Northern Ireland that those are working effectively and efficiently? They are always reluctant to change and to split those responsibilities because they look at other parts of the UK and see that things are not really working.

[44] **Professor Bolton:** I am afraid that I have not looked in detail at the outcomes from the Northern Ireland boards. To my knowledge, they do not provide the data in the way that I

would like to see them in order to look at the measures. If you could acquire the information, it would be interesting to look at the admissions to residential care per 100,000 of population in Northern Ireland in the same way that we have been able to present to you with regard to what happens in Wales.

[45] **Darren Millar:** That is the key, is it?

[46] **Professor Bolton:** That is one of the measures. Emergency admissions to hospital, emergency readmissions to hospital and admissions to residential care will all be signs of whether a health and social care system is working well or not, in my view.

[47] **Darren Millar:** I have one final question. Returning to another point in terms of the proportion of local authority spend on older people, and their social services budgets, having looked at the graph, on which Gwynedd is the highest and Monmouthshire the lowest, it seems that the local authorities with an older demographic tend to be at the higher-spend end of the spectrum, which is precisely what you would expect, is it not?

[48] **Kirsty Williams:** We are quite old in Powys. [*Laughter.*]

[49] **Professor Bolton:** I think that the answer is ‘no’ to that.

[50] **Darren Millar:** I am just talking in general terms.

[51] **Professor Bolton:** I do not think that there is any correlation in the findings with the demography in relation to deprivation or the demography in relation to the number of old people. I think that it is entirely an evolution of the policies and practice in the area.

[52] **Mark Drakeford:** I think that you are suggesting two things to us as a possible explanation for the variables here. One is history—that is the way that it has always been done, and you tend to roll forward what you are already doing—and the other is the relationship between supply and use; if it is there, it tends to be used. There is very good evidence from special needs education that would re-emphasise that: some local authorities use separate special needs education much more than others, because the supply is there. If the places are there, they get filled; if they are not there, other things are done.

[53] I have to remind myself to come back to one question in the final part with you, which is to pick up on a point that has emerged a few times in our earlier discussions, namely the split between residential and nursing home care, and whether it is a boundary that is worth preserving. I want to come back to that at the end with you.

[54] However, we will move to part 3 of the paper, which looks at the vexed issue of how the costs are calculated. Thank you very much for providing some very useful detail on all of that. Do you want to pick up on key points or something?

[55] **Professor Bolton:** Again, this is something to which your clerks particularly asked me to give some attention, as they felt that it was something that you were missing. A major source of data is Laing and Buisson, which covers England and Wales. It has separated out one area, but most of it is combined data, so I am sorry that we do not have separate data for Wales. I thought that it would be helpful to get a sense of what we might expect the cost to be, based on the Laing and Buisson report. I should add a caveat here that most local authorities would perceive Laing and Buisson as an organisation that is very sympathetic to the private sector, so you might just say that, if anything, Laing and Buisson’s costs will be at the slightly higher end. However, when we begin to look at the issue in detail, I can show you where the margins are, and they are tight.

[56] I suppose that takes us on to the critical issue in the cost of a residential care home, which is capital. Depending on where you put your decimal points, the capital on the home accounts for about 40% of the cost of residential care—that is, the capital has to be borrowed and repaid. The key question in the sector is: what is the repayment on that capital and who has lent the money? We have seen joint venture companies in England and Wales being prepared to lend the money, because all their indications are that, having put two and two together, they think that the demographic growth means a certain return. I do not agree with them, but that is their analysis, and therefore they are prepared to invest. Generally, venture capital is looking for a relatively good return on that. The Laing and Buisson formula puts that at 12%.

[57] So, if you are talking about the costs of residential care, you probably have a 12% margin. However, I know of a well-known English-run housing association that would put that figure at between 6% and 8%, because an established housing association that is able to borrow money against its own assets can get a much preferential rate of interest, particularly at present. Therefore, it will not be looking for such a generous return on its investment. If I was going to point you to a critical area, that would be it.

[58] The secondary issue, which is a local authority issue, is the wages of staff. We point out in this paper that evidence would suggest that, on average, staff working in residential care homes in England and Wales are paid about £1 per hour above the minimum wage. So, they are being paid above the minimum wage, but not significantly above it. Local authorities tend to pay above that rate. On top of that, local authorities will have—or have had—generous pension options that will add to that cost. That is not the only reason local authority homes are more expensive, but it is one factor. I am sure that you have dealt with this dilemma during the whole of your review; this whole issue about what we are prepared to pay for care is driven by wages, although not entirely, because, as you can see here, if the cost of care is around £600, the wage element is around £358 of that. So, it is not all of it, but it makes a big impact. The big dilemma for everyone working in this sector is whether we as a society and as a state can afford to pay more. I sat and listened to the budget yesterday and, apparently, we cannot.

[59] **Mark Drakeford:** I am keen that we get to the other parts of the paper, so I will try to move us on at around 10.30 a.m.

[60] **Darren Millar:** I am really interested in this part of your paper, because I think that it is fundamental to the committee's work. In terms of the definition of an efficient care home, could you tell us what that actually means? The costs are based on an efficient care home model. Is it one that has a certain percentage of bed occupancy, or is it one that is of a certain size? What does that actually mean?

[61] **Professor Bolton:** Sorry, I did not bring the material with me. It is there in the Laing and Buisson report under the reference that I have given. Interestingly, on occupancy, Laing and Buisson, in its most recent reports, is talking about 85 per cent. When I was a lad, 90 per cent was much more the norm that people talked about in terms of occupancy for residential care homes. So, it is falling slightly and it is around 85 per cent. There is no clear recommendation on size in this. However, there is certainly very clear evidence that, between the 1990s and 2000s, residential care homes were getting smaller. As the economics have got tighter, new care homes are much larger now. Sometimes, they are built in wings to break up the homes. If you talk to Bupa, for example, which is still investing in residential care homes, you will see that its homes typically house 60 residents, because of the economies of scale.

[62] **Darren Millar:** One thing that care home owners in my constituency have told me—it is probably replicated elsewhere—is that one of the challenges that they face is that individuals are placed within their home on an individual contract basis. They say that they

would be able to provide much more efficient care at a better price for local authorities if there were block contracts for a certain number of beds within their homes in order to reduce the overall price. Is that something that you have considered?

[63] **Professor Bolton:** In the 1990s, it was relatively popular for English local authorities to block contract a number of residential care beds. Often, and maybe slightly sadly, the block contracts were with providers who had taken over the running of the council's previous in-house supply. So, they would say, 'You take over the running of our supply and we will guarantee you some business'. That has tended to die down. I was in Wales the year before last and I cannot remember an example—as I am sitting here, I am racking my brain—of any local authority telling me that it was getting good value from a block contract, apart from the ones that, in my language, block contracted with themselves if they were running their own homes. However, that is a different issue to the one you are raising.

10.15 a.m.

[64] Last year, I was doing some detailed work in the London Borough of Westminster, which still had a significant number of block contracts. I determined that it was not getting value from those block contracts, partly because it was paying for voids—what was that all about?—and partly because I did not notice that the price or quality was any better because of the nature of the block contract. It is not common practice. Care providers would have to make a very strong case to the local authority. If I was a provider, I would be doing that. I would go to my local authority and say that every year it had 20 people in my 30-bed home, and if they took those 20 beds, I would give them £20 a week off. If I was a local authority, I would bite the provider's hand off. It is a two-way process.

[65] **Darren Millar:** As regards dependency levels in homes, if the assessment process is tightened—which it has been over the past two decades with the threshold being raised in relation to how frail a person is before they are admitted into residential care, for example—that puts extra pressure on the home's costs, as they have to lay on extra staff, and so on. To what extent are you predicting significant increases in the cost of being able to provide care, as a result of improved assessments?

[66] **Professor Bolton:** You were wrong in that last point. The number of staff in a care home is pretty well determined by regulations. Most providers will provide whatever the minimum is. There will very occasionally be a care home, because it has an individual who is creating particular challenges, that feels it needs extra staff on a particular shift—at night, for example—to help manage. My experience of local authority homes is that, if that happens, they are quickly on the phone to the local authority saying that Mrs Bloggs is creating particular challenges, and that they need more money if they are going to care for her. There is a correlation between a person who is going beyond the call of the ordinary staff team—price is pretty much determined by the regulator—and what the regulator says, though you are right that the evidence suggests that the assessments lead to most people going into care homes having quite high care needs, at least when they arrive. Given the phenomenon that I suggested, a study recently undertaken in Warwickshire indicated that about a third of residents who were not well when they arrived got a hell of a lot better—a credit to the care home, you could say, given the good environment in which they were looked after, well fed and watered. However, about a third of the residents were not at the very serious level any more. Many in that group probably could have survived by carrying on in the community.

[67] **Darren Millar:** One of the issues is that if we are going to improve the assessment system, and people with greater levels of need and dependency are going to be placed in care homes, while other people, quite rightly, will be supported to live independently, or in sheltered accommodation, it is going to put pressure on the quality of care that people are able to deliver under the current regulations. One of the issues that we are looking at as a

committee is the quality of care and whether the regulations on staffing requirements need to change. If extra staff are required, it is going to put the price up. Finally, as regards the case that you made earlier on rehabilitation, which is critical, are you advocating a new type of care home emerging, where people could be put for six to eight weeks in order to recover and recuperate properly before there is a further assessment of their need? I am not quite clear what you were suggesting.

[68] **Professor Bolton:** I would suggest two things. I would agree that a part of a care home should serve that function, or a dedicated care home, depending on the size of the area. Given the size of most authorities in Wales, evidence suggests that most of them need one care home to serve that function, with around 30 beds. That would vary according to size, but that is an average. It would be dedicated to intermediate care process. However, my long-held belief, for 20 years, is that although there are some outstandingly good residential care homes providing very caring environments, residential care as a model may well have had its day. However, the evolution of extra-care housing in particular—an environment where someone can live independently but have care on site—may well be the twenty-first century model, bearing in mind that residential care grew out of the eighteenth century workhouse. So, I have to put the secondary caveat that we have to think about the future that we will want and expect in old age, and it might be that.

[69] **Kirsty Williams:** I share your enthusiasm for extra-care housing, and you only have to go into an extra-care housing complex to feel the step change in atmosphere between that type of care and traditional residential care. I do not know whether you would agree but, for me, the beauty of extra-care housing is this phenomenon, as you say, of people's health and care needs varying over time and being more appropriately met in that setting. An assessment is made when someone moves into the extra-care housing and care is put in place. Then, they are reassessed some months down the line. If people need less, that care is withdrawn. They are then assessed again, or they can ask to be assessed again, and care can be put back in. This could happen, for instance, if someone has a bout of pneumonia and is unwell. So, that varying kind of input is much more easily achieved in the extra-care housing setting than it would be in a traditional residential care setting.

[70] **Professor Bolton:** I absolutely agree with you. When I was a local authority director in Coventry, our rule was that you could only go into extra-care housing if you either met the criteria for residential care or were at a high risk of needing residential care. So, half the people went into extra care and half to residential care. It probably would have been higher if we had more extra-care housing—there is more now, since I left. We used to employ an occupational therapist in the extra-care housing, visiting the older people, just doing a little check to see if they were doing the kinds of things to help themselves to continue to live independently, such as exercises of the arms so that they could brush their own hair, which is quite simple stuff, but it kept people living independent lives.

[71] **Mick Antoniw:** Is there a link or synergy between occupancy levels and the percentage of elderly persons being cared for in the community? This question follows on from what was said earlier about filling in the demand, in that the profitability of residential care is highly dependent, as you say in your paper, on occupancy levels. If private care homes are dependent on maintaining occupancy levels, does that then play into the homecare element and adversely affect it?

[72] **Professor Bolton:** I do not think that we can clearly say that. One of the pleasures I had in doing this report in Wales was that I had to read every local authority's strategic community care policy for the next five years. There was not a single Welsh authority that was not committed, as its first and prime aim, to helping older people to stay in their own homes. That was the prime policy objective. I cannot recall any that did not have that written upfront as the first line of their policy. So, obviously, if councils are continuing to look at the

variety of ways to better help people to stay in their own homes, that is likely to have an impact on demand for residential care. That, in turn, will have an impact on occupancy.

[73] There are so many other factors. I have a list here of the residential care homes in Wales, and looking across the authorities, you can see that there is a massive oversupply of residential care homes, with Ynys Môn and Conwy being two examples. They are both places where people move to on retirement. They more often than not move there from England and move into residential care, even though they do not have any Welsh ancestry. However, most of them will have lived in Wales for a period of time before moving into a residential care home and will be funding themselves. So, there are particular challenges in that north-west part of Wales.

[74] So, to answer your question directly, as councils continue to understand better the required interventions and care, the use of assisted technology, reablement and intermediate care and offer better health services, the number of people going into residential care is likely to reduce. So, if we continue with this level of supply, occupancies are likely to decrease in some places. Last time I was here, we touched on the evidence that Southern Cross homes in Bridgend had quite big occupancy challenges way before anyone talked about Southern Cross as a company in difficulty. So, there was a lot of writing on the wall before the crisis emerged.

[75] **Mark Drakeford:** In looking through the tables, where can I see the profit?

