Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

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

Dydd Mercher, 16 Mai 2012
Wednesday, 16 May 2012

Cynnwys
Contents

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mick Antoniw	Llafur Labour
Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour
Vaughan Gething	Llafur Labour
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

Ruth Crowder	Coleg y Therapyddion Galwedigaethol College of Occupational Therapists
Sue Davis	Dirprwy Rheolwr, Cymdeithas Gofal Cymdeithasol Deputy Manager, Social Care Association
Paul Gage	Trefnydd, Rhanbarth y De Orllewin o'r GMB Organiser, GMB South Western Region
Donna Hutton	Gwasanaethau Cymdeithasol Unsain Unison Social Services
Nick Johnson	Prif Weithredwr, Cymdeithas Gofal Cymdeithasol Chief Executive, Social Care Association
Mike Lubienski	Uwch Gyfreithiwr, Gwasanaethau Cyfreithiol, Llywodraeth Cymru Senior Lawyer, Legal Services, Welsh Government
Steve Milsom	Dirprwy Gyfarwyddwr, Polisi Gwasanethau Cymdeithasol Oedolion, Llywodraeth Cymru Deputy Director, Adult Social Services Policy, Welsh Government
Sarah Owen	Rheolwr Preswyl, Cymdeithas Gofal Cymdeithasol Residential Manager, Social Care Association
Eve Parkinson	Coleg y Therapyddion Galwedigaethol College of Occupational Therapists
Rob Pickford	Cyfarwyddwr Gwasanaethau Cymdeithasol a Phlant Cymru, Llywodraeth Cymru Director of Social Services and Children Wales, Welsh Government
Dr Catherine Poulter	Cymdeithas Gweithwyr Cymdeithasol Prydain British Association of Social Workers

Julie Rogers	Dirprwy Gyfarwyddwr, Gwasanaethau Cymdeithasol a Plant Cymru, Llywodraeth Cymru Deputy Director, Social Services and Children Wales, Welsh Government
Dr Pauline Ruth	Coleg Brenhinol y Seiciatryddion Royal College of Psychiatrists
Chris Synan	Coleg y Therapyddion Galwedigaethol College of Occupational Therapists
Sue Thomas	Ymgynghorydd Gofal Sylfaenol a'r Sector Annibynnol, Coleg Nyrsio Brenhinol Cymru Primary Care and Independent Sector Adviser, Royal College of Nursing Wales
Lisa Turnbull	Ymgynghorydd Polisi a Materion Cyhoeddus, Coleg Nyrsio Brenhinol Cymru Policy and Public Affairs Adviser, Royal College of Nursing Wales

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

Catherine Hunt	Dirprwy Glerc Deputy Clerk
Meriel Singleton	Clerc Clerk
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

Nid oes recordiad ar gael o'r cyfarfod tan 9.02 a.m..
No recording is available of the meeting until 9.02 a.m.

Ymchwiliad i Ofal Preswyl i Bobl Hŷn–Tystiolaeth gan Gyrff Proffesiynol
Inquiry into Residential Care for Older People–Evidence from Professional Bodies

[1] **Mark Drakeford:** [*Inaudible.*]—elaborate on the written evidence we have received and thank you very much indeed for that. We will go straight into Members' questions.

[2] **Rebecca Evans:** Good morning, all. Thank you for your evidence, which we found very useful. All of you have mentioned workforce planning in some way. We have this vision of keeping people at home for longer and making them more independent,with reablement and so on. What are your views on whether your different professions are going to be able to meet that need and keep people in their homes as the number of older people increases? Are those workforce plans and training plans in place for the future, and what are your thoughts on the number of staff?

[3] **Mark Drakeford:** Ruth, do you want to lead? We will then go to Lisa.

[4] **Ms Crowder:** Thank you. We have an all-encompassing workforce planning process within the NHS; there is a separate workforce planning process within social care, which is obviously important in terms of occupational therapy, as we work across the whole statutory sector. Since the predecessor health committee's report, we have been really pleased that the

Care Council for Wales has been feeding data on the workforce needs of occupational therapists in social services into the NHS process. That has made a significant difference. We are concerned that, for the last two years, we have seen a significant cut in the number of occupational therapy posts. The number had risen consistently over the last 10 years to about 102, but last year, there were 69. We are not quite sure of the figure for this year, but we think it will be around 69 to 71. So, that is a significant proportionate cut from just 100; it is a significant percentage. It may be a small number, but that has quite an impact, particularly when you look at the current policies and the need to support people at home, reconfigure our services and move out into community preventative services and more upstream services, if you like, so that we are able to prevent admission and crises later on. We are significantly worried about that. Some members have told us that they are only able to include retirements and turnover in their actual workforce plans, which means that there is no ability to build in any development or move to create greater community services.

[5] **Ms Turnbull:** There are two groups of people that we could address. The first is the group of nursing assistants, or healthcare support workers, to give its proper name, which is a huge group. We do not really have any effective data on that group in the independent sector. I recently spent quite some time, on a different project, speaking to a number of organisations and agencies in Wales and in the UK, and there really are no data available on that sector. The best that you can get is an estimate, based on some of the labour market surveys that have been done. We believe that that group should be a regulated profession. So, we are concerned about making sure that there is consistent education, training and standards for that group of people. There really is no workforce planning at all at the moment, and it is left completely to the market.

[6] There is then the nursing profession, with registered nurses. Again, there is very little statistical information in Wales on the numbers of those outside the NHS. The Nursing and Midwifery Council used to produce a useful statistical analysis of the register, showing where people were working, but unfortunately ceased to do that around 2007 or 2008. So, again, the planning is difficult, but I emphasise that we are talking about specific nurses who have specific skills that are needed to support the population that we are talking about in residential care. It is not just about producing enough nurses, but about producing the right nurses with the right skills, who can intervene successfully to help that population. Sue, do you want to say something about that?

[7] **Ms Thomas:** Just that I support that, really. I reiterate that a lot of the research shows that the use of a social care model alone is not able to meet the complex health needs of people living in residential homes, so I suggest the need to bear that in mind when you are looking at the workforce, because where we have a predominantly social care based workforce, you may well be missing out on opportunities to support people in more holistic ways by considering the future addition and complementary participation of nursing roles.

[8] **Dr Ruth:** Regarding doctors going into mental health in Wales, there is a significant problem at the moment with recruitment. For example, for the past six months, we had only half the junior doctors that we normally have, and that meant that there was difficulty sustaining the on-call rota as well as a significant deficit covering in-patient units, looking after people. That has implications for the future because we have a maturing workforce, and we are concerned about how we will replace staff. Although huge amounts of modernisation can occur with nurse prescribers, advanced nurse practitioners and the development of other professionals in the team—and we all want to be very much working in teams—there is still a need for doctors, because these are frail, elderly people with comorbidity and the most complex needs, and they need doctors to be involved in the teams. So, there is a big issue now of how to recruit people into Wales to work in mental health services.

[9] **Rebecca Evans:** My question is about Lisa Turnbull's comments on care home staff

not being registered. You said in your paper that there could be work for the Care and Social Services Inspectorate Wales

[10] 'to be investigating numbers, qualifications and continuous professional development of staff'.

[11] What tools would it need to go about doing that? What inducements could there be to get privately run care homes to engage with that kind of data-gathering exercise?

[12] **Ms Turnbull:** There is an issue about creating regulation for that group of people, healthcare support workers, who are not currently regulated. Once a profession is regulated, there is a consistent set of standards that it has to meet—and has to be seen to be meeting—and that it can be inspected against. So, that is one issue.

[13] Alternatively, there is evidence to suggest more appropriate ratios of healthcare support workers, given their type of skills. So, if you were to set that into an inspection regime, you could inspect against those criteria. You could say, 'The ratio should be this and the number should be that, so what are your numbers?' and then carry out an inspection against that. It is possible to incorporate that into an inspection regime. As for incentives for the private sector, the question is perhaps best addressed to the sector, but my suggestion would be that, if you can demonstrate that you are meeting the best possible standard, you are obviously going to be reassuring your clients. I would have thought that would be quite an incentive in itself. If you raise the bar so that all others are competing equally, that also provides an incentive. At the moment, the difficulty is that there is almost a disincentive. What we know from our members who run care homes and work in the care home sector that the financial pressures are quite great. At the moment, there is pressure to make cuts to things such as continuing professional development, training and education for staff, wages and numbers. At the moment, it almost seems as though there are quite a lot of disincentives built into the system, rather than incentives.

[14] **Mark Drakeford:** Ruth, do you want to come back on this quickly? Then we will have questions from Lindsay and Kirsty.

[15] **Ms Crowder:** Just to clarify, the Care Council for Wales registers care home staff from the social side. You may want to confirm with it which levels of staff it registers, but there are very clear and strong inspection regimes through the Care Council for Wales and the Care and Social Services Inspectorate Wales.

[16] **Mark Drakeford:** That is useful, thank you.

[17] **Lindsay Whittle:** Good morning, all. I am a great advocate of encouraging people to stay in their own homes and communities. However, recently, as a committee, we have gone out to look at some of the emerging models of extra-care housing. Frankly, one that we saw recently was of the same standard as a five-star hotel, and I am changing my mind and planning for the future, which is a good thing. [*Laughter*.] Is there a danger of professionals thinking that they should encourage more people to go into these homes, perhaps against their will? What is your opinion on that? Should professionals absolutely insist on working with individuals and their families, or is it easier for professionals? Please accept that I may be playing devil's advocate here.

[18] **Ms Synan:** The important thing is that we listen to older people's preferences. Some research published recently asked older people their preference, and what they actually want at the point when they need care, and 62% of them wanted to stay in their own homes and be supported by their family and friends, where possible, with a second group who, where that was not possible, would be supported by paid care workers. As a professional group, we

would be foolish to ignore the preferences of the people we are working with. Obviously, we need to consider the environment that they are living in and, where possible, our main aim is to keep people in their homes and to provide the equipment and adaptations to enable them to live as independently as possible.

[19] You rightly pointed out that the extra-care housing schemes are a really exciting alternative type of housing for many older people. They have also been researched and evaluated recently to establish how effective they are, not only from the point of view of cost-effectiveness compared with residential care, but from the point of view of older people's socialisation, and having their own front door, which they can close. It is a way of looking after people that perhaps allows them more dignity, and it also means that there is help at hand should they require it. In summary, we listen to people's preferences, we work with them in a client-centred way to achieve the goals that we jointly agree with them, and we enable them to stay where they want to stay or to move to where they want to move.

[20] **Lindsay Whittle:** I am sure that the whole of Wales would be delighted with that answer. With the greatest respect, I do not think that anyone else should answer because that is all that older people want to hear—it really is. However, please answer if you want to. [*Laughter*.]

[21] **Ms Turnbull:** It is absolutely right that people should have their preference of where they want to be supported, but you need support to do that. For people to maintain their independence in their own homes, we have included some comments about some of the pressures on community nursing. It is also about ensuring that they have access to primary care. So, for example, if they are in a home, they may, for all sorts of reasons such as transport or frailty, be reluctant or find it difficult to go out proactively to see their GP. So, we need to think about ensuring that there is care support for them. Whether someone is in their own home or in residential care, we are saying that you still need to ensure that proper healthcare is available to them. You might do that in different ways.

9.15 a.m.

[22] **Dr Ruth:** For people who have cognitive impairments and dementia, which one in five of us over the age of 75 will have, we need to think about training up the workforce that works in the community to cope with those problems. Ideally, people who have cognitive impairments should be kept in their own homes for as long as possible. That is because that is where they are best orientated. The evidence is that, when you move people with dementia, they do very poorly. Skilling them up in the community is an issue, and how to keep their skills going instead of doing things for them, which is happening at the moment. When home carers go in, they go in for 20 minutes and do everything for them. However, we should be working alongside the person to try to maintain their skills for as long as possible. So, it is a change of orientation, and it requires specialised home carers, particularly when people become obstreperous, difficult and a bit behaviourally disturbed as part of their dementing illness. It requires people who have some knowledge and understanding. In some areas, we already have a specialised homecare workforce, but not across the whole of Wales, and that is a gap in services that needs to be filled.

[23] **Mark Drakeford:** Dr Ruth, thinking of Lindsay's question, an earlier expert witness suggested that one of our key recommendations ought to be that no-one should be admitted to a residential care home from a hospital bed, as there should always be a period of assessment elsewhere first. He also suggested to us that medical voices in the hospital at that point generally erred on the side of caution and, on the whole, were in favour of residential care admission rather than what might seem to be a slightly riskier alternative. Lindsay's question was on which side do the professions that you represent tend to come down at the point at which that decision is being made? Do you think that what we were told about doctors is fair?

[24] **Dr Ruth:** No, but I would like to explain it. In secondary care, there is a huge problem of being risk averse. It is not just doctors, but nurses and occupational therapists and all the people working in general hospitals who are not familiar with the services available in the community. It is because secondary care has been too divorced from the community until now. That is not the case with mental health services, which cross those boundaries, because we all have beds and we look after people in the community, so we follow their journey through their life. We know that, when we admit somebody, that means using one of our few and precious beds, and we get them back to the community as quickly as we can. We know what the risks are and we manage them. It is very different when an unknown person comes into your bed. Someone says, 'They might fall over' or whatever, and then everybody gets worried about sending them home. That is about expert assessment in the hospital and advice from people who know the community, ensuring that you have the liaison teams available to say that a person can go home, actually, and good connections with the frailty teams or the community mental health services to try to get people home, rather than keep them in hospital. I agree that, ideally, you should not admit people to residential or nursing homes directly from hospital but, sometimes, going into hospital is a stepping stone to an appropriate placement, because things have broken down in the community.

[25] **Mark Drakeford:** That is helpful. I will go quickly to Sue and Eve, and then to Kirsty.

[26] **Ms Thomas:** I will pick up on what Dr Ruth just said, if I may. Recently, I have spent some time in a hospital where a multidisciplinary team looks weekly at each patient on its ward with a view to getting them to their normal place of residence as soon as possible, to avoid any deterioration during their hospital stay. However, the process that enables that to happen is so burdensome that there are delays just because of all the assessments and all the steps necessary to achieve that in a speedy way. That is one thing that I would like to point out.

[27] Another point, which you were talking about earlier, is the preference for people to remain in their own homes. I wonder whether it is also worth considering the features of that that are seen as ideal, such as retaining independence, choosing when you want to get up in the morning, choosing when you want to have your food, and all those other things that we take for granted in our own homes. If we assume that we can then call that a 'model'—maybe a model of care—why could that model of care not happen elsewhere? Why could it not happen in every residential home and in every establishment where people could be, at any time in their life, even if that is because it is seen as being a place where reablement can occur? In that way, what is deemed to be best, at any stage, occurs everywhere and there is always a team on hand to be able to support someone through that period, helping them to retain their independence.

[28] **Ms Parkinson:** I wanted to add to what Dr Ruth said, particularly regarding assessment. As occupational therapists, we would say that secondary care is probably not the most appropriate place to be making that decision or, in fact, conducting those assessments. We need to think about shifting to more of a model for intake, whereby people get out of secondary care as soon as possible and back to their normal environment. We could conduct the assessments and their reablement or reability programme at that point. You can make it more relevant and more proportionate to that person in their own home. We know that, by the use of reablement and so on, we reduce the number of care packages and the function outcomes that that person has at the end of that journey.

