



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

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

Dydd Iau, 26 Ebrill 2012
Thursday, 26 April 2012

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

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

Eraill yn bresennol
Others in attendance

Yvonne Apsitis	United Kingdom Homecare Association Ltd.
Ed Bridges	Gwasanaeth Brenhinol Gwirfoddol y Merched, Cynghrair Ailalluogi Cymru WRVS, Welsh Reablement Alliance
Philippa Ford	Cymdeithas Siartredig Ffisiotherapi; Cynghrair Ailalluogi Cymru Chartered Society of Physiotherapy; Welsh Reablement Alliance
Francis McGlone	Uwch Swyddog Polisi, United Kingdom Homecare Association Ltd. Senior Policy Officer, United Kingdom Homecare Association Ltd.

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

Meriel Singleton	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Victoria Paris	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 12.59 p.m.
The meeting began at 12.59 p.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

- [1] **Mark Drakeford:** Prynhawn da a chroeso yn ôl i bawb ar ôl y Pasg. Dyma ni yn y sesiwn gyntaf ar ôl yr egwyl. Rydym yn aros am Phillipa ac Ed, sy'n dod i mewn i'r ystafell yn awr. Diolch yn fawr i chi'ch dau am ddod i'n helpu y prynhawn yma.
- Mark Drakeford:** Good afternoon, everyone and welcome back after Easter. Here we are in the first session after the recess. We are waiting for Phillipa and Ed, who are coming in now. Thank you very much to you both for coming to help us this afternoon.

1.01 p.m.

Ymchwiliad i Ofal Preswyl i Bobl Hŷn—Tystiolaeth gan Sefydliadau a Darparwyr v Trydydd Sector ac ar Fodelau Amgen
Inquiry into Residential Care for Older People—Evidence from Third Sector Organisations and Providers and on Alternative Models

- [2] **Mark Drakeford:** Rydym yn bwrw ymlaen y prynhawn yma gydag ymchwiliad y pwyllgor i ofal preswyl i bobl hŷn, ac rydym yn mynd i dderbyn tystiolaeth gan sefydliadau a darparwyr y trydydd sector ar fodelau amgen. Ar gyfer y sesiwn gyntaf, estynnaf groeso i Ed Bridges o Wasanaeth Brenhinol Gwirfoddol y Merched. Mae Ed hefyd yn cadeirio Cynghrair Ailalluogi, Cymru. Croeso hefyd i Philippa Ford o Gymdeithas Siartredig Ffisiotherapi.
- Mark Drakeford:** We are going ahead this afternoon with the committee's inquiry into residential care for older people, and we will be taking evidence from third sector organisations and providers on alternative models. For the first session, I welcome Ed Bridges from the Women's Royal Voluntary Service. Ed also chairs the Welsh Reablement Alliance. Welcome also to Philippa Ford from the Chartered Society of Physiotherapy.
- [3] Dechreuwn fel o'r blaen drwy ofyn i chi am sylwadau byr agoriadol, ac, ar ôl hynny, trof at aelodau'r pwyllgor i ofyn cwestiynau.
- We will start as before by asking you for brief opening remarks and, after that, I will turn to committee members to ask questions.

[4] Philippa and Ed, who is going to lead off?

[5] **Dr Bridges:** Thank you very much, Chair, for that introduction. Good afternoon. The Welsh Reablement Alliance, as you have probably realised from our written submission, is an umbrella organisation for professional associations, voluntary sector partners and care providers, who all come together to provide reablement services in Wales. As Pip will explain shortly, reablement services help people, particularly older people, to make the transition back to life at home after a prolonged stay in hospital. Services that come under the banner of reablement might include physical adaptations to the home and physical rehabilitation services, but they might also entail social support to combat isolation and loneliness. Together, these services provide tangible benefits to physical health as well as savings to the public purse. It is vital that we make a step change in Wales towards reablement and that it happens now.

[6] Projections suggest that, by 2020, care services in Wales will need to expand by 24% to maintain the current level of service, which would equate to an additional 5,000 care home places; that is a figure that concentrates the mind somewhat, I think. Clearly, something has to give, and we think that reablement has a massive role to play in reconfiguring services. We as an alliance bring together 12 very diverse organisations. That diversity is a strength, because it means that we are speaking with a united voice on reablement and giving a clear indication

to Government and commissioners about what is needed to improve provision. We are keen to talk to you, and to the Welsh Government, about how thinking on reablement can be developed so that Wales benefits from consistent high-quality reablement services. Consistency is the key thing that we will keep coming back to today.

[7] There are some very good examples of strong practice out there, but, if we are to have excellent services across Wales, there needs to be much clearer guidance on how local authorities can develop reablement services. I will pass over to Pip to explain what we as an alliance mean by reablement and where we feel reablement fits into your inquiry on residential care.

[8] **Ms Ford:** I am very pleased to be here to give evidence today. Our written evidence has attempted to provide you with a range of information about the benefits of reablement. In your review of residential care, the Welsh Reablement Alliance hopes to make the case for the importance of reablement, for keeping people independent in their own homes but also within residential care. Reablement is the key to helping people make choices about their care and to their not having to make those choices at crisis point. There is no single model of reablement, and, in fact, a range of different models are operating around Wales. The Welsh Reablement Alliance takes a broad perspective of what reablement is. At its heart, it is about helping people to do things for themselves and maximise their ability to live life as independently as possible. It is also about supporting the whole person, addressing their physical, social and emotional needs. It must be outcome-focused, with the person setting their own goals, supported by a team over a limited period of time, and it requires a reabling ethos, which means that people are supported by a workforce that works with them rather than doing things for them. It focuses on what people can do, rather than what they cannot do, and it aims to reduce or minimise the need for ongoing support after reablement.

[9] I am sure that, within this evidence and other evidence you have received, there have been all sorts of terms used interchangeably, so we are going to give you a few definitions, if that is okay. To begin, we see 'enablement' as providing a person with adequate power, means, opportunity or authority to do something. 'Reablement' helps people to learn or relearn skills necessary for daily living that have been lost through a deterioration in health or as a result of increased support needs. A focus on regaining physical ability is central to this, as is active assessment. 'Rehabilitation' is a complex set of processes usually involving the input of several professions aimed at improving the quality of life for people facing daily living difficulties caused by chronic disease. There may be a focus on posture, balance, strength, mobility and function—the sort of things you would hear a physiotherapist talking about.

[10] 'Intermediate care' is the intervention between the acute setting and the community setting. Some models are called 'step-up' and some models are called 'step-down', implying either a step up from the community setting or a step down from the acute hospital setting. Ideally, this type of care allows time for rehabilitation so that someone who has deteriorated in the community can have a period of rehabilitation or so that someone in hospital can have the chance to continue rehabilitation before decisions are made about their long-term care.

[11] The Welsh Reablement Alliance fully supports the work of Professor John Bolton. We watched his evidence with great interest. In particular, we have drawn on the report, 'Better Support at Lower Cost', which clearly recommends the use of reablement and intermediate care. The startling statistic he found was that 60% of older people who enter reablement services do not require further services after a six-week intensive period of help and assistance. He also found that effective reablement services can deliver a reduction of between 10% and 20% in the demand for domiciliary care. Those statistics are from that report, so they are very recent. His report and evidence to the committee have been supportive of the approach taken in Wales and developments put in place by local authorities with their

partners. However, we hope that this committee will make further recommendations that will continue to drive the development of reablement. We want to see health and social care working closer together and more closely with the third sector. We would like to see a framework for reablement across Wales, and we want to see that no-one goes straight into residential care for a new long-term placement without reablement or intermediate care so that people do not make crisis decisions.

