



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

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

Dydd Mercher, 25 Medi 2013
Wednesday, 25 September 2013

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Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynndi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol **Committee members in attendance**

Leighton Andrews

Llafur
Labour

Rebecca Evans	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
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

**Eraill yn bresennol
Others in attendance**

Sarah Rochira	Comisiynydd Pobl Hŷn Cymru Older People's Commissioner for Wales
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**Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance**

Stephen Boyce	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk
Sarah Sargent	Dirprwy Glerc Deputy Clerk

*Dechreuodd y cyfarfod am 09:30.
The meeting began at 09:30.*

**Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions**

[1] **David Rees:** Good morning, everyone, and welcome to this term's first session of the Health and Social Care Committee. The meeting is bilingual and headphones can be used; simultaneous translation from Welsh to English is available on channel 1, and channel 0 provides amplification. Please switch off your mobiles and other electronic devices, other than your iPads and non-Wi-Fi equipment. There is no scheduled fire drill today, so if the fire alarm sounds, please follow the directions of the ushers. We have received no apologies today.

**Gwaith Craffu ar Adroddiad Blynyddol Comisiynydd Pobl Hŷn Cymru
Scrutiny of the Commissioner for Older People in Wales's Annual Report**

[2] **David Rees:** I welcome Sarah Rochira to the meeting. We will have a session on your report, but we will also hopefully consider the report 'Dignified Care: Two Years On',

which you published on Monday. In that vein, I would like to start by asking questions, and I will give you a chance to speak towards the end if we have extra time. I will go with a bit of technology now; your office tweeted on Monday that at the heart of the NHS there must be a culture of refusing to accept or tolerate poor care. Do you want to comment on that? Is it your view that that culture is there, or do you believe that that culture no longer exists?

[3] **Ms Rochira:** The NHS, not just in Wales but probably across the UK, has to remember its core business. This core business is very clear to me and to older people. It is about keeping people safe when they are in hospital, making sure that their care is effective and that they are treated with dignity, respect, compassion and kindness. It is my view that, over the years, our standards have slipped across our hospitals and we have forgotten what those fundamentals of care look like. So, many of the things that I talk about are very fundamental, such as continence care or the levels of training among staff, for example. We have forgotten what ‘good’ looks like. Standards have slipped and there is now a call—not just from me but from many others such as the Public Services Ombudsman for Wales and Healthcare Inspectorate Wales among others—to put those standards back into place. We have learned to walk by things that we should not have walked by, across the board. That is really what zero tolerance is: it is about not walking by. It is about stopping and saying, ‘This is not good care, we need to do something about it now’.

[4] **David Rees:** During the last 12 months, we have also seen initiatives from the Welsh Government, such as ‘Doing Well, Doing Better: Standards for Health Services in Wales’ and ‘Safe Care, Compassionate Care’, and the recent initiative resulting from the Francis report. Are those, in your view, going in the right direction and are you looking for a timescale on the implementation of the initiatives that are coming out of those programmes?

[5] **Ms Rochira:** They are going in the right direction. I tried to be very measured in my report to reflect what is going on, because it is not all bad across the NHS, and people tell me about the good care that they receive. It is almost a tale of two cities: on the one hand, there is great care but there is also truly appalling care. Those initiatives matter, and I will come back to one or two of them in particular. However, when I reviewed what was going on across Wales—and it was only in relation to my 12 areas of recommendation, so it was not an overall critique of the entire NHS in Wales—I discovered an industry of initiatives and activities. Initiatives, strategies and policies matter enormously, but what really matters is the patient experience. When I met the chairs of the health boards last week and the Minister for Health and Social Services to talk about my review, I was very clear that we need to move away from the strategies, the plans, the policies and the initiatives. We do not need more of those; we need them to translate into tangible action at a ward level. So, they are the right direction and they are the right things, but it is about the proof of the pudding, and the proof of the pudding sits with the patient experience.

[6] There are two aspects that I would particularly like to focus on, because they are particularly important, and I spoke at length with the chairs and the Welsh Government about this. The first is listening to the patient experience. It is not enough to say that we have a patient satisfaction survey, a household survey, in Wales that states that 96% of people are happy with their care. That is not the same as understanding the patient experience on an ongoing basis. We have to get significantly better at that. Health boards are now starting to realise the importance of that. So, work around that is particularly welcome and important.

[7] The other area that I think is a particularly important step forward is the Welsh Government’s announcement that health boards will publish annual quality statements and that there will be an annual Welsh Government quality statement as well. We must put into the public domain the performance of our health service in Wales—both good and bad, because older people understand that we do not always get it right across Wales, but they want to know that we know when we are not getting it right. Those two are particularly

important. I agreed with the chairs of the health boards and the Welsh Government that, in terms of my further scrutiny of the 12 areas that I am focused on, those will now be lifted into the annual quality framework. I will advise them on what I expect them to be reporting on, because I want it to be in the public domain. I am also going to take my further reporting of this into the new assurance framework. So, I want to make sure that we are reporting on the right issues, not the issues that the NHS thinks it should or wants to report on.

[8] **Darren Millar:** In terms of the update that your office has published on the ‘Dignified Care?’ report, it was very pleasing to note that you had found some evidence of progress having been made in different parts of Wales. You have some interesting examples of best practice in the report as well. Were there some parts of Wales that appear generally to have taken the issue more seriously than others? Were there some parts of Wales where things seem to be lagging behind? Was it consistent within health board areas in terms of the sense of direction and the momentum moving in the right way, or were there differences from one ward to the next in individual hospitals?