[29] **Mick Antoniw:** Is it the case that the assessments done in hospitals are effectively more to do with vacating the beds than they are to do with the particular needs of the individual?

[30] **Ms Parkinson:** Yes; there is a degree of that, and they are looking to expedite that discharge from hospital as soon as they possibly can. We all know that there are occasions when those assessments are such that that discharge does not work successfully. Also, for that individual, that assessment is not then relevant to their actual life, experience, history and future. However, if we do that assessment in a place that is familiar to them, whether they have cognitive or physical issues, we can tailor it to that person's needs and incorporate the person's family and their occupations and normal lifestyle into that programme.

[31] **Ms Turnbull:** There are specialist discharge liaison nurses in some places, and they are very effective at ensuring that parties are brought together, that the assessment is done correctly and appropriately and that the discharge takes place. It is interesting, however, that, although we can demonstrate that, where those nurses are in place, they are expediting the whole process, it is also an area that we are worried about. People are making cuts by taking those nurses out and, therefore, creating more problems for the service.

[32] I have a few other points that I would like to make. There is pressure on the hospital system to try to keep the bed, because the bed numbers are now so low, but, at the same time, it is better for the person to be cared for appropriately. We do not want to get into a situation where people are inappropriately kept for too long. Our members have reported an issue, however, in that they feel that some people, because of the pressure on beds, are being moved to a nursing care bed when residential care would be more appropriate, or moved to residential care when a nursing care bed would be more appropriate. So, going back to the first point that was made, we have called for some kind of planning of the needs of the community as a whole, and for the local health board to look at what resources are available to the community as a whole, whether that is elderly mentally ill placements, nursing care placements, residential care or community care. There needs to be some kind of planning for the whole population so that, when you get to the process of assessing someone and asking what options are available and most appropriate for them, the options are there to be used. The danger at the moment is that the pressure on the system is so great that delays are happening. The opposite is also happening—that it happens too fast and goes in the wrong direction. It is quite a complex issue that needs to be addressed.

[33] **Kirsty Williams:** I would like to come back to your point, Mark, about risk-averse decision making. The evidence that we have gathered is quite clear about what a good patient pathway would look like. However, it is frustrating that the evidence is old—it is not new or groundbreaking. Everyone is signed up to that seamless move through the system for an individual patient but, for whatever reason, those barriers continue to be in place. What, usefully, could we recommend that would actually see that seamless system being put in place uniformly across Wales, not dependent particularly on the personalities involved? We cannot legislate for human nature, but what, usefully, can we recommend? It is kind of frustrating; we all know what needs to happen, but there are 100 different reasons for why it does not happen for each individual. Therefore, what can we usefully recommend so that we do not have this conversation again in five years' time?

[34] **Ms Crowder:** For us, one of the key things is about having the space to make a decision at the right time and to have a conversation with the individual, as Chris said. One key thing that needs to happen is a substantial change in how funding is organised, to enable care to be provided in the right place. If you look at how most health-based occupational therapy services have traditionally been provided, you will find that funding follows the beds. If we take stroke care as an example, you create a stroke unit and employ a stroke consultant, and put a team around them. They focus, in the main, on rehabilitating people while they are in the bed and getting those people out of the bed. We need a funding stream in primary and community care that enables access to therapy and reablement in the community right from the start. Eve works in Gwent frailty and Chris leads reablement services in Cardiff.

[35] **Kirsty Williams:** Then we have the RCN complaining about a lack of beds. [*Laughter.*]

[36] **Ms Crowder:** We must have the ability to put some services up front, before people are admitted, and to create the space to have a conversation so that we can start to do a thorough assessment in the right place. Unless you have options for GPs to call an ambulance and to make an admission, you will not change the number of people going in. That has to be a fundamental change.

[37] One factor is inevitably around the historical patterns of funding and debates about whether it is a local authority duty or a matter of continuing care, and whether a person is continuing in care or not. Those kinds of issues must be resolved. With any move towards pooled budgets, there is an opportunity to legislate in terms of a requirement to work in partnership.

[38] **Kirsty Williams:** We have had pooled budgets since 1999.

[39] **Ms Crowder:** We have, but we have not practically had many pooled budgets, but we are—

[40] **Kirsty Williams:** We have had the law since 1999.

[41] **Ms Crowder:** Yes, we have. One of the big things that occupational therapists have discovered in the last few years is that we are suddenly being enabled to generate integrated services. You will know, of course, that we work in both health and social services and that our employers have, traditionally, required us to do different things. Finally, in the last five years, we have been able to actually do what we want to do and work across the whole pathway. The managers' group in Wales has recently produced a report looking at the integrated services across Wales and at all the models that we have, and these are delivering significant differences. If we could drive that a little more so that we had a service that followed the person out, and ideally knew them before they went in, we could make sure that the rehabilitation part, the knowledge of the person in their environment, the ability to pull in housing and signpost people in the right direction, made a significant difference.

[42] **Kirsty Williams:** I am playing devil's advocate, Lisa. Do not worry. I am not having a go at the RCN.

[43] **Ms Turnbull:** I want to put it on the record that we are very supportive of the points that Ruth has just made. There is a tendency sometimes to use beds as shorthand for services. That is not to say that, in some places, we do need beds, but beds come with the team and with the people. However, we are very supportive of Ruth's point. We are currently preparing our response to the social services consultation that is out for the forthcoming Bill. The point that has come across most strongly in that is the point about funding: that we need to break down that barrier. At that point of assessment, although it may be a perception issue, our members and healthcare professionals feel that it is a squabble over money. It is causing delays. They cannot physically get the people into the room to make the decisions, and they feel that it becomes an argument over entitlement and eligibility rather than what is the most appropriate care for the person. That is a huge frustration to our members and it is the one issue that they want sorted out. That impacts quite significantly on that assessment period.

[44] **Mark Drakeford:** Did you want to make a further comment, Sue?

[45] **Ms Thomas:** I was going to make the same point, just to have it on record. I spend a lot of time out in the field with nurses trying to support patients to move as quickly as

possible to the best place for them, and my observation is that there is a continuous defending of budgets. That is how it appears and that is how I am told it is. It is the defending of budgets at all stages that causes these delays.

9.30 a.m.

[46] **Dr Ruth:** In terms of risk-averseness, there needs to be a cultural shift. That is about people who work in district general hospitals having more opportunities for secondments and rotations into the community, so that they become more aware of the community—what it offers and what it is like—and to have teams, for example geriatric medicine teams, working across boundaries delivering hospital and community care in a different way, like the frailty teams and so on. If you have a social worker or a dedicated key worker, that person should follow you into hospital. You should not be allocated someone who does not know you at all when you reach the hospital door and who then manages your discharge, even if you have someone in the community who has known you for years and who knows all about how you are looked after at home and the risks that are usually managed for you. So, those are important points that would make a big difference.

[47] Everyone in hospital needs to be trained in caring for people with cognitive impairments, given that 70% of elderly people in hospital have cognitive impairments. We will have to be more aware of those problems. We have been the pilot site for the intelligent targets, and we are introducing 'This is Me', which is the Alzheimer's Society booklet that describes what the person is like—what they were like before, what they like to do and how they live their lives—and their calendar of activities and so on. Just filling that leaflet with healthcare assistants on the general wards is already leading to a transformation in how much people know on the ward about the person. It is helping people to decide whether a person needs to go home, which services need to be put in place and which family members need to be gathered to support them.

[48] So, it is those kinds of interventions—training and development, rotation, experience of the community—that are needed. We also need a mature workforce in general hospitals and community hospitals, similar to what we have in mental health community teams, to support people in returning home.

[49] **Ms Parkinson:** On what Kirsty was saying about pooled budgets, it is useful to note that, although we have had lots of evidence of integrated budgets, that has not always meant that we have had integrated ways of working. Although I am sitting here representing occupational therapists, I also work as part of the frailty programme in Monmouthshire and lead the services there. This is the first time that I am seeing integrated care from a whole-systems perspective. We talk about integration, but until we can completely transform the way that we deliver services in the community, we will not get away from the problems of individual budgets, people competing against each other and risk-averseness. The individual, or the referral, needs to be dealt with collaboratively and from a collective point of view. Until that happens, we will not see that shift. In that respect, we need to promote not only the intake model, but the pooled model. Those working in the community need to take responsibility for the discharge of people in secondary care, because they know those people and they know what can be offered. Those working in secondary care cannot and will not know that. They need to be specialists in their area of business, and we need to be specialists in maintaining people in their own homes.

[50] **Mark Drakeford:** Before bringing other Members in, I want to offer a different view on this. Elin and I went to Carmarthenshire last week and we met people from the reablement side of things. They did not once mention budgets to us; they simply described the different way that they now do things. They said that it is now exceptional for anyone to go straight from hospital into residential care, and almost everyone goes through a six-week period of

assessment and reablement. At the end of those six weeks, seven out of 10 people go home, whereas, under the previous system, seven out of 10 people went into residential care. That has nothing to do with money or budgets; they just changed the system. That is very much in line with some of the evidence that we have had from the reablement alliance and so on. They say that their outcomes are strikingly different as result of that change. Do you have anything to add on that?

[51] **Ms Crowder:** The investment in and growth of reablement has created a changing culture that has allowed those staff to be able to focus on what they are doing. The report that we get from reablement services, certainly the ones that I have spoken to, is that that is the point at which you are able to do the work that you need to do without worrying about budgets. I suppose that behind that, from the perspective of the practitioners, is the question of how the reablement process became funded. That is why we talk about the funding of budgets, but reablement in itself has delivered phenomenal outcomes, and suddenly the practitioners are able to focus on the individual and what they need, and not worry about the budget. So, actually, it a real pleasure to hear you say that.

[52] **Mark Drakeford:** So they did not need to raise it with us because the problem has been solved already.

[53] **Ms Crowder:** Yes, it has been eliminated.

[54] **Vaughan Gething:** I just wanted to return to some of the points made earlier about models of care. We have seen a number of homes on different visits, and we have heard a lot of evidence about reablement and allowing people to maintain more independence, whether in extra care, their own home, or in residential homes. We have also seen some older homes where there is a different model of care that, if you like, is much more paternalistic. The point is about the lack of capacity, or the loss of capacity, for residents who go into those homes. I am interested on the one hand in whether that is a picture that you recognise, but secondly, if it is, I am musing about what you would recommend that we do. At its crudest, do we just accept that there will be this category of homes where people lose independence, and that is just what happens and we cannot do anything about it? Alternatively, at the other end of the scale, should we recommend that the Government intervene and make them do something about the model of care? If we were to do that, how would we do it? Many of the residents in those homes appear to be quite happy, even if we objectively think that there is a better outcome of care that they could receive.

[55] There was a clear statement in the Royal College of Psychiatrists' evidence about wanting not-for-profit homes, ideally, for the future in this sector. Mention is also made of Southern Cross, and I wonder whether it is simply the financial stability that draws you to that conclusion, or whether there was anything in the quality of care that you thought distinguished the sector. We have had information circulated to the committee from the Care Quality Commission in England that shows that there is an appreciable gap in quality between the private sector and the voluntary and local authority sector. Again, I wonder if that is something that you recognise in Wales.

[56] **Mark Drakeford:** I will go to Chris first and give Pauline a chance to think about that.

[57] **Ms Synan:** There were lots of questions there. First, yes, there is recognition that there are different types of models within the homes. You talked about the paternalistic approach, and, 20 years ago, I took part in a piece of research for the College of Medicine where I followed people into residential care and then reassessed them after three months, and it was a very sad picture of decline. Today, I hope that there have been changes to the models. We absolutely cannot accept that people must be in a downward spiral, and the way to do that

is to show the benefits of an enablement approach within even the most traditional, paternalistic settings. There are all sorts of benefits, not only to the individual, but from an economic point of view. You will prevent admissions to hospital from residential homes if you can encourage that enablement approach. It is down to education and training and showing the effect on the mental health and wellbeing of that individual. You can change the approach and the ethos of the more traditional homes, so we cannot and must not accept it, and it is in everybody's interest—the individual and the provider of the care.

[58] **Vaughan Gething:** How do you suggest that we get there in terms of recommendations that we will make?

[59] **Ms Crowder:** There is a piece of work that the College of Occupational Therapists did with the National Association for Providers of Activities for Older People some years ago that produced some activity provision benchmarks that support both managers and activity providers in looking at their activity provision. One of the concerns is that you put on an event or run a group, which, actually, is not very meaningful. It has to be about enabling people within homes to understand how they get at people's life stories, exactly as Dr Ruth described, and how you understand what people's values are, and then create a programme and a culture that allows them to participate. I think that we have all blithely said in our evidence that you should allow people to go to the pub or the church or join in with the ironing, and so on; those are trite statements because the reality is about the way in which individuals work. It does come down to budgets, because that is about how you buy people the time to do it. However, if someone's background is that they were very house-proud as a housewife or a cleaner, then when someone is going around dusting, what is the problem with giving them a duster and working with them? When you are working with someone to get them dressed, there is nothing less dignified than doing it at a rush and not talking to them as a human being.

[60] It is about buying time, but it is primarily about culture and training, for which people need very simple tools. One of the things that we are doing at the moment is to update these benchmarks to provide a really simple toolkit for people that is about how you look at what a meaningful activity is, how you can build in what is a task that you have to do as part of your job anyway, and how you can evaluate whether the quality of that is good enough to really enable dignity, independence and choice for individuals. So, it has to be about access—we would say that, would we not?—to good-quality advice and supervision for staff, and there are really good examples of where occupational therapists are supporting activity providers in homes to make a difference. We must never, ever accept less.

[61] When this came out, we were really pleased that the CSSIW talked about looking at these benchmarks as part of its inspections. We think that once you start looking at that quality as part of the inspections, it tends to focus minds.

[62] **Mark Drakeford:** I am afraid that we are running very close to time already, so I will ask for brief answers to Vaughan's point, because Darren has a question that I am keen to get in as well.

[63] **Ms Thomas:** Briefly, you would not really want to accept anything that is short of your ideal. So, to see that sort of disparity is unacceptable. A model of care that you think should be consistently applied across the residential care sector in Wales is something that you could promote and then measure—you could ask about the people who are involved in delivering that care, be they occupational therapists with a particular knowledge and skills base or nurses, and the same goes for medics and all the professional groups that contribute to it. So, you can use markers to assess, but the RCN would say that we absolutely do not accept that we have to continue in the same way as we have seen it develop.

[64] **Mark Drakeford:** Pauline, what lies behind the royal college's call for the growth of not-for-profit provision in this sector? That is what I think Vaughan was asking you. What led you to that conclusion?

[65] **Dr Ruth:** May I comment on the first bit very briefly?

[66] **Mark Drakeford:** You may.

[67] **Dr Ruth:** I went to the Age Cymru meeting recently, and the CSSIW said that it was going to change the inspection process. That is one very important part of it. When I do clinics, I find that seven out of every eight people may not have been outside in the fresh air since Christmas, let alone doing any activities—this is in nursing homes that I go to in Monmouthshire. So, we need to be alarmed at the way that people are being looked after in nursing homes, not just mildly concerned. Dealing with that requires a trained, co-ordinated team approach that involves care homes with a plan-do-study-act intelligent target-type cycle, and staff from outside, such as in-reach nurses, community pharmacists, GPs and, if necessary, psychiatrists, going in to support the staff to change the way in which they regard and support people and maintain their activities. It is something that we need to think about in great detail, home by home.

