



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

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

Dydd Mercher, 14 Mawrth 2012
Wednesday, 14 March 2012

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

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

Eraill yn bresennol
Others in attendance

Carol Shillabeer	Cyfarwyddwr Nyrzio, Bwrdd Iechyd Addysgu Powys Executive Director Nursing, Powys Teaching Health Board
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Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

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

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

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Mark Drakeford:** Croeso i bawb i'r cyfarfod hwn o'r Pwyllgor Iechyd a Gofal Cymdeithasol. **Mark Drakeford:** I welcome everyone to this meeting of the Health and Social Care Committee.

9.30 a.m.

Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Tystiolaeth gan Fyrddau Iechyd Lleol
Inquiry into Residential Care for Older People—Evidence from Local Health Boards

[2] **Mark Drakeford:** Yn yr awr gyntaf y bore yma, byddwn yn parhau a'n hymchwiliad i ofal preswyl i bobl hŷn a byddwn yn cael tystiolaeth gan y byrddau iechyd lleol. Croeso, felly, i Carol Shillabeer, cyfarwyddwr nyrsio Bwrdd Iechyd Lleol Addysgu Powys.

Mark Drakeford: In the first hour today, we will continue with our inquiry into residential care for older people and we will be hearing evidence from the local health boards. Welcome, therefore, to Carol Shillabeer, executive director of nursing, Powys Teaching Local Health Board.

[3] Good morning, Carol, and welcome. Thank you very much for coming today to help us with our inquiry into residential care services for older people in Wales. For the next three quarters of an hour or so we will concentrate on the perspective of local health boards in Wales and the interaction between health services and residential care services. We have received written evidence from almost every health board, and I know that you are going to try to cover a wider waterfront than Powys itself.

[4] What we normally do is ask whether you have any opening remarks that you wish to make. We will then go straight to questions from Members around the table and, with a bit of luck, we will be able to come back to you for any closing points that you may want to make before the session finishes.

[5] **Ms Shillabeer:** Thank you for inviting me to give evidence. I hope that this will prove helpful. I am afraid that I have a cough, so I will try not to cough too loudly and be an irritant, but excuse me if it overcomes me a little bit.

[6] I am here to represent Powys Teaching Local Health Board, although the evidence that I give may be generalised to other areas, but where there are specific questions that do not relate to Powys and I am not in a position to give the view of the other health boards, I would be happy to go away and seek that opinion for you.

[7] **Mark Drakeford:** Thank you. We will go straight into questions on the evidence that we have had.

[8] **Vaughan Gething:** I am interested in the particular issue of discharge from hospital and moving into care services, whatever those services may be. I am interested in a number of the comments made by a range of local health boards around the evenness of both the assessment and the discharge process itself, and, in particular, the potential loss of ability of an individual. Given the unevenness that is outlined, what are the local health boards doing in terms of trying to make that more even? How do you see the relationship with local authorities and the third sector in terms of providing the assessment and the discharge?

[9] **Ms Shillabeer:** First and foremost, it is important to say that health boards recognise that the longer an older person is in a hospital setting, the greater the chances that that individual will find it difficult to return to their home. So, planning a discharge starts as soon as someone comes in to hospital, or as soon as possible thereafter. There has been much greater focus in recent years on the multidisciplinary team, so that discharge is no longer an issue for just nurses or doctors, but for carers, the patients themselves, therapists, social workers and, increasingly, the voluntary sector as well. There are some excellent schemes around Wales, for example, the British Red Cross hospital discharge schemes that help to support people back into their own homes.

[10] Assessment is really important because a discharge needs to be safe, and it is important that we do not set up a system where patients need to be readmitted because the measures have not been put in place appropriately. So, assessment, particularly of the older population, takes place prior to discharge. Many discharges are taking place earlier these days than previously, but with good community support. For example, reablement services, which I hope that your committee has already heard some evidence on, are now widespread throughout Wales. They support people back into their own homes, so they can go home a little sooner. They follow the patient through for approximately six weeks and then reassess the level of support that is required.

[11] In terms of summarising the response: first and foremost, let us keep people in hospital for as little time as necessary, because we need to support them back into independence, where we can. A multidisciplinary assessment is also important. Increasingly, that involves patients and carers, and with the Carers Strategies (Wales) Measure 2010, that is a really important interface. Post-discharge support comes from a variety of means: reablement is a good example, but some of the voluntary sector schemes that are in place also provide a very useful service.

