

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 1 – Y Senedd

Dyddiad:
Dydd Mercher, 8 Chwefror 2012

Amser:
09:15

Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales



I gael rhagor o wybodaeth, cysylltwch â:

Llinos Dafydd
Clerc y Pwyllgor
029 2089 8403
HSCCommittee@wales.gov.uk

Agenda

Cyfarfod preifat

Yn ei gyfarfod ar 2 Chwefror 2012, penderfynodd y Pwyllgor i gyfarfod yn breifat ar gyfer eitemau 1 & 2 yn y cyfarfod hwn.

1. Cyflwyniad, ymddiheuriadau a dirprwyon
2. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Trafod y prif faterion (09.15 – 09.35)

Sesiwn cyhoeddus

3. Blaenraglen waith – Trafodaeth pellach ynghylch sesiynau tystiolaeth un-tro (09.35 – 09.45)

HSC(4)-05-12 papur 1

4. Ymchwiliad i ofal preswyl i bobl hŷn – trafodaeth â Jean-Pierre Girard mewn perthynas â thystiolaeth ysgrifenedig a gomisiynwyd gan Gydweithredwyr Cynyddol Cymru (09.45 – 10.30)

HSC(4)-05-12 papur 2a – ymateb ymgymghoriad

HSC(4)-05-12 papur 2b – gwybodaeth ychwanegol

Jean-Pierre Girard, arbennigwr ar ddatblygiad a rheolaeth sefydliadau cydweithredol, di-elw a cilyddol (enwebwyd gan Gydweithredwyr Cynyddol Cymru)

5. Papurau i'w nodi

Cofnodion y cyfarfod a gynhaliwyd ar 25 Ionawr
HSC(4)-03-12 cofnodion

Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-05-12 papur 1

Blaenraglen waith – Trafodaeth bellach ynghylch sesiynau dystiolaeth un-tro

At: Y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol
Gan: Gwasanaeth y Pwyllgorau
Dyddiad cyfarfod: 8 Chwefror 2012

Diben

1. I drafod a chytuno sut i ddefnyddio'r pedwerydd diwrnod sydd ar gael i'r Pwyllgor Iechyd a Gofal Cymdeithasol, rhwng nawr a thoriad yr haf, ar gyfer sesiwn dystiolaeth un tro.

Cefndir

2. Yn ei gyfarfod ar 2 Chwefror, trafododd y Pwyllgor bynciau ar gyfer pedwar sesiwn dystiolaeth 'un tro' yn ystod tymhorau'r gwanwyn a'r haf.
3. Cytunodd y Pwyllgor i drefnu ymchwiliadau un-dydd yn ymwneud â'r pynciau a ganlyn:
 - amseroedd aros am gadeiriau olwyn yng Nghymru: gwaith dilynol ar yr argymhellion a wnaed yn Adroddiad Pwyllgor Iechyd, Lles a Llywodraeth Leol y Trydydd Cynulliad ar Wasanaethau Cadair Olwyn yng Nghymru;
 - atal thrombo-emboldd gwythiennol; a
 - lleihad mewn symudiadau'r ffetws a marw-enedigaethau yng Nghymru.
4. Yn ogystal â hyn, cytunodd y Pwyllgor:
 - i ail-ystyried, yn hwyrach, pa bwnc i'w ddewis ar gyfer ei bedwaredd sesiwn, gan ddewis rhwng gwasanaethau cyd-ymatebwyr, argaeledd meddyginiaethau, ac amseroedd aros am wasanaethau orthopedig;
 - i aros am adroddiad Pwyllgor Materion Cymreig Tŷ'r Cyffredin ar ei ymchwiliad cyfredol ar Anhwyllder Straen Wedi Trawma (PTSD) cyn ymgymryd â gwaith ar y pwnc hwn; a
 - bod anghydraddoldebau iechyd yn bwnc sydd yn mynnu cyfnod hirach nag un dydd i'w ystyried ac, o ganlyniad, y dylai'r pwnc hwnnw gael ei osod ar restr o ymchwiliadau posib at y dyfodol.

Opsiynau

5. Efallai yr hoffai'r Pwyllgor ddewis un o'r tri phwnc a ganlyn ar gyfer y pedwerydd diwrnod rhydd sydd ganddo:
 - gwasanaethau cyd-ymatebwyr;
 - argaeledd meddyginiaethau; ac
 - amseroedd aros am wasanaethau orthopedig.

Atodir gwybodaeth am y pynciau hyn yn Atodiad A i'r papur hwn.

6. Ar y llaw arall, efallai yr hoffai'r Pwyllgor gadw bwlch yn ei raglen er mwyn caniatau digon o ryddid i ymateb i unrhyw faterion sy'n dod i'r amlwg neu / a deddfwriaeth.

Camau i'w cymryd

7. Gwahoddir y Pwyllgor i ystyried a chytuno sut yr hoffai ddefnyddio'r pedwerydd diwrnod sydd ar gael yn y flaenraglen waith rhwng nawr a thoriad yr haf.



Atodiad A

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Blaenraglen waith

Dyddiad y sesiwn:

2 Chwefror 2012

Cyflwyniad

Diben y papur hwn yw darparu gwybodaeth berthnasol i gynorthwyo Aelodau o'r Pwyllgor Iechyd a Gofal Cymdeithasol i wneud penderfyniadau wrth gwmpasu ymchwiliadau byr yn y dyfodol.

Cynhyrchwyd y papur briffio hwn gan y Gwasanaeth Ymchwil i'w ddefnyddio gan y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol.

I gael rhagor o wybodaeth, cysylltwch â Victoria Paris yn y Gwasanaeth Ymchwil
Estyniad 8678
E-bost: victoria.paris@wales.gov.uk

Research
Service



Cylch Gwaith y Pwyllgor

Rôl y Pwyllgor Iechyd a Gwasanaethau Cymdeithasol yw ystyried materion yn ymwneud â gwariant, gweinyddiaeth, polisi a deddfwriaeth o fewn ei gylch gwaith. Rhestrir prif feysydd cyfrifoldeb y Gweinidog sy'n dod o fewn cylch gwaith y Pwyllgor isod.

Y Gwasanaeth Iechyd Gwladol	Byw'n Annibynnol
Gofal cymdeithasol	Gofal yn y gymuned
Gwasanaethau Iechyd meddwl	Comisiynydd Pobl Hŷn Cymru
Iechyd y cyhoedd a diogelu'r cyhoedd	Diogelwch bwyd
Gwella Iechyd	Gwasanaeth Iechyd y Gwasanaeth Carchardai
Gofalwyr	Rheoleiddio lleoliadau preswyl a chartref i oedolion
Gweithgareddau gwasanaethau cymdeithasol awdurdodau lleol	Ymchwil a datblygu ym maes Iechyd a gofal cymdeithasol
Cymhorthion, addasiadau a chymorth yn y cartref	Materion polisi perthnasol yr UE

Hyd yma y tymor hwn, mae'r Pwyllgor wedi cwblhau'r gwaith canlynol:

Ymchwiliadau

Ymchwiliad sy'n canolbwyntio ar ddarparu **gwasanaethau i leihau'r risg o strôc** ac effeithiolrwydd polisiâu Llywodraeth Cymru o ran mynd i'r afael ag unrhyw wendidau yn y gwasanaethau hyn – cwblhawyd fis Rhagfyr 2011

Sesiwn dystiolaeth ar oblygiadau **toiledau cyhoeddus annigonol** i Iechyd y cyhoedd – yn parhau

Ymchwiliad i effeithiolrwydd y contract Fferylliaeth Gymunedol o ran gwella cyfraniadau **fferylliaeth gymunedol** i wasanaeth Iechyd a lles – yn parhau

Ymchwiliad i'r ddarpariaeth **gofal preswyl yng Nghymru** a sut y gall fodloni anghenion presennol pobl hŷn a'u hanghenion yn y dyfodol – yn parhau



Deddfwriaeth

Bydd yr Aelodau yn ymwybodol o'r datblygiadau deddfwriaethol canlynol:

Bil Cynllun Sgorio Hylendid Bwyd (Cymru): cyhoeddwyd y Bil drafft a'r papur ymgynghori gan Lywodraeth Cymru ar 14 Rhagfyr 2011. Daw'r cyfnod ymgynghori i ben ar 7 Mawrth 2012.

Bil Rhoi Organau (Cymru): cyhoeddwyd y Papur Gwyn gan Lywodraeth Cymru ar 8 Tachwedd 2011. Daw'r cyfnod ymgynghori i ben ar 31 Ionawr 2012.

Bil Gwasanaethau Cymdeithasol (Cymru): caiff ymgynghoriad cyhoeddus ei lansio fis Mawrth 2012 gyda'r nod o gyflwyno'r Bil i Gynulliad Cenedlaethol Cymru fis Hydref 2012. Caiff Rheoliadau a Chod Ymarfer ar gyfer Gwasanaethau Cymdeithasol eu datblygu ar ôl i'r Bil gael Cydsyniad Brenhinol.