[68] The Mountains Nursing Home in Brecon, as you may know, is making huge advances in managing psychotropic medication, for example, by keeping a record of everything that everybody is on, how often it should be monitored and who is monitoring it and in trying to cut it down. It is showing substantial reductions in the use of tranquillising medication by putting activities in place and by using other tactics and so on. That is a good example and it is something that we should all be aspiring to. What we need to do is to get other care homes to take that up. However, when you go to care home meetings, the difficulty is that all the good care homes are there, but the rubbish ones are not. So, one of the issues is how to involve and engage them.

[69] As regards profit, one of the difficulties with charging at the moment is that some homes charge a top-up fee, which means that people who cannot afford it, or do not have family to pay it, are sometimes placed miles from their own homes and they lose contact with their local family and friends and so on, because they cannot pay for the nice home around the corner that charges a top-up fee. It is creating huge disparities in people's care. Some homes are just wonderful—they are absolutely marvellous: it is like living in the Hilton or somewhere similar. Others, however, are crappy old places with poor-quality care and staff from abroad who do not even speak English and all that stuff and with high turnover. That has an enormous influence on the culture and the activities in a home, and on consistency and continuity, along with the preservation of a person's history—keeping alive who a person is, particularly when they are dementing, is what counts. If you have a change of staff all the time, as they are not being paid enough and it is just a profit-making organisation, the organisation does not have the right ethos of looking after its staff and its residents. That is our concern.

9.45 a.m.

[70] **Mark Drakeford:** Thank you very much. The last question in this session this morning comes from Darren.

[71] **Darren Millar:** Thank you for your papers and for your oral evidence. I am sorry that I was not here for the start of the session. I wanted to ask about those people who are not registered with any of your professions but provide the bulk of care, particularly in residential care settings, in care assistant roles. I know that, in the past, the RCN has called for the regulation of healthcare support workers, and we all want to see an improvement in quality.

Do you think that there is a need to regulate the individuals in the residential care home setting in some way, shape, or form? Is that something that we might be able to make as a recommendation in order to drive up standards? If we do that, of course, there will likely be a cost to the industry; can we afford to pay that cost? You have already alluded to the fact that many private care homes—because they cannot compete on a cost basis because of the fees that are being paid by local authorities—have to charge top-up fees for some residents. I know that that is obviously an issue. Local authority homes and other homes can be financed in different ways that mean that their cost bases are lower. So, what do you think specifically about the regulation of care assistants within residential care home settings?

[72] **Ms Turnbull:** The short answer is that, yes, we think that they should be regulated. However, the additional point I would make is that there needs to be respect for the different perspectives that are involved in delivering care. We have all echoed several times today the idea that the best approach is a multi-professional approach. We have recently seen the ridiculous situation in Wales where nursing home managers are now doubly regulated in the sense that they can be a registered nurse, and regulated by the Nursing and Midwifery Council, but are now required to be regulated a second time by a regulator in Wales. This is extremely bizarre when, as you rightly point out, the bulk of the care is currently very personal, intimate care and very important care in terms of dignity and reablement and is actually being delivered by—[*Interruption*.] Gosh, I am sorry, I did not mean to break the glass as a dramatic statement. [*Laughter.*]

[73] **Mark Drakeford:** That is fine; I am afraid that that end of the table is very crowded.

[74] **Darren Millar:** May I suggest that we have beakers with straws in future? [*Laughter*.]

[75] **Ms Turnbull:** Yes, plastic beakers. I am sorry about that. That was not intended as dramatic punctuation.

[76] That care is being provided by a group of people that is currently unregulated and we think that that is where we need to direct attention. So, yes.

[77] **Dr Ruth:** I do not know about regulation, but we are keen for everyone working in residential and nursing home settings to have some training in older adult mental health issues so that they know how to deal with this group. We would like that to be a requirement.

[78] **Ms Thomas:** Much of the research points to the model of care being in place, but also strong leadership so that organisations can clearly demonstrate that, in a situation where you do not have a regulated workforce but where they, nevertheless, provide the majority of care, they are working in a culture that is sensitive and is all that you would wish it to be, because the leader and the organisational structures are in place to enable that best care to take place. It is not necessarily just down to regulation in a situation where that is unachievable; there are other ways. You are looking to ensure a certain standard and quality of care. So, strong leadership and models of care need to be seen to be in place and should involve the person in charge, all of the staff, relatives and carers, and provide an entire environment that is conducive towards helping the people there to have their own sense of identity and self-worth. It is basic stuff, but it comes down to leadership to a large extent.

[79] **Mark Drakeford:** Ruth, would you like to make some final remarks?

[80] **Ms Crowder:** I echo that point. As we said at the start, the care council regulates the workforce across Wales and it may be worth approaching it for specific information. From our perspective, delegation and supervision are the words that I would add. If I delegate a task to a support worker, it is my responsibility as a registered professional to ensure the quality

and competence of the individual to carry out the task that I have delegated. If I am not happy that it is there, it is my responsibility to do something about that. Therefore, you need to build in supervision of support staff, and that ties in with the need for training and generally valuing our staff. If we do not value people who deliver care, then we will not change the culture to one of quality. That has to be important. If you can go to work in Tesco for the same wage—as you have been told several times in this inquiry—then you will not get people who are able to do what our care workforce want to do, which is to care for people effectively. My very last sentence is that it is not just about care; it is about creating an enabling ethos—not 'looking after', but 'working with'.

[81] **Mark Drakeford:** Thank you all very much indeed, and thank you for your help in getting through such a vast amount of stuff in a short time. I am sorry that not everybody managed to contribute to every question. We say at the end of all these sessions, but I say it especially today, that if we did not manage to draw out some points that are important and which you believe we as a committee need to have very much at the forefront of our minds when we come to making recommendations, we would be very pleased if you wrote to us. There may be things that we did not manage to emphasise enough and we would be glad to have that information from you in that way. Otherwise, *diolch yn fawr iawn i chi gyd*—thank you all.

9.52 a.m.

Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Tystiolaeth gan Undebau Llafur
Inquiry into Residential Care for Older People—Evidence from Trade Unions

[82] **Mark Drakeford:** Bore da a chroeso i'r tystion i'r Pwyllgor Iechyd a Gofal Cymdeithasol. Diolch yn fawr i chi am ddod yma i'n helpu ni y bore yma. Croeso i Paul Gage, Trefnydd Rhanbarth y De Orllewin o'r GMB ac i Donna Hutton o Wasanaethau Cymdeithasol, Unsain. Gofynnaf i chi os oes gennych unrhyw sylwadau agoriadol byr.

Mark Drakeford: Good morning and welcome to the witnesses to the Health and Social Care Committee. Thank you very much for coming in to help us this morning. Welcome to Paul Gage, Organiser of the South Western Region of the GMB and to Donna Hutton from Unison Social Services. I will ask you whether you have any brief opening remarks.

[83] The committee has had a chance to read the written evidence from the GMB, so we are grateful for that, and we will just go into Members' questions. Donna, is there anything to which you would wish to draw our attention?

[84] **Ms Hutton:** First of all, I apologise for not getting written evidence to you before the committee meeting; it will be with you within the next few days. We have done quite a bit of research into this and have taken a lot of evidence from our members. Unison has just over 100,000 members within Wales and, although we cover most of the public sector, people working in social care and social services are, by far, the biggest group of members within that, so we have a lot of experience. That is not just in the public sector, but in the community and voluntary sector as well. In terms of staffing, we have concentrated in our evidence partly on the effect on people who are trying to get into care homes, as well as their families, but also from the point of view of staff. At the time we captured the information, there were 439 residential care homes for the elderly in Wales; 27 of those were voluntary, 106 were local authority and 306 were privately owned. Some of those will be in groups; there are some companies or owners who have individual homes, but there are quite a lot of companies that will have more than one home, whether they are voluntary sector or not.

[85] Our members face an uncertain future; the majority of care homes were provided by local authorities—it was roughly around 90% in the 1980s—and that is very much reduced now. That has happened in a piecemeal way and our members are facing changes of employer, changes to their terms and conditions and changes to the service that they want to be able to provide. They feel very vulnerable. The amount of casework that we get from people who work for smaller employers or sometimes the larger voluntary employers—because you do not always know the exact name of the employer—is phenomenal. It takes up an awful lot of time and that is just from a Unison full-time officer's point of view. In terms of those who work in that sector, that is an absolutely huge amount of distress and stress for those individuals. That is partly because there is no overview—no-one is capturing what is happening to how people's terms and conditions are transferred. Although there is the transfer of undertakings legislation, it is not as strong as it could be, which causes problems for staff, who are already on low wages as it is. They are then faced with all sorts of changes that come in as soon as the home is taken over.

[86] In the paper that I will submit to the committee we outline 10 recommendations, which I will quickly pinpoint for you so that you can ask questions.

[87] **Mark Drakeford:** Would you like to highlight just two or three of them? We will not retain them in our minds otherwise.

[88] **Ms Hutton:** Fair enough. We wanted to make a point about access to care in residential homes. We have heard anecdotal evidence, because our members are also members of the public and when you are trying to get your parents into a home, it is difficult because there is not one point of contact. I am sure that you will have heard that from others, but we wanted to underline that. We are also concerned about the quality of care if staff feel vulnerable or staff numbers are reduced—and they are always reduced, because the main way that any third sector or private sector organisation can make a profit is by cutting the staffing costs, because that is the biggest part of their costs.

[89] We have situations where people are on their own, working at night in a big organisation. One member said to me last week that they are working on their own one night in a residential care home in north-east Wales and, if someone dies, which occasionally happens, they are tied up with dealing with getting the doctors and so on and so it is then that much harder to provide the necessary care for the rest of the residents. So, that is just one piece of first-hand evidence. The biggest point would be looking after terms and conditions so that you keep a well-trained and well-motivated workforce, and also invest in their professionalisation, which has been going on in the social work profession and which also needs to be done and consolidated for care workers.

[90] In terms of diversity, we need to ensure that there is a proper oversight of how companies deal with their residents as well as their staff. We had one case that was taken to a tribunal in north Wales where a local authority's care home had placed an emphasis on religion as being the most important factor, over and above how well someone could care for the residents in terms of their relevant skills. The case that we had was where people had been refused promotion from the first grade to a supervisory grade because they did not share the same Christian beliefs as someone else. We are not talking about Christianity or Islam or different religions, but about two specific belief systems within Christianity. We won that case. That was also done with the British Humanist Association. There are basically two elements here: one is how that work goes on, but also that people in a local authority can be placed in a situation in a residential care home where diversity is not valued. We wanted to highlight that. The remaining recommendations will be outlined in the paper.

[91] **Mark Drakeford:** Thank you; we look forward to seeing the paper. It is helpful to have recommendations set out for us. We have seen the GMB's written evidence, but would

you like to highlight anything briefly, Paul, before we move on to questions?

[92] **Mr Gage:** I will highlight a couple of points. I have another document with me, which I will submit to the committee later, which includes more information in support of what I have written. There are two areas with which we are concerned and that I have highlighted: staffing, resource and training is one and financial matters is the other. The former touches very much on what Donna has already told you. We are concerned about staffing levels where, currently, they are still not up to where they should be. We do not think that there is a standard there. People are under stress because there are never enough people on shift.

10.00 a.m.

[93] One of the major concerns around the resources side of it is training. Care workers are traditionally some of the lowest paid. The training that they get is often in-house training; it is not proper professional training as we would see it. It is basically there to tick boxes. We are finding that, when something goes wrong, the employer turns around and says, 'Well, we have given you the training, so it is your fault'. That is mainly concentrated in the private sector. GMB's involvement in the private sector, historically in Wales, has mainly been with Southern Cross. I think that everyone is aware of what a disaster that turned out to be. While Southern Cross was in situ we were its recognised trade union. We worked tirelessly for years, building a membership base, improving terms and conditions and getting better rates of pay—still not as they should be, but better—only for Southern Cross to fall through the floor.

[94] The homes were then handed over to several different companies. In Wales, I think that we deal with eight companies now, instead of the one. Only one or two of them have continued to recognise us. HC-One is one of those companies, and it is giving us limited access compared to what we had before. The rest of the companies, Four Seasons in particular, do not recognise us as an organisation, and, as a result, we have seen terms and conditions eradicated and people's pay being dropped to the minimum wage. More importantly, we cannot get access to these members any more to come back to fight for their case. We are having to talk to people at the gates in the early hours of the morning and late evening. It is almost getting clandestine, because the employers are bullying their staff not to come to talk to us. Until we can get back to a situation where we can talk to the employers and improve their circumstances these guys will continue on a downwards spiral, and we will not get the best people in there to do the job. At the end of the day, if you do not pay the right money you will not get the calibre of staff. So, there is a major concern around that.

[95] **Mark Drakeford:** Thank you for that. I will go to Lynne for the first question.

[96] **Lynne Neagle:** I have a question about staffing ratios, which you have highlighted in your paper. You have said that there should be a return to a minimum staff-to-client ratio. I do not know whether you would know the answer to this, but that suggests that at some point there was that kind of protection there, but that it was taken away. Can you say a bit more about that? Could you expand a bit on what we are actually talking about in terms of dangerously low levels of staffing? What would be an example of a good staff-to-client ratio, as opposed to where you feel that staff-to-client ratios are dangerously low? Can you comment on whether there are any particular differences in terms of staffing ratios among the different types of care home providers, such as local authorities, not-for-profit and private providers? Can you see differences in their approach to staff-to-client ratios?

[97] **Mr Gage:** The dealings that I have had have all been with private providers. Therefore, I can only give evidence on that side of things. Mainly dealing with Southern Cross and the occasional other provider, basically what I have found is that the night shift, in particular, becomes a huge problem, because you have one or two qualified people in the

building, perhaps. Very often the place is run by a non-qualified person, maybe one nurse manager. A care home could have more than 50 or 60 people in it, and, at night, as Donna said earlier, the staff have other jobs to do. If someone needs attention, how can you cover that? That is when I believe that it gets serious. During the day, there is an improvement in the numbers, but they are still nowhere near where they should be.

[98] If you go into any care home and ask what the numbers are, very rarely will a manager tell you. They will say, 'We have sufficient numbers', but if you talk to the staff they will tell you that they are run off their feet. The biggest concern is that the professional staff are just not there. I do not know whether that answers your question.

[99] **Ms Hutton:** I echo what Paul said. I will highlight a recent example from the Wrexham area. The staff there feel that they are in a dangerous situation when there is only one person working at night or when they have been reduced to two or three people during the day, because not only are they having to cover the work they normally do, but, because of ongoing service reviews and the way in which local authorities are trying to manoeuvre the situation to undertake the change to reablement and outsourcing, the time they can spend with the people they care for is being cut. It is very distressing for the individuals sometimes when there is a sudden change to reablement. In one example in another area in north Wales, someone had been looking after someone in their 90s and they were told on a Friday that, from Monday, they could no longer go to see that person, when they had been caring for them for 20-odd years. That sort of care is then lost from the system. The poor person who was receiving the care is equally affected.