[12] That is my introduction. Thank you very much.

[13] **Mark Drakeford:** Thank you very much indeed, Philippa. We will have questions from Vaughan and Mick now.

[14] **Vaughan Gething:** That was very interesting and contained some messages that we have heard consistently from previous witnesses and in other papers. I am interested to pick up on some of the points you made on guidance and consistency. It is very interesting and useful to have the definitions you just gave as well. To clarify, when you talk about further guidance, I assume that you are talking about guidance from the Welsh Government. Who should that guidance be issued to? Are we talking about health bodies and/or local government? On the point about consistency and management, do you see consistency as an issue of quality or to do with the model? You spoke about the model being person-centred, which would suggest a need for flexibility. After that, I would like to come back to the point about management and the interface between the health service and local government.

[15] **Dr Bridges:** I will pick up those points and then Pip can jump in. On the issue of consistency and guidance, so far in Wales reablement has developed in a very organic way at local authority level. That has led to some very different models of reablement across Wales. As I said earlier, some of those are extremely strong. The one that is cited most often in the Assembly is the Gwent frailty project, but there are many others, from Bridgend and from Rhondda Cynon Taf, that are equally strong and do different things. That is fine, and very welcome, and there should be some flexibility at a local level for those models to develop to reflect the needs of those areas, but, having said that, there are big discrepancies at the moment—not just in what is being provided, but in what different local authorities interpret as being reablement services.

[16] For example, we submitted some freedom of information requests last year and asked local authorities what their budgets were for reablement. We found huge discrepancies. In Flintshire, for example, the local authority spends £1.83 per person living in the area on reablement; in Denbighshire, the spend is £2.35. However, in Torfaen, it is £23.20. That is a massive difference, and that is not because the service in Torfaen is 15 times better than the one in Flintshire—it is partly because the authorities are making very difficult judgments and interpretations about which services constitute reablement services. What we would say as an alliance is that there needs to be a steer from the Welsh Government to local authorities about what the Welsh Government considers to be reablement—which services should be included, and what local authorities should be seeking to provide. We hope that, in the work we have done in our position statement, we have set out some of the features of reablement services that could inform that guidance, because until there is a consistent picture across Wales of what is being interpreted as reablement there are going to be these big inconsistencies between local authorities.

[17] **Ms Ford:** I agree with that. John Bolton clearly showed that different authorities are at different levels of development of their reablement teams; no one size fits all, and there are many different types of models. There are 22 local authorities, so there are 22 different approaches being taken. What we are looking for is some kind of framework that allows for the good practice you need and the component parts. It does not matter how you shape them locally, but all the key parts have to be there, and, with our definition, you can see some of the

key parts that need to be there. There needs to be rehabilitation and the link with the third sector and a look at how those services come together. To answer your point about to whom this instruction should be delivered, it has to be the partners together. A key message from us is that health and social care and the third sector need to come together to plan their services across a geographical patch, looking at pooling their resources and thinking about how they commission third sector models and pilot schemes and projects to use that money as effectively as possible.

[18] **Vaughan Gething:** Moving on, you recognise that there is an inconsistent picture for reablement services, with regard both to how they are defined and how they are delivered and the fact that the models used are different. If the Welsh Government issues guidance, how do you actually see that working? The reality is that you still have different partners on the ground. How do you envisage that working so that the guidance bites? There is also the point that, when you have different local authorities—22 of them—one of them might say, ‘We don’t like that model, so we do not want to do that. The Welsh Government should not be telling us that this is what we have to do’. I am sure that all of our local authorities have very different views.

[19] **Dr Bridges:** Yes, and we would certainly recognise that regional flexibility is important. Just to give you one example, I think that one of the areas of discrepancy is perhaps around social support. There are some local authorities that see reablement being more about the rehabilitation model that Pip referred to, whereas there are others that understand that it perhaps encompasses a broader idea of social and emotional support for people. That is an area where the Welsh Government can say to local authorities, ‘You need to recognise that reablement is about a whole-person approach, and you should include an element of social support in any model of reablement’. That is not prescribing how they do something, but is saying, ‘This is a feature that should be common to all 22 local authorities’.

[20] **Vaughan Gething:** I have one final question on management. Are we saving money in the NHS budget that then gets spent in local government, or is it a total saving? There is also a point about whether budgets need to be pooled and how partners work together and take responsibility, because the spending may shift, even if there is an overall saving.

1.15 p.m.

[21] **Ms Ford:** That is a lot of questions. We could do the whole meeting just with Vaughan. [*Laughter.*]

[22] The bit about funding is quite difficult, because it looks as though some moneys are offset one way or another, but if you spend money on reablement, which is a bit more expensive than homecare, the savings are made down the line. So, reablement is seen to be cost-effective, because down the line you prevent people from going into residential care too early, and 60% do not need homecare packages, and savings are made. So, there will be savings offset between health and social care. However, if you discharge someone too quickly and you do not give them enough reablement rehabilitation, they will be back in again. So, you are offsetting costs.

[23] **Dr Bridges:** I do not have anything in particular to add to that, except that it is about preventing people not only from having to seek homecare but from readmission to hospital. There is scope for more evidence in relation to the financial benefits of reablement, but all of the evidence suggests strongly that if you invest in reablement services you save money further down the line by preventing hospital readmissions and homecare admissions. We make that quite clear in the written evidence we submitted.

[24] **Ms Ford:** I recommend research briefing 36 by the Social Care Institute for

Excellence, if you have not seen that. It is entitled 'Reablement: a cost effective route to better outcomes'.

[25] **Mark Drakeford:** Trown at **Mark Drakeford:** We will take Elin's gwestiynau Elin yn awr, cyn symud at Mick. questions next, before turning to Mick.

[26] **Elin Jones:** My questions have been aksed.

[27] **Mark Drakeford:** Okay. It is Mick next, and then Darren.

[28] **Mick Antoniw:** I have only two matters that I want to ask about, one of which has been mentioned with reference to a particular paper. Perhaps, Chair, it would be helpful to have some of these papers that are sometimes referred to and that contain the background evidence.

[29] You refer to a number of studies, including the 2007 study for the care services efficiency delivery programme, which says that, following reablement, 68% of people no longer needed a homecare package. Also, there is reference to a 2011 pilot study of stroke survivors, a study of chronic obstructive pulmonary disease patients and a Riverside Community Health Care NHS Trust study. A whole number of other studies by Heywood, Laing and Buisson and Joseph Rowntree are also referenced. You suggest that all of these studies give clear evidence that reablement effectively produces clear financial savings. To what extent, in all of the representations that you make with all of the main providers, whether they be local authorities or the NHS and so on, is there an understanding and acceptance of those studies, papers and that particular argument? You seem to suggest that the argument is still confused and that decisions are not taken in accordance with what you are suggesting is clear evidence.

[30] **Dr Bridges:** One of the factors that comes into play is the risk-averse nature of the system, which John Bolton mentioned when he gave evidence to you. Local health boards and authorities get the idea that reablement offers not just benefits to the health of the individual, but financial savings. They go down the route of referring people to homecare because of the risk-averse nature of the system. It is easier and safer to refer someone to residential care than it is to point them in the direction of reablement services, at times. That is a key barrier that must be overcome.