[12] **Vaughan Gething:** From my local health board area, I know that there are differing approaches from the two local authorities. There is unevenness as soon as you move from health service provision to what may be local-authority-led provision and I am interested in how you see that unevenness, if there are differing approaches from local authorities. What role do you think the health boards have in terms of resolving that uneven approach? Is there then an uneven outcome depending on where someone lives? As you have set out, there are differing results in terms of someone's level of independence, depending on how effective and how proper discharge is. So, I am interested in whether it is the leadership or the co-ordination that is making sure that that takes place. What relationships do you have at the moment to make those relationships work with local authorities? If they are not working, perhaps you could explain why you think that is the case.

[13] **Ms Shillabeer:** I am going to speak, if you do not mind, from a Powys perspective because that is largely why I am here and we are coterminous with our local authority. What that brings is stability of relationship between the health board and local authority leaders. Working together on issues of discharge or care right across the board, particularly in relation to older people, is a real strength that we have in Powys and we have been able to move things forward. I understand from colleagues around Wales that there are some challenges around working with multiple local authorities and there are different commissioning patterns, for example, within different local authority areas. Increasingly however, the integration on the health board footprint is helping to reduce those differences between different local authorities. On the ground, issues about discharge planning are usually far smoother if you are talking about a ward sister and a discussion with a social worker, and the boundaries of local authorities feature far less. There are some differences between local authorities' commissioning patterns and I am very happy to try to pull that out in terms of my other health board colleagues. However, I am very clear from a Powys perspective that we have the added advantage of being coterminous with the local authority. That brings a very unified and single approach to dealing with the needs of older people.

[14] **Vaughan Gething:** I think that that is an important message, Chair, but I certainly would be interested in seeing the differing commissioning patterns of local authorities and how health boards see that in terms of the outcomes that individuals have.

[15] **Elin Jones:** First of all, on this—[Inaudible.]—hospitals though, and not within Powys local health board; they are going to be Bronglais, Wrexham and England. How problematic is that in terms of the relationship with Powys health board and Powys local

authority in trying to release patients out of those hospitals back into Powys?

[16] **Ms Shillabeer:** It is fair to say that it was quite problematic. I have been in Powys for two and a half years now, and one of the first things I felt was that if people were receiving care outside of Powys, it was often very difficult for them to get back, and for understandable reasons. I will give you an example and talk about Nevill Hall Hospital because that is one of the main district general hospitals for south Powys. A patient may go into Nevill Hall and the staff nurse will be planning a discharge for the patient to return to south Powys, but that nurse may not know of all the services that are available to support that person. So, discharge was quite problematic at that time. What we did was put into place a new role called care transfer co-ordinators. They are largely nurses, but they have been, and they are, therapists. The role of that person is to find the Powys patients in the district general hospital and support staff and the patient back to Powys, ideally to a community setting—to their own home or to a community hospital setting. They have been really important, and for four out of five pathways, including Bronglais, we have care transfer co-ordinators in place to support that planning. It is the bridge between Powys and the others.

[17] **Kirsty Williams:** Good morning, Carol. It should be noted that under a previous regime, our discharge liaison nurses were all made redundant, which led to an increase in problems getting Powys patients out of district general hospitals. The reintroduction of these roles has made a huge difference in getting Powys people out of district general hospitals and back into the county. It is a model that works, because I have seen what happens when it is not there and it makes a massive difference.

[18] You talk in your paper about whole-systems thinking. Even with the coterminosity between the county and the LHB, it has taken a long time to develop that way of thinking and to develop services along those pathways. Could you explain what some of the barriers are, even in a conterminous local authority and NHS authority, to better joint working between the two, which would be even more difficult if the health board had to work with numerous county councils? What are the barriers?

[19] **Ms Shillabeer:** Some of the challenges that may be more particular to Powys are the fact that, following on from the previous question, there are no district general hospitals in Powys. So, in terms of our directly provided services, we have parts: the beginning, the end and often not the middle, which is the district general hospital part. However, we hope that we help to solve that. There are challenges that, as a health board, we have tried to overcome in that pathway. As a local authority, there are challenges in reaching out from the local authority perspective to all those district general hospitals and that part of the pathway.