[100] So, to come back to your question, staffing ratios are a huge problem. We try to ensure that people follow what is written in the care plans so that if it says that care should be 2:1, it is 2:1, but this issue is raised with us regularly by our members. Quite often, the home itself, particularly if it is a local authority home and it wants to do that, can achieve it, but it cannot always do that. Also, not enough attention is paid to handover times. If someone is late for a shift, the person who was working—who probably also has a home life and children they need to get to—cannot leave because there is no-one there to take over. That problem is regularly raised with us. Looking at staff ratios, we need to be mindful of the care plan, but we must also consider the practicalities of all those other things as well.

[101] **Lynne Neagle:** Is there a difference between the types of provider and how they approach the staff ratio issue?

[102] **Ms Hutton:** In one respect, no, because they are very mindful of care plans. They have learned through experience that if the care plan says 2:1, we will insist on that. That probably makes them sound worse than they are—they are careful about care plans. However, with regard to staffing levels, generally speaking, staffing reduces once you move out of local authority provision. However, we are noticing that it is now happening before that stage because they are getting ready for the introduction of reablement or whatever new service they are providing. They have to stick to care plans, but everything else gets cut to the bone. So, for example, if they can get away with having only one person on duty at night, there will be only one person on duty. It is common sense that that is not a safe practice, but they do not have a choice, as they see it, because that is how they have to fund it.

[103] **Mark Drakeford:** Kirsty is next on this point, and then we will go to Elin and Mick.

[104] **Kirsty Williams:** Mr Gage, you did not answer Lynne Neagle's question about your paper, in which you say that staffing levels are dangerously low and call for a return of a minimum staff-to-client ratio. Surely the inspection regime should be picking up your concerns and highlighting issues of staff-to-client ratios. Like Lynne, I thought that there were regulations on minimum staffing levels. Can you pinpoint when these levels were got rid of,

and what, in your view, is an adequate staff-to-client ratio?

[105] **Mr Gage:** I will try to answer as best I can. As far as them being got rid of, I do not think you could define the date, because it is something that has been whittled away over time. A shift may be allocated the right number of staff. I do not have the experience to be able to tell you what those figures would be. I have not been involved long enough. However, what I see is that a shift may be scheduled for cover, but when the cover is not there due to absenteeism or whatever, they do not cover that with relief staff. If there is anyone available to come in on relief, they are not being asked to provide cover.

[106] **Kirsty Williams:** Your paper says that there needs to be a return to minimum staff-to-client ratios, but as far as you understand it there was never a time when there was such a minimum and that that has been got rid of.

[107] **Mr Gage:** Again, I would expect there to have been a figure under regulations at some point. All I can say is that it has been eradicated over a period of time.

[108] **Mark Drakeford:** What about Kirsty's point about the issue being picked up by inspectors?

[109] **Mr Gage:** It should be, but we are continually seeing this problem, so I can only assume that, if it has been picked up, nothing is being done about it.

[110] **Mark Drakeford:** In some other evidence we received today, there was a call for more unannounced inspections.

[111] **Mr Gage:** I would support that.

[112] **Ms Hutton:** In terms of minimum staffing levels, I have been covering this area for about eight years, but prior to that, the anecdotal evidence from my colleagues is that there is a ratio that they look at for staffing levels and, off the top of my head, it is something like 1:8. However, you cannot apply that to each home, because there are different care plans for individuals with increasing personalisation and all those sorts of things, so it does not quite match that ratio. We are finding that those figures of staffing levels are being cut to the bone, but the duties and responsibilities that staff have to deal with are increasing. One of the most regular recent issues that we have is the fact that existing care workers now have to train or take responsibility for issuing medication and you really do need two people for that, because you have to count it and watch the service user. A lot of our casework stems from when pills roll under the bed and staff are busy or distracted and cannot deal with them. If you are trying to do that on your own, it is very difficult. I am assuming that most night-work medications will have been done by then, but, even so, something might come up. It is not as clear-cut as it once was. Paul is right; it has evolved over time and it is hard to say what the minimum is.

[113] On inspections, one of our recommendations is the same, which is that there need to be more. When you look at the work of CSSIW and the Care Council for Wales—CSSIW reports are online—and you look at a home's latest report before going in to talk to members, you see that those reports are quite helpful as they give an indication of what is happening, but they do not always reflect what the staff feel. In fact, they do so very rarely. I am going to contradict myself now, but we went into a home where the report reflected what the staff felt—it is a particularly good third sector organisation with staff involvement—and that was quite helpful. However, even that report gave very limited information. Our recommendation is that there should be one point of contact for any particular county, say that it was Conwy, where I live. So, if you had a member of your family who needed residential care, you would go to that one person, and they would sort out the social workers and everything else. If you try to do that now, it is impossible, and people fall through the cracks. In addition, CSSIW

should provide reports of its latest inspections to that one person, so if I were in a position where I was saying, 'I need a home and these are the choices', I would automatically have a copy of the latest reports. They need to be more frequent.

[114] **Mark Drakeford:** That is a regular theme in this inquiry. These are decisions that you make once, maybe twice, in a lifetime. There is no one point to which you can go to get the help that you need to make the decision that you are faced with.

[115] **Elin Jones:** I wanted to ask about training. You raised some of your concerns about the quality of the training for staff and your members, and you said that a particular concern that you had was that some of the training was being undertaken in-house and was almost a tick-box exercise. What boxes are being ticked? I guess that it is a matter of the regulation and that, in some way, there is an expectation or requirement for training, but it is not being undertaken in an accredited training form. How do you want to see that improved or tightened?

[116] **Mr Gage:** If I may refer back to the Southern Cross experience, again, we had a situation with Southern Cross where we introduced the new NVQ system, which was working quite well. It took us a while to get it established, but once it was, there was a natural progression, with incentives and hourly rates for staff who started going up the levels, in areas where, to be frank, the staff often questioned their ability to qualify in anything. They were encouraged by the NVQ system and started working through it, but I think that we have found, since the takeover by the new companies, that they are not sticking as rigidly to that line as they should be. From what my colleagues who are working on the front line every day are telling me, they have gone back—they are covering the basics and doing the essentials that they need to do to comply with the standards, but I do not know whether the staff are as well-trained or qualified as they should be.

10.15 a.m.

[117] I will give an example from when I was working in the trenches, many years ago: you would do a training course on manual handling or whatever and sit through what was perhaps a 20-minute presentation that covered all the basics and the statutory stuff, and you then signed a form to say that you had done it and that qualified you to say that you had passed the standard. I believe, from what I have seen, that that is what has been going on in private homes. So, they are ticking all the boxes to say that they have done it, but if you went along afterwards and asked the staff what they had learned, you would probably be surprised by the results that you received. It is all well and good saying, 'Yes, I have done that training and understood it', but it is another matter to put it into practice.

[118] **Elin Jones:** Is that a matter for inspection, so that there is a scrutiny element to the training?

[119] **Mr Gage:** Inspections could pick that up. If the inspectors went in and had a question and answer session with staff, that might be beneficial. They would then realise what the staff are really doing. Inspection has a big part to play in this.

[120] **Mark Drakeford:** I want to pick up on something before moving on to Mick. You may be aware that we have a reference group working with us on this inquiry. It consists of people who are either receiving care services directly or who have family members who are receiving care, and they are following what we are doing. That group asked us to ask you a particular question in this session.

[121] They point out that many occupations are involved in this and we have heard from representatives of the College of Occupational Therapists, the Royal College of Nursing and

the Royal College of Psychiatrists, but there are organisations that combine a staff representation function with a professional development function as well. The reference group pointed out to us that care home staff, for example, even if they are lucky enough to have union representation, do not have anything like the same sort of professional organisation that gives them status and so on. Paul, you referred in your written evidence to the establishment of an academy of care practitioners. That is planned to be developed, maybe even later this month. Would that organisation, if it comes about, help to fill that gap? Would it be another string to your bow, so that you did not always have to rely on inspections, and you would then have an academy that could say, with some authority, that training needs to be proper training, for example?

[122] **Mr Gage:** As we say in the document, we fully support that idea. It must be an advantage. However, if we go through that process, it is a matter of considering how it will be monitored and whether it will be monitored regularly enough with individuals. In a way, if it replaces the current system, it has to be an improvement; any advancement has to be an improvement. If we can get the message across to the staff that they are valued and are being trained properly, they will take some pride in their work again. So, it has to be an advantage, and we are fully behind it.

[123] **Ms Hutton:** Where we have recognition, we work with the Welsh union learning fund and we can offer something extra to employers in terms of, usually, supportive learning. A lot of people who work in this sector have left school without qualifications, so they have low confidence that they could attain anything higher. So, that is a supportive way of doing it. As Paul has already mentioned, recognition levels in the voluntary and private sector are very low, so people cannot cannot access that assistance, which is a real shame. Working in partnership is part of the ethos of the Welsh Government, but if we are not recognised, then we cannot work in partnership. So, that is a big issue.

[124] On training, the cut in staffing levels affects the time available for training. They have half an hour on, say, a Wednesday morning to do everything—their notices and everthing like that. It is the time for training that is always reduced and it does go down even further.

[125] **Mr Gage:** May I support something that was said about training? Quite often, these members of staff are asked to come in on their days off, which they often cannot do because their days off are for family commitments and things like that. So, quite often, they may miss some of the training that they should be coming in for.

[126] **Mick Antoniw:** I have a couple of questions on this. I want to look particularly at the larger corporate care homes, and you mentioned Southern Cross and the various other companies that have come in since then. In terms of the union's role within those homes, aside from terms and conditions, do you see it as being a contributory role to the quality and the safety standards within the home? Can you expand on how you see that particular role, of having an organised workforce within the care homes?

[127] **Ms Hutton:** I am not sure whether I understood the full thrust of your question. Are you saying that, because of union involvement—

[128] **Mick Antoniw:** One of your roles, obviously, is negotiating terms and conditions, wage levels and so on, but does the union have a role in maintaining the quality of care and safety standards within those homes?

[129] **Ms Hutton:** Yes, it absolutely does, and it comes through every part of the work that we do. So, whether we have a learning fund or some general negotiations ongoing, we will be raising those issues. That is because the members have said that they want to do a good job and feel that they cannot half the time. That always comes through when you have a

disciplinary or a grievance situation. When you are conducting a one-to-one interview with the individual to work out what needs to be done, they will always say at some point that they want to do something but they have only 15 minutes in which to do it, or they are no longer paid, in local authority cases, to travel from one place to another. They are mostly part-time employees, and they all have family commitments, and yet, in effect, they have to pay to go to work. All those things come into it. So, we do have a role with regard to quality—and not only are our members doing the work, but we access those services as well, so we see that a dual role.

[130] In a way, it leads into the professionalisation issue. If we do not value the work that they do—and we know that our members value that work—who will value it? Who are those poor service users going to talk to, who perhaps do not have family members to speak up for them? To protect our members as well as the public, they have to be more professional and be regarded as professionals, but that has not happened yet. We can see things going in that direction, but it just needs to be sped up a bit.

[131] **Mick Antoniw:** Paul, you mentioned that, since the changes in Southern Cross and so on, the atmosphere was becoming increasingly—you used the term 'bullying' but perhaps I could phrase it as 'intimidating'. Is that a fair description of the changes that you have noticed from your members?

[132] **Mr Gage:** Definitely. When we do manage to talk to the staff—because we usually have to camp outside the car park area as they will not even let us into their car parks—we find that they are continually looking over their shoulders and are nervous about even being seen to be talking to us at the moment. If they are like that about staff talking to the trade union side, I dread to think what things are like inside the building. We have definitely seen a marked fall. People used to be very enthusiastic and we had good relationships with these homes. In fact, the care home managers would quite often encourage their staff to join the trade unions, but the same people will not come near us now.

[133] **Mick Antoniw:** Since that change, does the inspection regime, whenever it takes place, involve consultation with the union formally as to what is going on in the home? If not, do you think that it should do so?

[134] **Mr Gage:** I think that it should, but I am not aware of it happening.

[135] **Mick Antoniw:** Are you aware of it ever happening?

[136] **Mr Gage:** Not personally, no. To be honest, we did not have many representatives willing to take the job on in the homes even when we had recognition. Now, it is impossible, as you can imagine. Even when we had representatives, people who were very keen on health and safety issues and care standard issues, they were never encouraged to get involved in inspections, as far as I am aware.

[137] **Mark Drakeford:** For the record, Paul, just to ensure that I understood correctly at the beginning, can you confirm that the GMB had a union recognition agreement with Southern Cross. What about its successor organisations—and I know that there are many of them, but the two main ones? With HC-One, you have—

[138] **Mr Gage:** HC-One has kept its recognition agreement, but it has not exactly been friendly about it.

[139] **Mark Drakeford:** Right, but you have one. Four Seasons did not.

[140] **Mr Gage:** No, it did not want to set one up.

[141] **Mark Drakeford:** Okay. That was just to make sure that I had understood. Thank you.

[142] **Vaughan Gething:** I want to go back to the point made in your evidence, in the GMB paper, about Southern Cross and financial regulation. Part of the committee's remit is to look at the potential for the financial regulation of care providers. I know that the GMB came out with some warnings about Southern Cross and also, in particular, about Four Seasons before the transfer took place. I am interested, on the first point, in what response you got from the regulators about the warnings that you gave about Four Seasons, which I know were proved to be right, because the debt was unserviceable and it could not manage to maintain those homes.

[143] I assume that the quotation that you have given about the Care Quality Commission refers to 30 March this year, but if it was last year, perhaps you could clarify that. I would also be interested to hear whether you have given any thought to how you see a system of financial regulation of care providers working. There is a range of views in the committee about the point of principle and whether it would be desirable, and then the practicality of how you would have some sort of system of independent or objective financial oversight. No-one here wants to see another Southern Cross or Four Seasons incident, where we have a significant collapse with all the impact that that has on the quality of care for the individual residents, as well as the staff, of course.

[144] **Mr Gage:** The worrying thing is that, although you say that you do not want to see the same thing happening again, it nearly has. For example, I think that it was only this week that Four Seasons announced the savings package from Terra Firma. I think that some £800 million has been invested as part of the deal to keep it afloat. Without that, we would have had another Southern Cross situation. From what we are seeing from the Care Quality Commission in England and its counterpart in Wales, there are mechanisms in place to ask for the information and I think that it is regulated that they give the information, but there is nothing that then goes further to validate that information to check that what is said is correct. Those are the major concerns that we have. It is all well and good having the regulations in place. As we said earlier, you can have an inspection but you have to be able to enforce it afterwards. We are seeing that that is not the case. These companies are providing the figures, but if the figures are not right and it goes wrong, who is there to pick up the pieces? You are putting not only the residents, but their families and the staff in a terrible position again. They have probably had just about enough of that. Something needs to be done and soon.

[145] **Ms Hutton:** I will just add an example of a voluntary sector organisation's experience from a few years ago. Where we are recognised—and we do have negotiation meetings—getting financial information is difficult because the employers generally think that it is in confidence or they are concerned that we might show the information to their competitors, whether they are in the voluntary or the private sector. That is not how we work. We obviously use that information ourselves, but we do deal with it in confidence. This particular example was in the north-west. The organisation had particular difficulties, but it came to our negotiating meeting and laid out the situation. After a bit of time, we got the information so that we could verify what it was saying, and we worked in partnership with the organisation. At the time, I think that it meant a reduction in pay for one or two years with a sliding scale, but the organisation recovered and that was done in partnership. No-one likes to see anyone go out of business or work, as long as they do it safely. It can work quite well if that relationship is there.