[76] **Professor Bolton:** The profit appears in the return on capital, which is probably the biggest variable that a provider has in looking for its return. The evidence suggests that a lot of care homes are not making a very big profit, despite the desire to invest. The care industry has such a range of different suppliers. So, a supplier may have one or, if it is fortunate, two care homes in one area. It has probably paid off the mortgage borrowed in the 1940s or 1950s and is getting a small turnover. That kind of supplier probably sees the buildings as being its investment and return, for what will be its pension pot, while Bupa care homes, which are highly professional and extremely well-run organisations, ensure that there is a return on the profit, but in an efficient and effective way.

[77] **Mark Drakeford:** Long-established, small family-run homes often rely on the capital value of the property to make money. I have read an analysis of Four Seasons Health Care, which has taken over a lot of Southern Cross homes, and it is stated that it needs to make a profit of £8,000 a year out of every bed space in order to service the debt. It needs to find a way of managing that debt in September of this year. Do you recognise that figure?

[78] **Professor Bolton:** I think that I sent you that report, Chair. *[Laughter.]*

[79] **Mark Drakeford:** Thank you very much. *[Laughter.]*

[80] **Professor Bolton:** Care homes are variable on price. Southern Cross and Four Seasons Health Care will find that most of their supply still comes from the local authority sector, which, at this stage, is not prepared to offer price increases. In many cases, they will be lucky to get an inflation-based increase in this financial year. I was looking at an English council's figures last night and saw that it is offering 1.75% to its residential care establishments for next year. However, after the Pembrokeshire judgment, which you will be familiar with, and a similar judgment in Sefton, care home owners are beginning to fight back and say to local authorities, 'Actually, you've not taken into consideration the proper costs of our care'. We will see tables like this being presented before judges at tribunals saying that local authorities are underfunding care and not being fair and reasonable. That will be quite a challenge over the next five years, which will only encourage local authorities to reduce demand for residential care even more.

10.30 a.m.

[81] **Mark Drakeford:** May I say something one more time? I am not being critical of private companies making profits, because that is what they are in business to do, so I am not criticising them per se. Your average council tax payer is paying the fees, week in, week out, for someone at a Four Seasons home, and £8,000 of that in a year is not going on care staff, food or the care component, but into the profit margin of the company concerned.

[82] **Professor Bolton:** That is laden with value, is it not? Someone has taken a risk to invest a significant sum of money to create that resource and they are making a return on that capital. That £8,000 is the equivalent of the money required to service the debt—the 12% that we talk about in the paper. I have done a lot of work with local authorities, and if they are paying £589, or let us say £463 for the bog-standard residential care that Laing and Buisson recommend, why are they running their care homes at somewhere around £900 a week? Does the council tax payer want to defend that? Sometimes they do, I hasten to add. So, whichever way you look at it, how will the council tax payer gain value from the money that they are putting into that care system? We must bear in mind, of course, that a significant proportion of care is paid for out of general taxation, not council tax.

[83] **Mark Drakeford:** Finally on this, as it links to the next issue, on models of care, on the point that you highlighted at the beginning on the 12% return on capital in the figures that you have given us, a not-for-profit housing association attempting to develop these sorts of services from its own resources would probably be looking at a return of about 7%; is that what you said?

[84] **Professor Bolton:** I will have to be careful here. I warned the clerks that I gave some serious thought to this. In Wales, only 10% of your supply is not-for-profit. Why is that? First, traditionally, why would an organisation in the not-for-profit voluntary sector invest in residential care? It would probably be because a significant endowment was given to it and that would be how it chose to spend it. There will be fewer examples of organisations raising money on the market to fund residential care, but that is also partly because the not-for-profit sector generally prides itself on being innovative and taking us to the next level rather than running traditional services. I would suggest that—I could not find the details, although I tried hard, but you definitely have a challenge in Wales in terms of your understanding of the market, which we will move on to in a minute—a proportion of your 10% will be younger people with learning disabilities rather than older people. The people I described as borrowing money would be in the housing associations that have been in the residential care market, but who are often getting out of it now for reasons that I have described. They probably could borrow money at a lower rate. However, if I were in a housing association now, I would invest in extra-care housing for the future, because that is what the voluntary not-for-profit sector does, instead of trying to prop up an existing welfare system.

[85] **Darren Millar:** I want to pick up on this issue. Is it not the fact that, while the return on capital is important, it is the overall cost of high-quality care that we need to look at? Of course, the return on capital will be different from one care home to the next. Even two privately run care homes within the same group will have different returns on capital from those individual homes, so it is a bit of a red herring to keep pursuing this return on capital at 8% or 12% when the actual efficiency of a home and its ability to provide good quality care is the critical issue. It may well be that a not-for-profit housing association home, for example, might be able to live on a return of capital at 8%, but if it is less efficient in the way that it is run, then it will cost more money anyway.

[86] **Professor Bolton:** I agree with that. All that I was trying to show you was that, if you are in the private market or the not-for-profit market and you are looking to establish a care

home, and you go to the authoritative source on how you might set your fee structure, the authoritative source, Laing and Buisson, says that you should be considering a capital return of around 12%. There is a lot of debate about that figure, and I absolutely agree with the points that you just made. I am just making the point that it would be a guiding principle for some in the market.

[87] **Mark Drakeford:** We move on to part 4 of the paper, on trends in the market. We have done quite a bit on this.

[88] **Professor Bolton:** We have probably touched on a number of these. I thought that it was interesting, given the comments that we have made, that even Laing and Buisson suggest that, even in their modelling, there is sufficient supply in Wales of residential care homes. You should be aware of that. Obviously, my view is that there is an oversupply, for the reasons that I have stated. There is a lot of debate in social care about demography, and we have to be careful here. There is a section in this report in which I go through why demography is not quite as simple as we describe it. If you consider the facts, the older population has increased over the last decade—it has been increasing, it is not a new phenomenon—yet demand for residential care has fallen. Let us not just jump to the obvious conclusion that, just because we can see that demography will further increase the older population, that will further increase demand for residential care. There is a whole set of factors that I have described that might change that, particularly because of the fact that—and again, we talked about this last time—the older population today has a bulge of wealth. We may not see it again, but we are seeing it at present, which means that a higher proportion of older people than we have ever known before will be procuring their own care. Therefore, the question of whether they use residential care or not will be determined much more by their choice. Bupa has recognised that, because it advertises on the television. That investment must be worth the return—it would not be doing it, as a highly reputable and well-run company, if it did not think that it was worth it. So, we must recognise that, among tomorrow's older people, a much higher percentage are going to be buying their own care, and the future patterns of care are much more likely to determine whether or not you have sufficient care homes than just what the local authority will do.

[89] **Mark Drakeford:** There is one quick extra question on this part of the paper from Darren.

[90] **Darren Millar:** It is about what I perceive to be an increasing demand for care homes that cater for specific groups of people, like veterans, ex-service personnel, Christians and Methodists—you mention Pilgrim Homes in your paper; those sorts of organisations. Is that something that you think will increase in terms of future demand, or decrease, or flat-line? How do you see the market developing in that sense?

[91] **Professor Bolton:** First of all, just to be clear, I am very familiar with MHA, or Methodist homes, which is a highly reputable, extremely well-run not-for-profit organisation that provides an excellent service. Its homes are not just open to Methodists. It obviously has that tradition, but the homes are open more widely. It is an interesting point, and I do not know—what is the future going to look like? What might we see? I would suggest that that is not going to be a major feature in the future. It may be a small feature.

[92] The housing-based options are going to be much more likely in the future. I do not know whether they are here yet, but you are going to be talking to people from Flintshire council—talk to them about how they are planning their future. Very carefully, but without any rushing, they are slowly phasing from residential care to housing-based models of care, and they think that that is the preference of older people in their communities.

[93] **Darren Millar:** I understand that, but where residential care has to happen, for



whatever reason, even given extra-care housing and sheltered accommodation and so on, are people indicating a preference for going to a home where they feel an affinity with other residents, because of a background in the services or whatever?

[94] **Professor Bolton:** There may be small examples of that, but I do not see that much. In this thing about preference, it may be that the decision to go to residential care is often made in adversity. It is not the kind of decision that we would make when we move house; it is not always a well-thought-out decision. The crisis has occurred and something pretty significant has happened to you. You are really not at your best, and everybody around you is saying, 'God, you're not going to be able to cope at home; you're going to have to go', and you say, 'Oh, all right'. Some people will say, 'Okay, if I have to go, please send me to one where I'm with my old comrades or fellow veterans'. I could well understand that, though we should of course be clear about the fact that the dominant group in residential care is women over the age of 85 who have been living alone. That would be your very typical profile of people who have become eligible. There is a possibility, but with caveats. My experience of talking to older people who are in residential care, however, is that very few of them have really sat down and thought through the issues before the challenge was thrust on them. They were not expecting the stroke; they were not expecting the consequence of their medical intervention to lead them to that position, so they had not prepared for it.

[95] **Kirsty Williams:** If housing-based solutions are the future, and we do have a demographic of older people with resources, is there any evidence to suggest that the extra-care housing model being developed by housing associations can be a model under which some people could purchase their homes, or must we have stand-alone facilities for people who want to retain their capital, so they have something to hand on? Is there any evidence to suggest that that is a growing trend?

[96] **Professor Bolton:** Very interestingly—I do not know that I have fully understood this—I think that the rules in Wales have somehow hindered that development. Typically, once the housing association grants from the relevant body ceased, which was about three years ago, many housing associations in England realised that there was only way that they were going to develop housing. So, a typical extra-care housing scheme now would have half for sale, a quarter for part sale for those who want to retain some equity, and a quarter for rent for that part of the market—it depends on your market and on your place. In Warwickshire, we have even modelled it so that, if we are building extra-care in wealthy Stratford, we will not need as many tenanted places. If we are building it in Rugby or Nuneaton, however, we will need a higher proportion of tenanted places. If the same housing association was to develop 12 centres across the county, it could manage the modelling of its money so that it would be getting 80% to 90% sales in Stratford and only 60% in the north, and it would get its return. It is a perfectly viable financial model for that association without any state grant. I think that the grant regimes, from the housing corporation, as was, or from the Welsh Government or the Department of Health, did not originally encourage that model, so many of the extra-care facilities that I have visited and seen in Wales already have a model that is entirely tenanted. For some older people, that will not be their choice, for the reasons that you gave.

10.45 a.m.

[97] **Kirsty Williams:** Does the way in which we handle that process in Wales prevent the involvement of housing associations? I have talked to housing associations—

[98] **Professor Bolton:** I think that I would ask the councils that question when you see them.

[99] **Kirsty Williams:** I have talked to housing associations that believe that, in Powys,

there would be a demand for a mixed economy within extra-care housing: there would be people with resources who would want to buy property and there would be people who would need to be tenants. However, we have no extra-care housing, and that might be the reason why not.

[100] **Mark Drakeford:** It will be interesting to pursue that with the Welsh Local Government Association and other witnesses later.

[101] **Professor Bolton:** It would be interesting to hear—

[102] **Mark Drakeford:** It depends on many other things, such as the state of the market. I went to visit the Bridgend equivalent of the home that we went to see in St Mellons; that was built with quite a large number of houses for sale, but they could not sell them because the people who wanted to move into them could not sell their houses. So, they were aimed at Welsh owner-occupiers, which, on the whole, are people from relatively modest financial circumstances, who wanted to have equity, but the problem was that they had to rent almost all of them to people who were unable to carry their equity with them.

[103] **Professor Bolton:** I remember that phenomenon in Bridgend. In my view, the best expert in the extra-care markets is a company called the ExtraCare Charitable Trust. It tells me that one of the issues is that housing associations do not have a history of marketing and helping older people, even with the sale of their properties. That has not been their business. It is a new business for them. It is a phenomenon that has arisen over the last three years. Part of the challenge is how the housing associations do that, as they are probably likely to be the early developers. I have noticed that, in England, I now see more McCarthy and Stone—entirely privately driven initiatives—coming into the market. It would be not untypical to say, ‘We will buy your house from you; we will manage that sale for you, if you come in’. There is a question as to whether one would get a fair price and a set of other issues, but that is the kind of marketing tool that a private sector developer may use that housing associations may feel less able to use. So, it is a challenge. These are early days. This is a new market that we can see developing slowly.

[104] **Vaughan Gething:** That sort of property swap is quite common now for many new housing developers for standard housing. I am very interested in all of the discussion, but particularly the point about the market—trends in the market and particularly the move away from residential care to alternatives, such as extra care and others. You talk in your paper about the move away from a tenanted position, but also what you refer to as a market position statement from local authorities. I am interested in the question as to how much of the future market will just be a trend that will happen. Should we just let that happen? That is, in terms of intervention or, if you like, the managing of the market and predicting future need, how much do local authorities already do and what we should expect them to do in terms of trying to help to deliver a market that matches the sort of need that we can predict? I would not want to see it being unmanaged and there being an acceptance that there will be trends, a hands-off approach being taken and the attitude that, ‘It is not really our problem; we will just pay for it’.

[105] **Professor Bolton:** Let us be complimentary. I have been very impressed by the evolution of aspects of social policy in Wales that have been led by the Welsh Government. Local authorities take the Government very seriously and the Government, in turn, places requirements on them. One of the reasons why I am really happy and very keen to be here is that I have a lot of faith in the Welsh Government trying to provide the right framework and the right shape to help local authorities to take this forward. I think that they will be encouraged, or not, by what you say to them. So, I would encourage you—as much as you do not want to be over-directive to local authorities, I am sure, because you want them to have their own freedom—to give them a positive framework for the way in which you want to take

forward these issues. My experience of the Welsh authorities is that they will listen to you and will take proper heed of the steer you give them. So, I would encourage you to do that.