[20] Some of the challenges have been around aligning what the vision is. What do we really want to achieve? We are overcoming that now quite markedly, and our focus on older people—we try not to use the term ‘the frail’ although many are very frail—is on working together to develop a clear outcomes base for older people, and that has been important and has taken some time to get to.

[21] Some of the other challenges may be the way in which the model of commissioning takes place. I particularly refer to that in terms of residential and nursing care. There has largely been a market-driven model of commissioning services from the independent sector from the local authority. Powys is typical of many local authorities in that over 80% is provided from the independent sector.

[22] The challenge for us is about whether that is a sustainable model, particularly when we have opportunities in a fairly large estate that is old and in need of some refurbishment, but could potentially offer more local services in the market towns. Kirsty will know that there is only one market town in Powys that has a population of over 10,000, so keeping care

close to home means having quite a different look at some of the solutions that are required in a rural setting.

[23] **Mark Drakeford:** Thank you, that was very useful. We will move on to a slightly different area now. I will go to William first and then to Lindsay.

[24] **William Graham:** Forgive me for being a little provocative, but in terms of consistency in constituency cases, I put it to you that a person in hospital, suffering from a stroke and with mobility issues, is desperate to go home. The care plan, such as it is, is put in place, and perhaps there are mild dementia issues—this situation could be in a rural area or in a city because the problems are different, but their nature is the same—and the patient feels dumped. It is their families, which they depend on, that keep them at home. So, what are the challenges that can be responded to in that context?

[25] **Ms Shillabeer:** First, it is fair to say that, as a health board, we listen to patients' stories. About a year or 18 month ago, we were told a rather uncomfortable story by Age Concern, which relayed some discharge challenges, and this was while we were putting in place the care transfer co-ordinators. It was a story about someone who was discharged from hospital, fairly late in the evening; it had been a fairly rushed process, because of capacity issues in the hospital, and the patient felt not supported, so to speak. So, I recognise, provocative or not, that that has happened.

[26] The challenges are about the flow through the whole of the health system. It does not sound very personal, but as we admit patients, we need to ensure that we have a bed for them and that we are discharging patients, and it is not good, particularly for older people, to stay in hospital very long. Some of the challenges are about mobilising the support required in the right way at the right time for an individual, and every individual will be different, and that takes time, and should take time, to get right. So, it is about ensuring that front-line clinical teams and social workers have the time and the capacity to do that. It is about following that through, so that all of the effort is not just at the front end to get someone home.

9.45 a.m.

[27] We have had some very interesting and fruitful discussions with the voluntary sector. It has helped us to undertake some follow-up survey work with people who have been discharged on how they feel at six weeks in and 12 weeks in. We may well be putting in some intensive support in the first six weeks, but, as that withdraws, are we leaving them high and dry, as you say, further down the line? The use of the voluntary sector in particular to continue that support is crucial. I recall speaking to a lady who had quite enjoyed her stay in our community hospital and who had been looked after well, I am very pleased to say. She had found it to be very social experience, and she was not really looking forward to going home. Our voluntary sector organisations were following her up with a befriending scheme. Those sorts of things will help people to feel that they are not being left high and dry, particularly after a long stay in hospital.

[28] **William Graham:** In your experience, what is the role of the GP in all of this?

[29] **Ms Shillabeer:** The GP's role is crucial. From a Powys perspective, it might be that, because we do not have district general hospitals, we have a greater focus on GPs. I was with a group of GPs yesterday, and they absolutely feel an ownership of their population and are very clear about what they want to see and what they need to support people in their own homes. They have a very strong leadership role. They are very keen to have multi-professional teams, often practice-based, working with them—something we were discussing yesterday—so that the whole team is working together. It might not be that the GP is the one with the key involvement; it might be the district nurse or the community psychiatric nurse,

but the GP will be in the loop of what is going on.

[30] **Mark Drakeford:** Kirsty, do you want to follow this point up as well?

[31] **Kirsty Williams:** No, I want to ask about a slightly different point. There is a big focus on getting people out of hospital, but I am interested to hear about how we stop people going into hospital and how many admissions we could avoid. How many are down to a lack of joined-up thinking between support in the community and others, which means that, sometimes, hospital is the only option, and that leads to all the other problems?