[9] **Ms Rochira:** I look for three things. There are three quite simple questions to ask. Is it being taken seriously? You will see that I was very clear in the report that I think that it is being taken seriously. The NHS has had a long-overdue wake-up call about who it is for and what its services and core business are. I thought that that was consistent across Wales. I thought that everybody was really taking it seriously—frantically taking it seriously. There is a danger there—do not run and trip, but focus on getting the basics right.

[10] Was there evidence of activities going on? Yes, across Wales, everywhere I went. I visited services as well. I have been on wards across Wales and have been out in community services. I have visited people in their homes and met with staff. There are initiatives going on across Wales, but there is real difficulty across all health boards in showing the evidence that they are making a difference. We are beginning to get there, but everybody is still struggling with that. That relates to the point I made earlier about initiatives. The real issue is that there is huge variability across Wales, not just between health boards where some are better at some things than others, but from ward to ward. You can walk five minutes and go from outstanding care to truly appalling care. That is why I am really focused on getting the basics right.

[11] When I met the chairs of health boards, they told me about the difficult challenges they face—service redesign and integration, unscheduled care, and those big issues. I recognise how difficult those are, but that is not what I am talking about. I am talking about getting the fundamentals of care—the most basic aspects of care—right. That should be consistent, regardless of where you go. If I am an older person and I go into a Welsh hospital, regardless of where I go, I want to know that no harm will be done to me; my care, hopefully, will be effective; my continence will be managed properly; people will understand my needs if I have dementia; my discharge plan will be right; communication will be decent; and, if this is not right, people will know, put it right, apologise to me and stop it going wrong again. There is huge variability and that is one of the most worrying things. The basics should be right wherever you go. It is about public assurance and we are nowhere near that yet.

[12] **Darren Millar:** Was there any evidence that older people feel more confident about going into hospital as a result of you shining a torch on these areas? One thing that has concerned me over the summer period has been the increasing numbers of people, certainly in north Wales, as a result of some of the inspectorate reports that have been published, having their confidence really undermined, particularly among older people, with issues like infection control having been reported as not having been in place properly in recent times. What evidence is there, in terms of your post bag and people contacting your office, that there might be an older people’s confidence crisis in the health service?

[13] **Ms Rochira:** I have to be careful that I do not extrapolate, from the people who contact me and whom I meet with, a picture that is a truly representative example of what everybody across Wales thinks. However, I will share with you my interpretation, because I meet with people on a very extensive basis. I think that the general public is incredibly concerned not just because of what they hear in Wales, but because of what they hear across the UK as well. People do not, in their minds, differentiate—they just have their one, beloved national health service. People are becoming very worried and concerned, particularly with the increased media scrutiny upon it. That is why I think that the annual quality frameworks matter. Those annual quality statements are designed to assure the public that we are getting it right. I have also said to health boards that I do not think that they are good enough in their communication with the public.

[14] I have had a quick look at some of the ones that have been published. They are a good start, but I do not think that they are anywhere near where they need to be in providing the reassurance in a way that the public can understand. I struggle to understand some of the things and I have worked in the NHS for 23 years. The reality is that I hear both things when I meet people. I was on a ward recently and a lady came up to me and said that the care was absolutely outstanding. People have contacted me and told me that. However, I also meet people who tell me about the most fundamental failures in care and public service. My message to the health boards was quite clear: ‘You are losing the confidence of the public; you need to regain it’. I say in the report that, when we are good, we are brilliant. That brilliant should become standard practice and that should be for everybody. There has been a real wake-up call for the NHS. If I was working in the NHS now, I would be really worried about what I need to do to reassure the public and give the confidence back that, most of the time, we get it right and that when we get it wrong, we are absolutely sharp in putting it better.

[15] **Lindsay Whittle:** I find that really interesting, because I have met many older people—in fact, I am becoming an older person myself. I do not want to categorise older people, but I would like to think that there are three types. There are those older people who are sharp, bright as a button, with their finger on the pulse, who no-one would every bully. There are those who would never complain, whatever service they had, be it good or bad. What frightens me most, and I think what frightens the general public the most, are those who perhaps do not know who they are or sometimes, sadly, even where they are. Those are the most vulnerable for me and that is what I am concerned about. I note that, in your report, you say that you are going to review the impact of the dementia vision for Wales and that you have appointed a new member of staff. How can this committee work with you to improve the issue of caring for dementia patients in hospitals and residential homes? In particular, I have had a case recently of a dementia patient who was in A&E and not very well looked after, and that frightens me. How can we work together with you? What can we do to not only have some impact, but to make a difference?

[16] **Ms Rochira:** You are right; that is what it is about. It is about making a difference, is it not? We have a dementia vision and the Carers Strategies (Wales) Measure 2011. Those are important steps forward, but I think that they should be called something else. They should be called promises; promises made to some of our most vulnerable people that we will get it right for them. There is not much in any of them that is rocket science; getting a diagnosis, getting the information and advice you need and getting a bit of support before you are on your knees begging for somebody to help you. They have to be ongoing priorities for us. The difference has to be to the lives of people who have dementia, their carers and the wider family who support them.

[17] I have already signalled clearly that I am minded to do a review of those promises made to people. I think that we can work together in a number of ways. One is through your wider Assembly Member roles. As you know, many of us have regular contact anyway, but it

is just about feeding back intelligence when I put out calls for evidence. It is about helping me get that evidence and keeping in touch with people at the local level, because those are the voices that I am really interested in. It is about people on the street. People do stop me on the street to tell me things. However, it is also about working together in more of a passing-the-baton way. I will give you the example of disabled facilities grants. As you know, at the end of my first couple of months in post, I spoke up about what I saw as significant failures in public service around DFGs. The Committee on Equality of Opportunity then went on to do a review around that. The two pieces of work together are building up the momentum and the pressure for change. It may be that, as a committee, we want to have a discussion next year about my scrutiny and my review of it, as well as potential scrutiny from you, because it is about holding to account. When people make promises and they put them into writing to people, we need to come behind it and say, 'Did you deliver? What difference did it make?' It has to be people's voices that drive that. So, 'yes' is the short answer within that long answer.