[106] **Vaughan Gething:** On the back of your paper, you refer to a market position statement; is that something you think that local authorities should be doing on a regular basis, rather than having to do it only if they want to?

[107] **Professor Bolton:** Two things have emerged as I undertook to look at the work of the Welsh Government, beyond the work that I had already done in Wales, and one of which was how difficult I have found it to understand the market in Wales from the data available. I have trawled through a whole range of websites to see where we can find out about the social care market. So, there is a question for the Welsh Government as to how it sees and understands its market and risks. Whether there are four seasons of risk in Wales would be the type of question to ask, similar to the one the Chair has raised.

[108] Equally, I do not think that local authorities have done sufficient work. They are getting better at it; I was working in Gwynedd recently, and it is almost ready to move towards a market position statement. It has done enough work with its local providers to begin to understand what the provider's offer is and what it thinks its future planning needs are. At one level, it is only taking your strategies that I have talked about—everyone has one—into reality, and also demonstrating to the market what it is going to look like. If there is going to be less of it, let us be honest and straight with people that we are likely to be buying 5% less residential care within that framework, and that will help providers to make their business decisions based on that. For example, banks are still prepared to invest in new homes, but it may not be required. Therefore, the market position statement is a strong tool for the local authority. The Government could set a positive example by demonstrating that it also understands the markets in Wales.

[109] **William Graham:** To pick up on that point, I was pleased to hear what you said about engagement. Is that also applicable to those making provision for the elderly mentally ill, because as we are all living longer, EMI patients are also living longer, so the short-termism that was such a feature of the market must now go?

[110] **Professor Bolton:** Yes. We touched on dementia care last time, which is obviously a challenge. Again, we are learning more about how you can help people live with dementia, because technologies are available to support people to carry on living in their communities. They are often reliant on a formal carer, a relative or strong informal care. However, you are right that they are a growing group for whom residential care is currently seen as the only solution, but dementia is not an illness that drives you to death; you could have dementia for a longer period, and an average of three years in residential care could be a longer period for someone with dementia, so all those decisions are really important.

[111] We are balancing that against the fact that there is some evidence of treatments that might help to arrest the development of dementia, although we have not reached a stage where we have a cure; we will know about that in 10 or 20 years' time. I am told that drugs are being trialled at present in the UK that show some potential that we will do more than arrest dementia, and that we might have a drug that can help us. Therefore, how can we predict what will happen? We have to be careful, but we also have to be optimistic. You are right about the longevity of the care that someone will need, and the importance of getting that care right. We talked last time about the fact that, for an increasingly high proportion of people in residential care, dementia of some type will have been a significant contributor to the decision to make that admission.

[112] **Mark Drakeford:** John, we are not going to have time to ask questions about part 5 of your paper. However, we have a second half to the morning when we will be seeing the

Welsh Local Government Association, ADSS Cymru and three local authorities. Much of the material in the final part of your paper seems to be a resource of questions that we will want to take up with them. As we are in the last couple of minutes, are there any issues arising from the final part of your paper that you think would be especially useful for us to pursue with them in the second half of our morning?

[113] **Professor Bolton:** I think that we have touched on most of them during this discussion.

[114] **Mark Drakeford:** Could you tell us something about the perverse incentive point that you made, because it comes up in the evidence of all three local authorities?

[115] **Professor Bolton:** The domiciliary care cap and—

[116] **Mark Drakeford:** How much of a perverse incentive do you think that the domiciliary care charging cap is in practice and so on?

[117] **Professor Bolton:** That is difficult. This was quite a strong feature. Councils were very concerned about it. Bearing in mind that this was two years ago, the cap was just on the point of coming in and, therefore, there was a lot of anxiety about it. However, I have not looked at the direct impact of that.

[118] **Mark Drakeford:** We should ask them what their experience of the last couple of years has been.

[119] **Professor Bolton:** It would be worth doing so. The data that would tell us what the impact of that has been are not yet available in the public domain. Councils were worried about the margin between the cost of helping someone to live at home and the cost of putting them in residential care. For example, if you were doing it entirely on a cost-base model, would the £50 ceiling just tip you the other way? That was the risk. I will say no more than that. Last time, we also touched on my belief in people paying according to their needs, which obviously is a political point. You can make your own judgments on the politics of that.

[120] The Scottish experience on one level might have been seen to be positive about residential care, but did it actually have the right set of outcomes? The one thing that we do know about Scotland is that there are waiting lists for people to have assessments to start that process. So, it has not quite delivered the vision that the Scottish Parliament intended when it created that policy. We always have to be wary when we create policy; we should always know what the risks are of that policy and what the unintended perverse incentives of what we are trying to create may be. That is what I would advise caution on.

[121] **Mark Drakeford:** Thank you very much. I have enjoyed the last hour and a half and have learnt a great deal. You have given us a lot of helpful information for our inquiry.

[122] Diolch yn fawr am eich tystiolaeth. Thank you for your evidence. We will now  
Cawn egwyl yn awr am 10 munud. A all have a break of 10 minutes. Could Members  
Aelodau ddychwelyd erbyn 11.10 a.m.? return by 11.10 a.m.?

*Gohiriwyd y cyfarfod rhwng 10.57 a.m. a 11.11 a.m.  
The meeting adjourned between 10.57 a.m. and 11.11 a.m.*

**Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Tystiolaeth gan Gymdeithas  
Llywodraeth Leol Cymru a Chymdeithas Cyfarwyddwyr Gwasanaethau  
Cymdeithasol Cymru**

**Inquiry into Residential Care for Older People—Evidence from the Welsh  
Local Government Association and the Association of Directors of Social  
Services Cymru**

[123] **Mark Drakeford:** Bore da a chroeso. Mae'n bleser gennyf gyflwyno Emily Warren o Gymdeithas Llywodraeth Leol Cymru, a David Street o Gymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru. Croeso i chi. Byddaf yn gofyn ichi am ddatganiad agoriadol byr i ddechrau. Diolch am ddarparu tystiolaeth ysgrifenedig cyn y cyfarfod. Mae aelodau'r pwyllgor wedi cael cyfle i ddarllen y dystiolaeth. Ar ôl y datganiad agoriadol, bydd cyfle i aelodau'r pwyllgor ofyn cwestiynau.

**Mark Drakeford:** Good morning and welcome. It is a pleasure to introduce Emily Warren from the Welsh Local Government Association, and David Street from the Association of Directors of Social Services Cymru. Welcome to you both. I will ask you for a brief opening statement to start off. Thank you for providing written evidence prior to the meeting. Committee members have had an opportunity to read the evidence. After the opening statement, committee members will have the opportunity to ask questions.

[124] Thank you, both, for attending. I will ask you to highlight any points from the written evidence for a few minutes at the beginning, if you want to do so. We are grateful to have received the written evidence and we have had a chance to look at it. If we are lucky, depending on how the questions go, there may be a few minutes left at the end, when I will come back to you for any round-up points that you think that it is important to leave us with. Emily, will you lead off?

[125] **Ms Warren:** Yes. First, thank you for inviting us here today. From the discussions that we have had back at the ranch, we felt that this inquiry was very timely. It is set in the context of 'Sustainable Social Services for Wales: A Framework for Action' and the publication of the social services Bill. So, we were grateful to come to provide evidence to you. We would want to reflect that local authorities recognise the importance and the place of residential care as part of a wider continuum, and we recognise the need for transformational change and an opportunity, as part of that transformational change, to develop new models of care, which we will allude to today.

[126] What is critical for us, as you would expect the WLGA to say, are appropriate resources to take forward that transformation and develop new models of care and ensure that there is sustainability and viability in the system. Alongside that, in delivering such change, the partnership with the health and housing providers and the voluntary sector will be absolutely critical. We will touch on some of that in our evidence today.

[127] **Mark Drakeford:** David, do you want to add anything at this point?

[128] **Mr Street:** No, I think that Emily has covered all the points.

[129] **Mark Drakeford:** Okay. We will go straight into questions from Members.

[130] **Vaughan Gething:** Good morning. I want to pick up on a point in the discussions that we already had this morning about the shape and nature of residential care and what that might look like. There is the model that we currently have where we have residential homes that include different elements of care. We visited a site where the dementia care was on the same site as the ordinary residential care, and there was extra care on the other side. So, I am

interested in how you expect local authorities, across the whole board, to plan for that change in nature and demand in what we think residential care should look like, whether it is extra care or traditional home-type residential care.

11.15 a.m.

[131] **Mr Street:** The commissioning strategies of authorities are already well understood and in place to a large degree. That change in the model of care is already happening. Certainly, if you look at the way that local authority commissioning has developed in the past five years, you will see that there is already a range of provision in county boroughs across Wales. We have seen a move away from what we call standard elderly frail care in large institutionalised settings to those types of providers that are providing more and more support for dementia sufferers. In my area of Caerphilly, we now have a number of successful extra-care facilities up and running. So, you can see those models of care emerging. The challenge that we have is that, at the moment, they are emerging separately. So, you will have a care home that will move away from providing elderly frail care to providing dementia care and, in another part of the borough, you will have a separate provider that will develop an extra-care facility. The ideal situation would be for there to be one property or one setting where there is that continuum of care.

[132] As people move away from being elderly and frail in their own home to receiving more support and perhaps requiring extra care, and then to a situation where they need more care again and require residential care, should they be unfortunate enough to develop dementia and require what we refer to as elderly mentally infirm care, it would be very good if that could be delivered on the same site. That is not possible or is certainly not very common at the moment. The challenge for us is how we can provide that continuum of care across the sector without people having to move from one building to another.

[133] **Vaughan Gething:** We know that, in some places, it is being provided in one setting. However, what do you think your role is as the local authority in planning for or intervening in a market to try to deliver the outcomes that you say you want to see? Earlier, Professor Bolton flagged up the point about market position statements that some local authorities have produced. Is that something that you would aspire to provide across every local authority in Wales?

[134] **Ms Warren:** Yes, what I am saying about where we are with sustainable social services is that this is a fairly critical time for social services. This is a huge agenda of transformational change, and, as local government, we put our response to the Deputy Minister in December setting out what we thought we could deliver under the six themes over the following year to 18 months. One of the key elements of that was to do with improving how we commission services. One of the critical areas is the development of a continuum of residential care. So, we are looking to develop market position statements, but that is something that the WLGA, working with ADSS Cymru, is going to do over the next 12 months at a national level.

[135] We know that some authorities have developed them and we know that some authorities have good regional arrangements, but we are now taking a lead and have made the commitment to the Deputy Minister that this time next year we will have an all-Wales picture of market analysis and market position statements. I think that what they are saying is that, as part of that, it is critical that we develop relationships with providers. Nationally, we have a good relationship with bodies such as the Care Forum, but we are looking at developing a programme of provider support that the WLGA and ADSS will oversee as part of our first stage action plan. So, if we were to come back to the committee in 12 months' time, we should be able to share a fair amount of progress in that respect.

[136] With regard to the changes in demand for residential care, we have heard that there is probably an oversupply of residential care beds and an undersupply for those with mental health needs in particular. With a population increasing in age, all people in the different categories will be living longer, so how can the sector best respond to that?

[137] **Mr Street:** This touches on the points that Emily made on local and regional commissioning plans. Certainly, in my area, we are working with providers on this. We are very transparent with providers about where we have capacity and whether we have overcapacity or undercapacity. We encourage providers to move away from providing standard residential care and to recognise that, increasingly, in future, the demand will be greater from people with mental health and dementia needs. That is not always easy. Some of those providers are very experienced at providing residential care and have done so for a considerable time. They are not necessarily comfortable moving to provide a new category of care. It comes down to those local commissioning plans.

[138] **William Graham:** So, would you say that you are getting some resistance from providers?

[139] **Mr Street:** I think so. There is a concern that they are moving into an area they are not familiar with. As I say, many of them have provided residential care for a considerable time and are perhaps in denial—although that may be too strong a word—that these demographic changes will happen to the extent we perceive they will. We are very clear with providers that demographic changes are not something that we see happening in the future; demographic changes are something that we are going through now. We are in the middle of these demographic changes.

[140] **William Graham:** Could you suggest a remedy?

[141] **Mr Street:** The national commissioning across Wales will help. I think that that needs to be more detailed at a regional level. We need to incentivise the system for people to change, by helping them and their staff to better understand the needs of dementia sufferers by providing appropriate support and training for those staff, so that they can qualify themselves and understand those needs before they make the decision to jump.

[142] **Darren Millar:** In terms of the categorisation, obviously dementia is becoming an increasing feature in the landscape of social care, particularly in residential care settings. However, we have this differentiation between EMI and non-EMI homes. Do you think that that should be abolished and that all residential care settings should have some element of dementia awareness and ability to provide care to people with dementia?

[143] **Mr Street:** Certainly, all settings need dementia awareness, because, even if you are providing elderly frail care at the moment, you will need to recognise the symptoms and needs of people who may be developing dementia in your care setting. That arbitrary process of a separate registration is not always helpful. To me, it is very much about whether a care setting can meet someone's needs. If someone can demonstrate that they have staffed their home appropriately and that those staff members are sufficiently trained to provide good-quality dementia care, then having that separate registration entity is not helpful because it can mean that people will have to physically move from one building to another.

[144] **Darren Millar:** So, do you think that separate registration ought to be abolished?

[145] **Mr Street:** I think that that would be helpful.