[32] **Darren Millar:** I want to cover some of that territory as well if I may, Chair.

[33] **Mark Drakeford:** Yes, we will take two or three questions and then wrap everything up together.

[34] **Lindsay Whittle:** May I just follow up the last bit, Chair?

[35] **Mark Drakeford:** Yes, Lindsay first and then Darren.

[36] **Lindsay Whittle:** It is the psychological impact of moving that is particularly important. I would not like to move now and I am pretty fit and healthy. On the psychological impact on an older person of moving into residential care, you said that you follow them up six weeks later, but, with respect, I think that that is too late. It is way too late. We should be preparing six weeks prior to the discharge if we can. I appreciate that that is not always possible and that that could be too far in advance. However, as you said, there are elderly people, who are perhaps quite comfortable, leaving hospital and being discharged into residential care in a place they may never have heard of. The psychological impact of that is that the situation is extremely worrying for them. As I say, with respect, it is too late to follow that up six weeks later because the damage has been done.

[37] **Ms Shillabeer:** I would just like to clarify this point. When I was talking about following people up six weeks later, I was talking about people who have been discharged back home. The intermediate care services, services such as reablement, are in place for six weeks. What I want to understand is how people feel six weeks after discharge back to their own homes and then, when intermediate care services start to pull back, how they feel six weeks after that again—whether they feel equipped for that? With regard to moving into residential care, I completely agree that this is absolutely life changing. It is a really important decision to be made. That is why it is increasingly important that, wherever possible, patients and their carers are absolutely a key part of the decision making about what is going to happen.

[38] I would like to come to Kirsty's question about what we can do to prevent admissions, because I think that there is an awful lot to be done about that. However, I completely agree that the seriousness with which a move is considered by front-line practitioners must be a fundamental issue. It is an issue of dignity and respect, really.

[39] **Lindsay Whittle:** Yes. Thank you.

[40] **Mark Drakeford:** With regard to Kirsty's question, today, we are mostly focused on the preventive services that can make a difference to people choosing to go into residential care. We are not focused on hospital discharge in particular. We are looking at the decision people might be facing about whether they can continue to manage at home or need residential care. What does the health service contribute at that point to allow them to weigh that decision up and perhaps choose not to go into residential care?

[41] To pick up another point, you talked about people being discharged from hospital and a follow-up at the six-week point and the 12-week point. When people go back into residential care, is the health service involved in things that would prevent early readmission? I am talking about that sense of people moving back and forth between hospital and residential care in a circular way.

[42] **Darren Millar:** My question is allied to those questions, and it is about the role of the third sector. You mentioned earlier, in your opening remarks, that you are working closely with the Red Cross on its discharge scheme, and you have touched on other third sector partners that you engage with as a health board. To what extent are they the most cost-efficient people and vehicles to provide those discharge advice services and support services to enable people to get back home rather than go into residential care in the first place?

[43] **Ms Shillabeer:** I will pull those together in my answer.

[44] **Mark Drakeford:** I realise that it is a large question.

[45] **Ms Shillabeer:** That is fine. It is important that, whether we come at this from the perspective of discharge from hospital or preventing admissions into hospital or residential care, the principles are much the same. What are we doing to support people to remain in their home if that is what they would like to do? I believe that that is what the majority of people would like. We are doing a number of things, and I want to pick up on a scheme that we have developed in Powys, supported by Government funding, which is called the Powys Urgent Response Service at Home. This is referenced in the evidence I have submitted, and it is an excellent example of the front end and the back end trying to support people who might otherwise have been admitted to hospital or, even, into an emergency residential care placement because something has happened. It could be that their carer is unwell or there has been a breakdown in care or a slight escalation. The last thing we really want to do is to admit them to hospital. We want to escalate and put in additional statutory sector support in the community.

[46] PURSH is a voluntary sector scheme, but it is a regulated scheme that is delivered by mid Wales Crossroads Care for us. It puts in additional support on a temporary basis, so carers will go into someone's home and help them through a 24-hour period while we mobilise social care, homecare, reablement and district nursing support. That started on a small scale in Montgomeryshire, but it has built up, and, yesterday, when I was meeting with GPs—who are quite a hard group to convince—they spoke highly of this service and of the impact it is having. A GP's worst nightmare is having on a Friday afternoon an elderly person who they are concerned about. Front-line practitioners are worried about people who might not be safe and so might fall and be on the floor for some considerable hours, and Friday afternoon is an issue. So, they have been calling on PURSH to provide that support.