[18] **David Rees:** Lindsay raised the question of A&E units. In the work that you did for your report, 'Dignified Care: Two Years On', did you also consider evidence on people's experience of A&E departments and how they were dealt with, particularly those with dementia? Was that included in your work?

[19] **Ms Rochira:** It was not a particular focus of mine, no.

[20] **David Rees:** You focused on patient care in wards, effectively.

09:45

[21] **Ms Rochira:** Primarily, yes, because I had to put some boundaries around it.

[22] **Rebecca Evans:** Commissioner, you wrote to us back in September 2012 regarding the NHS reconfiguration plans and you highlighted three particular issues in which you would be taking a close interest, so I would like to ask you a brief question on each of those three issues. The first was the extent to which older people were to be involved in discussion about the changes being made. What is your overall assessment of the level of consultation with older people? Are there health boards that have done it well and others that have not done it well?

[23] **Ms Rochira:** If I may, I will put some caveats around what I want to say, because I am shortly going to publish my findings and I do not want to pre-empt putting those into the public domain. What I will say is that I saw extensive evidence of engagement with older people, but that is different from effective engagement with older people. Of course, the key question when you ask about effective engagement is, 'What did you change?', because you asked and you listened. That is the evidence that I am going to be looking for. I do not want to pre-empt what I have found across Wales, because I am still completing that piece of work; I hope to publish it in the next few weeks. The issue around the equality impact assessment is particularly interesting and I am confident in saying, even before I publish my findings, that equality impact assessment across Wales needs to be much stronger. What is the impact of these changes on the lives of older people? That is what our services are about and that is who they are there for.

[24] I signalled early on, and my review has confirmed, the areas that I will want to focus on in more detail. One is about access to care for older people, but the other is the overall impact on their healthcare, their wellbeing and the status of the changes that are taking place. To give you an example, some health boards will say, for example, 'Well, we are closing some of our local hospitals, but we are going to invest in community services'. Where is the evidence that that is taking place and where is the evidence that it is meeting the needs of people? I am not quite answering your question, I know, but that is because I have not quite

finished the work and have not put it into the public domain. What I will also say, however, alongside the fact that I do not think that the equality impact assessment is strong enough yet across Wales, is that there needs to be a much stronger focus across not just health, but health and social care, in making sure that the information that we put out into the public domain is in a format that people can understand. These are complex issues, but they should not be so complex that we cannot explain them to those who use our services.

[25] **Rebecca Evans:** I assume that that report will be coming out some time before Christmas. How far do you dig down in looking at health board proposals? Do you make an assessment of each individual proposal in terms of whether it has, or will, adversely affect older people? Do you pay particular attention to proposals that have been referred by community health councils to the Minister? Do you feel, given the fact that there was a ministerial announcement yesterday, that the timing of your report does not necessarily fit very well with the pace of change and the way in which the process is moved forward?

[26] **Ms Rochira:** Pace of change is one of the things that I struggle with. I started looking at this almost as soon as I came in as commissioner, because I knew that the changes were happening and I was desperately trying not to miss the boat in terms of what was happening. I hope to publish my report in the next couple of weeks, so I am towards the end of that process. I have to say that it has been a highly complex and difficult piece of work, to try to unpick and understand the answers to those three questions. I have had to take quite a broad view of it, because it is the only way that I have been able, with the resources that I have, to really look at the range of changes that are going on. I have really focused on—this is right for my role—the process that people have adopted: how robust has their impact assessment been, how robust and effective has their engagement with older people been, to what extent have they looked at proportionality and so on. I have been quite careful not to overlap with the role of community health councils, so I do not take a view on the merits in itself; it is what the impact assessment will be telling me. So, I probably have not drilled down in as much detail as some people would have liked me to have done, but I have had to shape it in the only way that I can really shape it. There will be some hard messages coming out of that report—it will be measured, and it will reflect that, which is good—but I am also taking some time to build in some further good practice as well. What I do not want to do is just issue another piece of paper. I want to say, ‘This is where we are now; this is how you need to improve what we are doing’. I did issue section 12 guidance to health boards last year, in relation to the consultation, to try to shore up what they were doing. It has become clear to me that I need to issue further good practice guidance to them.

[27] **William Graham:** It was interesting what you were saying about carers. I certainly welcome the pilot scheme in west Wales. I wish to ask you for your experience of working with other agencies. Almost historically, the care of older people is often left to young carers. What has been your experience of that?

[28] **Ms Rochira:** I think that my experience is both, to be honest. We know that there is a huge issue across Wales for young carers, but I meet many older people, who themselves are vulnerable and frail, who are also caring for people. You then have a family of people who are vulnerable and who need support—the individual needs support, as does the carer. I could share with you an example of a lady who I met, who must have been—I do not know, because one never asks; well, I do not ask ages—80 years old, and she was caring for her son, who was 60 years old, I think. She was telling me how desperate she found it. I think that we have a change—we used to talk about just young carers, now it has to be carers, many of whom are older, and who have additional needs of their own, as well.

[29] **William Graham:** What support have you been able to offer to those people you identify?

[30] **Ms Rochira:** My work around driving forward better support for carers falls into a number of categories. One is that it is just pushing the issue up our agendas, that this is an issue that we have to deal with far more effectively than we are. So, I speak extensively with people, and I speak extensively in the public domain about it. Again, I give credit to what is good, but I am also quite clear in my view that we are nowhere near good enough at getting it right. I also support individual carers who come to me. I have had a number of carers who, through my office, we have helped access services and support, either through others or where we have had to intervene directly. However, I think that the most important thing that I can do—apart from putting my weight and my voice behind that growing movement—is to review the impact of the carers Measure, to come behind, and say, ‘Just show me now that the difference was made’. It is about that scrutiny role that only an independent commissioner really can, and should, undertake.