[31] **Ms Ford:** Some great work is going on, Mick, across all of the local authorities; they come together in the learning improvement network. So, reablement services from across Wales come together to look at their practice, share good practice and discuss strategies for the future. The Welsh Local Government Association, the Social Services Improvement Agency and the National Leadership and Innovation Agency for Healthcare will be developing a position statement, which we hope to work with them on as well.

[32] The evidence we have been presenting is taken up, because local authorities are developing ranges of different reablement models. The difficulty is that there are a lot of aspects that you can tap into, because there is no one set model. That makes it a little harder.

[33] **Mick Antoniw:** This evidence is part of the justification for the statement that you make early on, in which you suggest a number of tangible measures that the Welsh Government could take. One of those is that

[34] 'There must be a commitment to statutory funding'.

[35] Can you expand on that, because it is a broad statement? What does 'statutory funding' mean? What are you suggesting needs to be done by the Welsh Government in terms

of driving forward the benefits that would accrue from a reablement policy?

[36] **Dr Bridges:** This was partly hinted at in answer to one of the previous questions, when we talked about the lack of an incentive to local authorities to invest in reablement services, when a lot of the financial benefits are felt at an NHS level, and there is a gap. We were suggesting in making that point that there is scope for the Welsh Government to look at bridging that gap and addressing that area. England and Scotland have dedicated funds for reablement; Wales has no such fund. It is an area in which some investment in reablement services on the ground will help to move the debate on reablement further along. At the moment, as I said, very inconsistent models are being developed across Wales. If the Welsh Government is to give a steer to local authorities, part of that might involve funding services that need to be taken forward that perhaps do not exist currently.

[37] **Ms Ford:** I would add some examples that we have come across. People whom we have talked to have said that they would not be where they are now if they had had a blank sheet of paper and had been able to develop proper services in totality for the older population. They also feel that the way in which services have developed has been a bit piecemeal. So, where there has been a stream of funding for this, something has developed or there has been invest-to-save money and something else has been developed. They have ended up having to sit down and put together a jigsaw of all the different pieces of the service to try to get the whole picture. So, if there were some kind of a drive in terms of funding at a statutory level, that would give a strong steer about the importance of reablement services. Things are developing under their own steam, but statutory funding would help.

[38] **Mick Antoniw:** Are there any particular examples of best practice going on in a particular area that you would say is an example other areas could learn from?

[39] **Ms Ford:** Yes, there are. Will you start with a couple?

[40] **Dr Bridges:** Yes. I mentioned earlier that Rhondda Cynon Taf has a reablement service, which was established about 10 years ago and which brings together occupational therapists, physiotherapists and reablement workers. The authority has expanded that to create an intermediate care service that undertakes short-term rehabilitation for up to six weeks. That was all brought together into a single service with a single point of access and pooled funding. If you look at the outcomes of that, you will see that it was found that between 75% and 85% of the people using that service do not require further social care support. That is one that has been particularly successful.

[41] Bridgend also has an excellent intermediate care service that provides existing reablement, community disability rehabilitation and telecare services. It brings together nurses, OTs, physiotherapists and therapy technicians. That is another one that has been widely seen as a success.

[42] **Ms Ford:** I think so. 'Better Support at Lower Cost' highlights some good models and good joint working between health and social care with a single point of access and other areas where they have looked at preventive models alongside their reablement models. Some very good practice is available, and the learning improvement network is a useful vehicle for them to share good practice.

[43] **Mark Drakeford:** Lots of Members are indicating that they want to ask questions, so we may need to move through them a bit faster than we have been doing. I will go to Darren next and then to Rebecca and Kirsty.

[44] **Darren Millar:** Thank you for your paper. I am sorry that I was a little late and arrived during your presentation. I want to ask about the assessment process for reablement.

You say in your paper that reablement requires a good-quality assessment. When someone is at risk of needing to go into residential care, what triggers a proper assessment by an occupational therapist or a physiotherapist in particular, given their role in reablement, so that we can positively promote reablement as an option rather than a full care package in the home on the domiciliary side or referral to a care home? Does everyone get that option or not?

[45] **Ms Ford:** No, not everyone gets that option and, again, it depends on the services in a particular locality. The risk-averse aspect is quite a key issue. If a patient is seen in the community for their health needs and they then go into the acute setting, it may have been that their admission could have been prevented by a hospital admission aversion kind of model, which could include OTs, physiotherapists and social workers as part of that model. It may be that they would be taken into the accident and emergency department to be assessed by, hopefully, occupational therapists or physiotherapists as part of the team there. It may be that the GP is able to refer them directly to the reablement team that could come out to have a look straight away and assess them. Assessments will be by occupational therapists or physiotherapists. They may require social care assessment as well. When you say the word 'assessment' you are thinking about assessment by the multidisciplinary team and the multi-agency team so that we are thinking across health and social care.

[46] **Darren Millar:** You say that not everyone has access to a proper assessment from a multidisciplinary team.

[47] **Ms Ford:** People will have access, but they will not necessarily have a reablement team assessment. They may be going in and having an assessment by an acute team in a hospital setting.

[48] **Darren Millar:** Are you confident that access to reablement is being actively promoted for everyone? For example, do those in a hospital bed who have the opportunity to be discharged and who are at risk of going into a residential care home, have that access?

[49] **Ms Ford:** I would say that they probably do not, but I cannot give you a categorical answer. We would need to take a bit more evidence from all the local authorities to see what is available in each area. Our understanding is that health and social care teams are coming together to look at some of the trigger areas that bring people into hospital and to concentrate on those. They include stroke, continence issues, falls and dementia. Those are the sort of areas they are looking at.

[50] **Darren Millar:** I am pleased that you touched on dementia because I want to come to that in a second. With regard to this particular issue, do you think that, as a committee, we ought to be making a recommendation to the Government that, when someone is at risk of entering residential care, there ought to be a full assessment of whether reablement could be a viable option?

[51] **Ms Ford:** I totally do; yes.

[52] **Darren Millar:** You touched on dementia. There was no reference in any great detail to dementia in your paper. We understand from some written evidence from the Royal College of Psychiatrists that there appears to be no community-based models of reablement services for people with dementia. Are you aware of any that you could present to us as a committee as evidence?

[53] **Dr Bridges:** I think that there are very good models of social support services out there that cover people with dementia. Specific services aimed solely at people with dementia are harder to come by, but there are some good examples of social support, including good neighbour schemes, befriending services and so on, which can make an enormous difference

to people who are suffering from dementia.

[54] **Ms Ford:** I would argue that everyone should be able to have reablement, whether they have dementia or not. My mother has dementia and she is managing very well in her own bungalow, at home. She is being kept as able as possible with a fantastic care package that has a reabling ethos. It might take longer to help her to do things. I say ‘help her’, but I mean working with her to do things. She is doing that in her own home and is supported there. I do not think that dementia should necessarily be a criterion by which people are selected out of receiving reablement services. That would be my view; I am sure that many people would share that view. I can see the danger zone and the risk-aversion side of worrying about people who have dementia and who are living alone in their own homes. Telecare and all sorts of other things can be put in place to give people as much support as possible to continue to live in their own homes. I do not think that it should be a criterion by which you are selected out of reablement services.

1.30 p.m.

[55] **Darren Millar:** With those who want to self-manage their reablement, which I had to do, for example, in the case of my ankle after having physiotherapy, I presume that people with dementia sometimes may need to be reminded about certain exercises that they need to do, or whatever. It is basically about it being more of a tailored approach to the individual, is it not?

[56] **Ms Ford:** Absolutely. You would have the assessment, as we talked about, and then work with the person, their carers and the homecare team to ensure that you are putting in the tailored programme that would give them the additional support.