[47] We have put in a whole host of other support mechanisms in place, such as extended district nursing. We are trialling something called the communication hub, which means that it is a single point—it is in Radnorshire the moment. People who need help can ring one number and health and social care services and the voluntary sector plan together the support that could be put into place. That is all done to enable someone to stay in their home if at all possible. I will just check that I have answered your question. Is there anything that I did not cover?

[48] **Darren Millar:** You have mentioned some specific examples, which sound as though they are localised and not available across the whole of the health board area. Is there any reason that they are not available across the whole of the health board area? In your paper, you also referred to the volunteer bureau. How does that fit in and how does it work?

[49] **Ms Shillabeer:** In terms of how available they are, they started as tests in which we tried something out and saw whether it worked. If it worked, we would spread it elsewhere, and if it did not, we would park it and try some other things. PURSH has now been extended into Radnorshire and Brecknockshire, and all the GPs I met yesterday knew about it, so I was delighted to hear that. We are trying to roll out things that work, that people value and that fit the rural setting. There are some challenges. For example, we have been rolling out reablement services, starting in Brecknockshire, followed by Montgomeryshire, and we are trying to cover the Machynlleth area, but that has been a bit slower to get going. So, these programmes are being rolled out, and they are having an impact. The volunteer bureau—and I am sorry if I keep mentioning the voluntary sector—is absolutely excellent. It might be worth your speaking with the bureau at some point. These are often low-level schemes, but small amounts of money have a big impact, and these are small communities, so two, three, four or five volunteers can generally keep an eye on what is going on. If they have not seen an elderly resident around at the local shop to buy their newspaper, or if the curtains are not open, and Mrs Smith always has her curtains open by 10 a.m., then they think, ‘I will knock the door’. That is the volunteer bureau and the community cohesion stuff. I have to say that I think that that is very strong in Powys in particular. We are capitalising on that and trying to weave that in much more with our health and social care.

[50] **Kirsty Williams:** Everyone knows everyone’s business in Powys. You cannot get away with anything. [*Laughter.*]

[51] **Darren Millar:** It is the curtain-twitching brigade, is it?

[52] **Ms Shillabeer:** There is a positive side to curtain twitching; think of it like that.

[53] **Darren Millar:** May I just go back to the other question that I wanted to ask? It is completely unrelated, actually. It goes back to the issue of capacity within the residential care sector to meet the needs of patients being discharged from district general hospitals. You mentioned earlier on that there was very much a market-based or market-driven approach to the residential care sector in Powys. First, I would like to know whether you think that is the right or wrong approach, and if you think it is the wrong approach, then why. Secondly, in your paper you make specific reference to elderly mentally infirm residential care, and what you felt was a lack of capacity within the system. Some of the evidence we have received as a committee has pointed to the fact that, because dementia is so prevalent these days among the older population, it may be that all homes should have dementia awareness, and should effectively be able to cope with any patient who would be regarded as EMI in the future in order to deal with this capacity issue once and for all. Is that something that you would support?

[54] **Ms Shillabeer:** To take your first point on it being market-driven—and I do not think that this is typical of Powys by any means—there is a common conception that you need a great big, 60-bed home for financial viability, and we struggle with that, because that would mean that people in market towns would have to move town. Not only would they have to make a decision to go into a care home, but they would actually have to move to another town, and if they have lived somewhere all their life, why should they have to move? Our approach has been to try to develop—I am trying not to be too technical—a graduated model of care. That would mean that, within your town—to take Builth Wells, for example—there will be some provision for supported housing. People can live in their own homes, and have care in their own homes, but if they need to move into some supported housing or perhaps to residential care as their needs increase, we would like to see nursing care and GP beds within that market town, and ideally on the same campus, with the same care team looking after you all the time. However, we are limited in terms of what we can deliver from a capital perspective. There needs to be some different thinking about how we secure that sort of provision. We have been very reliant on the independent sector, and I am sure that you have

heard of the issues around financial viability with Southern Cross and others, and the risks that they pose. There are some interesting models emerging around social enterprise, co-operatives and different ways of doing things. We are particularly keen to explore that much more in the Powys setting. So, that is the market thing. Sorry—I have forgotten the second part of the question.