[31] **David Rees:** On that point, you are going to assess the impact of the carers Measure. Has your office looked at the impact of the Social Services and Well-being (Wales) Bill, to ensure that it incorporates all aspects of the carers Measure?

[32] **Ms Rochira:** I know that there is significant concern from carers’ organisations that the carers Measure will be passported into, or subsumed by, the new Bill. I do not think that that, in itself, is wrong, if the new Bill puts the same degree of protection, scrutiny and duty around public bodies that the carers Measure does. My concern, as I think it is for carers’ organisations, is that it will not, and that it becomes lost in it. To pick up on that point, one reason why I think that it is so important that we have principles on the face of the Bill—I have to say that I am concerned that we may not be having principles on the face of the Bill—is that it strengthens our ability to hold those who come under the Bill to account for its delivery. I think that it is for Welsh Government to evidence back, and to provide the reassurance that people are looking for. If it cannot, I think that we have to think very carefully about whether it is subsumed. I might also suggest a role for the committee, in terms of looking for the evidence that the weight of action behind the carers Measure will not be lost, in what is a very comprehensive Bill.

[33] **Gwyn R. Price:** Good morning, Ms Rochira.

[34] **Ms Rochira:** Good morning.

[35] **Gwyn R. Price:** In your view, what advocacy support do older people need in residential care homes—you have expressed some concern about that in the past—and how would you address those concerns?

[36] **Ms Rochira:** I have to say that I think that I have expressed more than ‘some concern’. Again, I have visited many residential care settings—nursing and social care—across Wales. I have met with staff, and it is rather like it is with healthcare: when it is good it is brilliant. Genuinely, I can think of homes across Wales where I would not hesitate to go to live when the time is right. The best homes give life back to people, but—and it is a salutary ‘but’—some of the care that older people receive in our residential care settings is atrocious and absolutely appalling. Let me be clear: we would not treat animals in some of the ways that we treat some of our older people in some of our residential care settings. Many of the people who come to me come about failures that they have experienced in residential care. I have seen and heard things that I thought that I would not see and hear.

[37] Shortly, I will start my legal review into residential care. It will be measured; I want to highlight what is good, because there is much good work. I will not shy away from shining the light on what is not right across Wales. So, I can do my piece of work in relation to that. There are other things, and it is always about a whole system. I try not to use the phrase ‘a whole-system approach’, but it is about that; all parts of the system have a role to play. So, it

is about strengthening the voice of older people within inspection, for example, and revisiting the regulations that we have through the new regulation Bill, and having one model of quality that everybody uses would be a good start in relation to that. Underpinning that, I think that there is a much wider issue about the value we place on older people within our society. I truly have seen examples of care where if it was in relation to a young person, we would pull them out immediately. For example, one care home that I am investigating took three years to close, and, in my view, it should have closed much more quickly. Why did it take three years to close? When it is not going right for older people in a residential care setting, why does it seem to take so long to find out that it is not going right and to put it right? We have a long way to go before we can assure older people that residential care will be good for them wherever they go. That does not take away from the great residential care that exists; it is just a realistic view of where we are.

[38] **Gwyn R. Price:** So, are you encouraged by the Deputy Minister's statement on 12 June that she will be making amendments to the Bill at Stage 2?

[39] **Ms Rochira:** I am encouraged by a number of the amendments that are being made. I feel, as I am sure that you do, too, that there are still further changes that need to be brought in. One of the most important things that the Bill does is to put the safeguarding of older people on a statutory footing, and that is about time. The reality is that we have seen many changes over the past decade across Wales that have pushed for the safeguarding and promotion of the care of older people, but it is not on a statutory footing. Until we get it on a statutory footing, it is not placed where it should and needs to be. That is a significant step forward, as I think powers of entry will be, given that these are some of the most vulnerable people. It struck me recently that the reality is that many of the people living in a residential care setting a decade ago would have been in hospital with a far higher degree of frailty and dependence. That is a very different demographic and, with that, there would have to be a higher duty of care for all of us in public service.

[40] **Leighton Andrews:** You have used very graphic language to identify the low quality of some of the care that you have observed, but there must be responsible authorities that have a duty to take action in those situations. So, what have you found in respect of the adequacy of the action that has been taken?

[41] **Ms Rochira:** I try carefully to reflect things accurately—it does not always get reflected in the media and press, of course. Many of the commissioning bodies in local authorities across Wales are working hard to try to drive up the way they commission and put quality at the heart of it, but it is not there yet. I have given public credit to the Care and Social Services Inspectorate Wales for the work that it has done on its modernisation programme. I think that that is the right approach and the right way forward. It knows that we are not there yet in terms of strengthening our ability to identify issues, the speed at which we respond to issues, and the extent to which we use the voice of patients and carers. However, there is a modernisation programme, and that has undoubtedly kept some people safe who would not otherwise have been safe before. So, all of that work is going on, and we have the safeguarding coming in the Bill.

[42] The question that I have in my mind is this: is all of that sufficient to make sure that we act quickly enough all of the time? The thing that concerns me is the amount of time that it takes, too often, to put it right. It seems to take too long. I have had many cases when I have wondered, 'Why was this not sorted earlier on?', 'Why was the care home not closed earlier on?' and 'Why was action not taken earlier on?'

10:00

[43] **Leighton Andrews:** How many is 'many'?

[44] **Ms Rochira:** Sorry?

[45] **Leighton Andrews:** You said that you had many cases. How many is ‘many’?