Bil Iechyd y Cyhoedd (Cymru): bwriedir cyhoeddi ymgynghoriad yn 2012.

Cyfeirnod y Pwyllgor: HSC(4)-05-12

Ymchwiliadau posibl: gallai unrhyw un o'r pynciau canlynol fod yn destun ymchwiliad amserol i'r Pwyllgor.

Teitl	Pwnc
<p>Anghydradd –oldebau iechyd</p>	<p>Fis Mawrth 2011 cyhoeddodd y Comisiwn Cydraddoldeb a Hawliau Dynol adroddiad yn dwyn y teitl <u>Pa mor deg yw Cymru?</u> a oedd yn galw am leihau'r anghydraddoldebau iechyd rhwng grwpiau economaidd-gymdeithasol, yn arbennig y rhai sy'n effeithio ar ddynion hŷn a dynion iau. Yn <u>Rhaglen Lywodraethu 2011-2016</u> nodir y bydd Llywodraeth Cymru yn rhoi'r camau sydd yn ei phapur gwaith technegol <u>Canlyniadau Iechyd Tecach i Bawb</u> ar waith er mwyn atal iechyd gwael a lleihau anghydraddoldebau iechyd.</p> <p>Efallai yr hoffai'r Pwyllgor ystyried y cynnydd a wneir o ran rhoi'r camau yn y cynlluniau gweithredu strategol ym maes iechyd ar waith a sut y mae hyn yn lleihau anghydraddoldebau rhwng grwpiau economaidd-gymdeithasol yng Nghymru.</p>
<p>Amseroedd aros am gadeiriau olwyn yng Nghymru</p>	<p>Fis Mai 2010 cyhoeddodd y Pwyllgor Iechyd, Lles a Llywodraeth Leol bryd hynny <u>Adroddiad ar Wasanaethau Cadeiriau Olwyn yng Nghymru</u>. Cynhaliwyd yr ymchwiliad o ganlyniad i feirniadaeth o effeithiolrwydd y gwasanaethau hyn o ran diwallu anghenion defnyddwyr y gwasanaethau, a'r ffaith bod amseroedd aros am asesiad a darpariaeth yn bryder penodol. Cyhoeddwyd <u>Adolygiad Cymru Gyfan o Ystum a Symudedd - Cam 2</u> fis Hydref 2010 ac yn sgil hynny dyrannwyd £2.2m o gyllid rheolaidd ychwanegol yn y gyllideb ddrafft er mwyn helpu i weithredu canfyddiadau ac argymhellion yr Adolygiad, ac yn benodol er mwyn sicrhau bod y safonau'n ymwneud ag amseroedd aros yn Fframwaith Gwasanaethau Cenedlaethol Plant a Phobl Ifanc yn cael eu cyrraedd erbyn mis Mawrth 2012.¹ Fis Mawrth 2011 sefydlwyd Bwrdd Partneriaeth Cymru Gyfan y Gwasanaeth Ystum a Symudedd, fel Grŵp Cynghori ar gyfer Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (WHSSC), i weithredu argymhellion yr Adolygiad.</p> <p>Efallai yr hoffai'r Pwyllgor adolygu'r cynnydd a wneir o ran gweithredu'r argymhellion yn adroddiad y cyn Bwyllgor Iechyd, Lles a Llywodraeth Leol mewn perthynas ag amseroedd aros am gadeiriau olwyn, yr argymhellion yn adroddiad <u>Adolygiad Cymru Gyfan o Ystum a Symudedd - Cam 2</u>, a'r cynnydd a wneir o ran cyrraedd y safon amseroedd aros erbyn Mawrth 2012.</p>

¹ Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru, Cyd-bwyllgor, [Gwasanaeth Ystum a Symudedd Cymru Gyfan, Eitem 15 ar yr Agenda](#), 29 Tachwedd 2011 [darllenwyd 23 Ionawr 2012]

Cyfeirnod y Pwyllgor: HSC(4)-05-12

<p>Cyd-ymatebwyr</p>	<p>Codwyd pryderon nad yw gwasanaethau cyd-ymatebwyr yn cael eu defnyddio'n effeithiol.</p> <p>Efallai yr hoffai'r Pwyllgor ymchwilio i'r defnydd o wasanaethau cyd-ymatebwyr ledled Cymru; y math o alwadau y mae cyd-ymatebwyr yn ymdrin â hwy ar hyn o bryd; effeithiolrwydd clinigol; y potensial i arbed costau; a'r amseroedd ymateb targed.</p>
<p>Atal thrombo-emoledd gwythiennol</p>	<p>Mae emboledd yn yr ysgyfaint ar ôl thrombosis gwythiennau dwfn ymysg cleifion sydd wedi'u derbyn i'r ysbyty yn achosi rhwng 25,000 a 32,000 o farwolaethau bob blwyddyn yn y DU.² Fis Chwefror 2005 cyhoeddodd Pwyllgor Iechyd Tŷ'r Cyffredin adroddiad yn dwyn y teitl <i>The Prevention of Venous Thromboembolism in Hospitalised Patients</i>. Fis Ionawr 2010 cyhoeddodd y Sefydliad Cenedlaethol dros Iechyd a Rhagoriaeth Glinigol (NICE) ganllawiau clinigol ar leihau'r risg o thromboemoledd gwythiennol: <i>CG92 - Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital</i> Yn y canllawiau rhoddir cyngor yn seiliedig ar arferion gorau ar leihau'r risg o thromboemoledd gwythiennol (VTE) ymysg cleifion a dderbynnir i'r ysbyty.</p> <p>Efallai yr hoffai'r Pwyllgor ymchwilio i sut y gweithredir canllawiau NICE ledled Cymru ac i waith 1000 o Fwydau a Mwy ar atal VTE.</p>
<p>Lleihad mewn symudiad-au'r ffetws</p>	<p>Fis Mawrth 2008 cyhoeddodd NICE ganllawiau clinigol ar ofal cynenedigol: <i>Antenatal care: routine care for the healthy pregnant woman</i>. Fis Chwefror 2011 cyhoeddodd Coleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr (RCOG) gyngor newydd i glinigwyr ar reoli menywod sy'n profi <i>Lleihad mewn Symudiadau'r Ffetws</i> (RFM) yn ystod beichiogrwydd, ac mae'n cynnig argymhellion ynghylch sut i reoli menywod ag RFM yn y gymuned ac mewn ysbytai.</p> <p>Efallai yr hoffai'r Pwyllgor ymchwilio i sut y gweithredir canllawiau NICE a RCOG ledled Cymru a'r gwasanaethau a gaiff menywod bechiog mewn perthynas ag RFM yn y gymuned ac mewn ysbytai.</p>
<p>Anhwylder Straen Wedi Trawma (PTSD)</p>	<p>Fis Chwefror 2011 cyhoeddodd y Pwyllgor Iechyd, Lles a Llywodraeth Leol ar y pryd ei <i>Adroddiad ar Driniaeth ar gyfer Anhwylder Straen Wedi Trawma i Gyn-filwyr y Lluoedd Arfog</i>. Yn 2010 roedd Llywodraeth Cymru wedi dechrau cyflwyno gwasanaeth iechyd meddwl a lles arbenigol i gyn-filwyr yn dilyn cynllun peilot yng Nghaerdydd a'r Fro. Yn yr adroddiad gwnaethpwyd argymhelliad ar wella'r broses o gasglu data ar nifer yr achosion o PTSD; codi ymwybyddiaeth o PTSD ymysg cyn-filwyr a'u teuluoedd; gwella mynediad i wasanaethau camddefnyddio sylweddau i</p>

² Pwyllgor Iechyd Tŷ'r Cyffredin, HC99, [***The Prevention of Venous Thromboembolism in Hospitalised Patients***](#), Chwefror 2005 [darllenwyd 23 Ionawr 2012]