[55] **Darren Millar:** The second part was about EMI, and the prevalence of dementia.

[56] **Ms Shillabeer:** This is very important. The demand for general residential care is decreasing. We have a number of schemes that I have outlined to you that support people within their own homes. Healthcare professionals who often prompt people to think about where they are living are feeling more confident generally that patients can be cared for within their own home. There is a difference where somebody has dementia, or some cognitive impairment that increases the risk to safety. Front-line practitioners tell me that that is the thing that concerns them most: whether this person will be safe at night, in particular. If they are up and wandering at night, or they can open their door and wander into the street, that is the thing that bothers the most. If that behaviour is being exhibited, there is a tendency to move towards saying that they perhaps need 24-hour care, and perhaps residential care.

10.00 a.m.

[57] I would agree that the EMI demand is high and will be higher. We have looked at the profile of older people in Powys, and it will be a significant issue for us. Building on the point that I made earlier about having a campus approach, we must be able to deal with the needs of people with dementia as a mainstream activity, not as something that happens somewhere else. We have to align all of our core services to be able to deliver that. We may need to help the sector provision on that, because currently there is a discrete split. Representatives from the care sector tell me that they feel quite aggrieved at times, because residents who they may have been looking after for some time have to move home because they have dementia. So, supporting that sector to gain the necessary skills will be really important.

[58] **Darren Millar:** The other issue, I suspect, is that if there are fewer EMI homes, someone can be even further removed from their locality, where they have friends and family who may want to visit them or support them.

[59] **Ms Shillabeer:** Also, there are still considerable waiting times. Although, certainly in Powys, we have worked really hard to reduce the number of people being delayed in transfer from a hospital setting, we will still see that patients who require an EMI placement have to wait a considerable time.

[60] **Darren Millar:** I would like to track that down. Is that the biggest proportion of your patients who have a delayed transfer of care?

[61] **Ms Shillabeer:** It is a significant factor. I could not tell you today whether it is the biggest proportion, but it is a significant factor, as is people wanting to choose a specific place. A place of choice is still a challenge for us.

[62] **Mick Antoniw:** You have specifically mentioned other models of ownership, such as co-operatives, and, in your paper, you refer to a keenness to

[63] 'explore options where NHS premises can be developed and built upon to provide such graduated care models'.

[64] Are you looking at hybrid partnerships that would create almost a totally new model, which would be more flexible and would be transitional? What about the expansion of the

NHS role into the local authority role?

[65] **Ms Shillabeer:** I need to be careful not to take over the world, of course, but this graduated care model is seamless. If you are a resident or a person receiving care, often you do not really mind who is delivering it as long as they deliver it when you want it and to the expected standard. The delivery can be a different type of model; it does not necessarily have to be the independent sector or the social care sector. There are other models emerging where there are social enterprises and different ways of delivering that care. The important thing for me is that we can deliver the care in a joined-up way, that it is local and that it meets the absolute needs that we have just been discussing.

[66] The reason why I included the issue of the NHS premises in the evidence is that in Powys—bear in mind that I am giving the Powys perspective—we have hospitals that used to have many more beds before we had community care. So, take Machynlleth—I know that people may be aware of Machynlleth—where there is quite a big old chest hospital, which now has about 12 beds. There is quite a big estate around there, and Machynlleth does not have a nursing home; you would need to travel over the border to south Gwynedd for that. So, to what extent should we all be joining up and asking what can we provide for the people of Machynlleth? It is very unlikely, and it has not happened to date, but, if a large independent sector firm were to come into Machynlleth and build 60 beds, they would probably not be needed. So, how do we think more creatively about providing that graduated care within our market towns? I am not saying that this is a model for the rest of Wales. There may be different needs in an urban setting, but we need to think creatively for a rural health setting.

[67] **Darren Millar:** You have made a few references now to the independent sector building a 60-bed home. Of course, there are optimum levels, because of the staffing ratios and so on, which make it difficult for the independent sector to develop very small, ‘cosy’ care homes. However, bearing in mind the point that has just been made, there is nothing to stop you from working with a commercial enterprise to provide something on the Machynlleth hospital site, is there? Why are you drawing a distinction between the social enterprise, not-for-profit sector and the commercial sector if the commercial sector is prepared to do it? Are you actively engaging with it?