[46] **Ms Rochira:** I would have to come back to you with how many I have on my desk at the moment—they are what I would call ‘live social care issues’. I think that I have about 23 issues on my desk at the moment—

[47] **Leighton Andrews:** Are all of those of the serious nature that you were just describing when you said that the care was not the kind of care that you would expect animals to get?

[48] **Ms Rochira:** Yes, many of them are. Many of those are really serious issues, which would involve real risks to individuals—abuse or neglect, deprivation of liberty, death. We are dealing with one case at the moment that involves the death of an older lady.

[49] **Leighton Andrews:** Are those cases also being investigated by other bodies?

[50] **Ms Rochira:** Some of them are. For example, I have conversations with the police about some of them, and sometimes I refer them to other agencies. I always share my information with CSSIW. These cases are those that should come to a commissioner and not to others. I guess that I have three kinds of cases: those that I often refer to other people, because they are better suited to deal with them, and I do not want to duplicate what others do; those that are quite complex, where there tends to be a whole-system failure, which probably needs a commissioner to unpick; and the very high-end ones, which tend to be issues around protection, discrimination and breach of the law.

[51] I know that the language I use is strong, but I have seen things that I did not think that I would see. It does not take away from the really good practice that we have, but it does shine a light on the reality and the experiences of many vulnerable older people. I try not to hide behind words and I try to use language that, I hope, is just everyday language that resonates with older people. I do not know how else to describe it, but when I see people who have received third degree burns because action was not taken, people who are at real risk of deprivation of liberty and of being locked away in a secure elderly mentally infirm unit because they have not had a proper assessment, and when I learn that people have died, despite relatives saying, time after time, ‘Please take action’, I try very hard to be measured.

[52] The one thing that I rarely do is criticise front-line public service staff. I was one of them for 23 years and I am fiercely proud of that time. I know how hard our public service staff across Wales work. The challenges are immense, but that does not mean that we should not aspire to crowd out that which is wrong, bad and should not be allowed, and to getting right, good care for all older people.

[53] **Lynne Neagle:** I have a question that is linked to residential care. I very much welcome the forthcoming legal review of residential care and I am grateful for your input in monitoring the care home closure that is ongoing in Torfaen. I want to ask about care home closures. You have highlighted the pressure that you are putting on local government, but the situation that you are familiar with in Torfaen—and in Caerphilly—where we are seeing a care home closure at the relatively short notice period of three months has illustrated to me that some of our most vulnerable people are at the mercy of those taking very hard-headed commercial decisions in quite a ruthless way. Do you think that the Welsh Government is doing enough to prepare for those kinds of situations to ensure that we are not at the mercy of those kinds of commercial decisions?

[54] **Ms Rochira:** You are absolutely right. One of the growing areas that I am contacted about by people is care home closures. After a while, when enough people contact you—and you and your colleagues contact me as well—you start to spot a trend and start to think, ‘This isn’t one or two issues; there is something afoot across Wales’. As you know, I provide support to individuals and groups of individuals where homes are closing and I work with local authorities—there is one in particular, within which there has been a large programme of care home closures—to make sure that they manage closures appropriately. I am becoming increasingly of the view that I need to look at this more systematically across Wales. The difference between health and social care is that health boards, by and large, publish a plan. It might be hard to read and understand the plan sometimes, but they publish a plan and they go out on a fairly systematic basis. What is happening in Wales in relation to care homes is that a care home here or there is changing. Sometimes, it is for financial reasons and sometimes it is for good reasons, because they have better ways through which to deliver care, such as through wellbeing services. That makes it very hard to track what is going on. I will probably need to do a more systematic piece of work with local authorities after Christmas to find out exactly what is going on.

[55] The reason why care homes are changing, as I just touched on, is that the situation is different to what it was. As many of you will know, I was asked by the Welsh Government to do a piece of work for it, to advise it on how we update guidance on the escalating concerns with, and closures of, care homes providing services for adults. That work is nearly finished and it does reflect that better environment. There is a lot more good practice built into that. It is a hugely worrying issue if your home is closing at short notice—we use the phrase ‘residential care setting’, which I do not really like; it should be called someone’s home.

[56] I think that there is a wider issue about the market in residential care—whether we have a functional market in terms of the provision of residential care. Commissioners and local authorities are grappling with this, as we all are. I have spoken many times about the need for diversity in the market—for example the role of co-operatives, social enterprises and small and medium-sized enterprises, as well as the local authority funded ones. In parts of Wales, for example in west Wales, I have been contacted by a number of people who cannot get elderly mentally infirm beds locally. I met one lady in tears who told me that she had to travel 80 miles to an EMI bed to visit her husband who had dementia. This is a growing issue.

[57] **Lynne Neagle:** I am grateful for your reassurances. Obviously, it is encouraging that this guidance will be in place, but as good as the guidance is, if a care home closes at short notice with no beds locally—and, as you know, the home in Torfaen is a dementia registered home—those patients will be in a difficult predicament whatever happens. You have talked about the need for more diversity in the market, but do you think that the Welsh Government should be doing more to encourage that diversity so that we are not as dependent on some of these private sector homes?

[58] **Ms Rochira:** The short answer to that is ‘yes’. Local government also needs to do so. We need to take an in-the-round look at what the market for social care is like. It is a matter of what it needs to be, not just for now but for the next 10, 15 or 20 years, because there are continuing demographic changes. I think that we need to map, without intervention across parts of the public system in Wales, what we will have. As an aside—this is a conversation for a different time—in Quebec, a very high percentage of its social care is provided, to great effect, through the social enterprise co-operative model. There are many examples from elsewhere as well, and I just think that we have to grab this bull by the horns, so to speak. We will have the future that we create and shape, and I think that that is a debate that has to take place by a number of people.