[146] **Mark Drakeford:** We are quickly coming to the end of this session, but Darren and Kirsty both wanted to come in on this point, so I am keen to allow time for that.

[147] **Darren Millar:** I just wanted to follow up on how you verify the financial information—or 'validate' it, which I think was the word that you used, Paul. Obviously, accounts are audited by external auditors, particularly for large public companies, but one of the problems that we have identified is that, if you have a large care home group, there may be many homes within that group that are profitable and a small number that are unprofitable but that suck the rest of the organisation down. To what extent do you feel that there might be a case for an effective breakdown within the audited accounts that then might be made available to CSSIW and anyone else with a regulatory responsibility for those particular care homes? Perhaps you could give us a response to that, if you would.

[148] **Mr Gage:** I disagree with you on that. I will be honest with you: I am not very good with words, but, to get the picture, it is a matter of how you get the correct information. You can disguise information, as you said. If you have the global picture, that is fine, but if there are particular regions or areas in which an organisation is really struggling, they are the ones that could do the damage. As a regulatory body, you should have that information available to you. I totally agree with you there. If we could drill down further, it might give a better picture of how that company really is functioning.

[149] **Darren Millar:** When people go in and conduct an inspection of a home, they have a responsibility to make sure that something is viable, but if they are not able to check the data, that becomes really difficult.

[150] **Ms Hutton:** Just to give another example, this is public money that is being used, and there does seem to be a lack of public accountability in the verification of that information, as you have rightly said. There is an example, again in north-west Wales, of a residential care home run by a voluntary sector organisation that received public funds and had absolutely no proper knowledge of employment law. We ended up in a tribunal and it cost that organisation a lot of money that, ultimately, was public money. That could all have been avoided had there been proper checks along the way. We are taking that forward separately, but that just highlights the point about residential care, which is so much more important because individual lives are involved. The information that we rely on is what the employer gives us, and we really do not have the opportunity to verify it—not really. It needs something like this recommendation of ours for the Wales Audit Office to be involved, or for the verification to be done by someone with the authority of the Welsh Government.

[151] **Kirsty Williams:** Donna, I have been struck by the number of times this morning that a voluntary sector organisation has been found wanting as far as your members and your experience of dealing with the sector are concerned. One of the things that this committee is looking at, given what happened with Southern Cross, is whether there are better models of providing this care, and the third sector, voluntary sector and the not-for-profit sector have been held up as potentially being an answer to this. However, I have been struck this morning that you have said numerous times that, actually, you have found them wanting as well. Am I misreading what you have said?

[152] **Ms Hutton:** I make no bones about it. Unison policy is that we believe that this service should be provided by the public sector, largely because of accountability. The problem is that, once you introduce a step between the provision of that service and whoever provides it, whether it is private or voluntary, there is a gap there, or a crack, and unless that is properly policed or validated, as was just said, people get lost in the system, although the services and the terms and conditions are the same.

[153] **Kirsty Williams:** So, from your perspective, you think that this committee should recommend that social care be delivered by local authorities of the state.

[154] **Ms Hutton:** That would be our preference, but we accept the world that we live in,

and we would welcome any inclusion in the talks about what kind of other options there might be.

[155] **Mark Drakeford:** Thank you for that. The very last question is probably for Paul. In the context of Terra Firma, there is a cross-party group at Westminster that is proposing that, in any future takeover of residential care on that sort of scale, the organisation potentially taking over ought to declare its business plan publicly in advance of the takeover. Would the GMB be likely to support that?

[156] **Mr Gage:** I think that we would, yes, and that is not hard to answer. We need openness and we need to know what is happening. Donna mentioned that these companies do not like giving us information. Maybe that is because they are afraid that we will give it to their competitors, but it is in our interests for these organisations to succeed. Once they have our members there, we want them to succeed for the sake of our members and the public. At the end of the day, we are there to represent the staff, but they are there to do a job of work, so if the company is successful, everyone is happy. We are not demons—we really are not. We like working with people. That is our ethos.

[157] **Mark Drakeford:** Thank you both for what has been a very interesting session. If there is anything that has not emerged in the session with quite the strength that you think it ought to have, and you consider that we should be thinking about it, by all means add them to the additional material that you both said you were likely to send us. So, that is an opportunity to add any particular points that we did not get to today, but which you think are important for us to take forward. That would be really helpful.

[158] Diolch yn fawr iawn i chi'ch dau. Cawn egwyl byr yn awr am 10 munud.

Thanks very much to both of you. We will now have a short 10-minute break.

Gohiriwyd y cyfarfod rhwng 10.34 a.m. a 10.47 a.m.
The meeting adjourned between 10.34 a.m. and 10.47 a.m.

Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Tystiolaeth gan Gyrff Staff
Inquiry into Residential Care for Older People—Evidence from Staff Bodies

[159] **Mark Drakeford:** Bore da, a chroeso. Diolch am ddod yma heddiw i helpu'r pwyllgor yn ei ymchwiliad i ofal preswyl i bobl hŷn. Byddaf yn gofyn i Catherine Poulter ac un person o'r Gymdeithas Gofal Cymdeithasol wneud rhai sylwadau agoriadol byr, cyn inni droi at aelodau'r pwyllgor am gwestiynau.

Mark Drakeford: Good morning, and welcome. Thank you for coming here today to help the committee with its inquiry into residential care for older people. I will ask Catherine Poulter and one person from the Social Care Association to make some brief opening comments, before we move to questions from committee members.

[160] That is how we will proceed. I ask for brief introductory remarks, which you might want to offer from a British Association of Social Workers perspective, Catherine. Nick, are you leading on behalf of the Social Care Association? I see that you are. Therefore, I will also ask you to make some brief introductory remarks.

[161] **Dr Poulter:** Good morning. The only introductory comment that I wanted to make was that, in the submission, we have focused on what are the negative aspects of how things work, but there is a lot of good practice out there. We sometimes focus on the things that are going wrong and forget the things that are going right. I make no apologies for pointing out the things that are not working so well, but I just wanted to make that point.

[162] **Mark Drakeford:** Thank you; there will be a chance for us to hear about some of

those things as we go along as well.

[163] **Mr Johnson:** I provided an electronic copy to Members of the guide for registered managers. You will notice that it says 'England'; I wanted to say that that was not because we forgot Wales, but out of respect for Wales. We did not have the resources to check whether there was any difference and we did not have the resources to have it translated. In the end, Skills for Care came along and said that it would pay to have it printed but that it could only say 'England'. However, we believe that the content is applicable to registered managers in Wales. We have a hard copy, which we are happy to leave with you.

[164] SCA is a membership association for care professionals. It was founded in 1949. Our first secretary was Kathleen Lewis who worked for National Children's Home in Cardiff, so we consider our roots to be deep here. We are particularly interested in the role of registered managers and front-line workers, the support and delivery of best practice and the methods. We would be happy to deal with any questioning in that area.

[165] **Darren Millar:** You have identified in your paper, Dr Poulter, that there is very often a delay in the discharge of care—or there have been delays, historically—and that there is pressure on social workers to undertake assessments to get people out of hospital beds that might be needed for someone else. To what extent does that pressure mean that, sometimes, decisions are being made on the hoof, in a rush, that may not necessarily be in the best interests of the individual concerned?

[166] **Dr Poulter:** There are two aspects to that. The first is that people may not have an assessment at all, and certainly people who have financial resources may be pressurised to move out more quickly without access to an assessment to allow them to review all of the options that may be open to them. I certainly have experience of medical and nursing practitioners telling relatives, 'Your relative needs to go into a care home, and you need to go and sort that out'. The relatives think that the practitioner must know what they are talking about, so they go off and do the best that they can without advice. Sometimes, they will get a list of care homes, if they are lucky, without understanding what needs different homes can meet. That is one aspect.

[167] There is then the aspect of the assessments, for which the pressure is huge. There are not many opportunities for people to take their time. Often, people in hospital will be moved to a care home without having the opportunity to choose where they will go. We will discuss the registered manager later, but the registered manager would come to see that person to say whether they can meet that person's needs. However, the older person does not have the opportunity to go to look at somewhere and make a definite choice. Sometimes, it may not be at all their choice—it will be a matter of finding somewhere with a vacancy. We do not do this to children. I thought about this last week. We are very careful about the way in which we match children and foster parents; with older people, there is pressure to get them out of hospital. I am not advocating that people should stay in hospital indefinitely, but our system is very much about making the best use of what we have, but is this done at the expense of older people's choices and what is best for them?

[168] **Darren Millar:** That is a very important point about the difference in approach to children and older people. You will be aware, because of your professional experience, that the National Assembly for Wales has now passed legislation on the rights of children and young people, but no similar legislation has been taken forward in terms of the rights of older people. Is that something that you would encourage us to do?

[169] **Dr Poulter:** Sometimes, it is about language. Obviously, legislation has a role, but the language that we use is so different. If we started to change the language, perhaps we would change the practice and get people to think differently. If we bring in legislation, it will

have major positive impacts, but it will also have major impacts in terms of resources, which we may not have. However, on the whole, yes, I might encourage that. We have the Human Rights Act 1998 and if we applied that to older people in a robust way, we would not need further legislation.

[170] **Darren Millar:** Mr Johnson, what is the experience of your members in terms of this pressure on beds perhaps adding to the sense of crisis about the need to discharge people quickly from hospital?

[171] **Mr Johnson:** I think that it is true. I was previously a hospital social work manager and one of the things that we did was to insist that people who were considered clinically fit for discharge, which is different from being socially fit, were sent home and social workers were then able to assess them in their home environment. Older people would ask, 'How do you know who I am? I am sitting on a ward in a sterile bed that is not mine, and you are trying to assess me.' It is an impossible task. So we worked hard to get people home, even if it was only for a few hours, in order to allow social workers, occupational therapists and physiotherapists to see them in their home environment and to listen to them describing their own aspirations. However, from a care home's point of view, people arrive, as Catherine said, in a hurry and the care home finds itself writing a care plan, which, in my view, is in effect an assessment. Sarah, who is a manager in a care home, and Sue who was a manager, may be able to add something to that.

[172] **Ms Davis:** I would like to add that my experience in recent years has been that there are some very unrealistic expectations placed upon care homes. At one time, people would be in hospital for longer, but the hurry to get them out of hospital now means that they often end up not having a full assessment, but being transferred. Different authorities have different ways of doing it, and it is that unrealistic expectation that is a disappointment to people. Sometimes, the resident will have been told that it will be like a hotel and that it will be about being looked after, and their experience, of course, is about promoting independence and trying to do as much for themselves as possible. So, there is this sort of mismatch, which causes tension between families, as well. Family members often experience a sense of guilt and discomfort that they cannot be the primary carer for their relative, and they then find that the care home does not do what they want it to do, which is what the hospital was doing—providing 24-hour care. What we see is people making very hasty decisions. I always tell people to think about their own home, and what they would do if they had to condense their own home into one room with very little notice, because of a medical accident, incident or sudden illness; how on earth can you make those decisions quickly? Think of all the photographs and knickknacks that you have around your home; suddenly having to put all of those things aside and completely changing the way you live is a massive decision, which needs to be made with a great deal of support. It should never be made quickly, yet we know that people are being asked to make those decisions very quickly. It is then a case of repenting at leisure.

[173] Some authorities are doing things that are quite innovative, in that they are making it a requirement that people stay in a home for about a month so that they can be assessed, and bringing in all of the practitioners that they can muster to work at finding the best solution for that person. Based on that assessment, funding is then agreed. It is then up to the person and their family to find the right resource to match that funding. That gives people a great deal of freedom to think about the decision. Direct payments come into this as well, because some people can opt not to go into residential care, but rather stay in their community. All of these things, and this poor-fit business, are a challenge for the people who run homes.

[174] **Mark Drakeford:** We will probably not have time to ask everybody to answer every question, but if there is anything that you want to add, by all means do so.

[175] **Kirsty Williams:** To date, we have had a lot of evidence on the consensus about the need to improve the status and continued professionalisation of the care workforce. I wonder whether you have any views on the adequacy of the current registration or regulation arrangements for staff working in care homes. What could this committee recommend that would assist the process of ensuring the continued professionalisation of the workforce and an appropriate balance of regulation? I have not seen any evidence to date that this registration would lead to a higher quality of care, which is our ultimate goal.

11.00 a.m.

[176] **Mr Johnson:** Just to begin on the strategic level, the Social Care Association, with the British Association of Social Workers and others, fought for 30 years to have the care councils. So, we are delighted that they are there and are doing an excellent job in the three Celtic countries. England is a disappointment to us because apart from registered social workers, no-one else in England is to be registered other than in a voluntary way. Sarah has moved from England to Wales, so she might have a view on this.

[177] We would be delighted with the professionalisation of social care workers. However, what is emerging is that calling them professionals and paying them the minimum wage is something of a conflict. It may well be better to describe it as a trade rather than a profession. For example, you could call it a guild of social care workers rather than a college of social care workers because, in truth, if most of them are working, and will work, for the minimum wage and you are trying to raise their status, then raising their status in a more appropriate way might be a more creative way of approaching this.

[178] I note that, in Wales next week, you are relaunching the Academy of Care Practitioners, and, in the SCA, we do the same sort of thing; those kinds of things, such as employers helping their staff to be registered and to take care of themselves are an important part of that. We would say that one of the critical measures of quality of any social care is the interaction between the front-line worker and the service user, wherever that is. If that is wrong, it will not matter how polished your public relations are—it will not work. We have all seen on *Panorama* what happens when that goes wrong. So, we are keen on saying to a worker, 'You are signed up to a code of conduct and we expect you to perform properly, regardless of your pay', but we know that there is not necessarily a correlation between pay and behaviour. Sarah may have a view on this from the front line.

[179] **Ms Owen:** Recruitment is difficult. When we recruit, we want to get the right care worker for the job because, as Nick said, they are at the front line of this and are providing care for the residents, so we need to get it right. However, when we get applicants in at the age of 18 for whom university fees are too high or whatever, some of them think that they cannot go to university and need to get a job somewhere. So, they apply to care homes where there are vacancies and yet, they are not quite right because they do not have any experience at all. However, with the code of conduct and so on, you can teach them and help them to learn that there is a right way to care and how they can do things properly. It may be a good idea to offer apprenticeships so that when they get to 18, instead of going straight into social care and think that they have to make a career out of it, they could have a trial run and see how they get on and get the necessary knowledge during those first couple of years and make a career out of it then.

[180] **Vaughan Gething:** I wanted to come back to training because we have had a lot of evidence on the subject throughout this inquiry, including some just before this session from trade union representatives. In its written evidence, the Care and Social Services Inspectorate Wales claims that its inspection shows that, generally, staff are informed of registration requirements, but there is evidence from others that they are concerned about the cost of adequate training and the organisational challenge of releasing staff for that adequate training.