Cyfeirnod y Pwyllgor: HSC(4)-05-12

	<p>gyn-filwyr â PTSD; a throsglwyddo hanes meddygol o'r lluoedd arfog i bractisau meddygon teulu. Mae Arolygiaeth Gofal Iechyd Cymru (HIW) yn cynnal adolygiad o ddigonolrwydd, argaeledd a hygyrchedd darpariaeth y GIG i bersonél y Lluoedd Arfog, eu teuluoedd a chyn-filwyr yng Nghymru. Dechreuodd yr Adolygiad ddydd Gwener 9 Rhagfyr 2011 a bydd yn parhau hyd 20 Chwefror 2012. Bydd adroddiad ar y canfyddiadau'n cael ei gyflwyno i Weinidogion Cymru fis Ebrill 2012. Mae'r Pwyllgor Materion Cymreig wedi cyhoeddi y bydd yn cynnal ymchwiliad i Gymorth i Gyn-filwyr y Lluoedd Arfog yng Nghymru, a fydd yn edrych ar gydgyssylltu trawsffiniol a'r modd y mae'n effeithio ar gyn-filwyr, a'r cydgysylltu rhwng y Weinyddiaeth Amddiffyn, Swyddfa Cymru a Llywodraeth Cymru. Y dyddiad cau ar gyfer cyflwyno tystiolaeth ysgrifenedig oedd 18 Tachwedd 2011 ac mae'n debygol y bydd y sesiynau casglu tystiolaeth lafar yn dechrau fis Chwefror 2012.</p> <p>Efallai yr hoffai'r Pwyllgor edrych ar y cynnydd a wneir o ran gweithredu'r argymhellion yn adroddiad y cyn Bwyllgor Iechyd, Lles a Llywodraeth Leol ar PTSD ac, wedi iddynt gael eu cwblhau, yr adroddiadau a'r argymhellion a wneir gan HIW a'r Pwyllgor Materion Cymreig mewn perthynas â PTSD.</p>
<p>Amseroedd aros am wasanaethau orthopedig</p>	<p>Fis Rhagfyr 2010, cyhoeddodd y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol bryd hynny, Edwina Hart AC, ddatganiad ar amseroedd aros am wasanaethau orthopedig. Dywedodd y Gweinidog y byddai'r gwaith yn dechrau ar ddatblygu cynlluniau i gynyddu capasiti orthopedig, ac ym mis Mawrth 2011 cyhoeddodd Llywodraeth Cymru fuddsoddiad ychwanegol o £65 miliwn dros y tair blynedd nesaf i gwtogi amseroedd aros am wasanaethau orthopedig yng Nghymru. Fis Gorffennaf 2011 dywedodd y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, Lesley Griffiths AC, fod arian ychwanegol yn cael ei ddefnyddio i ddatblygu atebion cynaliadwy i gynyddu capasiti ac i leihau'r galw am wasanaethau orthopedig ac erbyn mis Mawrth 2012 na ddylai neb fod yn aros mwy na 36 o wythnosau. Mae cynlluniau ar waith i gynyddu capasiti, yn cynnwys adeiladu dwy theatr fodiwlaid yn y gogledd, a fydd yn cyflogi meddygon ymgynghorol ychwanegol. Yn y de, mae BILlau yn ymchwilio i ffyrdd arloesol o leihau'r galw ledled y Rhanbarth.</p> <p>Efallai yr hoffai'r Pwyllgor adolygu cyflawniad BILlau o ran y targedau amser aros; y defnydd o gyllid ychwanegol a ddarperir gan Lywodraeth Cymru; ac effeithiolrwydd y cynlluniau i gynyddu capasiti a lleihau'r galw.</p>

Health and Social Care Committee

HSC(4)-05-12 paper 2a

Inquiry into residential care for older people – Supplementary evidence commissioned by Wales Progressive Co-operators from Jean-Pierre Girard



Co-operative models of care for older people

Learning from the Quebec experience 1997-2012

Summary of a report prepared by

Jean-Pierre Girard M.A. B.Sc. B.A.

January 2012

The **co-operative** membership
Cymru/Wales

Contents

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Domestic Help Social Economy Enterprises (DHSEEs) in Quebec

- i. Their establishment
- ii. Services provided
- iii. Funding
- iv. Promotion of new DHSEEs

Appendices:

- i. Background to establishment of DHSEEs in Quebec
- ii. Additional comments on questions M. Girard was asked to address, mainly based on the HSCC Inquiry terms of reference
- iii. Glossary

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Foreword

A thorough understanding of co-operation, its ethics and commitment to reciprocity and democratic participation, and acceptance of its world-wide principles, is surely necessary, especially when in contrast to Quebec, we do not have legal recognition of UK multi-stakeholder co-operatives.

In March 2010 we organised, through WCVA, a study day, funded by The Co-operative Cymru/Wales, to provide foundations for the redevelopment in Wales of just such an understanding of co-operation.

To follow this, as our contribution to the celebration of the United Nations Year of Co-operatives 2012, we have commissioned this report and arranged a visit to Wales of the author, Jean-Pierre Girard, who will be speaking at a seminar, to be hosted by Rosemary Butler, AM, at Ty Hywel, on February 7th 2012. We hope this will help to give impetus to care co-operatives in Wales.

M Girard has been intimately involved with home care co-operatives in Quebec since 1997. He has been a Commissioner and since 2001 a member of the board of the International Health Co-operative Organization (north America region); and a frequent contributor to OECD publications related to social enterprises. He has considerable knowledge of the incentives and decentralised resources for local co-operative development in Quebec.

In the hope that this could translate into positive action in Wales, a two day visit has been organised in a co-operative fashion through voluntary action by the Wales Progressive Co-operators and Cartrefi Cymru: funded with a grant from The Co-operative Cymru/Wales, Public Health Alliance Cymru and the Welsh Food Alliance.

In a context of a rapidly aging population and significantly growing elder needs, we hope to provide a spark to assist in the development of new forms of care in addition to state provision, following modern lines of involvement and participation but building on methods of reciprocity and co-operation that have developed over the past 160 years.

We also see through co-operation a great potential to improve the status and terms and conditions of employment of a predominantly feminised home care workforce. By their very nature, multi-stakeholder co-operatives offer a real opportunity to address this accountability gap.

We hope that Wales can provide a beacon to other parts of the UK in developing genuine stakeholder co-operatives and in so doing help to avert any drift towards less accountable mutuals, which could mask the privatisation of public services.

David Smith, Wales Progressive Co-operators
Adrian Roper, Chief Executive, Cartrefi Cymru

January 2012

Domestic Help Social Economy Enterprises (DHSEEs) in Quebec

1. Establishment of - DHSEEs

Two socio-economic summits were held in Quebec in 1996 bringing together representatives of the provincial government, management, labour and civil society. The women's movement played a significant role in promoting the idea of the government's funding social infrastructure to tackle major unfulfilled social needs, particularly in relation to home care services. This was conceived as a way not only of responding to an unmet need but also as a way of creating a significant number of jobs – predominantly for women. A working group was established to consider this proposal and recommended the establishment of social economy enterprises to deliver housekeeping services to individuals with physical and cognitive disabilities. It was further agreed that these enterprises should avoid duplicating services offered by the public sector. Four main objectives were identified:

- (1) To provide quality domestic help services
- (2) To create quality jobs (especially for women)
- (3) To combat undeclared work (moonlighting)
- (4) To avoid substitution of public sector jobs

These recommendations were agreed and a network of DHSEEs was established in each of Quebec's 17 regions – a total of over 100 across the province. A selection process was established to provide official recognition of these DHSEEs. Some were established by recognising existing services providers, others by an agreed merger of existing charitable organisations whilst others were newly established organisations deemed to have the capability of fulfilling the tasks outlined.

Initially 104 DHSEEs were recognised. Of these, 57 were Non-Profit Associations (NPAs) and 47 were Co-operatives – see Appendix iii. for details of the difference between these two kinds of organisation. Most of the co-operatives opted for the multi-stakeholder rather than the single member category – again see Appendix iii.

2. Services to be provided

The main tasks identified for the DHSEEs in 1996 were:

- (1) Housework – both light and heavy
- (2) Laundry & ironing
- (3) Errands and purchase of groceries
- (4) Preparation of non-diet meals
- (5) Light outdoor maintenance work.

Over time, services have been extended to include:

- (6) Personal hygiene services such as waking, bathing, dressing and assistance with eating
- (7) Civic assistance such as help in venturing outside the home, form filling etc.
- (8) Family relief such as sitting with people to allow free time for carers and longer periods of respite care.

Data for DHSEE activity in 2007 shows that at that time there were 101 enterprises (54 NPAs and 47 Co-ops) which between them provided 5.1 million hours of services to over 76,000 people. They had sales close to \$106 million and employed 6,000 staff (nearly 90% of whom were women).

3. Funding

The Quebec Government adopted a scheme known as “Financial Assistance for Domestic Help Services”. This states “Persons using domestic help services provided by a Domestic Help Social Economy business that has been accredited for program purposes may receive financial assistance applicable against the hourly rate the business charges. There are two types of financial assistance:

- Basic financial assistance of \$4 for each hour of services rendered is granted to any eligible person regardless of family income
- Variable financial assistance of \$0.55 to \$8.25 for each hour of service rendered may be granted over and above the basic financial assistance, and is determined on the basis of the eligible person’s family income and situation,

The person pays only the difference between the rate charged by the business and the financial assistance granted”.

There is also a tax-credit for home support for seniors for persons over 70 “so that they will not have to move to an establishment in the public health and social services network or so that they can delay having to make such a move”.

Most of the income of individual DHSEEs comes from the charges made to service users, but this is backed up by a provincial government grant representing between 15% and 20% of their total revenue.