[59] **David Rees:** We now have a question from Elin, who is to be followed by Rebecca.

[60] **Elin Jones:** My question is also on care homes. It is not about when care homes close, but about when an older person is asked to leave their home because they have been reassessed. You have a 'Mr Jones' example in this report, and Mr Jones's mother was reassessed as needing nursing dementia care and was asked to relocate to another home. You specifically refer in that case to powers that you have to seek an injunction, given that a proper assessment was not made. I want you to explain a little bit about the powers that you have in that regard.

[61] To refer back to what you said about homes not being available in local areas, I am currently dealing with a case with Methodist homes in Aberystwyth, where three 90-year-old women have been reassessed from 'residential dementia' to 'nursing dementia'. All three women have been asked to leave the home and to look for alternative accommodation. That alternative accommodation is not available within at least 40 miles of Aberystwyth. Do you think that it is time that we looked to a situation where, if your assessment changes, your home does not change but your care package in that home changes, so that we use the opportunity of the new legislation on registration and regulation that is proposed by the Government to make homes, particularly those related to dementia, multi-registered and not just registered for a particular care assessment? Do you have a view on how appropriate it is for 90-year-old women to be asked to relocate their home at that time in their lives?

[62] **Ms Rochira:** I might not take them in the same order, so please excuse me. In terms of the categorisation of care homes, CSSIW consulted on whether that categorisation should be removed. I agree with its position on it. As a result of the frailty, acuity levels and dependency of people who are now in residential care settings, people move very quickly up that. You are absolutely right; you do not want to leave the place that you call home when you are in a very vulnerable position and in the last few years of your life as well. More to the point, for many people, moving home has a significant impact—particularly people with dementia—on their ability to cope. So, I agree with the CSSIW position on the removal of that categorisation; I think that it is the right thing to do. It worked in the past; it is now working to the detriment of many people, so it seems prudent to remove that.

[63] In terms of whether I think that it is appropriate or whether it should be avoided, I think 'at all costs'. I would not want it for me and I would not want it for my mother or father; therefore, I would not want it for any other older person. Where possible, we need to try to keep older people in the places that they call their homes. It is not always possible, but, when it is, that is what we should be aiming for. It is about consistency of care, not just quality of care. I can think of many not dissimilar examples to the one that you gave.

[64] In relation to—I have been contacted by seven or eight people from your constituency with a similar issue. I have already contacted the local authority and said, 'Look, I want to know why it seems to be so difficult to find somewhere that's reasonably local for people who have EMI needs'. I have asked it to report back to me on that, and I will go back to it. It may lead to my doing a wider review of what is going on in that area, which will not be as big as my residential care review, but, nonetheless, it will be a review into what it is doing, because there is clearly an issue there locally. I have met with people—one lady, who really stood out for me, stood up with tears streaming down her face. She told me that she had been married for 57 years and the nearest place that her husband could be was 80 miles away. I was almost lost for words. That is not delivery of good public service or care; it is just not delivery of good care.

[65] To go back to the legal duty and Mr Jones in the case study, it was actually far more complex than what I have put there; I did not want to breach his confidentiality. I have a legal duty to, and powers to, assist individuals. I have provided advocacy support in terms of meetings with the individual, his family and the care home, but it had got to the position—I had required it again and again to redo the assessments, because they were not sufficient—

where he had three or four days until his eviction notice, because he was served with an eviction notice, was due to expire. I then wrote to it to advise that I would take legal action, and that would have been a prohibitive injunction. I would have gone to court and asked for a prohibitive injunction to stay the eviction, because he would have gone into a home or a locked ward. There would have been two mandatory injunctions, one against the health board and one against the local authority, to undertake a proper assessment. It was the only way. On a number of occasions, I have had to have similar conversations with bodies. The reality is that they then tend to take the action, but I would rather it did not have to get to that point. This was an appalling case, far more appalling than the short case study does justice to. He was at real risk of deprivation of liberty, and he is now happily living in another care home. It has been a transformational outcome for him.

[66] **David Rees:** Kirsty, did you have a question?

[67] **Kirsty Williams:** Thank you, Chair. There has been a lot of focus this morning on delivering care in settings such as hospitals and residential homes, but the direction of travel is for more and more people to be cared for in their own home, out of settings of that kind. Forgive me if you have already mentioned it, but I would be interested to know whether concerns about the quality of domiciliary care feature heavily in your correspondence and whether you have any plans to look at and to comment on the quality of such care and, in particular, the principle of commissioning care in 15-minute time slots.

10:15

[68] **Ms Rochira:** Thank you so much for asking me that question, because the short answer is, 'Yes, it does come up'. I published a report last year that looked into the quality of domiciliary care, because you are absolutely right—home is where most people want to be, and it is where we all want older people to be cared for. The evidence from that—and that was a significant piece of research—was clear. People valued their domiciliary care greatly, and they valued the public service staff providing that, but there were two big issues: one was continuity and one was time. I have done many home visits with people and they have said to me, 'Look, what is happening is the hours are now being cut back; the time is now so tight in terms of what we do'. Of course it gives me concern, as I suspect it gives concern to many of us who are contacted by people. It is potentially an area that I am going to have to give consideration to looking at in terms of the commissioning strategies. It is not just the domiciliary care—there is wider support. I was in Carmarthen recently looking at its integrated care model, and I thought it was outstanding, actually; I thought it was really good, what it was doing. It had third-sector brokers coming in, and so it was shoring up with a wide range of other staff and organisations. However, this is worrying and is something that we need to track very carefully, because I am getting increasing traffic through, and, when I am out with people as well, it comes up a lot when we talk. The real challenge I have in relation to the action I can take, if I am honest, is starting to be one of capacity. I represent 800,000 older people, and the issues cover the entire breadth of public service. Despite changes I have made internally, I am very soon going to get to a capacity issue, and I will have to make difficult decisions about what I focus on and what I do not focus on. However, I have made it clear from day one that quality of care—social care and health care—is one of those priorities. It is in my framework for action, so where I am now is tracking it, trying to understand what is going on, and then I will need to make a decision about whether I need to do a wider piece of work around that. I suspect I will.