[57] **Darren Millar:** Do you think that we should recommend to the Welsh Government a pilot scheme that is focused on reablement for people with dementia?

[58] **Dr Bridges:** It might be something worth exploring, and it is something that I think we would support.

[59] **Ms Ford:** I would argue that we would need to look at all the different types of models out there. I find that I am always asking for a baseline, but I think that it would be very useful to look at all the different types of models and the criteria for selection that some of the models have and those sorts of things. That would be a useful view for the committee to take on what is out there.

[60] **Mark Drakeford:** I think that Darren was making a very specific suggestion. It might be useful, if you have a chance, to ask among the network and your members to see what the reaction would be and then let us know whether people think it is a useful idea that we could adopt. Kirsty, do you have a question on dementia, specifically?

[61] **Kirsty Williams:** Yes. I noticed that the Alzheimer’s Society is part of the network. There is quite clear evidence from specialists coming out of the University of Stirling in Scotland that aids and adaptations to the home can make a huge amount of difference in enabling people with dementia to stay in their homes. Something as simple as a glass-fronted fridge, which puts food on display and helps to remind people that they need to eat, can make a huge difference. I guess that you have answered this, but I was just wondering about the limitations of where reablement starts and finishes. At the moment, the paper seems to focus very much on what I would regard as traditional issues of reablement. You would agree that, potentially, with ongoing research, there is a role for reablement with regard to dementia. We know what happens to people with Alzheimer’s if they go into hospital—it is very bad news for them—so we need to keep them at home for as long as possible.

[62] **Dr Bridges:** Absolutely, and one of the things we have tried to put across is that reablement has constantly to be open to new research and to new organisations coming in with new ideas. The only way in which reablement can be effective is by involving different organisations from across the sectors, using all sorts of different approaches. It has to be about the complete-person approach, and that is physical support, social support and emotional support. It might involve adaptations to the home, or it might—

[63] **Kirsty Williams:** Old-fashioned taps, apparently.

[64] **Dr Bridges:** Absolutely. All these things have a role to play, and I guess that the challenge in policy terms is in getting all those different organisations to work together. Where you can do that, and do it effectively, it makes an enormous difference to the older person's quality of life, but it also has a dramatic impact on financial savings.

[65] **Kirsty Williams:** It would be useful, Chair, if the Research Service could help us to track down the lady's name. Her first name is June—I cannot think of her surname. I think that she is the lead on this at Stirling university in Scotland. They have some very interesting work on how you maintain wellbeing in the home for people who have dementia.

[66] **Mark Drakeford:** We will do that, certainly.

[67] **Ms Ford:** There is a key role for the third sector here as well, because reablement is a short, sharp period of really intensive work with the person and their family, but that then stops. Where do people go after that? Do they need additional care? If so, how do you set that up? If you have really good working relationships with the third sector and you are funding good third sector projects, such as the befriending project and some of the facilities that are provided by the Alzheimer's Society and so on, it could be fantastic. My mother has had befriending; she is going to the day centre. These are all social activities, which are great, because they get her out of the house, and from the physiotherapy perspective, they are mobilising through walking, stretching and doing all that kind of stuff.

[68] **Rebecca Evans:** Picking up on your comments on the third sector, to what extent is the voluntary sector relied upon to provide social services such as befriending? Are you concerned about the long-term viability of those services, given the financial pressures the third sector is under?

[69] **Dr Bridges:** The third sector has a huge role to play in community-based social support services. The voluntary sector is probably in the best place to provide services that help to embed people in their local communities. All sectors are under pressure to meet targets and so on and where the voluntary sector can really help is with those social support services, whether it is with befriending or good neighbour schemes, where a volunteer spends time with an older person and they are not under pressure to move on to their next appointment or anything else. They can spend time having conversations and putting someone at ease who might otherwise be lonely or isolated. That is something that the voluntary sector is best placed to deliver.

[70] My feeling is that the voluntary sector is still doing very well in delivering those services across Wales. WRVS, which I work for, has recently been granted money by the Welsh Government to deliver more befriending services. I see that the British Red Cross is expanding its schemes, particularly in north Wales. The voluntary sector is very healthy in that respect and is doing well at delivering those services at the moment. The challenge is integrating those within a reablement model so that services are not delivered on a limb; it is about integrating them within a wider reablement team. It is also about signposting people towards them, because there is a big gap at the moment. People often hear about social

support services through word of mouth. As an alliance, we have said that there needs to be much better signposting towards those services, whether that is done through reablement teams or as part of the over-50s health checks that the Welsh Government is looking to introduce. It is about making sure that there is a system for signposting people towards those social support services. That will make a big difference.

[71] **Ms Ford:** A local authority that I spoke to very recently said that its health and social care come together to look at the funding pots they have for third sector projects, and they are pooling those to make sure that they use them in the best possible way. The services are not undertaking separate contracts with Age Concern, for example, and are finding that they are very similar, without talking to each other. That is a very positive way in which to do it, and that is something I would like to see happen throughout Wales. I do not know whether that is currently happening, but it would be very positive if it did.

[72] **Rebecca Evans:** Are there geographical gaps in provision that you are particularly concerned about? For example, people in rural areas may not have access to social support, so is that currently provided online or on the telephone? How do you address that issue in those areas?

[73] **Dr Bridges:** It is very easy to fall into the trap of thinking that isolation is more pronounced in rural areas than in urban areas, but it is possible to live in the middle of a big city and be isolated and lonely. We often miss a trick by just focusing on rural areas when developing those types of services. I would not say that there is necessarily a particular gap in rural areas. In some ways, the signposting is slightly stronger in rural areas because tighter-knit communities are better at pointing people towards services they might need.

[74] **Ms Ford:** I was thinking about responses from LHB representatives in Powys and about what is available in those areas, fitting the services that are needed. They were talking about models such as the crisis Carers Trust model and providing support at a time when you need to try to sort something out to stop someone from going into hospital. The third sector will find those particular gaps as they come up.

[75] **Rebecca Evans:** To what extent and how do reablement services involve carers in deciding what provision can be made?

[76] **Ms Ford:** That is a key part of reablement, because you must set goals with the person, their carers and their family. It is important to have a good assessment. The setting of goals and involving the family will only help in the outcomes for the person.

[77] **Elin Jones:** You have talked mainly about reablement in homes and in preventing hospital admissions. What about reablement for those people who are in long-term residential care? How much reablement is happening in Wales for people who have gone into long-term residential care, to keep them active within those care homes, or is the priority on the home setting?

[78] **Dr Bridges:** That is one of the big points that we really wanted to push today: too often, residential care is seen as the end of someone's ability to access services like reablement. We would really want to challenge that. In some circumstances it would be completely right for someone to be taken into residential care, but that should not mean that they can no longer access effective reablement. Pip has already referred to some of the services that her mother has been using, such as helping people to make a cup of tea or even lunch for themselves. Just because someone is in a residential care setting, it does not mean that they cannot be helped to relearn skills and to carry out everyday tasks along with a reablement team, rather than just sitting in a residential care home having stuff done to them all day. That warehousing approach really needs to be challenged. We would absolutely agree

that there needs to be a challenge to the assumption that, as soon as someone is warehoused in that residential home setting, they can no longer access reablement services.

[79] **Elin Jones:** How much reablement is happening in long-term residential care?