4. Promotion of DHSEEs

A Federation of DHSEE co-ops was formed at the outset in 1996 offering a forum for exchanging views and providing training and advice for board members, advice on human resource issues, implementation of common management software, setting and monitoring quality standards, business development support, legal advice etc. A similar organisation was established

for NPAs, but that has tended not to be as effective as the Co-op Federation and has since fragmented.

New enterprises also benefit from pump-priming funds including start-up grants and funds from the anti-poverty programme, which are used to subsidise employees' salaries.

For over 20 years the provincial government has also funded a network of 11 Regional Development Co-operatives (RDCs) - covering all 17 regions of the province. These RDCs hire specialists (some 60 in all) to support the grass-roots development of new co-operatives by networking, provision of business and legal advice etc. The RDCs receive additional grants for each new co-op established and for jobs that are either saved or created.

APPENDICES

1. Background in Quebec

Provincial governments are responsible for health and social services in Canada and provision across the country varies considerably. With a population of some 8 million, Quebec is the second largest province in Canada. Some 80% are French speaking whereas the vast majority are English speaking in other provinces.

Prior to 1996, home care for the elderly in Quebec was provided almost entirely by voluntary organisations, which depended largely on volunteer support, for profit organisations (focussing mainly on fee-paying service users whom they regard as profitable customers) and three emerging co-ops. There was a considerable amount of moonlighting (undeclared work) and many unmet needs in the population.

Over the last 100 years, although only three co-ops were providing an element of social care, co-ops as well as private for profit enterprises and public organisations have been a significant feature of the province's economy. Co-ops include large-scale organisations in banking, financial services and agri-food. Co-operatives are also engaged in production (eg forestry and para-medical products) and in retail, housing and funeral services. Legal recognition was given to multi-stakeholder co-ops (see Appendix iii) in 1997 and this has led to the extension of co-operative enterprises in child care, health and social care, tourism, outdoor activities, fair trade, the environment etc.

2. Additional Comments on Questions Jean Pierre Girard was asked to address

How do people gain entry to co-operative models of Residential Care in Quebec? The service is available to all.

Do people become members before they need care? About 5%-10% do – mostly family members of households where a service is already provided. But this is not necessary. On receiving a service most recipients become co-op members as it increases their involvement in decision-making regarding the care provided.

Is there a members “waiting list” or are they referred to a co-operative by professionals of the state following an assessment of need? Recipients of care may be referred by a professional from a public service but many self-refer. There is usually little delay in instigating a service and waiting list have not been found to be necessary.

How does the ability to pay (as a self-funder or recipient of state funds) impact on entry to co-operative care? In view of the funding

arrangement described in the body of this report ability to pay has little impact on the decision to enter a co-operative.

What is the co-op's role in terms of availability and accessibility of alternatives (to residential care) such as reablement services and domiciliary care and possible progression to residential or nursing home care? Some co-operative DHSEEs are investigating the possibility of offering their members a continuum of care: eg home care/housekeeping services – personal hygiene services – nursing/health care - long term residential care facilities.

How responsive is the co-operative care sector in Quebec to the level of demand? Very good.

How quickly can it respond to need/demands? Usually with a week or two.

What is the potential or actual achievement of the co-operative sector in terms of meeting the varied needs of significant numbers of older citizens? See figures for 2007 quoted in main report. Co-ops have proved to be more pro-active and entrepreneurial than other DHSEEs – eg by extending their range of services, providing support services to private residential homes and opening their own residential accommodation.

If services are available to both members and the wider community, what are the benefits of membership? Providing a sense of ownership and involvement by participation in board meetings etc. This enhances their status and staff respect. They would also share in any profits generated.

3. Glossary

Co-operatives

A Co-operative is an organisation with members who have a democratic say in how the enterprise is run and what should be done with any profits/ surpluses. They should conform to internationally agreed principles: ie membership must be open and voluntary, each member must have an equal say in the management of the organisation which must be autonomous and independent of the state, information, education and training must be provided for members, they must co-operate with other co-operatives and they must show an active concern for the community. Co-ops may be user co-operatives, worker co-operatives, producers' co-operatives or multi-stake co-operatives, which combine more than one of the above categories. Multi-stake co-operatives were legally recognised in Quebec in 1997. Most co-operatives in Quebec are now multi-stake co-ops and many, if not most, also have an additional category of Supportive Members. Such members share the aims of the co-op but do not share in its day-

to-day activities. They are seen as particularly valuable in service providing co-ops where they can provide a range of additional experience/expertise.

Social Economy Enterprise:

Following the major Socio-Economic Summits held in Quebec in 1997 it was agreed that a Social Economy Enterprise must:

- Serve their members and the local community instead of prioritising profits
- Be autonomous of the state and have independent management
- Have a democratic process involving users and workers in their operations
- Use any surplus to promote people and work
- Build their activity on the basis of participation, self-help and individual and collective responsibility.

Domestic Help Social Economy Enterprises (DHSEEs)

In practice, DHSEEs are either Not-for-Profit Associations (NPAs) or Co-operatives. Co-operatives are governed by Quebec Co-op Law (more than 300 articles!) and the name “Co-operative” is legally protected in contrast to the position in the UK. In particular, in relation to Multi-stakeholder co-operatives, no member can belong to more than one category of membership and supportive members are limited to a maximum of 33% of the seats on the Board. NPAs are much less restricted. They may decide for themselves who can be accepted as participants in the venture, the composition of their Board etc. The only restriction placed on them is that they must be non-profit making. As such, they cannot address the accountability gap which is associated with private for-profit services and all too often with public services as well. By their very nature, it is only multi-stakeholder co-operatives that can address this accountability gap.

Health and Social Care Committee

HSC(4)-05-12 paper 2b

Inquiry into residential care for older people – Supplementary evidence commissioned by Wales Progressive Co-operators from Jean-Pierre Girard – Additional information



Co-operative models of care for older people

The Quebec experience 1997-2012

Jean-Pierre Girard M.A. B.Sc. B.A.

*

The wider Canadian experience

John Restakis

January 2012

A report commissioned by the Wales Progressive Co-operators, Cartrefi Cymru, Public Health Alliance Cymru, and the Wales Food Alliance

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Co-operative models of care for older people

FOREWORD: The context in Wales

Today's opportunities to implement Co-operative principles within home care services for older people.

Social care in the UK and Wales is in a state of flux. An ageing population and the economic context of cuts and debt reduction have put services under severe pressure. The main providers of services are local authorities, although local authorities commission significant parts of the third sector and private provision. All these organisations suffer from deficits in citizen engagement, involvement and influence. This remains true despite recent efforts to overcome the baggage of historical organisational models, which have high levels of bureaucracy and a top-down management approach.

The vast majority of older people in Wales manage their own lives with the assistance of families and friends and do not receive social care services from local authorities. Yet within this group there is a considerable level of unmet need. As local authorities tighten their eligibility criteria, the proportion of older people receiving local authority services will be less. This is likely to continue into the foreseeable future. These financial constraints not only limit the local authorities' own services but also its ability to commission services from the third sector and private businesses. This situation is forcing local authorities and the Welsh Government to examine innovative services and modes of provision, such as extra care housing, assistive technology and improving information services.

Across the economy, co-operative models of organisation have a long history in the UK and within Wales. They have the potential to provide an effective alternative to present patterns of service provision. The experience in Scandinavia, Italy, Japan, and Canada and in particular Quebec (and recent pilot projects within England) throws valuable light on establishing and operating co-operative care services. Some of the potential advantages of co-operative models are: service users, workers and community supporters owning and managing their provision; partnership working between service providers; local employment opportunities and community enrichment; and stronger preventive services which enable older people to maintain independence and live in their own homes for longer with an improved quality of life.

Co-operatives Engage Members: Citizen engagement and involvement has been a powerful mantra in many public services in the last decade as well as third sector organisations – rather less so in the private sector. Yet there remains a deep scepticism that many forms of consultation are tokenistic and even when appearing to be undertaken in good faith citizens ultimately feel that they have little influence in key decisions. The advantage of multi-stakeholder co-operative is that they are organisations run for and by members, with service users, workers and community supporters having rights and responsibilities for service provision. In Wales some of this range of provision is already provided with public finance, for example, by Care and Repair, Crossroads, Age Concern, WRVS and churches.

The issue of 'control rights' for service users, as opposed to being passive service recipients, is equally relevant to such organisations.

Local Employment Opportunities and Community Enrichment: Co-operative organisations can be very local and evolve within co-operative structures to secure economies of scale. Multi-stakeholder co-operatives can provide a range of provision (e.g. domestic services; gardening; shopping; assistance with meals; befriending; social activities), and can potentially provide a mix of employment opportunities. There are links to greater opportunities for social interaction with peers; vocational education; adult education in enhancing people's skills in management, bookkeeping and communications (both individual and group and IT). They can also improve the status and terms of employment for a predominantly feminised workforce.