[69] **Kirsty Williams:** I am interested—as you said, a great deal of time and resource has gone into the publication of your report, and your analysis last year, and I am trying to gauge what impact that has. You have put a lot of time, effort and resource into producing that, and it demonstrates that you have concerns about quality, and there is concern within the population of people that you represent. What, if any, changes can you track from the

publication of your work last year into practice in the field this year? I am just concerned about the effectiveness of being able to translate and drive change in policy and practice as a result of your investigations.

[70] **Ms Rochira:** You make a very valid point. We live in a world full of pieces of paper and important bits of research. I am very clear that anything I publish is part of a continuum of work. It has to map back to my framework for action—that is why I published it, so people could see what I could focus on and what I probably could not focus on. I would say that research was an early piece of work to better understand the situation. What it did was seek older people's voices on this, so I could really hear systematically what they were saying. It backed up what I thought was a concern, and helped me focus on what the two issues were—continuity and amount of time. It has been part, really, of growing that knowledge and growing that understanding. The next stage for me, now that I have that kind of evidence base—and I hesitate to say an exact date, because it does not stretch, but it will probably be sometime before the end of this financial year—is to start to engage with local authorities in terms of saying, 'Okay, tell me what your commissioning practices are, tell me what changes you are making and what impact they are having, and show me how you are mitigating that'. So, that is how we can drive that piece of work. I suppose it has to start somewhere.

[71] **Leighton Andrews:** I want to ask about priorities. You said that there were 800,000 people who can be defined as older people; is there a case for you focusing on the needs of, for want of a better term, significantly older people?

[72] **Ms Rochira:** It is a real challenge. It is an incredibly difficult challenge for me, actually, as it is for all of us in public service, because there are many issues and we have to stay focused on those, or I try to stay focused on those, that have—. It is why I called my report 'impact and reach', really; I have always said I have a particular duty of care, in my mind, to those who are frail and vulnerable. You kind of have to get that bit right first, but it cannot only be for those who are frail and vulnerable, because otherwise we never get ahead of the curve and we never stop the frailty and dependence that can come, but does not have to come, with growing older. So, when I published my five priorities, I ordered them deliberately. Yes, health and social care and the quality of that matters enormously, but there are these other big issues. Community services, community facilities and community infrastructure matter enormously, and, if we do not protect those services, more people will become frail and vulnerable and go on to the statutory services' books. I think that it is a defining challenge for all public services how we protect those who are frail and vulnerable now while doing things that will keep people well for as long as possible. We call it the prevention agenda and all sorts of other things, but one cannot be at the expense of the other, or all we will do is to build up even more people who need support later on.

[73] We have spoken a lot about health and social care this morning, and it is very topical at the moment, but older people talk to me as much about buses, park benches, public toilets and the stuff in the places where they live their lives, and what they say to me is, 'Look, these are the things that are helping us to maintain our independence and to just get on and do it for ourselves, because we are quite good at that, really—we have practised it for most of our lives—but these are the things that we are worried are under real threat, and, if we lose them, these are the ones that will throw us into dependency', and I think that that is the defining challenge for all of us across public service. I try to be measured, but, you know, when push comes to shove, I have to be there for those who are frail and vulnerable, particularly in my casework and in the case support I provide to individuals. However, what I do try to do is to make sure that, where I support an individual, I take the wider learning from that. I had 1,000 people contact me last year, but it could be 2,000 or 3,000, and I simply would not cope. I need to really focus on those cases that not only support the individual, but also have wider public interest.

[74] **David Rees:** The next question is from Rebecca.

[75] **Rebecca Evans:** During the session, you have given us some really stark examples of poor care. Do you think that there is any merit in including much more detail about your casework in your annual report? You highlight the five most common subjects that people come to you about, but we do not really have any further detail about the specific problems that people face. I think that it would be really helpful for me as an Assembly Member to know in much more detail about what people are coming to you about, so that we can also pick out those overarching themes that need to be addressed. I think that the work of the ombudsman shows that it can be done without breaching confidentiality.

[76] **Ms Rochira:** Do you know, I had a similar thought this morning, actually? As you do, I quickly glanced through my impact and reach report and I thought, ‘Actually, I need to get much better at reporting around these cases’. Now, the reality is that the business of my office has shifted, so we now support cases that we did not support before, and there has been some learning about how to do that, but I think that it is an absolutely right and proper thing to do; that is why my post was created and why I exist as a commissioner: so that people who had no-one to go to before could come to me. So, I want in my next year’s one to have much better reporting.

[77] The other thing that I want to try to start doing is to put reports in the public domain as some of my case support is closed, so that people can see the learning from it. I want to get better at putting that into the public domain and sharing it—so, yes.

[78] **Rebecca Evans:** On your budget, do you feel that the money you have is sufficient to enable you to do the work that you need to do?

[79] **Ms Rochira:** Um—.