We heard a concerning example from the trade unions that suggested that a 20-minute briefing on manual handling may suffice when it comes to putting a tick on someone's training record. If that were the case, I would be concerned about the safety of the member of staff and of the residents in their care. Do you recognise that as being a problem in either the private, voluntary or state sectors? What are your views on the adequacy of the CSSIW's inspection regime on this point about training—not just to ensure that training records are available and maintained, but whether they reflect that an adequate level of training is being applied to staff that we would all want and recognise?

[181] **Ms Davis:** The regulation requires a certain number of staff to be in a building at any time. That impacts on the number of people who can be released for training. The solution that care homes are finding is the use of e-learing. E-learning is quite dangerous in this situation, because what you are actually doing is training people to have relationships with people who are very vulnerable. That is what it is about, and that is a challenge. We have to be able to ask people 'So, what do you think about that?' and 'How do you think you should be behaving, and what is important?'. That is separate from the very important stuff, such as moving, handling and health and safety issues. There may be some room for e-learning, but not with moving and handling; there is no substitute for practising on each other. What concerns us greatly is that people are not challenged and are not given the opportunity to think through the importance of the impact that they have. They bring the world to the resident. The resident lives in a world that is usually their room, and maybe the sitting room. The staff's job is to bring the world to them, and they have to understand the importance of that. They have to be able to grasp that, and I do not think that you get that from sitting in front of a computer. So, we need to think carefully about the training and qualifications that are needed.

[182] It was wonderful when we got NVQ, but I think that that has all been watered down. If you look at the issues that Sarah spoke about in relation to getting the right people, you are looking at people who, if they are not in these jobs, are likely to be shop assistants or to be working in bars; it is people of that level of society that we employ in the care sector. We need to have some very rigorous opportunity, but there is a need for the space to do it. There needs to be a requirement, which perhaps should be pre-employment, but I am not sure. I think that the apprenticeship idea in an excellent idea.

[183] **Ms Owen:** The staff need the opportunity to ask questions as well, and you do not get that with e-learning. If they can ask questions and get knowledge from experienced people then it helps the process of becoming a good carer.

[184] **Dr Poulter:** My experience is that the good homes will make sure that there is training, either formally or otherwise. Training is not just about having a programme; it is an ongoing, everyday activity, and it is about correcting bad practice. So, it is an ongoing process. However, the homes that are struggling are the ones that cannot release staff to go to formal training. They have a huge turnover of staff, so, even if you train them, they do not stay because the conditions are not right. So, there is a correlation between the performance of the home and training, but it is not lack of training that makes performance poor. It is the other way around: if the home is not working well, then the training will suffer. So, it is not just about training; it is about a whole-systems approach to ensure that the home is functioning well. The training will almost follow that, as well as underpinning it.

[185] **Vaughan Gething:** To come back to one part of my question, if you think that those problems exist in how training is delivered through the sector, is the inspection regime adequate? Are the expectations right, and are they being effectively measured in that inspection regime, bearing in mind that CSSIW says that its findings are that staff are generally being trained to registration requirements?

[186] **Ms Davis:** I think that the requirements perhaps need to be enhanced to demonstrate an understanding of the complexity of the challenge, rather than just looking at the bread-and-butter issues. The training requirements are much more about health and safety, food handling and other important things that go on in care homes. However, what is missing is the attitudes, values and the real understanding of how to build relationships with people. I think that we need enhanced requirements on how people view their jobs and how they get on with people. That is difficult to do but it needs to be done.

[187] **Mr Johnson:** I think that access to the register in Wales is signed off in induction in the first cycle, with an expectation of getting the vocational qualifications subsequently. Providers would all say to you that this is partly about fees. I am sure that you have all heard that a lot. Certainly, I am confident that Mario Kreft will be hammering that point home with you. However, what I would say is that part of that could be a commissioning thing. When commissioning, the local authority says, 'Part of the reason we buy from you is that you provide these things, and one of those things is a well-trained and competent staff group, and this is what that means'. People will describe functional things—mandatory things—such as moving and handling. I suspect that the 20-minute briefing the trade union talked about was part of someone's induction, with someone going through where the toilet was and how they record information and so on. They may also have said, 'And we have to do this'. However, you have to do proper training with a trained trainer.

[188] One of the difficulties for social care nationwide is that there has been a realisation of the amount of money in the business, and there has been a plethora of consultants and trainers, and people like us are pushed to the edge as a consequence. We are here only because we value what we do and for no other reason.

[189] **Lindsay Whittle:** On this point, I am all for professionals being in the caring profession. They are very important and training is vital. I do not regard care assistants as anyone lesser than the manager or the social worker. They are probably more important really, and I passionately believe that they should be adequately trained and adequately paid—this minimum wage nonsense should go out the window. However, what is the professional's approach to working with the voluntary sector, for example, which has a wealth of experience in this field?

[190] **Mr Johnson:** We have done significant work. There are quite a few voluntary providers. There is a forum in England with members in Wales called the National Care Forum, which is made up entirely of not-for-profit providers. We differentiate between volunteers and the voluntary sector. The voluntary sector is pretty big and includes big organisations such as Barnardo's, the Royal National Institute of Blind People and so on, which are big and very well funded. Are you referring to the use of volunteers in the application of professional practice?

[191] **Lindsay Whittle:** It could be both really. There are organisations such as the WRVS, which relies on good spirited people in the community. There are a lot of people who are looking for things to do who can bring the benefit of their experience of caring for elderly relatives in the home environment or in the care environment through visiting. They could offer help not only to the homes but to the families.

[192] **Mr Johnson:** Lots of care homes have exactly such arrangements in place. I will let Sue come in on this.

[193] **Ms Davis:** We find that, by being very specific about what we want people to volunteer to do, we get some very good volunteers. I think that that has been your experience as well, Sarah, has it not?

[194] **Ms Owen:** Yes, and it can be done in a safe way. There are Criminal Records Bureau checks and so on.

[195] **Lindsay Whittle:** Of course, yes.

[196] **Ms Owen:** Being specific is the way forward with volunteers because if you just ask people to chat with the residents, you will get some people, but it helps to give them direction if you are specific and ask them to take a resident on a shopping trip or to a concert, for example.

[197] **Lindsay Whittle:** Chair, that is equally important. As we heard earlier, many residents do not even get out of the home and get fresh air. Most homes are surrounded by very nice landscaped gardens, so they should at least be encouraged to go there.

[198] **Ms Davis:** Like staff, volunteers need to get job satisfaction. If you are going to volunteer, you need to know what you are going to do, and you need to know when you have done it and whether you have done it well. That applies across the board. It is important that we ensure that we never allow volunteers to do the other side of the work, the more intimate side. That is quite a challenge for us because some volunteers think it is perfectly natural to stray into that aspect. Professional people have an understanding of confidentiality. It is about giving that understanding to volunteers so that they appreciate that what they see, hear and experience is private to that person. I do not think that any of us would want to be looked after by volunteers because we want the controls that come with professionalisation and paid work. So, it is about carefully managing it, but using volunteers massively to improve the quality of the experience of people in care.

11.15 a.m.

[199] **Mr Johnson:** The Social Care Association led on a project in 1991 for the Department of Health called ‘A window in homes: links between residential care homes and the community’, which looked at how well people looked out and how well they got out. The only thing that I would add to what has already been said is about the rising inclusion of families and the need to ensure that families continue to be in touch, particularly with the rise in people with dementia. Sons, daughters and friends will come in and help someone to eat, for example. Either we are going to increase staffing levels dramatically over the next five or 10 years, or we will be dependent on families reaching into the home to do things that add value to the care that we are already giving. However, families are a crucial contributor, as Carers UK will tell you.

[200] **Lindsay Whittle:** If the families live here in Wales, of course, but so many do not.

[201] **Mr Johnson:** No, that is right.

[202] **Lynne Neagle:** You say in your evidence that the role of the registered manager is crucial. I wonder whether you want to expand on that and on whether you think that there are any changes that the committee should recommend to the role of registered manager.

[203] **Ms Davies:** The role is fine; the task is challenging. I do not know whether any of you watched the recent *Panorama* programme where very serious abuse was broadcast to the whole nation. It was a dreadful programme and on it there was no mention of the role of the registered manager. That was so frustrating, because they are the safeguard. They are responsible for what goes on in a home. What concerned me, as I watched that, were the people out there who are thinking about going into residential care—the programme lost an opportunity to say that there is somebody there. There is a guardian; the guardian had let the people in that home down. The role of registered manager is complex; it is about managing

the life of the residents. When I was a registered manager, I used to say, 'I'm responsible for hundreds of people's comfort in life', because the residents are just a small part of that job. You have the people who are interested in what is going on in the home—the relatives, friends, neighbours and people all around. The registered manager is the focal point for all of those people. You can make or break somebody's quality of life as a registered manager—for the residents, staff and relatives.

[204] **Mr Johnson:** We put 'Champion, Leader, Protector' in the title of our guide. The manager is liable under the law and if the inspectorate forcibly closes a home, the person who will be taken to the care tribunal will be the manager. They are underrated and understated. My perception of them is that they are not driving the car, but that they are the gear stick, often being controlled by somebody else. When Railtrack had problems with trains crashing, it was because it did not have an engineer on its board. My view would be that any company that has multiple properties should have registered managers or at least one person below the directors, and often more than that, on the board talking about registered manager issues to people who may be bankers, businesspeople or health specialists, so that there is someone who knows how to make the railway work—or knows how to make a home work, in this case. Castlebeck ran into the mess that it ran into because it was not in touch with what was going on on the ground. My suggestion would be that, where a company has multiple registrations, one of its registered managers should be a board member.

[205] **Lynne Neagle:** In our previous session, we heard evidence from the trade unions about concerns about poor staffing levels and that some of the levels were dangerous. You have highlighted the role that the registered manager plays in protecting residents, but presumably the registered manager is also the person who puts together the staffing rotas. To what extent are they under pressure with the resources that they are given by the owners? How do they marry that up? They have a protective role, yet we are still hearing that in some places staffing levels are dangerously low. Something is clearly going wrong in those places with the role of the registered manager, is it not?

[206] **Ms Owen:** There are definitely other pressures, as well as those of finances, but most registered managers are in the job because they care for those residents and they see that a basic level of staff is needed to support them properly. Volunteers can then be brought in to help with the holistic care. You need a basic level of staff to ensure that the fundamentals are being done, but it is also about using the people in the community to make the lives of residents better. In my opinion, the basic level of staff needed should never be compromised. You can always fight with those above to get more than you need.

[207] **Mr Johnson:** In the early part of this century, we had a national minimum standard for staffing, which was produced by the residential forum for the Department of Health and was used in England and Wales. One of the major providers—I cannot remember which one, so I will not suggest a name—was over the minimum and went to the Commission for Social Care Inspection, which was the English replacement for the National Care Standards Commission, and asked whether it was committed to the previous regulations. It said that it was not. The provider then asked, 'So, the staffing standard is off, then?' and the answer was 'yes'.

[208] The Social Care Association sells a disc with a working document in which you can put high, medium or low dependency and a couple of other statistics and it will give you an idea of how many care hours you need in that setting. That is the model that we have developed. People's dependency levels have increased, so that probably needs a revisit. However, managers, owners and inspectors need to have a vague idea of what is okay—what you would expect to see when you go into a care home and how many people you would expect to see. You could say that you would expect to see at least two care assistants in a room of people. However, if one person needs two people to take them to the toilet, for

example, then there are no carers left in the room.

[209] **Ms Davis:** The constant cry from residents is, 'We don't have enough time with the staff, and they don't have the time to do the things that we want them to do with us.' That is always the cry. I rarely meet residents who say that they are really comfortable.

[210] **Dr Poulter:** Over the past 10 to 15 years, dependency levels have increased and the staffing has not. The fees are also squeezed down. I know of homes that are really short of staff, but because the staff are so committed to the residents, they will come in and work ridiculous hours. The care of those residents is dependent on the goodwill of staff who are not paid very much and who are perhaps making money for international chains.

[211] **Mr Johnson:** There is a quality issue, of course. If you use a lot of agency staff, the quality goes down. The better a home can manage with permanent staff and committed staff, the better the care.

[212] **Mark Drakeford:** We will quickly turn to Kirsty and Rebecca on this issue and then the last question will come from Mick.

[213] **Kirsty Williams:** Is it possible to legislate for minimum standards of staff?

[214] **Mr Johnson:** Yes, I think that you can.

[215] **Kirsty Williams:** Is that something that we should recommend?

[216] **Mr Johnson:** Having a minimum level of staffing that describes what you cannot go below is very good, because it helps everyone. You could then, as a quality measure, for example, say that you are better than that level. However, if you just have what you think is right, you can argue with the inspector or the person involved, so there will always be a debate. Managers still contact us and buy this disc because they want some guidance.

[217] **Mark Drakeford:** Thank you, that is very interesting. We had evidence from the Alzheimer's Society in an observation study that showed that, other than in relation to direct care needs, the average resident was spending two minutes in a six-hour period interacting with staff or other residents. It is sobering when you think of it like that.

[218] **Mick Antoniw:** One of the areas that we have been looking at is the balance between care homes in the private and in the not-for-profit sector, as well as the new models that are emerging. When we visited Llys Enfys in Llanishen, we were told that all care homes have to make a profit, but in the not-for-profit sector you can put that back in and so on. Do you have any comments about the balance between the private and not-for-profit sectors, and do you have any experiences that we can learn from in terms of the ethos or the quality of care delivered by them?

[219] **Mr Johnson:** We probably all have a comment. Catherine might have a comment about buying us social workers, but the only statistic that I know is that it is 84% private, 11% not-for-profit and 4% public in England. You can see that what has driven that is the fact that there is money in it, and, with quite a few of the big companies, the money is not in the UK at all, but outside—it is offshore investment. We all saw the Southern Cross debacle and the dilemma that you face when investors are outside the country. If they lose confidence, the company can lose its value within weeks, as Castlebeck did, and as Southern Cross did. That is the vulnerability for commissioners and providers. One of the things that I was talking to an investment company about was it getting its act together and offering something similar to what we have with travel, like an Association of British Travellers or an Air Travel Organisers' Licensing bond, which says, 'If you buy with us, you are protected'. That is

where the greatest vulnerability is. Some of the private companies offer very high-quality, very expensive care at a good standard, but the small single provider is much more vulnerable, because it cannot keep up to date or keep up with training; it has no training and staffing infrastructure because it is a one-horse operation. I think of the Glastonbury home where people were dying unduly quickly in the care of a man and his wife. There are thousands of those small homes and engaging with those is something else.

[220] **Mark Drakeford:** Thank you. The ATOL bonding idea is one we have not discussed directly, but I have seen it in circulation as a way of giving confidence to people that a home could not suddenly collapse and go out of business.

[221] **Mr Johnson:** Yes, and councils and commissioners. You may be buying 30, 40 or 50 beds from a council in a place, and if it starts to keel over what is the director of social services supposed to do?

[222] **Dr Poulter:** I have not had much experience with the not-for-profit sector, other than the Methodist Homes for the Aged, and the standards there are very good. However, as Nick has said, there is an issue about the financial vulnerability of smaller homes. There are individual homes scattered about that are run by not-for-profit organisations, but do they have the financial strength to keep these homes running? The fees are very often higher than a lot of councils will contract for, which brings its own difficulties.