[80] **Ms Ford:** It is really patchy, Elin. The experience and the knowledge we have from our members is that, in some health board areas, physiotherapists, occupational therapists and reablement teams are going into residential homes, but that is not the case across the whole patch. So, that would be something worth investigating. The reablement teams in Rhondda Cynon Taf, for example, go into residential care homes. Some of the residential care homes have intermediate care beds available. So, how they look at care as a whole is being well managed, because there is that ability to step up and step down if someone needs that additional rehabilitation.

[81] Also, if people can access reablement in a residential home, it might prevent them from sliding down and having to go into a nursing home. So, there are savings to be made, as well as securing quality of life for the person.

[82] **Mark Drakeford:** This morning, some of us visited an extra care complex, where we met someone living a very independent life now who had come there from residential care. John Bolton suggested to us that one of the big picture problems of public policy towards older people—not just in Wales, but probably more widely—is that public policy, somewhere at its root, has a view of old age as a one-way direction in which you can only become more and more dependent. However, what we saw—and part of your evidence suggests this—tells us that we should challenge that idea. Older people can go through bad times and can get better. They can regain ground that they might have lost when they were not very well. We do not build that possibility actively enough into the way we conceptualise public policy. It has been very useful.

[83] **Ms Ford:** I totally agree with that.

[84] **Mark Drakeford:** Do you have any last thoughts, or is there anything we have not covered or given you the chance to say that you think we should take away?

[85] **Ms Ford:** I think that you have just put what we have been saying into a nutshell. Are there any other points that we have not picked up on?

[86] **Dr Bridges:** I will only reiterate what we said at the start: with reablement, there has to be a mixture of different services and sectors for it to be effective. That would mean using trained professionals such as occupational therapists, physiotherapists, social workers, state care services and the voluntary sector, and also seeing a wide range of different components: social, emotional and physical support.

1.45 p.m.

[87] The key aspect about reablement is that it has to be flexible. It is not a single unified service; it is more like a loose affiliation of different providers providing different services, but hanging them together and making it work. As I said at the start, if you can get that right, it will keep people out of residential care in the first place and it can then make the journey through residential care much easier and happier for the person involved and for their family.

[88] **Ms Ford:** It also needs to be a part of a continuum, which includes intermediate care, as well as the hospital avoidance services. As well as long-term care, it is part of a continuum. It is a real key part. Thank you.

[89] **Mark Drakeford:** Diolch yn fawr iawn i'r ddau ohonoch am eich tystiolaeth, sydd wedi bod yn ddiddorol ac yn ddefnyddiol i ni fel pwyllgor. Diolch yn fawr hefyd am eich amser y prynhawn yma.

Mark Drakeford: Thank you, both, for your evidence, which has been interesting and useful to us as a committee. Thank you also for giving of your time this afternoon.

[90] Symudwn ymlaen at yr ail grŵp sydd yn ymddangos ger ein bron y prynhawn yma, sef yr United Kingdom Homecare Association Ltd.

We now move on to the second group to appear before us this afternoon, which is the United Kingdom Homecare Association Ltd.

[91] If you do have questions, Lynne and William, I will come to you first as you did not have a chance to come in during the first round of questioning.

[92] Prynhawn da, a chroeso ichi. Good afternoon, and welcome to you both.

[93] Thank you, both, for taking the time to come to help us with our inquiry into residential care services for older people in Wales. You will know that, as part of our terms of reference, we are very interested in looking at those services that may offer people different sorts of choices at that point in their lives when they may be beginning to think about the sort of care that they will need. I am grateful to you both for coming to help us with that. I welcome Francis McGlone, the senior policy officer with the UK Homecare Association, and Yvonne Apsitis, the vice president of the UK Homecare Association. We normally ask whether you would like to make a few relatively brief introductory remarks just to help us into your evidence. We have had a chance to read your written evidence, of course; therefore, thank you for that. After that I will go to the members of the committee, who I know will have questions for you. Are you going to lead off, Francis?

[94] **Mr McGlone:** Thank you very much for inviting us. I am sorry that Colin Angel could not come along, but Yvonne will do sterling work. One of the main points that we would like to make is that, although this inquiry is into residential care and older people, it is crucial that the committee understands that homecare is an essential service if you wish to ensure that people can stay out of residential care.

[95] Homecare is really essential. It is already a service that is being used by large numbers of people in Wales: approximately 28,000 people are using homecare services. However, one of the problems that the homecare sector, in general, has is that it is under stress, like never before. Part of the reason for that is that local authority fees do not enable homecare providers to pay the sorts of levels of wages that they would like to pay, to meet the regulatory costs, and to provide training and so on. It puts a lot of pressure on the providers. They cannot get the quality of workers that they would like because of the low wages, and there is also a large turnover in homecare workers, which has an impact on the quality of care that they can provide. At the same time, homecare is expected to deal with more complex issues in people's homes—the sorts of things that, in the past, the district nurse would have done.

[96] On the sort of impact that the low levels of fees that are currently being paid are having, for example, something like one in five homecare providers now think that they will be out of business within a year. We run a hot spots file at the United Kingdom Homecare Association, and I am getting daily reports, admittedly from all over the country, of homecare providers saying that they are facing all sorts of problems. There are cuts in the level of fees they are getting, they have not been given any uprating for inflation, and yet, at the same time, more and more demands are being placed on them, or the local authority has decided to reduce the number of providers it deals with in the area from something like 30 to around four. The expectation is that their workers will simply transfer over to the new provider, but

that is not happening because, often, those care workers are making a decision between whether to stay in homecare or go to work in Tesco, for example. Those are the sorts of issues they are facing. Therefore, what we are saying is that if you wish to maintain a sustainable homecare system in Wales, you must ensure that the level of fees can meet the true cost of providing care.

[97] Let me just finish by saying that many of the things the Welsh Government has done are absolutely excellent. We are really behind you on commissioning and the memorandum of understanding—these are excellent things—but there seems to be a difference between what is being said by the Welsh Government and how local authority commissioners are implementing that at the coalface.

[98] **Mark Drakeford:** Thank you very much indeed. That was a very helpful summary of some important issues. I will now go around the table to see whether there are any questions. William is first.

[99] **William Graham:** Thank you for your written evidence and for your comments today. Previous committee evidence touched on the point you made about the staff. How can we help to get greater recognition for those who work in the homecare industry?

[100] **Mr McGlone:** Something like 67% of state contracts for homecare are dealt with by the independent sector, so this is coming through local authorities and if local authorities are not paying the level of fees necessary to recruit, train and support the workforce, it is quite difficult. For me, the key must be that the proper level of fees is paid so that there is recognition of the real costs of providing homecare. Right now, that is not happening.

[101] **William Graham:** Does the same apply to enabling those staff to undergo training, particularly where more and more is demanded of them?

[102] **Mr McGlone:** Yes.

[103] **William Graham:** So, you would say that the key to this is entirely to do with commissioning and the fees structure.

[104] **Mr McGlone:** That is a key element, yes.

[105] **Ms Apsitis:** We support that. Training is the first thing that has to drop off the budget line when there is not sufficient money coming in. Everyone is anxious to value their workers, but it is very difficult to value them when, in fact, if they move from a level 2 NVQ to a level 3 NVQ, which is where we need them to be now because of the skill expectations, we have to say, 'Well, you can go up to level 3, but we won't be able to pay you any more because we can only provide basic money, low pay, and it does not matter what your expectations are because there isn't an opportunity for us to pay you any more'.

[106] **William Graham:** Does your association recognise that there is recognition of the problems you are talking about today?

[107] **Mr McGlone:** We fully recognise it.