Stronger Preventive Services: Local authorities in Wales are only providing services to those people deemed to have a substantial or critical need. The effect is that it is often when situations reach a crisis that any assistance is provided. At the same time there are many patients admitted to hospital because of a medical/social crisis who would not have needed a hospital admission had support been provided at an earlier stage. Similarly many patients remain in hospital for long periods through lack of support services in the community. Low intensity social care services, provided locally at an early, non-crisis stage, can reduce levels of admission to hospital or residential/nursing homes and the demand for high intensity services in health and social care. The contribution that low intensity social care services can make would positively support public health as part of a 21st Century agenda.

The Challenge: The institutional framework in Canada and Quebec has similarities but also differences from the UK and Wales, especially the highly regarded legal status of co-operatives in Quebec. The challenge is to be clear about some of the deep-seated problems in social care and health and to clarify the practical solutions which co-operative models can bring. This needs detailed work in disentangling some of our present complex structures and funding mechanisms in supporting a co-operative social care model, which would work in Wales and which would help to resolve some of the seemingly intractable problems in social care and health services in Wales.

Multi-stakeholder co-operatives: The determinants of health have a large social component. Multi-stakeholder co-operatives have the potential to unify provision of low intensity social care support services, which support social care, wellbeing, health, education and employment objectives. Wales can provide a beacon to other parts of the UK in developing genuine multi-stakeholder co-operatives, run for and by their members and in so doing help to avert any drift towards less accountable social enterprise.

Dr Ron Walton and Hilda Smith
January 2012

Co-operative models of care for older people

PART ONE: THE QUEBEC EXPERIENCE

1.1. Background

With a population of some 8 million, Quebec is the second largest province in Canada. Some 80% of the population are French speaking whereas in other provinces the vast majority are English speaking. The language situation has had a significant impact on the development of co-operatives in Quebec. The co-operatives came to be seen as a way in which the French speaking population could take control of their economic life outside of the big enterprises, which were mostly under the control of English speakers.

Over the last hundred years of Quebec history, the co-op model has become a key component of the economy, alongside the private and state sectors. In addition to large-scale co-op organisations in financial services (eg. the Desjardins co-op bank) and in the agri-food business, smaller co-ops also developed in diverse areas of activity, including consumer organisations, housing, funeral services, forestry and para-medics. Thanks to the recognition of “multi-stakeholder co-ops”, or **‘social solidarity co-operatives’** in 1997, Quebec has now had fifteen years of co-operative expansion into new sectors and activities, including child-care, health and social care, tourism, outdoor activities, fair trade, and the environment. Quebec now has over 500 ‘social solidarity’ co-operatives, with more than 50% of new registrants preferring this model than the ‘single individual member’ category comprising, for example, workers or service users.

Quebec is now unique in North America in the range and depth of co-operative activity throughout its economy and society, and in the way that co-ops are nurtured and supported by networks of organisations and by the policies of the Quebec government.

1.2. How co-operation is helped in Quebec

1.2.1. Support from government

The development of co-ops in Quebec benefits not only from expert support, networking and grants from other co-op organisations, but also from a favourable legal framework and numerous supportive public policies. All the political parties (liberal, nationalist, etc) that have governed Quebec in recent times have fully recognised the role of co-ops in the economy and have shown their support through their policies, laws and regulations.

1.2.2. Regional development co-ops (RDCs)

In order to support co-operative development in a new area of activity, the Quebec government has, over the past twenty years, funded a network of regional development co-ops that serve seventeen regions covering the whole province. The RDCs employ sixty specialists who support co-op development with legal aspects, business advice, and networking. Each RDC is itself a co-op, and together they have a membership of 1200 co-ops, allied organisations and individuals. Each RDC receives funds from the Quebec government for their day-to-day operations, and a bonus for every new co-op that is established in which jobs are either created, or are co-operative conversions from an existing business. Each RDC has their own board representing their membership and providing a strong link with their region's socio-economic reality and development challenges.

1.2.3. Supportive financial structures

Quebec has established a strong reputation in North America in terms of its financial system, with financial instruments dedicated to collective enterprise such as co-ops, non-profit associations, and "social economy enterprises". The author (JPG) sits on an investment committee of a risk fund that manages 10 million dollars dedicated to loans for co-ops and non-profit associations. (Note that each loan is given without the requirement of any traditional guarantee...).

The promotion of social economy enterprises (SEEs)

Although social economic activity in Quebec has roots in the late nineteenth century, it received a significant boost as recently as 1996 when a socio-economic "Summit" led to the creation of a network of non-profit associations and co-ops with the prime purpose of developing the social economy. In order to receive support an organisation must meet the criteria of a "social economy enterprise" as follows. It must:

- Serve its members or some wider social purpose, rather than focusing on profit and financial output
- Have management autonomy, rather than being a controlled dependent of the state
- Be governed and operated through a democratic process involving users and workers
- Prioritise the use of surpluses and income for the benefit of citizens and workers, rather than the interests of capital
- Base their activity on rules of participation, self-help and individual and collective responsibility.

Organisations, which embrace these principles and can thus be defined as SEEs may be either non-profit associations or co-ops. Despite this inclusive definition, there is an on-going debate within Quebec between followers of the co-op and mutual models of organisation and the newer non-profit but not necessarily co-operative models.

1.3. Co-operation in the field of home care

Provincial governments are responsible for health and social services in Canada and, consequently, provision across the country varies greatly. In Quebec, pressure from social movements and political circles has led to a significant development of social economy initiatives in the health and welfare field, in particular in relation to home support services.

Prior to 1996, home care for the elderly in Quebec was provided by a mixture of a) voluntary organisations, which depended largely on volunteer support, b) for-profit organisations (focussing mainly on fee-paying service users whom they regard as profitable customers) and c) three emerging co-ops. There was also a considerable amount of moonlighting (undeclared work) and many unmet needs in the population.

1.3.1. The creation of Domestic Help - Social Economy Enterprises (DHSEEs)

Following the socio-economic "Summit" in 1996, and with notable pressure from the women's movement, the idea of a "social infrastructure" with government funding was developed. This was intended to address major unmet social needs whilst at the same time creating formally recognised employment for women. A social economy working group was formed which drew up proposals aimed at creating a network of social economy enterprises (SEEs) that would deliver domestic help services to individuals with physical and cognitive disabilities.

Four main objectives were identified:

- (1) To provide quality domestic help services
- (2) To create quality jobs (especially for women)
- (3) To combat undeclared work (moonlighting)
- (4) To avoid substitution of public sector jobs

In order to augment rather than duplicate the services offered by the public sector, the range of services to be nurtured was identified accordingly. The main tasks identified for the DHSEEs in 1996 were:

- (1) Housework – both light and heavy
- (2) Laundry & ironing
- (3) Errands and purchase of groceries
- (4) Preparation of non-diet meals
- (5) Light outdoor maintenance work.

(Over time, these services have been extended to include:

- (6) Personal hygiene services such as waking, bathing, dressing and assistance with eating
- (7) Civic assistance such as help in venturing outside the home, form filling etc.

- (8) Family relief such as sitting with people to allow free time for carers and longer periods of respite care.)

The 1996 working group recommendations were agreed and a network of DHSEEs was established in each of Quebec's 17 regions. The idea was to create a DHSEE for every 'territory' with a public health clinic of which there are 103. A selection process was established to provide official recognition of these DHSEEs. Some were established by recognising existing services providers, others by an agreed merger of existing charitable organisations whilst others were newly established organisations deemed to have the capability of fulfilling the tasks outlined.

At the end of the start-up process, 104 DHSEEs were recognised. Of these, 57 were Non-Profit Associations and 47 were Co-ops – see Appendix iii. for details of the difference between these two kinds of organisation. Most of the co-operatives opted for the multi-stakeholder / social solidarity structure, rather than the single member category – again see Appendix iii.

By 2007 there were 101 enterprises in operation (54 NPAs and 47 Co-ops), which between them provided 5.1 million hours of services to over 76,000 people. They had sales close to \$106 million and employed 6,000 staff (nearly 90% of whom were women).

1.3.2. How the Domestic Help SEEs were helped to become established

A Federation of DHSEE co-ops was formed at the outset in 1996 offering a forum for exchanging views and providing training and advice for board members, advice on human resource issues, implementation of common management software, setting and monitoring quality standards, business development support, legal advice etc. A similar organisation was established for NPAs, but that has tended not to be as effective as the Co-op Federation and has since fragmented.

New enterprises also benefit from pump-priming funds including start-up grants and funds from the anti-poverty programme, which are used to subsidise employees' salaries.

The network of 11 Regional Development Co-operatives (RDCs) covering all 17 regions of the province were and are a major source of support for co-op development, including home care co-ops. (See section 2 above re RDCs.)