[223] **Ms Davies:** I would just like to add that my experience has been mainly with voluntary organisations in recent years, and I feel that that is where most of the quality care is being delivered. That is partly because it is subsidised from other sources, like the Methodist Homes for the Aged and Christadelphian Care Homes, and because they have a goodwill intention. However, I do not think it is money that determines whether a home is good or not. A home is good if it has a good manager, a good ethos, good safeguards and enough money to provide a good environment and relationships with people such as volunteers and families. That is the important ingredient. It is not necessarily who owns the building or who pays the staff.

[224] **Dr Poulter:** I think that one of the other aspects that have changed over the last few years is the number of smaller homes that have gone out of business, because it is not financially viable. The size of care homes have increased. Going back to my comparison with children, although the number of children coming into care is rising, I do not think that we will be opening 50-bed children homes around the country to accommodate them. Yet, that is what we do with older people and it is not even considered a problem. It may be what we have to do, but it is not something that people even challenge. So, that goes back to how we look at language and use language. Maybe we need to think about that.

11.30 a.m.

[225] **Mr Johnson:** I suspect that you may not have heard the idea of older people being shareholders in the care home that they live in if they have a big lump of capital. That is what makes people get hot under the collar, and so their investment would be part of the home. If the old people who lived in the home owned the home, the relationship between them and their staff would be quite different. There must be an opportunity to pilot that somewhere.

[226] **Mark Drakeford:** Diolch yn fawr iawn ichi i gyd. Thank you very much indeed. Apologies to Rebecca that we ran out of time and that she was not able to ask her question. It has been a very interesting session, and we have heard a few new ideas, which, given that we are well into this inquiry, were particularly useful. Thank you for leaving the hard copies with us. If afterwards, when you reflect on the session, you think that there are points that did not come out strongly enough or we did not manage to get to but that are particularly important

for the committee to bear in mind, we would be grateful if you were to write a note to us to remind us of those. You will get a transcript of the evidence in any case to check it for accuracy.

[227] **Mr Johnson:** We also have a guide on closure, which I will send to you, Chair.

[228] **Mark Drakeford:** That is very kind, thank you.

[229] While the other witnesses are coming in, I remind Members of two domestic issues. Next week, on Thursday, we are taking a break from looking at residential care issues, and we are having a one-day inquiry into venous thrombo-embolism. On 30 May, the Minister will be here at the start of the relatively brief session on wheelchairs. We said that we would hold back on coming to a conclusion if we could get the Minister in quickly, and we have managed to find a slot before the end of the month, so I think that that was worth doing.

11.32 a.m.

Papur Gwyn Gwasanaethau Cymdeithasol: Briff Technegol gan Swyddogion Llywodraeth Cymru
The Social Services White Paper: Technical Briefing from Welsh Government Officials

[230] **Mark Drakeford:** Symudwn ymlaen at yr eitem nesaf ar ein hagenda y bore yma. Bore da a chroeso. Diolch am ddod.

Mark Drakeford: We will move on to our next item on our agenda this morning. Good morning and welcome. Thank you for coming.

[231] This is one of those sessions that we are becoming more familiar with now as a committee. We are fairly soon to enter a storm of legislation, and so we are trying to keep in touch as closely as we can with the emerging thinking of the Welsh Government so that, when we come to do the job that we will be asked to do, we are as well informed as we can be. So, this is not a session about the nature of the policy so much as a chance for us to learn where the thinking has got to on the consultation on the Social Services (Wales) Bill.

[232] We will take it in three stages, if that is ok. First, we will ask the panel to give us some background information: how the consultation document was developed, and what the Government is aiming to achieve through the consultation. We will then go on to the document itself, and then we will talk about the next steps and where we go from here. Rob, you will orchestrate things for us at your end of the table. So, I will ask you whether you want to tell us something briefly by way of background first, and then we will have some questions before we move on to the next part.

[233] **Mr Pickford:** Good morning to everyone. If I start to splutter and cough and run from the room, it is probably an attempt to avoid answering any awkward questions, leaving them to my colleagues. [*Laughter.*] My apologies for that if I do.

[234] Thank you for the opportunity to meet you and discuss this important topic. Perhaps I should go back slightly to provide some context, as you suggest, Chair. Back in November 2009, the Deputy Minister for Social Services established the independent commission on the future of social services. It reported a year later, in November 2010. In essence, it spent a year listening to people around Wales, talking to a variety of people, ranging from the individuals and stakeholders that you might expect it to talk to, such as directors of social services, through to, for example, the leaving care team in Caerphilly. It also took written evidence. It produced a report that said a number of things. The first important thing that it said was that

social services were not a broken toy. Social services had an enormous number of strengths around Wales and it felt confident that, in moving forward, social services would build on those strengths. However, it suggested that there were some key issues for the sustainability of social services. The report was discussed widely at that point.

[235] In February 2011, the Government produced its White Paper, 'Sustainable Social Services for Wales: A Framework for Action'. It was debated then and has been debated subsequently on several occasions in Plenary. Colleagues around this table have taken part in those debates. I think that the last one was in late November 2011. That White Paper picked up the themes in 'From Vision to Action', the report of the independent commission. It said that the pressures and issues that social services were facing were driven by three core considerations. One was changing social expectations, because what we expect of public services and how our society is today create a whole set of issues for social services. The second was demography. Although a lot of debate is quite rightly conducted in relation to older people, some of the demographic issues and pressures are spread across the life cycle and do not relate only to older people. The third was the challenge of demand and resources. 'Sustainable Social Services for Wales' said that were social services to seek to carry on as they were, they would not be sustainable for the future; hence, the title.

[236] In the year subsequent to that, there have been a variety of discussions, meetings and conferences on what that means and how we take it forward. Around this time last year, the Government announced that one of the ways in which 'From Vision to Action' would be implemented would be through a social services Bill, and you will see that a number of the key themes are in the White Paper. In particular, 'Sustainable Social Services for Wales' says that there must be a number of key game-changers to move to a sustainable position. Those were: a stronger national purpose and expectation; a clear accountability for the delivery of services; a commitment that social services were a core part of local government and its responsibilities; a clear national outcomes framework; a stronger focus on citizen-directed services; a step change in the integration of services; the reduction of complexity; a more confident and yet more competent workforce; a different and stronger focus on safeguarding and promoting the wellbeing of citizens; and a new improvement framework. You will see that the structure of the consultation document and, therefore, it is likely, the Bill follows those broad game-changers.

[237] That is the history. Would it be helpful to move on to the consultation now?

[238] **Mark Drakeford:** I think that we should pause for a moment in case anyone has any questions on how we got to where we are today, which is what Rob has been outlining. Most people around the table will have been a part of this, so there may not be any questions yet. I see that there are no questions, so we will move on to the consultation document and process.

[239] **Mr Pickford:** In January, the Deputy Minister for Children and Social Services made a statement to Plenary that outlined the broad chapter headings of the consultation document, and there was a discussion on that and more widely. The overall direction and oversight for this process is through the Deputy Minister's partnership forum. The body was set up following 'Sustainable Social Services for Wales' and it brings together, on a cross-party basis, the key interests in the social services world and in local government. It also brings the political leadership of the other aspects of social care. So, the chair of the Wales Council for Voluntary Action is part of that process, there is a vice-chair of a local health board, Sue Kent, and the chair of the Care Council for Wales is there, too. That is deliberately established as a group of senior politicians who are able to look at these issues, and it is set up as, for want of a better word, an obstacle-clearing group. If there is a problem or issue that needs to be solved, if those people around the table cannot knock it on the head, it is unlikely that anyone else in Wales could do it for them. That is mirrored by a leadership group that I chair, which, in essence, comprises the chief executives, as a short hand, of those interests around

the table. We are currently working on a means of including service users and carers alongside that process so that they have a meaningful input into both those groups.

[240] The document was published on 12 March, and the fact that it was launched at the Dewis independent living centre on Mick Antoniw's patch was itself a statement about the importance of having a voice and control. We have held a number of formal consultation events. There were three around Wales attended by roughly 350 people, giving them an opportunity to explore what the document meant and, importantly, to talk to each other about that. So, it was not just to debate what it meant with us as Government, but also to discuss what it meant to each other. That has been supported by a number of other activities. Earlier this week, for example, the WCVA held an event, which Steve attended, and Children in Wales has held an event, and there were about 70 to 80 people at each of those events. There has been a whole variety of other activities. Cymorth has come at it from a housing perspective. I think that you will be speaking at one of its meetings, and that you have spoken to its representatives. There have been discussions with LHB vice-chairs. I went to the LHB vice-chairs' meeting two weeks ago, and I have just come from a meeting now with the director of the NHS Confederation. The Aneurin Bevan Local Health Board has also organised a seminar for board members. So, all that is illustrative of the sort of activities under way.

[241] On the consultation document itself, there is the formal document, and it is inevitable that there is a degree of technicality about such a document. We supported that through an easy-read version, a leaflet and a version for children and young persons. The committee would possibly be interested in hearing from Julie Rogers how we are seeking to involve children and young people in the process, and colleagues may want to ask Julie questions about that. In broad terms, that is the shape of the consultation, which closes on 31 May.

[242] **Mark Drakeford:** Are there any questions about the process of consultation and about how it has been conducted? I see that there are none. Rob, what about social services users? Where is their voice being captured in all this?

[243] **Mr Pickford:** Quite a lot of the consultation events and activities are directly with users. For example, Steve, you told me earlier today that you have a meeting with Deafblind UK.

[244] **Mr Milsom:** It is next week.

[245] **Mr Pickford:** It might be worth your saying a bit about the children and young persons angle.

11.45 a.m.

[246] **Ms Rogers:** We are doing quite an extensive consultation with children and young people. We are using some of the existing networks. We have identified 13 networks that could contribute on the children who are most affected by the proposals. We are using them in a variety of ways to engage with children and young people directly. The kind of organisations that we have been working with are the junior local safeguarding children boards, in relation to developing the safeguarding proposals, as well as Voices from Care Cymru, particularly targeting looked-after children and care leavers. We have also been working with Funky Dragon and the Children's Commissioner for Wales. We have also commissioned specific work to get feedback directly from young carers and disabled children and their families. So, there is as range of activity going on, not just around the consultation paper, but in the months leading up to its production.

[247] **Mark Drakeford:** There is nothing more on that. I know that the consultation is still

going on, so I am not asking you to anticipate its outcomes, but just in terms of us keeping in touch with the debate, does anyone on the panel have a feel yet for where areas of consensus are emerging and areas on which people have differing views that are being thrashed out as part of the consultation process?

[248] **Mr Pickford:** I think that it is probably fair to say that it is still at a fairly early stage. That is the honest answer. My experience of going to a meeting where a group of people are talking about this tends to be characterised by, 'This was a really helpful session, Rob, and we can now get our heads into what it means'. That probably characterises where people are. The most important point at the moment is that people want to be engaged and are seeing that it is important. That is probably the overwhelming message and they are welcoming the opportunity to directly have that engagement.

[249] The other issue that struck me was that 'Sustainable Social Services for Wales: A Framework for Action' was published 12 months ago and there has been a lot of activity around that. However, when you sit down and go through a Bill, or a consultation on a Bill, it takes people to a different intensity of discussion. That is a good thing. So, in that sense, it is forcing people to get away from generalities and get off fences and say 'What I really mean and what is really important to me is this'. It is currently at that stage.

[250] **Lindsay Whittle:** I might be wrong—and I do not mind being told that I am wrong—but should we ask for details on what social services do with regard to adapting people's homes, which makes an enormous difference to people's lives? Are they getting it right? Would that be part of this process?

[251] **Mr Pickford:** One of the big debates that we have had is around how legislation helps with these sorts of issues. There is a relationship, in that sense, between sustainable social services as a change programme—a transformation programme for social services in Wales—and the Bill. While a Bill is an important tool in the toolbox—probably a pretty big spanner in the toolbox—it is not the complete toolbox. One interesting debate that will emerge as we go through this process is that some will say, 'I think that it is really important that we do A, B and C', and while it may be important to do A, B and C, legislation might not be the means of achieving that; it may be achieved through better collaboration, through delivering the service in a different way or by doing something in a different cultural way. One challenge is going to be to tease out what legislation can help with and what primary or secondary legislation can help with. So, that will be one issue.

[252] **Lindsay Whittle:** In simple terms for me, that is a second phase then, is it?

[253] **Mr Pickford:** Yes, I think that something like that would likely be second phase, but it is something that we will have to learn as we go through the process and that we will need to distil from the consultation. Clearly, legislation affects culture and the way people think and we have to unpick that as we go through it. So, I would not be shy about saying, 'Isn't this something that we ought to consider?' The answer might be 'yes' or 'no', but that might be the way to tease that out.

[254] **Lynne Neagle:** Are any themes emerging from the consultation so far in relation to the proposals to merge adult and child safeguarding boards?

[255] **Ms Rogers:** The safeguarding proposals in the consultation paper have been on the table since the middle of October last year, I believe, when the Deputy Minister announced them. At that time, there was some misunderstanding of what she said and her intentions around the merger of safeguarding boards. I know that there are policy needs in this area and that there has been something of a debate around the matter for some time. However, through the consultation events and through engaging closely on this issue, we have been able to

reassure people that it is not the intention to merge the boards from next year or the year after. This is a longer term proposal to merge the boards in future if it makes sense and it is safe to do so. We have tried to steer the debate away from there. Nothing that I have seen so far—we have only had a handful of consultation responses—says that this is going to be a major issue.

[256] **Kirsty Williams:** I will turn to the proposals around a national eligibility framework. At the moment, we have social services departments that are working on different levels of eligibility. How would the new legislation impact on a local authority that found itself providing services for a client group that would no longer be entitled to those services under the law?

[257] **Mr Milsom:** Big issues have been identified in that regard.

[258] **Kirsty Williams:** Yes; a lot of people might find that their care package does not exist anymore.

[259] **Mr Milsom:** We have approached this issue through the recommendations made by the Law Commission on adult social care and recommendations by the Dilnot commission on creating a single national threshold of eligibility. The consultation document spells out how the legislation will change in this respect. Evidence from the Care Standards Inspectorate for Wales's work on eligibility in particular shows how these criteria are not meeting everybody's needs in the way that they should and that we need to move to a less complex system that provides the services that people need. National eligibility has to be tied into the proposals around assessment; they go hand in hand. The proposals around a single threshold will avoid some of the confusion that exists regarding the four current levels of eligibility, namely critical, substantial, moderate and low need. In different parts of Wales, people end up on different parts of that spectrum, and the different levels might mean different things in different areas, according to the evidence in the report. We hope that a single threshold will simplify that.

[260] **Kirsty Williams:** How does the concept of need marry up with the concept of eligibility? You could identify a need but still not be eligible for a service. The cornerstone of these proposals is meeting need. However, in your paper you go on to talk about eligibility, and I wonder how those two concepts marry up.

[261] **Mr Pickford:** The way that I am trying to get my head around it is to say that, if we start with the population of Wales—3 million people or so—a smaller proportion of that population will have a particularly significant set of needs. You are aware of the children in need concept that we have at the moment, which covers about 25,000 children in Wales in broad terms. The Bill suggests that local authorities and their partners need to understand that broad need as a way of encouraging early intervention services, for which you do not need to have an assessment. It may be a community alarm system or ensuring that there is an adequate number of services for children available in a particular area.