[146] **Mick Antoniw:** I have a quick point. Could you just clarify your position so that I fully understand what you are saying? Following on from the question from William Graham,

we heard evidence this morning that in Wales, across the board, we have sufficient residential care and, quite possibly, a surplus. Is that a position that you agree with?

[147] **Mr Street:** Locally, yes, I would. I think that you have to differentiate between residential care for older people and residential care for people with dementia. There is certainly an oversupply of general residential care, if I can use that phrase, but that certainly is not the case for residential care for people with dementia; either the supply is adequate or there is an undersupply.

[148] **Lindsay Whittle:** I have been an elected politician since the 1970s and I have noticed a huge change in residential care. What is the WLGA's overall view on training? David, you mentioned training, and I think that that is really important. For people who work in residential care, it is a vocation. I think that it is important that we have well-trained staff.

[149] **Ms Warren:** I agree. In our evidence, we reflected the need to have appropriately trained staff for the care setting in which they are working. As part of some of the work of the Social Service Improvement Agency, we have our own development programmes for staff, up-skilling team managers, senior managers and middle managers. As part of the programme that we are about to undertake in relation to commissioning and supporting the development of care settings, training will be a key feature.

[150] **Lindsay Whittle:** In times of crisis, budgets for training are always the first to be cut, certainly in local authorities. What about the private care? How is it going there?

[151] **Ms Warren:** We have reflected that we need to build the relationship with providers and that providers have a role in ensuring that their staff are appropriately skilled and trained to be able to undertake their duties. The development of the relationship between the authorities and the providers is key to that, in working out how we provide training that is meeting their needs and that their staff take up training, because I think that there has been a problem in the take-up of some of the training that has been offered.

[152] **Elin Jones:** Earlier this morning, John Bolton spoke about the concept of intermediate care and that by far the most common way that people go into care is direct from the hospital bed. He said that one in five older people who are admitted to a care home may have avoided admission had more time been taken over the assessment. In order to try to break the cycle, he introduced the concept of intermediate care, from the hospital bed to intermediate care, which enables reablement and recuperation, and, at the end of that period, a more permanent assessment is made. Have you come across that before in different areas of Wales? Are they considering that concept in any way, perhaps with intermediate care in a care home setting or even in the individual's home?

[153] **Ms Warren:** I think that part of what John was touching on was the work he did on the SSIA. In his report, there are examples of where that is taking place, so there are authorities in Wales that are adopting that approach. I cannot find the list, but I am sure it is Wrexham that has gone some way towards ensuring that there are no new admissions into residential care direct from a hospital setting. That is starting to become fairly common across Wales. Is that fair to say, David?

[154] **Mr Street:** Absolutely. Reablement services are now widespread across Wales. There are few authorities that have no reablement services. From my own authority's perspective, reablement is very successful. Statistics that we looked at recently showed that when people go through a reablement service, 60% leave that reablement service without needing an ongoing package of care. That will not be the situation for everyone. There will always be 20% to 30% who will need ongoing social care services. The pressure the health boards face to discharge people from hospital inevitably leads to some people going into



residential care who do not need to do so. A number of authorities, including my own, have brought in the concept of intermediate care, or 'step down', or what we call assessment beds. People can go into a care home for a six-week period to receive reablement services, and to give them and their family more time to make a fundamental judgment about where they want to be for the rest of their lives. That is very difficult to do when people are under pressure to vacate a hospital bed. In my authority, we are in the process of introducing six assessment beds, to give you an idea of the scale. That is not that many at all. That would work more effectively if the assessment beds were jointly funded by health boards and local authorities. In the current financial climate, this is not easy to negotiate. So, it is very much a pilot scheme from Caerphilly's perspective, to see what the outcomes are and whether we can sit down with health colleagues to try to broker arrangements that would make them more widely available.

[155] **Kirsty Williams:** My question relates to the interface between local authorities and the health service. On page 8 of your paper, you say,

[156] 'Collaborating more closely with the NHS has encouraged whole systems thinking, and this has resulted in effective strategic planning.'

[157] You make a whole series of statements about how good your working relationship is with health. Rather than evidence, they are simply statements. How can you demonstrate to the committee that what you say on page 8 of your paper is happening on the ground, and what improvements has the greater collaboration between health and social care delivered from patients' perspective?

[158] **Ms Warren:** From a strategic perspective, the point that we are trying to make in our evidence is that there are very few things that social care can do alone. There are a lot of co-dependencies, and health is a key partner in that. We feel that it is part of the sustainable social services agenda and 'Together for Health'; we must not miss those opportunities and make policy in silos. We need a strong national and political statement that social care and health need to be more integrated in the delivery and development of services. From the WLGA's perspective, in taking that forward, we have a joint programme of work with the NHS Confederation. Perhaps we could send our implementation plan to the committee, which we submitted to the Deputy Minister this week. That shows some examples of where we have determined we need to work in practice. As far as local examples go, David can probably talk about Caerphilly, but there are a number of examples in John Bolton's report. The evidence submitted by the authorities and local health boards are a fair reflection of the scope of joint working.

11.30 a.m.

[159] **Kirsty Williams:** On page 9, you talk about the need for joined-up policy making at a Welsh Government level. Could you explain why the lack of such a policy, as you perceive it, is causing problems on the ground? We heard clear evidence from John Bolton this morning that the last thing that we should do is think about structures and changing structures, because that made no difference to outcomes whatsoever. So, could you explain what you are not able to do at the moment because of the lack of joined-up thinking at a national policy level? What is that preventing you from doing?

[160] **Ms Warren:** The point that we are trying to make is that we think that there is a lack of joined-up thinking. However, we are not lobbying for structural change or joint arrangements in any way. At a local level, LHBs and local authorities are currently working to different performance management frameworks, objectives and financial pressures. In areas such as residential care, where the need is for health and local authorities to work together to commission and plan, strong national leadership and a clear understanding that

that is co-dependent would be extremely helpful.

[161] For example, two weeks ago, the social care Bill was published. However, it was not a social care Bill at all; it was all about wellbeing and health, and other local authority departments are critical to that. However, the language is very much around social care. We are lobbying for recognition at a national level that health and social care need to be supported to work together.

[162] **Kirsty Williams:** I am still not clear about what is being prevented from happening on the ground through not having a national statement. Are you being polite and saying that unless the Minister for health tells the health service that it has to take this seriously, your health colleagues are not taking it seriously?

[163] **Ms Warren:** That is part of it, and part of what we were writing in the document was that you have two huge reform agendas for health and social care. One is 'Sustainable Social Services for Wales' and the other is 'Together for Health.' There is little interface between the two documents.

[164] **Darren Millar:** I want to take a look at this area of the financial viability of the residential care sector. We were all upset when we saw what happened to Southern Cross and the uncertainty that that created. Also, there are smaller, independent homes that struggle, and, as a result, have to close. That can cause huge upheaval for residents and their families. Who do you think ought to be responsible for undertaking a check of the financial viability of homes?

[165] **Mr Street:** Initially, when a home first comes into being, it is an issue for the Care and Social Services Inspectorate for Wales to ensure that the business planning and the methodology for setting up a home are sound and robust. Beyond that, it is a joint responsibility between the care standards inspectorate and local authorities. Clearly, that requires an element of trust, which, if I am honest, is lacking at the moment. Despite my best efforts, I find it difficult to get providers to provide me with things such as profit and loss accounts. So, to monitor the financial viability of a provider is difficult. That comes down to some tensions around the fee-setting process, and perhaps a reluctance on behalf of some providers to demonstrate that they are doing okay. Perhaps they feel that being seen to be doing okay will be viewed negatively by local authorities, whereas, in reality, we would be far more worried if we had a home that was in the red, as that would be indicative of more serious problems down the road.

[166] **Ms Warren:** One of the things the Social Services Improvement Agency has done in the wake of the Southern Cross experience is to put some of these issues in the public domain. It is holding a one-day seminar at the beginning of May, and partners such as the inspectorate, providers and the local authorities have been invited to have a closed session in order to go through the risks, what we need to know, how we prepare for it, and how we can better manage it in the future. It is unfortunate, but examples such as Southern Cross put these issues in the limelight, and people then seek to address those issues.

[167] **Darren Millar:** In the first instance, you think that CSSIW ought to be responsible for the regulation and effective monitoring of new homes. Where you have a home that has been in existence for a long time, do you think that the regulatory and inspection framework ought to take the financial viability into account? At the moment it does not do that at all, does it?

[168] **Mr Street:** There is room for that, but, equally, that responsibility also sits with local authorities as the commissioners and contractors. So, where we have those contracts in place, and we are placing people in individual care homes, we would have some knowledge about

their viability or potential viability for the future.

[169] You are right on the Southern Cross agenda. People who went into those Southern Cross homes just before the difficulties became public asked me, ‘Hang on a second, how did you let this happen?’ and ‘How did you let my mum go into this home when you knew this provider had all of these problems?’. However, those problems had been going on for a considerable period of time and no-one was clear when the tipping point would come.

[170] **Darren Millar:** One problem with Southern Cross is that some of its homes were profitable while others were making huge losses. It is quite difficult to grasp the viability of an individual home if it is part of a much larger group, is it not?

[171] **Mr Street:** Yes. I have tried to do that locally, and it is difficult. It is much easier if you have a small, privately run home. However, it was almost impossible in terms of some Southern Cross providers. Given the complexity of the accounting arrangements, it was almost impossible to understand how a single home was doing.

[172] **Darren Millar:** You talk about the need to build up better levels of trust between providers and commissioners. The issue of the fee-level negotiations is a perennial one that causes pain and perhaps a breakdown of trust on both sides sometimes, particularly with the public purse under pressure and care homes facing upward pressures in terms of costs. Is the current model of county-wide fee levels appropriate, or should there be individual rates that people are prepared to pay for individual homes in the future, given that different homes have a different cost base?

[173] **Mr Street:** If there were different rates for each home, there would need to be clarity about why that was the case. If my mum was being cared for in a home that cost the council £500 a week, but, down the road, the care was costing £300, does that mean that the care that she is getting is different? Is it better in the £500 care home and worse in the £300 home? So, it is about understanding the methodology. You have to understand the history of the fee-setting process, which has been done at a local level. There is room for regional work and there is potential for regional fee-setting, although it is not easy. However, having individual rates for homes within a borough would cause me some anxiety.

[174] **Darren Millar:** We heard evidence this morning from Professor Bolton, as you have heard, and he set out some information that was in a joint Joseph Rowntree Foundation and Laing and Buisson report, which indicated what they felt would be a fair fee level for different categories of care. The cost base for each individual home is different and what is fair for one home might not be fair for another.

[175] **Ms Warren:** It is a complex area, and I have recently tried to get my head around it. ‘Sustainable Social Services’ attempted to resolve some of it by talking about a national contract for care fees to avoid some of the problems that you are aware that local authorities have had. There are regional approaches in north Wales, south Wales and in the Swansea western bay area to develop a common methodology. So, while the price might be different, recognising the different needs levels of homes, the methodology by which those fees are set would be consistent. That is where we are starting to develop work and push work forward as part of the local government implementation plan.

[176] **Darren Millar:** That is an important message, because if you think about the way that we fund schools, for example, you will see that there is a common formula within each local authority, but the rate per pupil in each school is different. That might be a potential way forward.

[177] **Mark Drakeford:** I have three questions to ask before going to Rebecca. We spent

quite a bit of time with Professor Bolton looking at the fact that different local authorities spend different proportions of their social care budgets on residential care—more than 60% in Gwynedd and less than 40% in Monmouthshire. Professor Bolton offered us a couple of explanations as to why that might be, and he ruled out a couple of factors that were suggested to him. How would you help us understand that variability from a Wales-wide perspective? Why do some local authorities spend so much more than others?

[178] **Ms Warren:** From a Wales-wide perspective, it is probably related to some of the work that we are doing in understanding the demographics—the demographics in Gwynedd are probably quite different to those in Merthyr Tydfil, for example—the demand on services, the historical pattern of services delivery and the problems of decommissioning and commissioning new services. We tried to put in our evidence that we need to understand those processes better. We need to develop a better dialogue with the constituents whom we serve when we are trying to decommission or close a care home. I am sure that you have all probably been involved in local campaigns, but we are just not very good at it. We are not good at developing the narrative around the modernisation of services and different approaches. So, that would be something that could be done nationally to support you to understand. You probably have a more learned view, Dave.

[179] **Mr Street:** At an all-Wales level, it is also dependent on the ability of authorities to develop alternative models of care. As I said earlier, reablement has been particularly successful in my area in keeping people out of residential care. In addition, in the former Gwent authority, the five authorities have come together with the Gwent frailty programme, which is an integrated model of care across health and social care. One of the fundamental concepts behind that was to reduce the number of people who will enter residential care in the future. Models of care have developed in different ways in different places across Wales, regionally and locally, and that has an impact on the percentage spend at the moment compared with counterparts in other areas.

[180] **Ms Warren:** One of the flagship SSIA programmes was around reablement, and quite a large reablement conference is being held in Cardiff today, which is where Professor Bolton has gone. We could probably give you a fair reflection of where local authorities are in terms of developing their reablement services and how they have tried to reduce the reliance on institutional models of care, if that would be helpful.

[181] **Mark Drakeford:** That would be helpful, thank you. One of the common messages that we are getting from all witnesses to this committee, and it was in your evidence today, is that, in thinking about residential care, we need to stand back from the immediate issue and think about models of care for older people that are fit for the twenty-first century. Residential care will have a part to play in that, but maybe a different part to the one that it has had in the past. Your evidence says that the process of modernisation

[182] ‘is often met with significant local political opposition’.