[80] **David Rees:** I think the answer there is ‘no’. [*Laughter.*]

[81] **Ms Rochira:** I am beginning to struggle in terms of capacity. When I came into office as commissioner, I laid out very clearly for my first year my five priorities, and that is what I have reported. I have tried to work out what I was going to do, and say what I am going to do, and then report back against that. However, one of my internal priorities was to review my own efficiencies internally. So, I have completely restructured the commission internally to free up resources to be put into what I would call more front-line work. That has had a significant impact, and I am confident that my return on the investment, and my productivity, has increased significantly over the past year. However, I am starting to struggle with capacity. Just the breadth of the issues that people come to me with is starting to be an issue. There is some more work than I can do internally, I think, in terms of diverting resources to support some of these very complex safeguarding cases, which only I as the commissioner can take—and I am just about to do that. However, I am soon going to reach the position where I have to say that I do not have capacity to undertake these issues. So, as to the ‘Framework for Action’, I was trying to put some shape around it, based on what older people have told me, but I am starting to struggle with capacity because of the breadth of issues. They all have a phenomenal impact on the lives of older people. What we might call little things can have a devastatingly huge impact on older people’s lives.

[82] **Darren Millar:** Last year, the Deputy Minister for Social Services asked you to undertake a piece of work on older people’s rights. I know that you have made a good start on that. Can you bring the committee up to speed on the current situation and tell us when you will be reporting back to the Deputy Minister and when you expect to be able to move things forward?

[83] **Ms Rochira:** Yes, I can update you. I just want to say a little bit about why I think it was so important to have a declaration of rights for older people. The rights-based position of older people is much weaker than it is for many other groups, such as children, and rightly so in the case of children. Children have a much stronger rights-based approach, and they have a declaration of rights at United Nations level. I have principles, which are not binding; they are just that—principles. It became clear to me very early on that this issue was undermining the lives and image of older people, and the ability of our services to get it right for older people.

[84] Following a number of discussions, I was delighted that the Deputy Minister asked me to advise her on what that declaration of rights should look like. I wrote to her yesterday with a draft, which was developed in conjunction with older people, the Welsh Government and others. We tested it on older people, and I am really pleased with what we have. I hope that Welsh Government will swiftly go to formal consultation on that. I also hope—dare I say, it is my expectation—that Welsh Government will endorse that formally next year. It is not legally binding, but it is a first stage. What we have at the moment is the Human Rights Act 1998, but it is right up there. It is really hard for people to extrapolate that on a day-to-day basis as to what that looks like. Even the courts have really struggled to uphold that.

[85] The reality for many people is that the Human Rights Act 1998 is not making a difference to their lives. The declaration is that bridging point, and it is a very important starting point, but it is only the starting point. I am a rights-based commissioner, and I think that rights matter enormously, but if you are an 85-year-old lady being evicted from a care home and you have no voice, does it really matter that you have a right if there is no-one to uphold it for you? So, it is an ongoing piece of work. It went up yesterday to the Deputy Minister.

[86] **David Rees:** Do Members have any other questions? I see that there are no further questions. I thank Sarah Rochira, the older people's commissioner for Wales, for coming in today and responding to questions from the committee. You will receive a copy of the transcript to check for factual accuracy. Thank you very much for attending, and thank you for the work that you are doing on behalf of older people.

[87] **Ms Rochira:** It is a privilege; thank you.

10:28

Papurau i'w Nodi Papers to Note

[88] **David Rees:** You should have received all the papers, and we will go through each one. The first paper to note is a letter from the Petitions Committee on equal rights for tube-fed youngsters. From reading the papers, this is more for information purposes, as the committee is asking us to keep an eye on this. However, the Chair of the committee asked whether we could report back to that committee as to how we wish to deal with this issue. Are there any comments? Is it okay if I just respond on behalf of the committee? I see that Members are content with that. Thank you.

[89] The second paper to note is a letter from the Petitions Committee on ambulance services in Monmouth. Again, the committee simply wants to be kept updated on our forward work programme. If it is okay, I will send the committee that detail, and, if we include ambulance services in our work programme, we will include the details.

[90] The third paper to note is a letter from the Minister for Health and Social Services as a follow-up to the ministerial scrutiny session. Do Members have any points that they wish to raise on that letter? I see that there are none.

[91] The fourth paper to note is a letter from the Minister for Health and Social Services following the letter about the measles outbreak that we sent to him. Do Members have any points that they wish to raise on that?

[92] **Rebecca Evans:** I was sure that I read over the weekend that the measles outbreak had not ended, and I looked again online to find it but I am sure that I must have dreamt it because I could not find it anywhere.

10:30

[93] **Darren Millar:** There is one interesting mention of immunisation in the 'Health Finances 2012-13 and beyond' report, which was published by the Auditor General for Wales over the summer. It suggests that the immunisation budget had a significant sum—it was over £1million, but I do not have the precise figure—from which money was vired into other parts of the NHS budget. I do not know what the impact of that may or may not have been on measles per se. I just wondered whether we could seek some clarification as to its impact from the Welsh Government, just to satisfy ourselves that it was an appropriate move.

[94] **David Rees:** We will write to the Minister on that.

[95] **Darren Millar:** Yes.

[96] **David Rees:** Have you had a copy of the e-mail from Brendan Mason? It was issued to everyone and was in your pack. He was concerned about the accountability of the inspectorate in relation to the single vaccine clinic and 'not clinic'. Is it okay if I write to the Minister for clarification on this issue as well?

[97] **Darren Millar:** Yes.

[98] **David Rees:** I will include that in my letter as well. Thank you.

[99] Finally, we have the forward work programme for this term. You will see the various issues that we have set out for this term. We have cleared most of the second half of the term for Stage 2 proceedings of the Social Services and Well-being (Wales) Bill. On Thursday, 21 November, we have the possibility of doing something else, which we will discuss later. Is everyone okay with that? I see that you are. Thank you very much.

10:32

**Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r
Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the
Meeting**

[100] **David Rees:** I move that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

[101] Are all Members happy with that? I see that there are no objections.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 10:32.
The public part of the meeting ended at 10:32.*