[108] **William Graham:** I do not mean recognition on your part but from the commissioners.

[109] **Mr McGlone:** No, I do not think that they recognise this. However, of course, the situation is that commissioners are facing cuts to their budgets. Therefore, they are looking very closely at their budgets and putting pressure on providers to reduce their costs as well.

However, what they are not recognising is that providers are already at the point where there is no more they can actually cut.

[110] **Lynne Neagle:** You mentioned the pressures with regard to fees levels. Obviously, there is the issue of how much commissioners are choosing to pay, but, presumably, we are now also seeing local authorities significantly reducing the level of homecare packages. What evidence are you finding on that and the impact it is having on providers?

[111] **Mr McGlone:** The United Kingdom Homecare Association carried out a survey: some of the evidence is in our paper and it clearly shows the reduction in homecare packages. It also shows that the amount of contact time that homecare providers are having with service users is being reduced. Some local authorities are making the rules regarding eligibility for care provision very tight indeed, and some people who would have received a certain level of care in the past are now not eligible, and those who are left are the most critical, with the most complex packages of care.

[112] Right now we are involved in another survey, for which we have only the preliminary results at the moment, but, again, it is showing further cuts. That is leading to some homecare providers being concerned about the safety aspects. For example, instead of having two homecare workers going in, it may be only one, which would raise issues about manual handling and things like that.

[113] **Lynne Neagle:** I have a further question on the memorandum of understanding. You said that you welcome it, but you are not really seeing the benefits. Is that because local authorities are excluding it from their commissioning and just pursuing it in relation to their own staff?

[114] **Ms Apsitis:** The memorandum of understanding does not include a reference to the council's own staff; it is actually about the organisations in the sectors coming together. However, after the difficulties that there have been between the residential sector and the local authorities over the last 12 months or so, there has not been a meeting at all. It is not possible because people do not want to come together to talk to each other. So, although this is a really good idea, and I know that the Deputy Minister is well behind it, in fact, it has been 12 months since the group met. That is sad because it was an opportunity, and it is not happening at the moment.

[115] **Kirsty Williams:** Notwithstanding the comments on page 14 of your paper with regard to quality, in recent months there has been a strong focus nationally on quality of care issues for older people, whether they are in a hospital setting, a residential care setting or a homecare setting. In all three cases, the evidence about quality and the experiences of individuals have been quite shocking on occasion. I appreciate what you are saying about the pressures on people because of low fee levels. What is the industry doing to ensure that those who are going into people's homes are going when they are supposed to, doing what they are supposed to doing when they get there, and doing it in a way that maintains the dignity of the person in receipt of that care package? What is the industry doing to address the issues around the quality of the experience?

[116] **Mr McGlone:** In the majority of cases, the care that people get is very good. However, you are absolutely right that there have been a number of cases where it has been appalling, and that stretches right across from the independent sector to the national health service, so it is quite clear. The sector is responding to that. It is quite aware of that, and has been stepping up training. My own organisation is heavily involved in training. We were part of the Equality and Human Rights Commission—we were part of that commission—and we reported heavily on that. Another thing that we are doing is advertising good quality care, and what it looks like.

[117] I would like to make a point about the new survey that we are carrying out. One of the questions that we asked providers was whether local authorities were commissioning for quality or for cost. In the preliminary results, 60% of our members—sorry, it is not just our members because other providers also responded to the survey—60% of respondents said that it was based on cost, not quality. Therefore, it is a bit of a two-way process. The sector will respond and it is responding, but we need to ensure that local authorities recognise that they also have to commission for quality.

2.00 p.m.

[118] **Kirsty Williams:** One aspect of the work that the committee is looking at is alternative models. It brings to mind the example of a gentleman who was in receipt of homecare, but the homecare company folded. The only option then was to resort to another service where the carer, who was coming to carry out the most intimate care needs of this gentleman, would change practically on a daily basis and the time of the call would also change daily. What the gentleman wanted more than anything was to be able to purchase the services of the two ladies who had previously been employed in the now folded care company because he knew them and could get them to visit him daily at a time that was convenient for him. After a long battle, we were able to get a direct payments system going, which allowed him to do just that, namely to purchase the kind of homecare that best suited his needs, from people who he trusted and had confidence in and who he was happy with. If the Welsh Government was to move to a greater use of personalised budgets and individual and personalised care, which it says is its intention, is your sector in a position to respond to that?

[119] **Mr McGlone:** Very much so and it would welcome it. The UK Homecare Association has been at the forefront of pushing for choice and control, that is, for self-directed support or personalisation—whatever you want to call it—in order to provide for people. One big issue facing many of our members is that they would like to get a number of their service users on a direct payments system, but they cannot do so because of delays from local authorities. In fact, we have what is called the ‘hot spots file’ at the office—when our members phone in we keep a record of the sort of issues going on. They are telling us that many obstacles are put in the way of providers getting direct payments for service users. Some have even been threatened by adult safeguarding committees; that has been used as an excuse.

[120] The type of thing that happens is that a new provider wins a contract, but the service user wishes to stay with their existing provider. They find that difficult, because of delays and how long it takes to get the direct payment through. The other point relates to the amount of direct payment because, often, it is much less than the local authority will pay for a service. Indeed, a very good report that the Welsh Government commissioned from John Bolton, which I am sure you know about, set out the rates—it was the first time I had seen them—that people were paying in direct payments. The report included a whole list of local authorities in Wales and what rates were being paid. One was unbelievably low—it was below £8. You cannot buy a regulated service for that amount per hour. Therefore, if you want real choice and control, local authorities have to recognise that direct payments are good because people need the choice and control, but they have to be at a rate at which they can pay for a proper service. Furthermore, delays should not be put in the way of that happening so that people can exercise that level of choice.

[121] **Mick Antoniw:** You said something earlier about uneconomic fees. I think that you are suggesting that the consequence of that impacts on training, retention, wages and so on. Are you saying that the impact is, effectively, that the quality of the service reduces?

[122] **Mr McGlone:** That is the risk.

[123] **Mick Antoniw:** Is it reducing?

[124] **Mr McGlone:** I am not sure that it is, because a lot of homecare providers maintain the quality despite the pressure. Often, they may well decide that they can no longer do that type of business. I get calls from providers who will say to me that they cannot provide a quality service at the contract price that is being offered and so they will not do it. Others phone up and say that they cannot provide a certain service in 15 minutes—it may be that 45 minutes or an hour used to be allowed for it and now providers are being told to do it in 15 minutes. They say that it is not safe and it is not a quality service, so they will not provide it; we have providers who will say that. However, there may well be some providers who will be pushed down, because, if they do not take the contract, they may well go out of business because in some areas the local authorities may be the only purchasers of homecare. There may be no private purchasers, so they will have no choice if they are to stay in business but to try to maintain the service. Therefore, they will take it and do everything that they can to maintain the quality, but they are under tremendous pressure in doing that.

[125] **Mick Antoniw:** I understand why you do not want to say that quality is reducing as a consequence, but surely it must be the case that if the fees that are being paid are uneconomic, quality will go down as a consequence of there being less well-paid staff, less well-trained staff and so on. That must be the consequence, must it not?

[126] **Mr McGlone:** The evidence is that, when the regulator has gone in, it has not found that the quality is going down, but that it is going up.

[127] **Mick Antoniw:** Does that not then justify what the local authorities are paying? They are being more economical in terms of saving public money. I have concerns about how accurate that can be in that circumstance. You are saying that quality is going up despite the fact that you are being paid less.