[183] Do you want to say a little more to us about that? How hard is it to move away from a service that people have known, and sometimes known very well, to do things differently? Is it a real challenge or is it something that local authorities have to learn to manage?

[184] **Mr Street:** It is extremely difficult. Having been through it myself in the last two years and spoken to a number of my counterparts who have had the same experience, I know that these facilities have often been in place for 20 or 30 years and are valued by the local community. In my experience of closing a local authority care home, everyone accepted that there was overcapacity in the system and that a care home needed to close, but the question that was always asked was ‘Why this one? Why can’t it be the one up the road or the one across the county?’ So, there is political resistance, but there is also substantial public

resistance. It is viewed as a cut and the authority saving money. The lesson for us to learn is that a better selling point is what those resources will be used for in the future, because that transformational change agenda can only be achieved by decommissioning existing services.

[185] **Mark Drakeford:** There is one more question from me, which is on the issue of self-funders, which we also discussed with Professor Bolton. He suggested that the balance in residential care is changing and that there is a higher proportion of self-funders than there used to be. His evidence was that quite a high number of self-funders end up in residential care without having had the advantage of a full assessment and advice that might have allowed them to see a wider range of choices. When they then end up in residential care, it is sometimes a lot earlier than people who are not self-funders. There comes a point at which their self-funding capacity runs out, and the local authority ends up paying the bill for someone who, in other circumstances, the local authority would not have placed in residential care. Is there anything that you think might be done to ensure that self-funders get the proper advice and understanding of what could be available to them in a way that they do not seem to get now?

[186] **Mr Street:** That support and advice is already out there for people, should they choose to take it. The position around self-funding residents is complex and different. There are authorities in Wales where the proportion of self-funding residents is increasing. That is not my experience in my authority or in the immediate region where I work. However, when someone goes into residential care, particularly if they have been there for a significant period of time, it is very difficult to move them out of that model, regardless of whether they meet the eligibility criteria. There is something around whether we could work with providers to direct potential self-funding people to us in the first instance so that we can explain other models of care for them.

11.45 a.m.

[187] There is perhaps a perverse incentive for providers, because they could be sending people away from their door who are potential future clients. While we have a system in place for people to go into a care home and simply pay the going rate, there is a risk that we will always have. Whether it would be possible to bring in some sort of process or regulation that requires people to have an assessment regardless of whether they are in a position to fund their own care is something that would need to be thought through. That is the only way that they can successfully gate-keep who goes in to a residential home—regardless of someone's financial means, if they do not meet the eligibility criteria they would have to be directed elsewhere. That facility does not exist at the moment.

[188] **Darren Millar:** I just wanted to ask a little more about this. In some parts of Wales, local authorities are using independent advocacy services to support people in helping them to make decisions. How prevalent is that? I know that it takes place in Conwy, for example.

[189] **Mr Street:** It is very prevalent. All authorities will have access to advocacy services for older people, or indeed other client groups, and the challenge is in ensuring that people take up those opportunities for advocacy. One of the things that we should not lose sight of in this debate on self-funding residents is that it is not always the individuals themselves who will make the decision to go into residential care. It will often be support/pressure from family members that encourages people into residential care, because they believe that that is the right place for them to be to have their needs met. The challenge is not necessarily just for the individual who goes into the home—it is within that wider family network as well.

[190] **Darren Millar:** But do you not recognise—and I do not want to labour this too much—that there is a financial benefit in the short term for local authorities in placing somebody in residential care, rather than taking the time to set up more complex homecare

support, which might be the best solution for that individual? I just wondered to what extent you are able to monitor the quality of the information and advice that is given from your own members of staff, for example, in your own local authority, and whether there is always a signposting to the possibility of independent advocacy. I do not think that that is a regular feature, frankly, in the landscape.

[191] **Mr Street:** Again, from my own perspective, our social workers are well-versed in the advocacy arrangements that are available for people, and we always attempt to signpost people to those advocacy services. The take-up is by no means 100%, but clearly there is an element of choice in that. There is certainly nothing from the local authority end that encourages people to follow the residential care route because it is cost-beneficial to the local authority. Our preferred route for anyone who identifies themselves with a need in the first instance would be to explore the reablement services that we talked about earlier, because if we can work with those individuals fairly intensively for a short period of time, we may be able to direct them away from service provision, or be able to maintain them in their own home with minimal services in place. If someone has a substantial and complex package of care, then our preferred option would still be to maintain that package of care and maintain that person in the community.

[192] **Darren Millar:** I should just clarify that the point that I was trying to make was about the time, effort and energy that it takes to set up a complex care package in the home rather than a simple decision to place someone in a residential care home. You are pulling a face over there—did you have something to say on this point?

[193] **Ms Warren:** Everything in social care can be extremely complex, but I would avoid generalisations about it being easier to place somebody in a residential home than to develop a package. From my perspective, not being in the service, the onus on social services at the moment from the Welsh Government is about reablement. There has been quite a strong expectation that there should be increases in the numbers of people supported to live at home. In terms of the policy direction, that is where our focus has been. Just to add, and it is not very often that we do this, we should hold our hands up to say that the provision of information and support is probably not consistent across Wales. That is something that the social services Bill might look to address, perhaps through more consistent provision of information, or by exploring regional options. We will be working with local authorities to shape those elements of the Bill, and that is something that will be addressed.

[194] **Vaughan Gething:** That picks up on one of the things that I was going to say. I do not know whether it was a slip of the tongue, David Street, but you said that that advice was available if people chose to take it up; the evidence that we have had is not necessarily that people elect not to take the advice, but that they are not aware of the advice. They are two very different points. I want to make the point that Emily just made about recognising the fact that the advocacy and the advice are not as consistent as they should be. I just want us to reflect on that.

[195] You floated a point about self-funders going into residential care. I do not know whether it is just an idea that you were floating or whether you have come to a view, but on the point about the competing objectives of choosing for somebody and not allowing them to go into care home unless they have that, there are fairly difficult questions for us if we say, 'You cannot go into residential care, whether you are a self-funder or not'. However, the counterpoint to that, as we know, is that we end up paying for many self-funders eventually, so, the choice that they make ends up being one that we do not happen to like as taxpayers. I am interested in how you would see not just an entitlement to an assessment, but a requirement to have an assessment. Is that something that you would support or want to think about? Equally, I would like to hear a little more about my earlier point about the choice or awareness of advice.

[196] **Mr Street:** The point that you make about choice and awareness is a fair one. Certainly, in my authority, those advocacy services are fairly well placed. Emily has already touched on a point that we would acknowledge, which is that that is not necessarily consistent across Wales. The point that I was trying to make was that, even where those advocacy arrangements are in place, it is not always easy to get people to use them. People and their families have sometimes made their minds up about what is best for them before you get to meet them, and that is a very difficult thing for us to unpick. When somebody, or their family, has the financial capacity to pay to go into a care home, and they have decided that the care home on the corner of the street is where they want to live, regardless of what you do in terms of advocacy services, signposting and other types of services, it is very difficult to provide an alternative.

[197] Your point about the assessment, or the eligibility criteria, is really tricky, for the reasons that you have laid out. There are pros and cons to both arguments. In many cases, because of the existence of extra-care facilities and the like, in the first instance, we would try to signpost people towards those facilities, where they can live in an environment that is their own home and where support is readily on hand should they require it, but it is not registered residential care. Given that extra-care is still a reasonably new phenomenon, particularly when you look at how long-standing residential care facilities have been, I do not think that its existence is as widely known as residential care homes. In Caerphilly, we have had extra-care for five years—one of the facilities is five years old, one is two years old and one is less than a year old—but it is still a new and emerging model of care. As we are able to publicise it and get it into people's minds more and more, we may well have more self-funding people going into extra-care, where they would previously have gone into residential care.

[198] **Kirsty Williams:** I want to take up this issue on which you categorically said that under no circumstances would you just go for placement in a residential home, even though it may be cheaper, as the right thing to do—that just does not happen. We have evidence from Rhondda Cynon Taf council, however, that identifies what it describes as a perverse incentive to support people in residential care:

[199] 'Generally the cost to the public purse is significantly less for those in residential care opposed to those supported in the community'.

[200] It was particularly about the maximum charge levels. Potentially, you could have a self-funder who would pay for all their care if they were sent to a residential home, or a self-funder who, if the council was supporting them in their own home, would not have to pay more than £50 a week. Your contention, Emily, that this never happens seems to be contradicted by the evidence that Rhondda Cynon Taf has identified as a perverse incentive. There was widespread concern from local authorities about the impact of the cap. I am just wondering: a couple of years down the line, has that perverse incentive become a reality?

[201] **Ms Warren:** There are a couple of things there that I will pass on to Dave.

[202] I was trying to avoid an overgeneralisation that local authorities in Wales put people in residential care because of the perception that it is cheaper. Actually, if you were to conduct a longitudinal study, it might find that it might be more expensive to keep people in their homes for longer, because you are trying to reable them and the support might go on for a longer period of time than if they were in a residential care home.

[203] The £50 cap relates to domiciliary care charges. That has caused considerable concern for local authorities. We are lobbying for a continued monitoring of the costs of the shortfall that local authorities will have to make up from now for as long as this remains in place.

[204] **Kirsty Williams:** Is there any evidence that, because of the cap, there is a perverse incentive for local authorities to choose residential care because they would perceive it to be cheaper—whether that perception is right or not—than supporting people in their own homes?

[205] **Mr Street:** The concept of identifying the perverse incentive was to try to flag up the risks that were attached to it. From some work that I have done, depending on the provider and the cost attached to a provider, between 15 and 20 hours a week of domiciliary care equates to the cost of placing someone in a residential care home. So, if someone receives care and support for more than 15 to 20 hours per week, it is more expensive to maintain that person in their own home than to place them in a residential care home. Despite that, all of our energies and efforts are put into maintaining people in their own homes for as long as possible.

[206] We have already touched on the key indicators that we have. One of the national performance indicators for local authorities is the percentage of the population that we maintain in their own homes. We are all endeavouring to increase support in that regard. We are aware of the cost implications of that, but it has not changed our practice in any way in terms of moving people, or encouraging people, into care homes because it is cheaper.

[207] **Kirsty Williams:** On the point of extra-care housing, are all the examples in Caerphilly tenanted models or are some of the models of extra-care housing in Caerphilly ones that allow people to purchase their homes?

[208] **Mr Street:** They are currently all tenanted models, but we did speak to the provider of a recent development about that concept at the outset. That is not a model that the local authority has a problem with, but it did raise some issues for the housing provider because of the matter of initial eligibility. So, if someone came in and wished to purchase one of those properties, would they have to have a social care need, or could they be well and perhaps have needs in the future? If one member of a couple went in and had a social care need, but then that person sadly required nursing care or passed away, what would happen to the person left behind if he or she was fit and well? Could they remain in that property, in which case, over a period of time, extra care could be increasingly occupied by people who do not have any social care needs, or would that person have to move out because their husband or wife had passed away? So, there are still questions to be answered regarding how that will work.

[209] **Kirsty Williams:** Is any work being done to look at how you could solve some of those problems?

[210] **Mr Street:** Some of the housing providers are certainly looking at that in detail. There are some examples in England of care villages or retirement villages, as they are known. They are built on that model of lease purchase and rent, so there could well be something to learn from those.

[211] **Mark Drakeford:** There is one last question on the role of families in these decisions. This may not be answered this morning because of the time that we have left, but I will ask in case there is some Wales-wide evidence on this. Lindsay Whittle asked our last witness whether, in those parts of Wales where there are substantial numbers of older people who have moved in from outside Wales, when someone reaches the stage when they need extra help, is there extra pressure from families for them to go into residential care because those families are not nearby and therefore think that it is a safer option as they know that relative will be looked after and they are not on the spot to help out? In those parts of Wales where there are larger incoming populations, is there extra pressure towards residential care, particularly as those people are likely to be self-funding because of the nature of the way in



which they have moved there? I do not expect you to provide an answer for us this morning, but as there is a different pattern in different parts of Wales, the association and the WLGA might want to give a bit of thought to that and, if there is any evidence that you think might be useful to us, perhaps you could let us know; if there is no evidence, then it would be useful to know that too.

[212] I am really sorry that we have run out of time without giving you a chance to round up any final points, particularly points that we have not managed to get to in the evidence and which you think it important for us to think about as part of our inquiry. If there are any afterwards and you are able to send us a note of them, that would be very helpful from our point of view.

12.00 p.m.

[213] **Ms Warren:** I will do so, Mark. In just one word: Dilnot. The Dilnot report and paying for care is another concern for us.

[214] **Mark Drakeford:** Absolutely; it stands as one of the major contexts for all of our discussions, and we will have some time to look more specifically at the whole issue of paying for care as part of the inquiry.

<p>[215] Diolch yn fawr iawn i chi'ch dau am eich help y bore yma. Rydym yn mynd i fwrw ymlaen at yr eitem nesaf ar ein hagenda. Rwy'n gwybod bod rhai Aelodau'n methu aros.</p>	<p>Thank you to you both for your assistance this morning. We are going to move on to the next item on our agenda. I know that some Members cannot stay.</p>
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[216] Lindsay, are you able to stay or do you have to go? You are going. I know that Elin is going, but she is coming back.