[262] Beyond that, some people will have a more marked and significant need, and that is what the assessment process will be designed to tease out. It will identify whether there is a social care need and what outcomes you are looking for. This then separates the outcomes and the needs from the service provision, because the danger with the service at the moment is that you are defining the need by the service. So, if you separate the identification of need—what I am looking for to resolve the difficulty that I am facing—from a particular service, our feeling is that that will open up a degree of creativity for the solutions that people can find for the difficulties that they face. So, you separate the service provision—the eligibility for a particular service—from understanding the outcomes that I am looking for as a human being, some of which may be best met through a social care service.

[263] **Kirsty Williams:** Finally, with regard to direct payments, the Bill would allow Welsh Ministers to prescribe the clients and the circumstances under which a direct payment may be used. Can you explain what that means?

[264] **Mr Milsom:** The direct payments legislation has a history that goes back to 1995. It has been gradually introduced and has encompassed more clients and broadened its coverage as time has gone by. We are looking through the main transformation programme—the voice and control programme—to see how we can make a greater reality of it. That has certainly caught the imagination of the third sector that we are dealing with on that. A consultation is due to commence fairly soon on how all of that will operate, and, within it, there will be a range of options to look at direct payments. The current system inhibits more people being able to take control of their own care, so there is a range of areas to consider in relation to that. One option, for example, is giving the individual more support, particularly in terms of the model in the independent living centre in Pontypridd and the one in Cardiff, to enhance the support that they receive. That is particularly relevant for older people, who, in the main, have shied away from direct payments. There are other options around the mechanics of direct payments in respect of who can be involved, because local authorities currently cannot be involved. So, one of the options would be to look at the role of local authorities, as they have done in England and Scotland.

[265] Through this consultation process, which begins soon, we will tease out the options for increasing the number of people who can use direct payments productively. The number is currently at around 3,000 people in Wales, so we have a way to go with that. So, there will be a consultation paper that spells out some of the detail shortly.

[266] **Mark Drakeford:** The basic policy thrust behind the sentence that Kirsty read out is to make direct payments more easily accessible to more people and to extend the range of purposes for which direct payments can be made.

12.00 p.m.

[267] **Mr Milsom:** Yes.

[268] **Kirsty Williams:** Only if the Deputy Minister allows it.

[269] **Mark Drakeford:** But that is what the Deputy Minister intends, is it not? That is what we have just heard.

[270] **Lynne Neagle:** Sorry, may I ask a question, because I have not seen that letter, is the intention to make them more widely available, as Mark said, or to make them an entitlement for everyone?

[271] **Mr Pickford:** What we put in the consultation document is the position if you chose this as the way in which the service ought to be provided to you and what could be done to enable you to exercise that choice. That is what the consultation document says. It also covers what you might need to support you in that choice, because you may need support to exercise it, and what the local authority might be able to do in that. The model is not one in which there is an expectation that you must have the service delivered through it.

[272] **Lynne Neagle:** No, but an entitlement is different to an expectation, is it not?

[273] **Mr Pickford:** Yes.

[274] **Mick Antoniw:** I very much take the point that you made about where it is appropriate to legislate and the danger that you may legislate because you can, while whether

it achieves anything is often another matter. In the regulatory regime, that is an area that is perhaps a lot clearer. Some of the things that we have been discussing and taking evidence on in our inquiry have raised a number of areas with regard to the financial probity of some of the larger corporate bodies, for example, as well as regulation in terms of staffing, qualifications and so on. Is there any theme arising about how the regulatory regime should change?

[275] **Mr Pickford:** If there is a theme, I suppose that it is that if you are providing a service, you are accountable for it. That is the core assumption that underpins it. Let us be crystal clear that it is your responsibility to provide it, to provide it to a proper quality and in a sustainable manner. That is probably the underpinning theme. What goes alongside that is a belief that regulation is important in getting you to that. The debate about regulation is about quality, but we also need to focus on how we put in place stronger arrangements to assist people to improve, and not only through the regulatory process. However, that theme of, 'You provide this service, you are accountable for it and let us be clear about that' is one of the driving forces in the consultation document.

[276] **Mick Antoniw:** One of the things that goes with that is the quality of the regulation itself and the quality of the enforcement, because one thing that has occurred to me is that we have often had plenty of rules, but the way in which they are considered and regulated is almost perfunctory, and there is a need for dynamic regulation of real quality. That is the message that is beginning to come over to me.

[277] **Mr Pickford:** It illustrates, as you say, what you do through a piece of primary legislation, what you may want to do in how you structure the regulations that govern it and what is about practice in that. You will be aware from the inquiry and the other work that you are doing that CSSIW is going through a process of modernising its regulatory activity. That is as important as any changes that will be made within primary legislation. The key is ensuring that any changes in primary legislation or the regulations governing care homes or children's homes fit together and point in the same direction. So, one of the items in the consultation document suggests that we do not talk about national minimum standards, but about standards. It is one word, but it sets a different tone in that debate

[278] **Elin Jones:** I was pleased to hear you say that you are using the consultation process to tease out what should be in legislation and what could be accomplished elsewhere, because this is such a huge piece of legislation that there is potential for it to lead to changes in the bureaucratic structures rather than delivering the improvements to people's lives that everybody wants to see.

[279] I particularly wanted to ask you about the engagement and consultation with local authorities—a lot of this is about local authorities and what they will end up having a duty to undertake, or partnership working, and all of that. In particular, I wanted to ask about the issues that are being raised around the cost of implementation, and the cost of complying with the new legislation, because that has to be part of any new legislation, especially these days—the ability to fund that legislation is an important component of the discussion on the legislation itself. I do not know whether there is anything coming through already on the consultation and engagement with local authorities about the cost of meeting the aspirations of this legislation.

[280] **Mr Pickford:** In terms of the engagement part of your question, clearly Welsh local government has been very much part of the process of discussion, including in formal terms, in meetings like the Deputy Minister's partnership forum, where the Welsh Local Government Association is obviously key. Its spokesperson has been part of all those discussions. So, there has been a web of discussions—that is probably the best way to describe it. From those, there have been a number of workshops and seminars with directors

of social services and heads of service. The last one, off the top of my head, was about February, and there was one in the autumn unpicking what this means. They are also engaged in the programme to deliver sustainable social services. We have a number of project groups that are involved in that, so there is a whole set of ways in which that links together. Clearly, as you say, if we are saying that social services are part of local government, then local government has to be part of this process.

[281] In terms of the resource issues, one of the things that 'Sustainable Social Services for Wales' makes clear is that social services are not sustainable in the way in which things are arranged at present, but not one of us believes that there will be large sums of money available that will provide the answer to that question. So, in the debate on the Bill, one of the tests is whether the Bill enables social services to become more sustainable, and that includes in resource terms. That is a different context. You rightly put your finger on how we often talk about a piece of legislation; we say, 'We have this piece of legislation, and we will do these four new, exciting and important things, and they will cost x, y and z'. This is a discussion about how a piece of legislation and a change programme can make the service as it is sustainable. That is the discussion. I will not pretend to you that a variety of people around Wales are not going to be saying, 'We think that this will cost x, y and z', and there will be a regulatory impact assessment that will obviously be at the heart of that.

[282] **Darren Millar:** I just had one observation and three brief questions. First, I have noticed that the consultation document refers to the Deputy Minister making lots of regulations rather than there being a lot of detail on the face of the Bill when you come to publishing it.

[283] I have three specific questions. The first concerns the complaints process, whereby the Public Services Ombudsman for Wales may have a role in dealing with complaints about residential care homes, for example, in the future. I wonder why the Commissioner for Older People in Wales, and perhaps the Children's Commissioner for Wales, have not been used as an opportunity to provide some support with complaints. Perhaps there has been some thought around that, or some consultation feedback on it.

[284] Secondly, in the introduction to the consultation paper, the Deputy Minister's foreword mentions an intention to regulate in terms of the financial viability of care providers, yet there is no further information other than in the foreword on how that might be done. I could not find any other references to that within the document, so perhaps you could talk a little about that.

[285] Thirdly, there is one glaring omission from the Bill. There is a lot in it that I welcome, but one thing that we all need to be brave enough to tackle is the issue of paying for care. Obviously, Dilnot has done his piece of work, but no-one appears to be picking up the ball and running with it and trying to solve that issue in the longer term. I wonder why the Welsh Government does not want to tackle that issue at this moment in time.

[286] **Mr Pickford:** The point that you made about the balance between primary legislation and regulations is an important one. We will need to tease that out as we go through the process. I am sure that this committee, as it goes through that process, will have lots of thoughts on that. One of the key distinctions is that, in simplistic terms, regulations can be much more flexible than a piece of primary legislation. What is it important to enshrine in a piece of primary legislation as opposed to a suite of regulations? There is an important debate to be had on that. That is territory that I am sure we will cover.

[287] In terms of the public services ombudsman, there have been discussions with commissioners on this, and with the ombudsman himself. The position in Wales is that if you are an individual in a care home, you have paid for that place yourself and you are

dissatisfied, you can complain only to the care home; there is not a body above it to which you can complain. If that place is funded by the local authority or a local health board, you can complain to the local authority that it has not properly ensured that the service is right for you. That seems to us to be an anomaly. It is not an anomaly that exists in England, for example. So, this would allow the public services ombudsman to be a stage of complaint resolution beyond the care home itself, because the local authority or the local health board would say that it was an arrangement made personally by the individual in which they have not been involved and it is therefore a matter between the individual and the care home. This suggests that this is not satisfactory to leave it at that point. People need another stage above that.

[288] In relation to the commissioners, I think that we have seen their role as enabling people to have a voice and to be sure that the process of making complaints is done properly, rather than dealing with an individual's particular concerns. If they were to become involved in that, they probably would not do much more than deal with individual complaints. Their role, except in very particular circumstances, has not been to deal with a certain Mrs Jones's particular complaint about the service that she has received. There are other routes that currently deal with that. However, there is a gap with regard to the routes.

[289] In relation to paying for care, this is not something that the Welsh Government can deal with on its own, which is why it is not in here. We are awaiting the response of the UK Government to the Dilnot commission report.

[290] **Darren Millar:** That is a bit of a cop-out, is it not? Scotland has addressed this issue, or has taken a step towards trying to address this issue. Why can the Welsh Government not take a leap forward and say that it wants to lead on this? Has there been a discussion on that as part of the drafting of the consultation document? What responses are you getting in terms of consultation? There is nothing to stop the Welsh Government from taking a leap forward and saying that it will address this issue itself, is there?

[291] **Mr Pickford:** There are issues about the interrelationship between the paying for care agenda and the benefits agenda. The key is the interrelationship between those two. Whether or not Ministers would wish to take a different stance is a matter for Ministers rather than for me. However, I think that that is what is driving it. The paying for care element is about what I as an individual contribute in financial terms to my care, rather than the pattern of care and the arrangements of care that are very general that this Bill focuses on. However, I know that there are very active discussions, as Ministers have reported to Plenary, between Welsh Ministers and UK Ministers on this issue.

[292] **Darren Millar:** It did not stop the Minister from taking action on domiciliary care costs in Wales. What about the third issue of financial viability? Why is it mentioned only in the foreword and nowhere else?

12.15 p.m.

[293] **Mr Milsom:** As regards it being in the foreword, it would be something, subject to the consultation on the regulation section, that could be dealt with in the detail in terms of strengthening the—

[294] **Darren Millar:** There is no specific question on it in the consultation, is there?

[295] **Mr Milsom:** No.

[296] **Darren Millar:** So, how do you hope to achieve decent feedback? To be honest with you, it seems as though it was a bit of an afterthought and, in drafting the foreword, this was

just thrown in. Has there been a great deal of discussion in terms of how the financial viability might be assessed?

[297] **Mr Milsom:** There are a range of ongoing discussions with the UK Government, and the Scottish and Northern Ireland Governments more generally, about market stability in the care sector, and particularly in the light of the Southern Cross situation. There is a broader range of discussions and issues to be worked through. For example, if you wanted to get at the root of some of that, it would be UK legislation that would be needed in respect of the financial constraints around company law. That was the nub of the Southern Cross issue, was it not? It was offshore holding companies that were at the root of this problem. Within the details, some options will become available to tighten the requirements on registration for care homes in Wales so that the degree of financial scrutiny, if you like, when they apply for registration is tightened. However, bigger solutions than that are taken into account in these wider discussions about market stability and the lessons learned from Southern Cross. Indeed, a seminar is being held today on that very issue across Wales.

[298] **Darren Millar:** With respect, there is no great detail in the document in terms of consultation, is there?

[299] **Mark Drakeford:** The important point, I think, is that a consultation is still ongoing, which means that there may still be opportunities that you will be able to use to find ways of making sure that that question, which is raised in the foreword, can be tested by you. I think that Darren was asking how the consultation is pursuing that issue and how you will collect evidence to be able to come to some conclusion on it at the end. That is a point that we will leave with you. We will pursue with our Minister, certainly, the whole issue of paying for care. However, in terms of technical briefing, you are reminding us that a series of Dilnot proposals depends upon changes in the benefits system as well as on the paying-for-care side of it. There is an interrelationship because there are capital thresholds and all sorts of things that Dilnot recommends, which the Welsh Government simply cannot do, so we will come back to that. I will just reinforce the point that Darren started with: the committee will undoubtedly take an interest in the way that primary legislation and regulations are intermeshed here, looking for the rationale and unlikely to be satisfied by a rationale that is simply easier for the Executive to proceed by regulation.

[300] Mike, I would like to give you one moment at this point. We have concentrated entirely on the policy dimensions of this, but are there things from a lawyer's point of view that you think the committee should just be keeping an eye upon throughout the consultation?

[301] **Mr Lubienski:** I cannot think of anything specific to add at this stage. It is work in progress.

[302] **Mark Drakeford:** That is fine. I just wanted to make sure that you had the chance to highlight points, if there were any. Rob, I will give you the last couple of minutes. As you know, Assembly Members will all have things to do during their lunch hour, but could you look ahead for just two minutes to say, when all the consultation material is in, how you intend to go about analysing it. Is there any indication as yet of a timetable against which you might be working in the next phase?

[303] **Mr Pickford:** Our anticipation is that, as we go through the next week or two, the consultation responses will start to come in so that, hopefully, we will not be waiting until the evening of 31 May before everything comes in, although, there is always a certain reality to some of that, as we all know. There is then a process of analysing the responses, which will take place in the weeks after that, and that will then feed into the drafting process. Ministers will then need to take that away and look at it alongside formal clauses of a Bill to be introduced as we go through this year. That is an explanation in very brief terms.

[304] **Mark Drakeford:** Thank you. That is as much as we need to know at this stage. Thank you all very much indeed. It is helpful to us in preparing ourselves for the work that we will be much involved with in the autumn. To be able to hear from you and how this is going, and to be able to raise a few points that you may want to think about, is helpful. We might look for one further session of this sort with you once the consultation is complete, so it could be in early autumn. Today's session has been very helpful. I also thank those members of the committee who are still here three and a half hours later.

[305] **Mr Pickford:** Thank you for your time.

Daeth y cyfarfod i ben am 12.21 p.m.
The meeting ended at 12.21 p.m.