1.3.3. On-going funding for domestic help

The Quebec Government adopted a scheme known as "Financial Assistance for Domestic Help Services". This states that:

"Persons using domestic help services provided by a Domestic Help Social Economy business that has been accredited for program purposes may receive financial assistance applicable against the hourly rate the business charges. There are two types of financial assistance:

- Basic financial assistance of \$4 for each hour of services rendered is granted to any eligible person regardless of family income
- Variable financial assistance of \$0.55 to \$8.25 for each hour of service rendered may be granted over and above the basic financial assistance, and is determined on the basis of the eligible person's family income and situation,

The person pays only the difference between the rate charged by the business and the financial assistance granted”.

There is also a tax-credit for home support for seniors aged over 70 “so that they will not have to move to an establishment in the public health and social services network or so that they can delay having to make such a move”.

Most of the income of individual DHSEEs comes from the charges made to service users, but this is backed up by a provincial government grant representing between 15% and 20% of their total revenue. Most of the expenditure of individual DHSEEs (80-95%) goes on salaries and other staffing costs.

1.3.4. Key challenges for the future

As has been stated above, the original list of tasks for which the DHSEEs were intended has (since 2004) been extended to include hygiene services, civic assistance and family relief. With the increasing demands of a growing older population, questions are now being asked as to whether the Quebec government should extend its financial assistance to DHSEEs so that they can offer their members an even larger continuum of services, in partnership with other elements of the co-operative social economy and local public health authorities.

For example, can home care co-ops collaborate with health co-ops to better meet the health needs of members? Can they collaborate with housing co-ops in order to offer accommodation with services (cafeteria, health support)? Can they collaborate with transport co-ops or paramedic co-ops for the provision of non-emergency transport? Can they collaborate with funeral co-ops to help members with their end-of-life planning?

The widespread and highly regarded infrastructure of co-operative home care, within a vibrant wider social economy, means that Quebec has options and opportunities for addressing its social needs which are unparalleled in north America and much of Europe. And these options are not only more cost effective than undiluted state care or contracted private care, they are also empowering of the citizen and strengthening of civic society.

Co-operative models of care for older people

PART TWO: THE CANADIAN EXPERIENCE

This section of the report is a Wales Progressive Co-operator resume of extensive research findings set out in “Co-op Elder Care in Canada”, a report by John Restakis published in 2008

2.1. Introductory observations

“The maltreatment of seniors in both state-run institutions and for-profit nursing homes is one of the most distressing and recurring scandals of our society....The kind of responsive, humane care that seniors have a right to expect takes a back seat to the imperatives of state bureaucracies on the one hand, or the demand for shareholder profits by commercial enterprises on the other”.

“Our research has shown that co-ops are now a crucial strategy in providing seniors with the care they need while greatly improving the quality of life they lead..... The high standard of care they provide is reflected in the preference for co-operative models of care among recipients when compared either to state delivered or private, for-profit alternatives”.

“Informal carers provided 90% of household tasks. Government programs, NGOs, provided only 10% of the help for these tasks or caregivers paid by the senior. The majority of the care provided by formal sources was provided to seniors in institutionalised settings”.

“The impression of elder care in Canada is a system wholly inadequate to address the growing needs of seniors.....The system has been described as patchy, unaffordable and unresponsive to the real needs of people ...much of the existing money allocated to elder care is being misdirected insofar as non-profit approaches that save public money are being replaced by for-profit models....that run services for profit, usually under contract to government bodies”.

“The number of seniors who have been cut off or are unable to access basic care has increased dramatically”.

2.2. Most urgent gaps

- Affordable housing
- In-home support services which ...often make the difference between relative autonomy and dependence
- More beds for both acute and alternate care are needed; people who do not need acute care beds should be placed more appropriately
- Transportation difficulties & closure of small local hospitals has entailed additional costs for relatives
- Increased cost of pharmaceuticals is a problem for many

2.3. What policy changes are needed?

“Any new policies should be developed in consultation with local communities and seniors’ organisations to ensure that policies respond to the unique needs of individual communities”

“The most useful role that non-profits and other community based models can bring to the elder care issue is higher levels of control for both users and the broader community. This is particularly the case with the co-operative model.”

2.4. Social Care Services provided by co-ops.

- a) Housing is the most common: options include apartments, townhouses, freestanding dwellings, shared living arrangements and handicapped units. Some are market housing, others subsidised. Some are exclusively for seniors, others for mixed families or other age groups as well.
- b) Assisted living & Home care services are the second most common: typical services include cleaning, lawn care, snow shovelling, shopping, cooking, transportation, counselling, hairdressing and visiting. Some of these services are provided by housing co-ops, but some co-ops focus exclusively on the provision of home care services (especially true of Quebec).
- c) Social & Recreational services: eg social outings, exercise & yoga classes, bible reading classes, gardening, games clubs and the organisation of social events. Such services are predominantly provided within housing co-ops.
- d) Health care: Health care co-ops provide services to the general public but have been cited as particularly relevant to seniors on account of their flexible and innovative response ..to this age group.
- e) Funeral services: as above such services are available to the general public.

2.5. Membership of co-ops

The size of membership varies from 1,000 in a housing co-op (of which only 20% are seniors) to a co-op of 3 members providing home care services.

Many co-ops are worker co-operatives whose members are care givers, but others include members with a variety of interests such as users, employees, community members and organisational sponsors or supporters and volunteers.

2.6. Sources of Funding

In housing co-ops the largest source of funding comes from member shares or life leases (see below) and rentals. They also receive some subsidy from government sources and some attract funding from private business. Start up funding has come from private donations, churches, foundations and loans from local credit unions.

The Housing & Urban Development Agency in the USA has special funding earmarked for seniors' co-ops as well as allowing co-op members to receive the same tax benefits as homeowners.

2.7. Advantages of the Co-op Model

- a) Control rights: "Control rights mean that members have a greater say in ensuring that services are delivered in a manner that most benefits them as providers or users of the service....(It) allows seniors greater opportunity for social interaction with peers, a greater sense of personal empowerment and control over their environment and a mechanism to ensure that service quality remains a high priority as well as service affordability"
- b) Previous research shows that 61% of respondents (ie co-op residents) said that they were either somewhat or extremely active in the governance of their co- op while only 9% were not at all active. 85% of the respondents said that the co-op gave them a voice in how their housing was run, while 84% said that the co-op provided opportunities to work with others on common goals".
- c) 74% of residents said that the ability to remain in their home community influenced them a lot in their decision to move to the co-op.
- d) Service quality: "This has been a key factor in attracting a growing number of seniors to the co-op model ... There is no incentive in a co-op structure to short change service quality for considerations like profit maximisation.The same has been found in studies of co-operatives whose members are caregivers (where) co-op members have the power to design and deliver services without the need to flow profits to private investors; this means that service content will better reflect what is in the best interest of caregivers".
- e) Studies in Italy and another by Kansas University have confirmed that the above advantages of a co-op model are replicated elsewhere and that "the co-op model still delivers the most affordable form of housing when compared to social housing".
- f) Reduced health care costs: "The relationships that are generated by increased interaction among members for purposes of running the co-op are also a source of mutual assistance and social relations that

have a direct impact on seniors' sense of personal well-being, on the ability of seniors to live outside of institutional settings and in their own communities and on the availability of assistance that would otherwise have to be supplied by professional care givers". "The consistency of ... results across time, provinces and countries suggests that residents living in for-profit facilities are more likely to be hospitalised than residents living in non-profit facilities".

2.8. Challenges of the Co-op Model

- a) Lack of awareness: This is true both among the general public and among funders and policy makers. This often leaves co-ops "scrambling to access sources of financing".
- b) Reluctance to share power: some government agencies display apprehension on this score.
- c) Complexity of the Co-op development process:
- d) Capital Accumulation and Enterprise Investment: largely a problem of building up enough reserves for development plans.
- e) Lack of managerial expertise: This is an "inherent weakness that can only be overcome if members recognise that the expertise required to sustain the co-op may have to be sought outside the available skill set of the co-op".... "The development of a co-op elder care sector will depend on the availability of systemic supports for the ongoing training and development of co-op managers".

2.9. Canadian Task Force Recommendations

The more important recommendations for a Canadian Task Force included:

- Improvement of income support systems for seniors
- A national coalition/campaign for the advancement of senior policy leading to a national elder care strategy backed by a degree of government funding
- Creation of housing programmes that address senior's needs (eg a requirement that a percentage of all new housing be set aside for seniors)
- Improvement of compassionate care leave programmes
- Explore the use of tax credits to support elder care services
- A guide/toolkit for use in community dialogues on elder care
- A national support system to develop and support elder care co-ops (financing, technical support, possible foundation and pension plan support etc.) and to mobilise co-op sector resources to support social care co-ops.

2.10. Examples of the different kinds of social care co-ops

Life-lease Co-ops

This model can apply to housing co-ops where the members purchase life leases, the proceeds of which go towards the development cost of the housing. The co-op retains ownership of the housing unit and the value of the lease is returned to the users when they no longer occupy a unit.