[68] **Ms Shillabeer:** The reason why I come at it like that is because the tradition and history has been for larger care homes for financial sustainability, and, while we focus on that sustainability more and more, the independent sector is under significant pressure. I would want to say formally that it does a tremendous job, so it is not about the standard of care; the issue is about what the financially viable models are in moving forward and whether there are alternatives to the way in which this has been approached in the past. This may well be a very mixed model, and the reason why I have introduced this in the evidence is to encourage and stimulate debate on this issue.

[69] **Darren Millar:** One of the issues—it is raised in the Betsi Cadwaladr LHB paper—concerns whether there ought to be more statutory regulation of staffing ratios. That could make it even more difficult for the independent sector, whether a not-for-profit enterprise or a for-profit enterprise, to deliver care within small settings, which are more suited to places in Powys. What are your thoughts on statutory staffing levels in care settings? It is very difficult, is it not?

[70] **Ms Shillabeer:** Staffing levels are a can of worms generally, because there are a number of factors that go into providing high-quality care. It might be staffing levels, but it could be education, training and support, and leadership—there is a whole range of issues. I suspect that the comment in the Betsi Cadwaladr LHB submission is really about ensuring high standards of care wherever you are being cared for, whoever is providing the care, and whatever market mix is delivering it. I am sure that we would universally agree on that, and I

am fairly sure that that is where the health board is coming from in saying that. The independent sector may well have a view on that.

[71] **Kirsty Williams:** Would you agree that the problem that we have had in Powys is, in some cases, one of market failure and that if it were possible for the independent sector to provide the kind of care facilities that we so desperately need, it would have done so by now, if there were a financially sustainable model for it to do so? Is not the reason why we have to look at things such as this because there has been a market failure?

[72] Would you also agree that it is not just the independent sector that has struggled to find a sustainable model of providing services? We have examples in Powys of the private sector, in the case of Crickhowell, leaving us in the lurch: beds that were commissioned by the health service in a private care home in order to allow GPs to admit people to them have been closed, because the care home could not be made to pay. We have also seen the charitable, not-for-profit sector—in this case, the Royal British Legion—leaving us in the lurch with regard to Crosfield House in Rhayader. The charitable sector decided that it could not afford to provide that anymore in Rhayader and pulled out. So, it is very challenging. Would you agree that it is very challenging to make the figures stack up?

[73] **Ms Shillabeer:** ‘Yes’ is the short answer. The slightly longer answer is that there are some challenges to do with economics in a rural setting. My apologies to those of you who have urban constituencies, but it is economically difficult to stretch out so far. I would imagine that that has been part of the issue in trying to make things work. For example, we know that, with regard to the provision of homecare, there have been some challenges in some parts of Powys, particularly for the independent sector provision—care agencies—in terms of recruitment. You will have seen from the evidence that there are fewer young people in Powys and more older people, so the trend is not helpful in that respect. So, the geography presents a challenge.

[74] If you stand back and take the argument away from the independent sector, the charitable sector and so on, there is a fundamental question about how we support care in this type of arena. It may not be to do with the independent or charitable sector, but about how we structure the payment and support for older people. So, it is a more fundamental issue.

[75] **Mark Drakeford:** Before we move to questions from Rebecca, I will put one more proposition to you, because I think that this is a fundamental part of our discussion. Darren started by asking whether the market model of residential care provision is adequate to meet the needs of the population. It seems to me that what you are describing is a managed market model in which there is an important role for the people who are commissioning and paying for these things. That is, we do not just allow the market to do things and then we respond to them, but we manage the market so that it is better able to meet need. Is that a fair summary of what you are suggesting?

[76] **Ms Shillabeer:** Yes, you have hit the nail on the head.

[77] **Mark Drakeford:** Thank you, that is useful to know.

[78] **Rebecca Evans:** You mentioned workforce training earlier. Some of the written evidence that we have received raised concerns about the adequacy of the training undertaken at the moment. What areas of training are needed to deliver quality care for residents? To what extent is current provision deficient?