12.01 p.m.

### **Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Tystiolaeth gan Awdurdodau Lleol Inquiry into Residential Care for Older People—Evidence from Local Authorities**

<p>[217] <b>Mark Drakeford:</b> Bore da a chroeso ichi i gyd i'r Pwyllgor Iechyd a Gofal Cymdeithasol. Diolch yn fawr ichi i gyd am ddod yma'r bore yma i'n helpu gyda'n hymchwiliad i ofal preswyl i bobl hŷn. Rydym yn edrych ymlaen at gael tystiolaeth gan yr awdurdodau lleol. Mae'r pwyllgor yn cael ei gynnal yn hollol ddwyieithog, felly mae croeso i unrhyw un sydd eisiau cyfrannu drwy gyfrwng y Gymraeg i wneud hynny.</p>	<p><b>Mark Drakeford:</b> Good morning and welcome to you all to the Health and Social Care Committee. Thank you all for attending this morning to assist us with our inquiry into residential care for older people. We look forward to receiving evidence from the local authorities. The committee is held completely bilingually, so anyone who wishes to contribute through the medium of Welsh is welcome to do so.</p>
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<p>[218] Croeso i Bob Gatis a Luisa Bridgman o Gyngor Bwrdeistref Sirol Rhondda Cynon Taf, Mr Parry Davies o Gyngor Sir Ceredigion, a Susie Lunt o Gyngor Sir y Fflint. Fel arfer, rydym yn gofyn i'r tystion a oes ganddynt unrhyw sylwadau agoriadol byr i'w gwneud i'n helpu. Ar ôl hynny, byddwn yn mynd yn syth i gwestiynau gan aelodau'r</p>	<p>I welcome Bob Gatis and Luisa Bridgman from Rhondda Cynon Taf County Borough Council, Mr Parry Davies from Ceredigion County Council and Susie Lunt from Flintshire County Council. We usually ask witnesses whether they have any brief opening remarks to make to assist us. After that, we will proceed to questions from</p>
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pwyllgor. Os bydd gennym amser cyn diwedd y sesiwn, byddaf yn dod yn ôl at y tystion i weld a oes ganddynt unrhyw bwyntiau pwysig i'w hychwanegu i'n helpu i feddwl am yr hyn fyddwn yn ei wneud yn y sesiynau sydd i ddod.

committee members. If we have time left before the end of the session, I will come back to the witnesses to see if they have any important points to add to assist us in our consideration of what we will do in future sessions.

[219] Thank you all very much for helping us with the inquiry. We are looking forward to hearing your evidence. Thank you for your written evidence, which we have all had a chance to read. Do you have any brief opening remarks to make? We will not have time to ask all four of you to do that, I am afraid. Mr Davies, are you going to start?

[220] **Mr Davies:** Hoffwn ddiolch i chi am y cyfle hwn i roi tystiolaeth ar ran y cynghorau lleol rydym yn eu cynrychioli. Rwyf yn ymwybodol o'r amser ac o'r ffaith y bydd llawer o gwestiynau. Rwyf yn siŵr y byddem yn hapus iawn i fynd yn syth mewn i gwestiynau'r Aelodau.

**Mr Davies:** I would like to thank you for this opportunity to give evidence on behalf of the local councils that we represent. I am aware of the time constraints and that there will be a lot of questions. I am sure that we would be very happy to go straight into Members' questions.

[221] **Mark Drakeford:** Diolch yn fawr iawn am hynny. Rwyf yn troi yn awr at aelodau'r pwyllgor i weld pwy fydd yn dechrau. Rebecca?

**Mark Drakeford:** Thank you very much for that. I now turn to committee members to see who will start. Rebecca?

[222] **Rebecca Evans:** I would like to pick up on the discussion that we have just finished with the WLGA on self-funding. We have heard that self-funders have more choice about whether they will enter residential care and when they will do so, and that they also often have lower needs than others when they enter residential care. However, it might come to a point when their funding runs out, which forces local authorities to take over that funding. What proportion of the people that you support in your local areas fall into that category at the moment?

[223] **Mr Gatis:** The figure for Rhondda Cynon Taf is that about 25% of people are self-funding. Within Rhondda Cynon Taf, that 25% have probably had an assessment of need through us, so in our experience, very few people will enter a home without some level of assessment. That is probably due to a couple of factors, including socioeconomic ones. Rhondda Cynon Taf is not one of the richer areas of Wales and, therefore, there is a likelihood that we will be supporting people. Secondly, I suspect that the sociopolitical nature of Rhondda Cynon Taf, which is a strongly Labour or socialist area, is one where, again, there is an expectation that the local authority will make some kind of provision and offer support. That 25% has increased over the last few years quite considerably, again, due to rising house prices principally. Property will put people in that position. In order to provide some level of protection, as we see it, for individuals who are self-funding, where we have undertaken an assessment, we offer them the protection of the Rhondda Cynon Taf council contract with the provider, so that they are also brought under those auspices.

[224] **Rebecca Evans:** So, what percentage were previously self-funders, who you now support?

[225] **Mr Gatis:** I am not sure that I understand the question. Do you mean: how many move out of self-funding into local authority support?

[226] **Rebecca Evans:** Yes, as a result of their own funds running out.

[227] **Mr Gatis:** I do not have that figure. I think that it is difficult for us to understand that. It would depend on house property. That is the principal reason why people will be self-funding. Even if they have some level of pension support in retirement, their property will be their principal asset.

[228] **Mark Drakeford:** Conwy council told us in its evidence that 100 people a year convert from being self-funders to becoming the responsibility of the local authority. It would be interesting—not for this morning—to have parallel figures because we are interested to see whether these patterns differ across Wales and whether there are particular reasons why some areas have a greater level of conversion.

[229] **Mr Gatis:** I am sure that we can look into that for you.

[230] **Rebecca Evans:** We have also heard this morning that how proactive local authorities are in making self-funders aware of the choices available to them in terms of residential care varies across Wales. How are you, in each of your local authorities, proactively engaging with people, who may be thinking about self-funding their residential care, to make them aware of the choices available to them in terms of what they could expect in the community?

[231] **Ms Lunt:** The gentleman before me talked about trying to provide information in lots of different places. Flintshire council tries to get information out there to hospitals, for example, about what options are available in the community, as opposed to having to opt for residential care reablement support. We provide short-term arrangements for people to have an assessment of whether they really do need residential care before they make that decision. Often, decisions are made in times of crisis and we are trying to move away from that. Getting information out to people is a key issue, as is providing that information in key places such as hospitals, GP surgeries, libraries and so on. That is the approach that Flintshire is taking.

[232] **Mr Davies:** On the importance of information, reference was made to the availability of advocacy. Such provision varies across authorities in Wales. We have identified that service as being something that we need to improve. A gap has also been identified in the social services Bill regarding the need for self-funders to be slightly more protected in terms of the decisions that they make. The point has also been made that often decisions are made irrespective of the amount of information or advocacy that is available. That can be down to the circumstances of the individual or of the family. Sometimes, it is systemic in the sense that one issue that John Bolton emphasises is that we tend to undertake our assessments when people are at their weakest and worst in terms of their circumstances. That is not the time for long-term decisions to be made, but in a hospital or home setting, the pressure is there, sometimes, from professionals, to take the quickest route. There are some dynamics at work there that we need to look at in more detail.

[233] **Mark Drakeford:** Professor Bolton suggested to us that, if you wanted a rule, it would be that no-one should be admitted to residential care straight from a hospital bed. Do you think that would be a sensible rule and, if so, how close are your own local authorities to achieving that?

[234] **Mr Gatis:** I think it is a very sensible rule. We are very great distance away from achieving that, for a number of reasons, probably. One of the difficulties, as Parry has alluded to, is that, when an older person is in a cycle of going into hospital, coming out, going back in and so on, it will reach a point where the family and the NHS itself will be trying to influence the individual to move into residential care. That is a very difficult issue for us. As I said, we are some distance away from achieving that, but we are putting measures in place. Luisa can talk about our reablement service, for example, and the pathways from hospital that we are

seeking to develop that will, we hope, began to address some of those issues.

[235] **Ms Bridgman:** It is a key issue that the services in the community should have a much closer link with health in future. Joint reablement services with health and social care are a strong part of that. We have some examples in Rhondda Cynon Taf of people being assessed as requiring residential care where we have put in reablement services and, in partnership with the health service, managed to return them to their homes, which is what they wished. Some of the things mentioned earlier are challenging for us in those circumstances where there is sometimes pressure from others. Sometimes, the pressure is from family members who are worried about risk and concerned about the person returning home, perhaps being readmitted to hospital or having a fall—something that could be seen as substantially impairing that person in future.

[236] It is a case of convincing people and winning the argument in the long term that it is important to give people the choice and an opportunity to regain their independence. We do not have strong evidence on this, but anecdotally and from what we see in residential services, where people are admitted straight from hospital, after a period of recuperation and recovery, their skill base improves. You then question the decision, but it is often not an option for them to return to the community at that point. At the time of the one-month review, they are not usually well enough for a move back home to be facilitated. So, you see it in the longer term, looking at two to three months. That is something that John Bolton's work identified when he came to speak to us in Rhondda Cynon Taf. It is certainly something that we would like our reablement services to look at. However, that cannot be done in isolation from social care. There must be a link between health and social care.

[237] **Darren Millar:** Can we talk about the financial viability of homes? This has been an issue over the past 12 to 18 months, certainly. Indeed, it has been an ongoing issue from time to time with individual homes. To what extent do your local authorities undertake a check on the financial viability of a home before an individual is placed in it?

[238] **Mr Gatis:** The vast majority of placements for us are within the council area, within Rhondda Cynon Taf. For those people who are placed externally, we will make enquiries of the host local authority on occasions to gather intelligence. Clearly, we try to identify whether they will meet our contractual arrangements. However, I would stress that we are talking about a very small number of placements. Within Rhondda Cynon Taf, our purchasing and commissioning teams will seek to establish the financial viability of homes as part of the fee setting and our overall monitoring. However, as Dave told you, that can be quite difficult to do, and increasingly so. The Southern Cross example is one where the financial funding of social care is called into question because of the manner in which those large companies are themselves funded.

[239] **Darren Millar:** How does your local authority ascertain the financial viability of a home at the moment if you are placing someone in the independent sector? Your teams are teams of social workers; they are not accountants. Do they have that expertise or is that something that the Care and Social Services Inspectorate for Wales rather than local authorities ought to be doing?

12.15 p.m.

[240] **Mr Gatis:** The CSSIW has a role and, clearly, as part of its inspection and regulation, it will undertake financial viability checks. It is a misnomer to say that we are social workers. These days, social care is far wider than social work.

[241] **Darren Millar:** But they are not financial professionals.

[242] **Mr Gatis:** No, absolutely. We have been undertaking work for the last two years on what is a reasonable return for the independent sector in Rhondda Cynon Taf. That has engaged accountants, contracting staff and social workers—I am a social worker—in looking at what is a reasonable response. Part of that is trying to look at what the financial viability is. Indeed, the commissioning strategy and the direction in the section 7 guidance on commissioning from the Assembly lays a duty on us to do those things and to understand what the cost pressures of the sector are.

[243] **Darren Millar:** The situation appears to be quite different in Flintshire. You categorise homes as approved and non-approved in terms of your commissioning arrangements. Can you explain the difference between them?

[244] **Ms Lunt:** We rely, as Bob said, on CSSIW in some ways in terms of the financial viability, but Flintshire also has an approved provider process, where providers have to go through a series of tests, if you like, and provide evidence on certain things in order to be on the list. If they do not do that, they do not get the rate of fee that we pay for approved providers. That helps us to manage some of that and be in control of the quality that we expect and the fee that we pay.

[245] **Darren Millar:** With regard to the contracting arrangements that local authorities undertake for maintenance jobs and so on, very often there are financial viability checks in order to get on the approved supplier list. Is it the same sort of process?

[246] **Ms Lunt:** Yes, it is the same process.

[247] **Darren Millar:** So, you then pay a higher fee rate to those individual homes.

[248] **Ms Lunt:** Yes, we do.

[249] **Darren Millar:** Is it a significant difference?

[250] **Ms Lunt:** No, it is not. I have not brought the fees with me, but if you are on the approved provider list you get a slightly higher fee per week for your person in the care bed than you do if you are not on the list. We are currently looking at those arrangements, because we are working more regionally.

[251] **Darren Millar:** Does it undermine confidence for service users and their families if you place someone in a non-approved care home? Has that ever been an issue?

[252] **Ms Lunt:** To be honest, the majority of the care homes in Flintshire are approved. There are out-of-county placements, which are local to Wrexham or Denbighshire, but we have very few that are outside of our local area.

[253] **Darren Millar:** As a general matter of interest, have you had any problems with financial viability of approved homes compared with the non-approved homes?

[254] **Ms Lunt:** No, we have not. I have not got any evidence of that.

[255] **Mr Davies:** From Ceredigion's perspective, as part of the fee-setting process, we are moving increasingly towards an open-book approach. That helps us to test the viability of the providers that we contract. With arrangements where there are block-contract arrangements, the test that you refer to will certainly have been made and carried out. It is about understanding not just the viability of a home at a certain time but also, with the open-book approach, there is something about setting a fee level that enables that home to function viably for the future.