Sometimes life leases are sponsored by local organisations that act as guarantors for the initial development; such organisations might be seniors' groups, social service agencies, credit unions, labour organisations and faith groups. Many seniors are able to finance the purchase of a life lease from the sale of their existing homes.

An example of this kind of co-op is the *McClure Place Foundation* in Saskatoon. It was initially sponsored by the McClure United Church. There were 130 member residents (in 2008), 36 of them subsidised by the provincial government. Fund-raising is also undertaken to subsidise low-income residents.

Purchase price of a lease was \$105,000, which is loaned to the co-op as a non-interest bearing loan, which does not affect any government income support entitlement. Residents also pay \$450 per month to cover operating costs and the building of a reserve. A part time nurse is available, 24 hour security, fitness equipment, social programmes, an activity director and personal laundry services.

There is a long waiting list and the model is being copied across Canada.

Equity Co-ops

Equity co-ops are similar to the life-lease co-ops except that members own the unit they occupy. In some equity co-ops members are required to take a second mortgage on their unit, which is repaid at the time of resale. The proceeds of this 2nd mortgage are used to finance new co-op housing projects.

An example of this kind of co-op is *Amberview Place Housing Co-op*, in West Vancouver. This is a 4 storey building with 42 units – each with its own underground parking lot - and a number of shared amenities (lounge, meeting room, workshop, laundry). The units are of varying sizes.

The project was initiated by the local council who advertised a plot of land for non-profit senior housing. A co-op development proposal from a local architect was accepted and the land leased at 67% its market value for 60 years on condition that the building was maintained for non-profit making seniors' housing. A credit union provided construction costs and individuals had to pay a deposit of 25% of the value of their unit prior to construction.

The credit union also arranged mortgages for those who needed them for the extra 75% individual members had to pay before occupation.

When completed, unit prices ranged from 73% to 83% of the local market value and this degree of affordability has to be maintained for future members. Members also pay monthly fees of \$100 to \$164 towards a sinking fund and common charges. Property taxes are paid separately, but amount to some \$400 pa.

“This approach, which combines a favourable land lease with equity contributions from co-op members, can be readily replicated in other municipalities”.

Foster Care Co-ops

This is a new care model recently developed which can provide an alternative for people not able to purchase or lease a housing unit. This scheme provides living accommodation to seniors in private homes. The members of the co-op are the home owners, most of whom also provide some degree of personal support – eg cleaning, recreation and socialising programmes and transportation. The co-op provides oversight, training services and quality control for all participating members.

Schemes are funded from payments made by the service users, sometimes supplemented by public subsidies available to seniors.

An example of this kind of co-op is the *Caring Connections Co-op* in Napanee, Ontario. This was still in its early stage of development in 2008, the aim being to provide a network of approved private homes able to offer an appropriate environment in which frail elderly people could maintain independent living. The co-op provides an umbrella organisation “to inspire excellence and promote respect, recognition, equality and service accountability in a team orientated atmosphere”.

When fully operational, the co-op will have 64 seniors living in 40 foster homes with a limit of 2 senior boarders per home.

The co-op provides access to private rooms or suites and the right to choose preferred location and lifestyle preferences. Frail seniors pay \$33 to \$63 per day for incomes up to \$24,000 plus. A government subsidy programme covers the balance of costs for lower income seniors. The home providers are paid by the co-operative for any support services provided. The co-op also organises:

- Monthly visits from a registered nurse
- Assistance with bathing where needed
- Quarterly visit by a wellness monitor to assess psychological well-being

The system provides accommodation and services tailored to individual needs. It improves well-being and reduces the need to call on emergency services and for hospitalisation.

Home Care Co-ops

Home care co-ops have taken off in Quebec – where the provincial government subsidises home care services - and are beginning to spread to other parts of Canada. The members may be care-givers, home care consumers – or both in a multi-stakeholder structure.

An example of this kind of co-op is *Care Connection* in Mission, British Columbia. The BC Co-operative Association and the BC Health Employees Union helped establish this co-op by providing technical assistance and organisational funding through a federal Co-operative Development programme. After four years (2008), the co-op has three members providing 365 service hours care to 97 clients, of whom 29 pay for the co-op's services privately, 66 are funded through the Veterans Independence Programme and two are funded by an insurance company.

Many referrals come from the home care agency that has the home care contract with the local health authority. The co-op itself has tried to secure a contract with the health authority but the small size of the co-op and their recent entry into the market has been a stumbling block in spite of the members' twenty five plus years experience of working in the sector and being registered care providers.

“This reluctance of regional health authorities to contract with smaller providers is common and has become a major challenge for the development of local, community based co-op options for health services, including home care, assisted living and elder care”.

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APPENDICES

Appendix 1:

The wider context: **UN Year of Cooperatives 2012**

The informal alliance of agencies and progressive co-operators that has commissioned this report is seeking to inform the developing of social care in Wales by promoting awareness and understanding of co-operation as an ethical and practical approach to human interaction and organisation. It is an approach based on a commitment to principles of reciprocity and democratic accountability, and one that has enormous global support and contemporary relevance.

In March 2010 we organised, through WCVA, a study day, funded by the Cymru / Wales Co-operatives Membership, to provide foundations for the (re)development in Wales of a more thorough and contemporary understanding of co-operation.

To follow this, as our contribution to the celebration of the United Nations Year of Co-operatives 2012, we have not only commissioned this report but also arranged a visit to Wales of the Quebec author, Jean-Pierre Girard, who will be speaking at a seminar hosted by Rosemary Butler, AM, at Ty Hywel in Cardiff Bay, on February 7th 2012. M Girard has been intimately involved with home care co-operatives in Quebec since 1997. He has been a Commissioner and since 2001 a member of the board of the International Health Co-operative Organization (north America region); and a frequent contributor to OECD publications related to social enterprises. He has considerable knowledge of the incentives and decentralised resources for local co-operative development in Quebec. We hope his visit will help to give impetus to care co-operatives in Wales.

We are subsequently planning to support, and maximise the benefits from, the visit to Wales in July 2012 of another highly informed Canadian co-operator and contributor to this report, John Restakis.

These and other activities are our contribution to the celebration of the UN Year of Co-operatives 2012.

Our hope is that some of the lessons from Quebec and Canada (and beyond) can translate into positive action in Wales. In a context of a rapidly aging population and significantly growing elder needs, we hope to provide a spark to assist in the development of new forms of care in addition to state provision, following modern lines of involvement and participation but building on methods of reciprocity and co-operation that have developed over the past 160 years.

We also see through co-operation a great potential to improve the status and terms and conditions of employment of a predominantly feminised home care

workforce. By their very nature, “multi-stakeholder co-operatives”, as described in this report, offer a real opportunity to address this accountability gap.

We hope that Wales can provide a beacon to other parts of the UK in developing genuine stakeholder co-operatives and in so doing help to avert any drift towards less accountable mutuals, which could mask the privatisation of public services.

David Smith, Wales Progressive Co-operators

Adrian Roper, Cartrefi Cymru

Appendix 2

Some questions we put to Jean-Pierre Girard

1. How do people gain entry to co-operative models of Residential Care in Quebec?

The service is available to all.

2. Do people become members before they need care?

About 5%-10% do – mostly family members of households where a service is already provided. But this is not necessary. On receiving a service most recipients become co-op members as it increases their involvement in decision-making regarding the care provided.

3. Is there a members “waiting list” or are they referred to a co-operative by professionals of the state following an assessment of need?

Recipients of care may be referred by a professional from a public service but many self-refer. There is usually little delay in instigating a service and waiting list have not been found to be necessary.

4. How does the ability to pay (as a self-funder or recipient of state funds) impact on entry to co-operative care?

In view of the funding arrangement described in the body of this report ability to pay has little impact on the decision to enter a co-operative.

5. What is the co-op’s role in terms of availability and accessibility of alternatives (to residential care) such as reablement services and domiciliary care and possible progression to residential or nursing home care?

Some co-operative DHSEEs are investigating the possibility of offering their members a continuum of care: eg home care/housekeeping services – personal hygiene services –nursing/health care - long term residential care facilities.

6. How responsive is the co-operative care sector in Quebec to the level of demand?

The sector is able to respond very well to the level of demand.

7. How quickly can it respond to need/demands?

Co-ops can usually respond to needs and demands within a week or two of a request for assistance.

8. What is the potential or actual achievement of the co-operative sector in terms of meeting the varied needs of significant numbers of older citizens?

See figures for 2007 quoted in main report. Co-ops have proved to be more pro-active and entrepreneurial than other DHSEEs – eg by extending their range of services, providing support services to private residential homes and opening their own residential accommodation.

9. If services are available to both members and the wider community, what are the benefits of membership?

Providing a sense of ownership and involvement by participation in board meetings etc. This enhances their status and staff respect. They would also share in any profits generated.