[79] **Ms Shillabeer:** Much of the training—training and support, really, so it goes beyond training alone—is around some of the fundamental aspects of care. For example, that would involve knowledge about maintaining skin integrity—sorry for the jargon—that is, how to

prevent pressure ulcers. If somebody is sitting for long periods, you need to try to get them up and moving around. Then there is knowledge about the importance of nutrition and hydration, emotional stimulation, and the care of people with memory problems, such as dementia. I struggle to believe that you can train people on dignity and respect—in my view, those are values. However, in communicating and working with patients and residents, those are really important in terms of the attitude and skills sets of workers who are often with vulnerable older people. Off the top of my head, those are some of the key areas where support is required. Most health boards—I will almost be brave enough to say all health boards—recognise the support required for the residential care sector and the nursing care sector in order to sustain good care for the people in those settings. Some have developed support teams and some have developed roles that work across the care sector. For example, tissue viability nurses will work in hospitals, in the community, and in the residential and nursing care sectors to support people. Increasingly, dieticians are working throughout the care settings, and there is some targeted support and dementia liaison nursing. As a health service, we recognise the importance of trying to support residential and nursing care staff. It is in our interests. We want people to feel settled and to not deteriorate. It makes good sense for us to support those settings.

[80] **Rebecca Evans:** Care home work is often low paid and is sometimes seen as low-status employment. What impact does that have on the care provided?

[81] **Ms Shillabeer:** I have met a number of people who provide homecare and they were extremely motivated to provide good care for the individual who they were looking after and enjoyed their job hugely. I agree that the pay is not at a level that says that it is hugely valuable work, but it is hugely valuable work. We are in economic difficulties, of course, but this is about where, as a point of principle, we place our priorities when it comes to the care of older people. I was talking with someone a week or two ago who had been in Canada, where they call older people ‘seniors’. There is such respect for older people in Canada that caring for them is seen as a role to aspire to. We should be moving along those lines. I want to reinforce the point that many people who work with older people do so because they really want to and not because of the money.

10.15 a.m.

[82] **Rebecca Evans:** How would we make people who work in care homes feel more respected and valued for the work that they do?

[83] **Ms Shillabeer:** If I was to look at what satisfies nurses in the workplace—let us deal with the pay issue—pay is on the list of issues from one to 10, but it is not number one, two or three. People feel more respected if they are involved in decisions about their work environment, feel that they are making a difference and that their voice is being heard. So, there is definitely a point to be made about trying to support people to improve care. I know that this is an NHS example, but the transforming care programme that is being rolled out throughout Wales is about empowering front-line practitioners to make a difference. It is extremely successful in enabling staff at all levels to come forward with ideas and suggestions and to make a demonstrable improvement for patients. One or two health boards are moving this into residential care sectors to try to encourage people to do much the same. So, there is something about empowering front-line staff and valuing their views and opinions. We believe that they have ideas for improvements and seeing those through makes a difference.

[84] **Mark Drakeford:** We are out of time for any further questions, but if there are any points that have not emerged in the session that you think are important for us not to lose sight of and that you want to remind us of, then you have a minute or two to do so now. If we managed to cover everything, do not feel that you have to find more issues for us.

[85] **Ms Shillabeer:** No, but I will draw together the key points. One is the overall respect and dignity issue that relates to residential care. Moving house, let alone moving into residential care, is a huge decision for people to make. It is important—we have been working hard on this—that we support people to make decisions at the right time in their life. Secondly, some models for delivering that may differ between urban and rural settings, and I hope that you got that message from me today. Third is the value that we put on supporting older people and the need for that to be a key priority for all agencies moving forward, working together. That is all that I wanted to say.

[86] **Mark Drakeford:** Thank you for this morning. It has been useful for us. Your cough has been remarkably well behaved, given the amount of talking that we have asked you to do. We are very grateful to you for coming here and for the offer that you made a couple of times while giving evidence to chase up some information that Members asked for. We will look forward to receiving that.

[87] That concludes our formal session for this morning. We will now have a 10-minute break and will then return for our informal session. I know that Members have other pressing engagements in their diaries, but I will make a small plea. We are meeting the reference group and the only formal time that we have is between 11.30 a.m. and 12.30 p.m.. People have come from quite a long way across Wales to join us, so please join us for that part of the session, if you can.

*Daeth y cyfarfod i ben am 10.19 p.m.
The meeting ended at 10.19 p.m.*