[128] **Mr McGlone:** That is what the regulator is saying.

[129] **Ms Apsitis:** The CSSIW report is saying that. It has reported that, in fact, it has found that services are improving. The evidence from on the ground suggests that the workers are working a great deal harder to try to deliver the same quality of service, and they are being successful in those cases, but it is because of their personal endeavour and determination to deliver because they are working with people with whom they have been working for many years. They are now trying to squeeze into 15 minutes what they did in 30 minutes before, in many cases. They are apologising from the moment that they get in through the door to the moment that they leave about the fact that that is how it is now and that they are doing their best. So, I am not sure that the quality in terms of the presentation to the service user is different, but it puts pressure on the workers to try to achieve and maintain that quality of relationship at the same time as trying to do as many tasks in half as much time as they originally had. That became apparent when we were doing the dignity in care work a couple of years ago, when we asked what the issues were. Dignity is affected very much by the speed at which one has to work. You do not have time for the important conversations and the listening that are so essential. Many care workers in the sector will walk away. We have providers and workers in the sector who say, 'I cannot do this any more', and that is an appalling state of affairs.

[130] **Mick Antoniw:** To move on to a slightly different point in your summary, one of the issues that arise is the issue that you describe as the economic regulation of the homecare sector. What is wrong with economic regulation in the light of the obligations that the Welsh Government, local authorities and so on have in terms of ensuring the viability of providers? What are your concerns regarding economic regulation? Why should there not be economic

regulation?

[131] **Mr McGlone:** First, I do not think that it is necessary. It would be costly, and that includes providers and whoever was doing the regulating. I do not think that, just because of Southern Cross, it is realistic to say that it applies even to small providers, because most providers in homecare are small or medium-sized providers. They do not have the same costs and financial issues that a large residential care provider has. For example, they do not have to purchase or rent residential care homes, because the care is done in someone's home, so they just need a head office or, if they are a bit bigger, some branches as well. The profit margins in homecare are pretty small, and, if you brought in economic regulation as well, they would be even tighter. It would be another additional cost.

[132] **Mick Antoniw:** You represent both the private and the not-for-profit sectors. Is that a view that is shared equally between both sectors?

[133] **Mr McGlone:** The answer to that is that I do not know, because we have not looked at that.

[134] **Mark Drakeford:** Yet, Mr McGlone, you said to us that one in five of your members do not expect to be in business in a year's time.

[135] **Mr McGlone:** It was one in five providers.

[136] **Mark Drakeford:** Do you not think, then, that there is a public interest in a local authority having an economic health check of those organisations with which it is contracting if that many providers do not expect to be there next year?

[137] **Mr McGlone:** You would not have the same sort of situation as with Southern Cross, in terms of a large number of homes would then go out of business and emergency procedures would have to be put in place. A lot of local authorities can easily have contingency plans in place, and they do have those plans. They could take a contract off a provider right now, or a provider may go bust, and, because of the number of providers out there, they would be able to issue another contract. The risk is that if the sector shrinks more and more because of these pressures on it, local authorities will not be able to do that because there will not be surplus providers that are able to take up these contracts.

[138] **Mark Drakeford:** Are there not two other things going on inside the market that makes economic regulation something that at least has to be thought of seriously? As you have reported to us, local authorities tend to contract with fewer providers. If you are down to four providers, as in the example you gave us earlier, and one of those is one of the one in five who will not be here in the future, that is quite a big risk for a local authority. Although the pattern in the industry is still dominated by small to medium-sized providers, is there a pattern emerging in the last year or so of acquisitions? Is the pattern for the future likely to be that some of the bigger firms will get bigger, and that the balance between the small and medium-sized providers and a few reasonably large, more Southern-Cross-like providers is looking like it might be the pattern in future?

[139] **Mr McGlone:** You are right that there is consolidation going on in the sector because of the issues that we have been talking about. However, the latest figures still show—this is off the top of my head; the actual figure is in the paper—that even the top number of providers has only about 15% of the market, which is well below anything that you could consider to be dominant.

[140] **Mark Drakeford:** That is very interesting. Thank you.

[141] **Darren Millar:** I have a quick comment on the financial arrangements. The fee rates that are being paid—you cited £6.58 an hour in Caerphilly—are clearly indefensible and are driving consolidation in the sector in order to have the economies of scale to make a living out of providing domiciliary care. If there will be regulation, there needs to be some regulation of local authority fee rates as well to give some fairness to the sector so that a living wage can be paid to the members of staff.

[142] I want to turn quickly to one of the other major things that the Welsh Government has done, which has recently been introduced, which is the cap of £50 per week for domiciliary care for individual contributions. I wonder to what extent that has had an impact on your industry. Is there any evidence that it has changed the way that commissioners are behaving, for example?

[143] **Ms Apsitis:** It is not apparent, if that is the case. That is very much an issue for the authorities and their budgets to deal with. I suppose that there is a slight risk that we end up with more people going into residential care, but that is much more to do with hearsay than evidence from the sector.

[144] With regard to money, and slightly tangential to where you are coming from, the difference in Wales is that there are huge areas where people are not in a position to top up their care in any way, whereas providers in others parts of the UK have a match of business between maybe very poor income from local authority contracts, although it might be of a reasonable volume, and independently paying clients who are paying a much more appropriate level in order to secure the services they want. In Wales, we do not have that luxury in many areas, in that, if providers lose their contracts with their authorities, they may have nowhere else where they can earn sufficient money to be viable.

2.15 p.m.

[145] **Darren Millar:** That is interesting. So, you are saying that those people who purchase their care themselves are effectively subsidising the poor local authority rates being paid by councils.

[146] **Ms Apsitis:** I do not know whether we have any evidence for that in the survey work that we have been doing, but, in talking to individual providers, we know that an increasing number are saying that they cannot afford to work on local authority contracts at those rates, and if they do not have another market that they can go to, they will not stay in business. Some will be looking to have contracts with health and others with some of the larger voluntary organisations. Those providers that have a private market will stay in business, while the ones that do not will not.

[147] **Darren Millar:** So, it is effectively the other income streams that are subsidising and offsetting the poor income streams from the local authorities. That is an interesting point.

[148] **Mr McGlone:** We run an advice line, so we can get a rough idea of the sorts of things that come up. The cap has not come up, but some providers are saying that local authorities are saying to them that they are providing a service at the direct payment rate, which is lower than the rate that they are charging their private clients, and they have been told on occasions that they must charge the same across both in certain circumstances. It therefore looks as though there is some evidence that providers are using the higher fees that they get from private clients to subsidise others. However, as I say, we have not collected that evidence and I do not know of any studies or research that has been carried out into this.

[149] **Darren Millar:** That is interesting, because the residential care sector is effectively saying the same, which is that it has to charge higher fees because of the lower fees that are

being paid by local authorities.

[150] **Mark Drakeford:** Before I bring Elin in, I want to make it clear for the record that what your paper says about Caerphilly is not that it pays £6.58 an hour for domiciliary care services, but that it offers £6.58 an hour to those people who want direct payments. That is a slightly different point.

[151] **Darren Millar:** The point is that £6.58 is £6.58.

[152] **Ms Apsitis:** Yes, it is not minimum wage.

[153] **Elin Jones:** I want to ask you about transport costs and work in rural areas in particular. The survey that you undertook in autumn 2011 highlighted that 10% of providers had turned down work in rural areas because it had become unprofitable with visit times. How much of an issue is it for your providers and those who cover rural areas that transport costs are increasing? How responsive have local authorities been in rural areas to recognise the costs involved in travelling for your carers?