[256] **Darren Millar:** You probably heard the discussion that we had earlier about the fact that individual homes have different cost bases. Therefore, is it appropriate to have county-wide fee levels or should there be more of a formula-based approach in order to determine what the fee level ought to be on a home-by-home basis? I appreciate that, if a home is run inefficiently and it has a high-cost base because of poor management, it is difficult to be able to say that there is a fair fee in terms of the application. However, is more consistency in the approach required?

[257] **Mr Davies:** That would be helpful.

[258] **Darren Millar:** You also mention block contracts, Mr Davies. Do they feature significantly in your local authority area? They do not seem to do in other local authorities.

[259] **Mr Davies:** I think that it varies across Wales. There are some examples in Ceredigion where there is a block contract, for example dementia residential care. That need was identified and it is still a need within the authority. In order to ensure some stability and to attract providers into that area—into a rural area specifically—we engaged in a block contract to ensure that that service was made available.

[260] **Darren Millar:** I have one final question on dementia. The prevalence of dementia has increased in recent years. Many people go into residential care with dementia problems, yet we still have this distinction between EMI and non-EMI registration. Should that be abolished now? Should all homes have the ability to care for people with dementia?

[261] **Mr Davies:** The categorisation of EMI residential care and EMI nursing care needs to be looked at quite urgently. From my perspective, there are two aspects of this that are of particular concern to me in terms of working in a rural area. One is the impact of a diagnosis that leads to the need for EMI nursing care when somebody is already within EMI residential provision, which is available within the county, and the impact of that on the family of the person having to move out of county. The second aspect for me is a basic human rights issue: why should someone move from their home because of a diagnosis that means that they should be receiving additional care to deal with perhaps more difficult behaviours?

[262] **Ms Bridgman:** This is, in part, due to the way it is currently registered; you have a dementia unit—an EMI, as you term it—or you have a frail elderly unit. The Care and Social Services Inspectorate Wales accommodates some people with a diagnosis of dementia there, but it carefully monitors the balance. If somebody is living safely in that setting and does not want to move, I do not think that they should be made to move. That is where the registration needs to be looked at. I think that it needs to be a far more local decision. In terms of deregistering the category of dementia altogether, I would have some concerns about that, because I think that that it is also about quality of care. Where you have specific units that are registered, you can set more stringent requirements in terms of training and what you would expect as a quality mark. As more and more people are admitted to residential care with dementia, the quality of the care that is provided to those people in a residential setting is something that we have to consider in terms of how we will monitor and measure performance in the future.

[263] **Mick Antoniw:** I was very interested to read the statistics in the RCT paper; they were very clear about the move towards community care and community support as opposed to residential care. I think that you have moved to a position of 84% and that you felt that there were some further moves even beyond that. What impact has that had on the existing residential care provision? Has there been underoccupancy? Has it resulted in closures? What has been the impact of that transition or has it been absorbed?

[264] **Mr Gatis:** Again, you need to put it into context. That 84% is the balance, in a sense, between the community care services that we provide and residential care. We know the demographic pressures that all councils across Wales are under. Our occupancy rate in residential homes is somewhere around 92% to 93%. So, within the market in Rhondda Cynon Taf, there is not underoccupancy. Indeed, we would see that as being about the right figure of occupancy in order to maintain a balanced market. All the way through this, we are trying to hold back a tide of need that is ever-increasing. We are doing that in different ways and, as we suggest in our paper, and as I am sure John Bolton suggested to you this morning, working together with health services around reablement will assist that. However, it is still holding back a great tide. We have talked about cognitive impairment and dementia. The statistics are telling us that these will increase as we are caring and supporting older people. That is one of the other issues that we are clear about. The average age of someone going into residential care is probably 80 to 85 now. The average age of those who are provided with long-term community-based support is the late 70s and early 80s. I do not have those figures but we can find them for you. When I started in social care, we were talking about people aged 55, 60 and 65. So, the services we are providing, and who we are providing them to, is a changing picture.

[265] **Mick Antoniwi:** On the issue of models of provision within residential care, over the years there has been a greater move towards private companies. One of the areas that we want to look at specifically is other models, including not-for-profit and co-operative type models. One of the figures in John Bolton's evidence, in terms of the profit return expected by private investors, such as a Southern Cross type model, is around 12%, which is perhaps lower for housing association models and not-for-profit sector models. Do you have any views on the balance of provision and the capacity of those different sectors to provide innovation and change? Is it a matter of relevance that you think impacts on the overall service?

[266] **Mr Davies:** The starting point for me is to question whether the current business model for traditional residential care is flexible enough to be able to change to support the new models of care. For instance, on the whole, you would rely on a high level of occupancy and long-term commitment for the person in the home, and that is an intrinsic part of the business model in order to make that a viable option. We are moving more towards a greater emphasis on respite care to help carers care for relatives in the community; and intermediate care, or step-down facilities from hospital and so on, where people are there for a time-limited period to regain their independence. There is a basic question about how the traditional operating and business model can move into that new world.

[267] We would welcome an increase in the range of providers and the different kinds of skills and outlook that they would bring. For instance, we are increasingly finding that new entrants—registered social landlords—to extra-care provision are increasingly interested in being involved in the care of people with more dependencies and different kinds of care needs. That is worth exploring, particularly because there is a mindset that is more about helping people to live in their communities.

[268] There are RSLs that also function as charities. It is worth looking at the third sector and social enterprise. My concern about welcoming that interest is whether the barriers for new entrants are too high. We are concerned about that, because as much as we want to welcome them and to change the paradigm, there are significant barriers for them to overcome.

[269] **William Graham:** I will ask you about training issues. You suggest in your evidence that there may be problems in staff recruitment, retention, and skills. Would you care to expand on that?

12.30 p.m.

[270] **Mr Gatis:** I will comment on the training and skills issues. Some of my comments are effectively strategic comments. At the end, perhaps I can counter Kirsty Williams's comments on my statement about the perversity of the funding. It is an economic issue, is it not? It is about the value we place on social care staff, and the value we place on them is actually very low. We pay them low wages, and that is because of pressures on resources. The opportunities for that level of social care worker in Asda and Tesco are well reported. Those companies will provide you with security of employment, 30 or 40 hours a week, steady time, agreed shifts, known shifts and so on. For me, that is the bottom line. This is about how we value the people that you and society are charging us to look after. Having said that, as we have demonstrated in our evidence to you, we are looking at ways in which we can get people into the market.

[271] One of the other issues has been that CSSIW and regulation have restricted the age at which we can employ people in residential care and homecare. The entrance point is probably 18. So, we are missing a group of youngsters who are leaving school who have not had the opportunity of moving into care work. We are countering that now through some work with local colleges to be able to find pathways for individuals. That is important. Another comment I have made, and I think that Luisa said the same, is about the NVQ and the qualifications and credit framework. The QCF is very helpful. It helps us to provide the theoretical knowledge to staff and provides an evidence base for the fact that they have the skills we need. We need to do a great deal of that in-house, in situ. Again, that creates some difficulties for us with regard to resources and being able to free up our senior care staff and managers to support that process. It is not a cheap process for us.

[272] **Ms Bridgman:** We are trying to be innovative about this on the ground. We are looking at projects that can improve the quality of care and therefore provide greater staff satisfaction, because it is about that as well. It is not just about recognition through qualification, but the opportunity to be involved in a new way of working, which is often something to be proud of. It is about the whole culture of the way we view care staff. We must make the drive to change that. We need to see care staff as very valued members of society who contribute a great deal. They work in people's homes on a one-to-one basis. There is nothing more personal than someone working in your home, whether it is a residential home or your own home in the community. We need to recognise that and encourage and engage with our staff so that they are proud of the work they do. That is not always about qualifications. It is also about developing leadership skills. A lot of the time, you see people in management posts who have made their way through the system. We have to ensure that the people who lead the residential sector have strong leadership skills and can look to the future and how we may need to adjust to what is coming over the next 10 to 15 years.

[273] **Ms Lunt:** There are some new ideas on the block, if you like, about apprenticeships in care. We are working with colleges on this. We have been working with Deeside College in Flintshire to provide the apprenticeship in care. You can offer that to younger people who go to college for the underpinning knowledge of social care and to provide some practice in care homes or individual environments. That is supported by Flintshire council. Although it is new, there are some good opportunities there.

[274] **Mr Davies:** I would like to make some general comments. Over the years, good use has been made of the social care workforce development grant, which has been made available to local authorities to ensure that training is available. The level of NVQs among care workers is high in Wales. That is something we can be rightly proud of. The work that the Care Council for Wales has done jointly with the Welsh Government and us has been done under the mantra of 'one sector, one workforce'. That grant has been used not only for social services staff, but the independent and private sector in order to raise the quality of care



within the individual counties. I would also make the point that regional social care partnerships have been established in Wales, with a specific focus on having that cross-sectoral emphasis on raising the awareness of social care and on training and recruitment. I have been involved with numerous conferences and events as the chair of our regional partnership, in which the importance of training has been highlighted to the benefit of the whole sector in the area.

[275] **William Graham:** So, the Assembly skills agenda is helping in that way. I note from John Bolton's paper that the recruitment percentage seems to be constant across nursing care and frail, elderly and dementia care, yet we know that there will be an increasing demand for dementia care. Do you feel that there is a need for training in this area also?

[276] **Ms Lunt:** Absolutely, there is a need for training in dementia care. There is a new qualifications and credit framework in dementia care at level 3. That involves on-the-job-training and going offsite for the underpinning knowledge.

[277] **Mr Davies:** We should also emphasise that there are challenges attached to that. Many of our independent providers are small businesses, and the challenge of being able to release staff to attend training is a real issue. We are looking at innovative methods such as e-learning, which enables people to undertake the training and achieve some of those competencies in their work setting. Another example would be access for 17-year-olds to taster sessions and placements, because there is a huge interest in health and social care in schools and further education colleges, but we somehow tend to lose them. Part of the reason for that is a systemic issue, and we are working hard to try to ensure that we keep that interest for the year or so before they can legally be employed.

[278] **Mark Drakeford:** An early witness in the inquiry told us that the reality of working in the care of older people in a residential setting was that it was a pariah profession—if you did it, you would not be keen to tell your friends that you were doing it. Are things as bad as that?

[279] **Ms Bridgman:** I feel sorry to hear that—[Inaudible.]—I come into contact with where that is the case. I see people who are proud of the work they do. We need to make the general public aware of what they do and feel proud of it. If you have a personal experience, you very much appreciate the work that is done in a residential home. That is not what I see day-to-day. Having said that, I stated earlier that it is about giving people opportunities—I am not sure how that pans out across Wales—to work in a different way and be proud of what they do.

[280] **Elin Jones:** Mae gennyf gwestiwn am fodlau newydd o ofal. Roedd John Bolton yn siarad gyda ni'r bore yma a dangosodd ei fod yn cefnogi'n frwd y cysyniad o fodel gofal *intermediate* fel y cam cyntaf allan o'r ysbyty. Rwy'n tybio bod hynny'n weddol debyg i'r hyn sy'n digwydd yng Ngheredigion gyda'r gwelyau ar y cyd yng nghartrefi'r awdurdod lleol, lle mae'r awdurdod lleol a'r awdurdod iechyd yn talu ar y cyd. Pa mor anodd oedd hi i ddatblygu cynllun lle mae'r awdurdod lleol a'r awdurdod iechyd yn talu ar y cyd am wasanaeth o'r math hwn? Pa mor gyffredin yw model Ceredigion o welyau gofal ar y cyd mewn ardaloedd eraill yng Nghymru?

**Elin Jones:** I have a question on new models of care. John Bolton talked to us this morning and demonstrated his fervent support for the concept of an intermediate care model as a first step out of hospital. I presume that that is quite similar to what is happening in Ceredigion with joint beds in local authority homes, where the local authority and the health authority share the cost. How difficult was it to develop a scheme in which the local authority and the health authority share the cost for a service of this kind? How common is the Ceredigion model of joint care beds in other parts of Wales?

[281] **Mr Davies:** A gaf i ymateb i ddechrau? Rwy'n credu bod y JCBs, fel rydym yn eu galw yng Ngheredigion—yn anffodus—yn llwyddiannus ac mae'n esiampl dda o gydweithio bwriadol rhyngom ni a chyrff iechyd.

**Mr Davies:** May I respond first? I think that the JCBs, as we call them in Ceredigion—unfortunately—are successful and are a good example of intentional collaboration between us and health.

[282] Mae'r gwerth rydym yn ei weld mewn datblygu gwaith ar y cyd rhyngom ni ac iechyd yn y gymuned yn rhywbeth mor hanfodol bwysig a gwerthfawr ei fod yn goresgyn y rhan fwyaf o'r anawsterau eraill yn y system. Fodd bynnag, ni ddylem fod yn ddall i'r anawsterau hynny. Mae pwysau ar lywodraeth leol a'r byrddau iechyd, yn enwedig yn awr oherwydd y disgwyl i'r llyfrau fod yn gytbwys. Byddai'n anghywir dweud nad yw hynny'n broblem—mae'n broblem oherwydd, er enghraifft, er mwyn i ofal canolraddol ehangu ac i'r ddarpariaeth dyfu a datblygu yn y sir, bydd angen dod o hyd i'r arian o rywle. Felly, os yw'r pwyslais ar leihau nifer y gwelyau, er mwyn cwrdd â'r anghenion ariannol, byddai'n llawer gwell pe bai'r arian hwnnw'n cael ei ailfuddsoddi mewn gwasanaethau cymunedol. Fodd bynnag, rydym yn ymwybodol bod pwysau i gwrdd â'r llinell isaf. Mae hynny'n esiampl braidd yn amrwd o sut y gallwch ddymuno un peth ond bod realiti bywyd yn golygu bod penderfyniadau eraill yn gorfod cael eu gwneud.