Appendix 3:

Explanation of terms used in Quebec: Co-ops, SEEs, DHSEEs and NPAs

Co-operatives

A Co-operative is an organisation with members who have a democratic say in how the enterprise is run and what should be done with any profits/surpluses. They should conform to internationally agreed principles: ie membership must be open and voluntary, each member must have an equal say in the management of the organisation which must be autonomous and independent of the state, information, education and training must be provided for members, they must co-operate with other co-operatives and they must show an active concern for the community. Co-ops may be user co-operatives, worker co-operatives, producers' co-operatives or multi-stake co-operatives, which combine more than one of the above categories. Multi-stake co-operatives were legally recognised in Quebec in 1997. Most co-operatives in Quebec are now multi-stake co-ops and many, if not most, also have an additional category of Supportive Members. Such members share the aims of the co-op but do not share in its day-to-day activities. They are seen as particularly valuable in service providing co-ops where they can provide a range of additional experience/expertise.

Social Economy Enterprise:

Following the major Socio-Economic Summits held in Quebec in 1997 it was agreed that a Social Economy Enterprise must:

- Serve their members and the local community instead of prioritising profits
- Be autonomous of the state and have independent management
- Have a democratic process involving users and workers in their operations
- Use any surplus to promote people and work
- Build their activity on the basis of participation, self-help and individual and collective responsibility.

DHSEEs and NPAs

In practice, Domestic Help Social Economy Enterprises (DHSEEs) are either Not-for-Profit Associations (NPAs) or Co-operatives. Co-operatives are governed by Quebec Co-op Law (more than 300 articles!) and the name "Co-operative" is legally protected in contrast to the current position in the UK. In particular, in relation to Multi-stakeholder Co-operatives, no member can belong to more than one category of membership and supportive members

are limited to a maximum of 33% of the seats on the Board. NPAs are much less restricted. They may decide for themselves who can be accepted as participants in the venture, the composition of their Board etc. The only restriction placed on them is that they must be non-profit making. As such, they cannot address the accountability gap which is associated with private for-profit services and all too often with public services as well. By their very nature, it is only multi-stakeholder co-operatives that can address this accountability gap.

Appendix 4 Biographical details: Jean-Pierre Girard

Jean-Pierre Girard MA, BA, BSc

<http://www.productionslps.com/en/default.html>

Jean-Pierre Girard is a specialist of **development and management of collective enterprises** such as co-operative, non-profit organization (NPO) and mutual. He has been involved in this area for 25 years, combining practical and academic experience, with roles as executive director, member of a board, consultant, speaker, writer, and teacher.

He has worked for, including as first executive director of, the Quebec Housing Co-op Apex Organisation (Confédération québécoise des coopératives d'habitation) supporting 1200 housing co-ops providing 25000 apartments.

He has taught courses related to collective enterprises in different universities including the Université de Montréal, Université du Québec à Montréal, Université de Sherbrooke, and Université Senghor (Alexandria, Egypt)

Since 1983, he has been involved on the board of up to 20 corporations in the Non-Profit, Co-op, and Public sectors (including, a regional public health board and three regional development co-operatives).

Since 2001, he has been a member of the investment committee of a risk fund with \$10 million assets dedicated to collective enterprise in Quebec (le Réseau d'Investissement social du Québec):

<http://risq.zonehttps.com/?module=document&action=get&uid=990>

Since 1996, he has developed a specific **expertise in health and social care co-ops** from local and international perspectives. He has conducted many surveys, published numerous papers and research reports.

In 2006, he released the book: *Notre système de santé, autrement L'Engagement citoyen par les coopératives* (Our different health system: Citizen involvement in co-operatives) a book showing the contribution of the co-operative model to improving the health care system in Quebec and more globally, in Canada, including inspiring examples from Japan and Belgium.

In 2007, he was on the editing committee for a special issue of the review *Making Waves* under the name *Community-controlled health care*

http://www.cedworks.com/mw1803e_01.html

In 2008, the Organisation for Economic Co-operation and Development (OECD) asked him to write a chapter related to the specific example of multi-stakeholder co-ops in Quebec including health and social care cases. The book was released in 2009, *The Changing Boundaries of Social Enterprises*
<http://www.oecdbookshop.org/oecd/display.asp?CID=&LANG=EN&SF1=DI&T1=5KZ9HDCMB3LS>

In 2007 and 2010, he organised a Canadian Study Tour to Japan in order to have a better comprehension of the way health co-ops in that country tackle ageing population issues such as health, accommodation and related services.

Since 2001, under a Canadian Co-operative movement mandate, he has served on the board of the International Health Co-operative Organisation (IHCO), a sectoral organisation of the International Co-operative Alliance. The board sits in different places around the world, Europe, Asia-Pacific, South and North America.

From 2003 to 2008, he has been a member of the Health Committee of the Conseil québécois de la coopération et de la mutualité, the Quebec co-operative and mutual apex organization.

As a consultant, he is involved in key new health co-op projects and also working for the Government of Canada (Rural Affairs and Co-op Secretariat) and Quebec Co-op and Mutual Apex organization (Conseil québécois de la coopération et de la mutualité). He has also worked as a consultant with an important NGO in order to offer training course for the development of health mutuals in Africa and South America.

In 2011, he was selected as a member of a Canadian panel for the 3 M Health Leadership Award, a prize that recognizes outstanding community leaders that have had an impact on the health of their community by addressing at least one of the social determinants of health (www.healthnexus.ca)

The **co-operative** membership

Cymru/Wales

Eitem 5

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad: **Ystafell Bwyllgora 3 – Y Senedd**

Dyddiad: **Dydd Mercher, 25 Ionawr 2012**

Amser: **09:30 – 11:00**

Gellir gwyllo'r cyfarfod ar Senedd TV yn:

http://www.senedd.tv/archiveplayer.jsf?v=cy_400000_25_01_2012&t=0&l=cy

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Cofnodion Cryno:

Aelodau'r Cynulliad:

Mark Drakeford (Cadeirydd)
Mick Antoniw
Rebecca Evans
Vaughan Gething
William Graham
Elin Jones
Darren Millar
Lynne Neagle
Lindsay Whittle
Kirsty Williams

Tystion:

Lesley Griffiths, Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Dr Chris Jones, Llywodraeth Cymru
David Sissling, Llywodraeth Cymru

Staff y Pwyllgor:

Llinos Dafydd (Clerc)
Catherine Hunt (Dirprwy Clerc)
Victoria Paris (Ymchwilydd)

1. Cyflwyniadau, ymddiheuriadau a dirprwyon

1.1 Ni chafwyd unrhyw ymddiheuriadau na dirprwyon.

2. Craffu ar waith y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

2.1 Bu'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'i swyddogion yn ymateb i gwestiynau gan aelodau'r Pwyllgor.

2.2 Cytunodd y Gweinidog i ddarparu rhagor o wybodaeth, yn ôl cais y Pwyllgor, am nifer y swyddi gwag sydd ar gael ar gyfer meddygon yng Nghymru, a gradd y swyddi

hyn; y meini prawf a gaiff eu defnyddio i fesur llwyddiant yr ymgyrch sydd ar y gweill i recriwtio meddygon i Gymru; a nifer yr ymwelwyr iechyd sydd eu hangen i ddyblu nifer y bobl sy'n eiwa o'r rhaglen Dechrau'n Deg.

2.3 Cytunodd y Gweinidog i ddarparu'r wybodaeth ddiweddaraf i'r Pwyllgor am y trafodaethau sy'n cael eu cynnal â Llywodraeth y DU am reoleiddio mewn perthynas â darparwyr preifat llawdriniaeth gosmetig, ac i ddarparu'r wybodaeth ddiweddaraf am wasanaethau cadair olwyn a chymorth ar gyfer cyn-filwyr y lluoedd arfog yng Nghymru.

3. Blaenraglen waith y Pwyllgor – materion yr UE

4.1 Cytunodd y Pwyllgor mai drwy ei waith cymharol ar gyfer ei ymchwiliad i ofal preswyl i bobl hŷn y dylai'r Pwyllgor fynd i'r afael yn bennaf â materion yr UE yn ystod tymhorau'r gwanwyn a'r haf.

4.2 Gofynnodd y Pwyllgor am wybodaeth ychwanegol am fodelau gofal preswyl yn yr UE, gan gynnwys modelau dielw a ddefnyddir mewn gwledydd eraill, ac unrhyw wybodaeth a gafwyd gan Gymdeithas Llywodraeth Leol Cymru drwy'r broses o efeillio awdurdodau lleol yng Nghymru â chymheiriaid yn Ewrop.

4.3 Gofynnodd y Pwyllgor am ragor o wybodaeth am y strategaeth iechyd, y cyfarwyddyd ar gymwysterau proffesiynol a mynediad traws-ffiniol i wasanaethau gofal iechyd.

4. Papurau i'w nodi

4.1 Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 11 Ionawr.

TRAWSGRIFIAD

Gweld [trawsgrifiad o'r cyfarfod](#).