The value that we see in developing joint-working between us and health is so vitally important and valuable that it overcomes most of the other difficulties in the system. However, we should not be blind to those difficulties. Local government and health boards are facing pressures, especially now that there is an expectation for the books to balance. It would be wrong to say that that is not a problem—it is a problem because, for example, for intermediate care to expand and for that provision to grow and develop in the county, the money will need to be found from somewhere. Therefore, if the emphasis is on reducing the number of beds, in order to meet the financial requirements, it would be far better for that money to be reinvested in community services. However, we are aware that there are pressures to meet the bottom line. That is a rather crude example of how you can wish for one thing but the reality of life means that different decisions have to be made.

[283] Nid yw hyn yn rhwydd, ond mae datblygu gwasanaethau yn y gymuned mor bwysig bod ymrwymiad i oresgyn yr anawsterau hynny orau y gallwn.

This is not easy, but developing community services is so important that there is a commitment to overcoming those difficulties to the best of our ability.

[284] **Elin Jones:** Ai anawsterau ariannol yw'r rhain, yn hytrach nag anawsterau strwythurol neu reoleiddiol?

**Elin Jones:** Are these financial difficulties, rather than structural or regulatory difficulties?

[285] **Mr Davies:** Mae'r model rydym yn ei ddatblygu yn lleol—a gafodd gefnogaeth y cabinet a'r bwrdd lleol yn ddiweddar—yn edrych tuag at reoli gweithredol ac integredig. Mae anawsterau i'w goresgyn, o ran trefniadau cyflogaeth, gwahanol atebolrwydd ac ati, ond maent yn bethau i weithio drwyddynt ac i ddod i ddealltwriaeth arnynt. Felly, nid problem reoleiddiol ydyw, er bod pethau i'w goresgyn. Y peth pwysig yw'r person sy'n derbyn y gwasanaeth yn y pen draw—er bod llawer o bwyslais wedi'i

**Mr Davies:** The model that we are developing at a local level—which was recently endorsed by the cabinet and the local board—looks at active and integrated management. There are difficulties to overcome, in terms of employment arrangements, different accountability and so on, but they are things to be worked through and on which an understanding is to be sought. Therefore, it is not a regulatory problem, even though there are issues to be overcome. The important thing is the person

roi ar ailalluogi heddiw—a bod nifer o wasanaethau yn cydweithio, ar ffurf ymyrraeth wedi'i thargedu, gyda'r bwriad o greu gwasanaeth sy'n gwneud gwahaniaeth i fywyd rhywun, i'w cael yn ôl i fod yn abl, ar ôl bod yn anabl. Dyna yw bwriad alinio gwasanaethau ymyrraeth wedi'u targedu.

who eventually receives the service—even though there has been an emphasis on reablement today—and that a number of services collaborate, using targeted intervention, to create a service that makes a difference to someone's life, getting them able again, having being disabled. That is the intention with the alignment of targeted intervention services.

[286] **Elin Jones:** O ran y gwelyau gofal ar y cyd, a yw hynny'n digwydd yn unrhyw le arall yng Nghymru, ynteu dim ond yng Ngheredigion?

**Elin Jones:** As regards the joint care beds, does that happen anywhere else in Wales, or only in Ceredigion?

[287] **Mr Gatis:** We do not have any. In answer to your question, I would say that it is a struggle. In my view, the direction in which the NHS is seeking to go is the right one, by moving money and resources from secondary services into the community, but it is struggling to achieve that.

12.45 p.m.

[288] Social services are often accused of having a slow pace of change, and the NHS is struggling with that as well. I do not think that it is a regulatory requirement. The will is there on both sides, and as Parry has said, it is critical to our being able to support people into the future that we work together more closely. It is just taking time to achieve.

[289] **Ms Lunt:** Flintshire does have some joint arrangements. We have four beds that are jointly funded through Flintshire County Council and the LHB, and we have recently freed up two other beds in our local authority homes. We have given up our residential place as it has come along, and health has supported us with some staffing on that—some physiotherapy and occupational therapy input—we provide the social work and the community nurses are doing some of the work on the ground. So, it is working quite well.

[290] **Mark Drakeford:** We move on to probably the last question, from Vaughan.

[291] **Vaughan Gething:** Just picking up on this, and going back to some points that were made in the previous session by Kirsty Williams, and this point about the work between health and social care, one of the things that she was driving at was how closely health and social care work together. A colleague from the WLGA was talking about two reform agendas in 'Together for Health' and 'Sustainable Social Services', and whether there was enough interface between the two policies, yet in the Chamber we hear a number of statements from Ministers, including the First Minister, about the expectation that health and social care will work more closely together.

[292] The other thing that I wanted to introduce is that we regularly hear about the Gwent frailty project, where services do work closely together and there has not been a change in legislation—it is down to local leadership and inter-working. So, I am interested in this question of where the leadership needs to come from to have a more consistent approach between health and social care, because it does not appear that the structures need to be a barrier at present, although perhaps structures could change to be a bit more helpful. I am interested in whether you think that there is enough clarity and direction from Government about what it wants to see with health and social care, and what you think could help to deliver that practical leadership and joint working on the ground in a more consistent fashion, bearing in mind the apparent signing up from local government and the Welsh Government

about what we want to see in terms of the nature of care provision.

[293] **Mr Gatis:** I suspect that you are getting into political arguments that I might get into some issues over, perhaps, but it comes down to will, does it not, at the end of the day? I do not believe that there is any further legislation, although clearly there is currently consultation on the social services Bill for Wales, and within that the Welsh Government is clearly indicating that issues such as pooled budgets, lead commissioning and so on are the way forward, and continue to be so. We already have those powers to work with our health colleagues. There is a genuine will to work with the NHS, but part of the difficulty, in my experience, would be that it is about resources at the present time. The NHS itself is trying to restructure and reshape itself so that it is fit for the future, and we are wrestling, as is the NHS, with increasing demands and volumes, and it is a case of finding the opportunity to bring those together. Sometimes they meet, and you get projects, as described in the examples from Ceredigion and Flintshire, and sometimes, for genuine and real reasons, they cannot happen, and are not happening. It is about a will, and it is the resource issues that ultimately make or break some of this.

[294] **Vaughan Gething:** It appears to me that the Gwent frailty project was not really supported by a huge gush of resources; it was more about the will to do something. I am interested in how far resource really is the question, because we all know that there will not be a great wash of extra resource going into local government or the NHS, bearing in mind the overall picture that we all have to live within. So, I am interested in why you think Gwent works in the way that pretty much everybody says it does, and why that sort of model has not developed across the rest of the country.

[295] **Mr Gatis:** It will come down to individuals, at the end of the day, and opportunities that arise.

[296] **Ms Bridgman:** I think also that people and health boards are at different points of their development. Not all local authorities and health boards have the Gwent frailty model. They certainly have many aspects of it, which perhaps are not as well known as the Gwent frailty project. It is about where people are on the journey as much as it is about there being the Gwent frailty project or there not being anything. It is a journey, and I think that where people are on their journey often relates to local circumstances.

[297] **Mr Gatis:** I think that Luisa is absolutely right. We would extend a welcome to you to come up to Rhondda Cynon Taf to see some of the work that we are doing. As Luisa has said, in that reflection, you will see aspects of the Gwent frailty project that, in some instances, will be in advance of what they are doing. I think that it is inevitably a mixed picture.

[298] **Ms Lunt:** I would just add to what Luisa said about it depending on where people are on their journey. If you can keep the person at home and avoid their going on to any of the acute wards, and if you can work together with the community nurse and the reablement team, or the rapid response team, to have hospital at home, as it were, then people are more likely to get all their services locally from primary care services. Once you get into the acute sector, it becomes about trying to keep the wards up to speed with what is out there and getting them to accept that it is perhaps not too risky to send people back home—it is about getting them not to be risk averse. That is the tricky part.

[299] **Mr Davies:** I have just a few comments on this. Work is under way to try to ensure the proper alignment of 'Together for Health' and 'Sustainable Social Services'. I think that that work is being undertaken at a Welsh Government policy level.

[300] In a more operational sense, the two drivers for local government and health

colleagues locally have been the alignment of the work of Dr Chris Jones in ‘Setting the Direction’ and the work of John Bolton in developing models of care. In any part of Wales, you will see those features; you will see efforts being made across health and social care within a community setting to implement and integrate those models in different ways.

[301] I cannot comment on the Gwent frailty project, but I understand that it was an invest-to-save arrangement.

[302] The point that you make about leadership is crucial. Leadership needs to be at all levels. That is the important thing. This cannot be about saying, ‘We can’t do it because you’re not playing our tune’. There has to be some agreement at all levels and the will to do it.

[303] The only other comment that I have is that we have to recognise that health is not a homogenous whole any more than local government is. There are internal issues of integration in the health service in the same way as there are in local government. The challenge for us is to make sure that secondary care appreciates the importance of developing things in the community, in the same way that colleagues from housing and leisure step up to the plate to help us to help people to live independently within the community as much as possible.

[304] **Mark Drakeford:** Diolch yn fawr i chi i gyd. Fel arfer, mae’r amser wedi mynd yn gyflym iawn. Rwy’n ymddiheuro am nad wyf wedi cael cyfle i ddod yn ôl atoch i drafod unrhyw bwyntiau nad ydynt wedi codi yn y sesiwn. Os oes unrhyw beth rydych yn meddwl ei fod yn bwysig i’r pwyllgor feddwl amdano yn y gwaith rydym yn mynd i’w wneud yn yr ymchwiliad, byddem yn ddiolchgar pe baech yn ysgrifennu atom gyda’r pwyntiau hynny. Bydd trawsgrifiad o sesiwn y bore yma ar gael. Diolch i chi i gyd am ddod i’n helpu gyda’n gwaith y bore yma.

**Mark Drakeford:** Thank you all. As usual, the time has flown by. I apologise for not having an opportunity to come back to you to discuss any points that were not raised in the session. If you think of anything important for the committee to think about in the work that we are to undertake in the inquiry, we would be grateful if you could write to us with those points. A transcript of this morning’s session will be available. Thank you all for coming to help us with our work this morning.

[305] **Mr Davies:** Rydym yn ddiolchgar iawn i chi am y cyfle.

**Mr Davies:** We are grateful to you for the opportunity.

12.54 p.m.

### **Ymchwiliad Undydd i Farw-enedigaeth yng Nghymru—Ystyried y Cylch Gorchwyl One-day Inquiry into Stillbirths in Wales—Consideration of Terms of Reference**

[306] **Mark Drakeford:** O dan yr eitem hon, mae’r cylch gorchwyl yn y papurau. A yw pob un yn hapus gyda hynny?

**Mark Drakeford:** For this item, the terms of reference are included in the papers. Is everyone happy with that?

[307] **William Graham:** I have just one point. I will research it and come back to the clerk, if I may. I think that the charity called ‘Birthright’—I do not know whether it is still going—would have an interest in this. However, as I said, I will come back to you on that.

[308] **Mark Drakeford:** Yes, of course. If there are potential witnesses or sources of

evidence for this inquiry that any Member knows of, please let me know. Diolch yn fawr.

12.55 p.m.

### **Papurau i'w Nodi Papers to Note**

[309] **Mark Drakeford:** Mae papur i'w nodi, sef cofnodion y cyfarfod a gynhaliwyd ar 8 Mawrth. Rydym yn nodi'r papur hwn yn ffurfiol, oherwydd iddo fod ger ein bron o'r blaen. Mae papur arall i'w nodi, sef papur ar faterion Ewropeaidd.

**Mark Drakeford:** There is a paper to note, which is the minutes of the meeting that was held on 8 March. We note this paper formally, given that it has been before us before. There is another paper to note, which is a paper on European matters

[310] Hoffwn egluro rhywbeth i Aelodau yn awr. Ar ein hamserlen, roeddem wedi gobeithio cael pedwerydd siawns i gynnal ymchwiliad undydd cyn yr haf, ond mae'n edrych yn debyg y bydd yn rhaid inni gadw'r diwrnod hwnnw'n ôl ar gyfer y Bil sgorio hylendid bwyd.

I wish to explain something to Members now. On the timetable, we had hoped to have a fourth chance to hold a one-day inquiry before the summer recess, but it looks as though we will have to keep that day reserved for the food hygiene rating Bill.

[311] We are likely to have to deal with the formal Stage 1 process of that Bill this side of the summer recess. So, I am afraid that the day that we were holding back for a fourth one-day inquiry is likely to be sacrificed to that.

[312] Ni fydd y pwyllgor yn cyfarfod yn ffurfiol yr wythnos nesaf, felly bydd siawns i Aelodau wneud ymweliadau. Bydd y cyfarfod ffurfiol nesaf ar ddydd Iau, 26 Ebrill, ar ôl toriad y Pasg. Diolch yn fawr iawn i bawb am y bore yma. Mae wedi bod yn fore diddorol, ond hir.

The committee will not meet formally next week, so there will be an opportunity for Members to do some visits. The next formal meeting will be held on Thursday, 26 April, after the Easter recess. Thank you very much to everyone for this morning. It has been an interesting morning, but a long one.

*Daeth y cyfarfod i ben am 12.56 p.m.  
The meeting ended at 12.56 p.m.*