[154] **Mr McGlone:** We have received calls to our advice line about this. We do not have very good data, but a number of our members have said that they cannot cover the rural areas because it is simply not economically viable for them. I cannot say to what extent local authorities have responded to that and I am afraid that I do not know whether that is in the survey either.

[155] **Ms Apsitis:** People may or may not be aware that, in most cases, local authorities do not make any payments for travel time or travel costs. Providers, when they put in a response for a tender, have to try to include all of those costs, because there is only one opportunity, which is whatever the hourly rate is. Fuel costs have been escalating in the past couple of months, which everyone has recognised, but once the providers accepted a price from a local authority, perhaps 12 months ago, the whole of that increase must be absorbed. It was not part of anyone's business plan at the outset to predict that this was going to happen to the fuel costs. However, there is a fundamental difference with services provided through local government's own services, where people are paid travelling time and mileage.

[156] **Kirsty Williams:** Not all of them do that.

[157] **Ms Apsitis:** No, but it certainly has to be fitted within the hourly rate ahead of time.

[158] **Vaughan Gething:** I have run claims against local authorities on the travel time point, and I know that not all authorities pay travel time.

[159] I want to touch briefly on the point about regulation. Mr McGlone, you have said that regulation would be costly—I cannot remember your exact phrase. Where is the evidence that a system of regulation would be costly to the businesses?

[160] **Mr McGlone:** The Scottish Government has also looked at this. We looked at the evidence that was coming in, which commented that it was costly and difficult, not only for those who would be doing the regulating—this was the Scottish Health and Sport Committee—but also for providers, because they would have to provide evidence for how much it cost in the accounts and various things like that. I do not know exactly how much it would cost; I was just going with that.

[161] **Vaughan Gething:** Okay, but they are businesses, whether they are not-for-profit or not. They must, therefore, understand profit and loss, their own costs, liabilities, income streams and future financial forecasts; otherwise they would not be able to tell you that they

may not be in business in 12 months' time, as one in five of them appear to have done. I am a little perplexed about how you can say that it would be costly when a system of regulation is not being proposed.

[162] **Mr McGlone:** You would have to send in your accounts. You would have to know your financial liability in advance, which I imagine is quite a difficult thing for a lot of small providers.

[163] **Vaughan Gething:** Do they not have to do that anyway?

[164] **Mr McGlone:** Just on an accountancy basis they would, but not to the same extent as if they were being regulated and had to provide financial details of how much they were involved in that area.

[165] **Ms Apsitis:** Currently, CSSIW inspects all domiciliary provision and interviews managers. One of the current requirements for those managers is that they have to be competent to manage their business. What is important is that most of the businesses are very small. Historically, many of them have worked from a farmhouse table, and there are still a lot of providers who do less than 200 hours a week. That is a very small business; it is corner shop stuff. Therefore, the expectation of financial micromanagement is very different from what it would be for a large business. So, something that would ask for much more information would, in fact, be quite challenging for small providers, but not for the bigger ones; that is where the difference in provision is. Many of the providers in Wales are still very small, and they are very small because they are rural and have to work in small areas. In fact, we do not have the big, macro businesses that many of the nursing homes and residential homes have. It is a very different business.

[166] An example would be providers in Wales who wanted to sell their businesses but could not do so because, when accountants from other companies look at their books, they say 'You are not making money; you are just paying yourself. We would not, therefore, be interested in buying your business.' Many people come into homecare because they want to deliver care, not because they want to run a business. That is a fundamental difference, I think, between the residential sector and the domiciliary sector.

[167] **Vaughan Gething:** It does rather presuppose what any similar regulation would be, and that is difficult.

[168] **Darren Millar:** This is an interesting discussion. The risk is that you pull the plug on businesses that could otherwise be very successful simply because they are going through a rough period in the business cycle, for whatever reason, such as if they have invested in something that looks, on paper, like they have made a loss. In such a situation, where the rug is pulled from under the providers on the basis that they had reported a bad quarter to the local authority, you will have a situation in which you will force lots of small providers out of the business and force consolidation in the industry, which is precisely what has led to the disaster that we have seen with Southern Cross, is it not?

[169] **Vaughan Gething:** Again, that is something that we are looking for and something that we expect people to do. So, you cannot prejudge what does not already exist.

[170] **Darren Millar:** I think, Chair, that the situation is this: local authorities do business with businesses of various sizes across the board on a day to day basis. If every one of those was judged on the basis of their viability as a business at any point in time, many would go out of business as a result of that type of regulation.

[171] **Mick Antoniw:** I think that we are moving away—

[172] **Mark Drakeford:** I want to put this point to our witnesses. What I have heard you say is less that you are against economic regulation per se, but that you are in favour of proportionate regulation. Where you have a small firm of the type that you just described, you would not expect it to have a burden of regulation that you would expect of a much larger supplier. If there is to be regulation, it must match the nature of the business that you are regulating.

[173] **Kirsty Williams:** Do you think that a proportionate amount of regulation, whatever that may or may not look like, is the key recommendation that this committee could make about improving the quality of a person's experience? Surely, that is the crux of what we are about, namely improving quality. Do you think that we can improve the quality of an experience by regulation, or is there something more fundamental that this committee needs to recommend, so that Mrs Jones has a really good and positive experience of domiciliary care?

[174] **Ms Apsitis:** I am quite happy to say that regulation most certainly is not going to improve care. As you may be aware, we work with two different groups of people—CSSIW, which checks that the regulation is met, and the Care Council for Wales, which is endeavouring to ensure that what is delivered is the best quality of care. As far as our members are concerned, they work to UKHCA standards, which is probably a more demanding master in many ways, because they would lose their membership and the support that goes with that if they are found wanting against our code of practice. So, regulation is certainly not going to help, as it will add an extra burden. The regulation that we have at the moment is still somewhat confused. I would like to see the current regulation being sorted out.

[175] Managing the delivery of domiciliary care is much more complicated and much more demanding, as the requirements of people being supported at home is going up, but none of that has yet been adequately recognised by the regulation within the care council. It is one of the areas in which we are working very hard to try to get the message across that front-line managers are the people who can improve care at the front door and the care of Mrs Jones. It is not the people who are dealing with the economics in the background, who are hanging on by their fingertips to see whether or not the contract that they have with the local authority is going to measure up or not.

[176] **Mark Drakeford:** As a very last point, I want to go back to a point that Darren rehearsed with you earlier about cross-subsidy in the industry. Darren's argument was that private payers may be subsidising the public purse. However, did I hear you say in a different sort of way that, in order for private purchasers of domiciliary care to have a service at all, it depends upon effective public commissioning, because, by themselves, there are not enough of them to sustain a supplier? So, if a publicly commissioned service folds, there is not enough work left paid for by private payers to sustain a business.

[177] **Ms Apsitis:** We certainly have that situation. In some authorities there are contracts running, and if those contracts are transferred to a different provider, that provider may not have a sufficient level of business to sustain them. UKHCA has a training course called Survive and Thrive, and it is about exactly that, namely how to deal with the situation if you lose one of your main contracts and where else you look for business. There are some very innovative places where people can go looking. So, there is certainly a risk, and when we talk about the one in five businesses that do not think that they are going to be there, it is much more to do with what their local authority is currently doing to them and the expectation that they will not have a sufficient volume or amount of quality work to retain the workers that they have at the moment.

2.30 p.m.

[178] If there was one message, it would be, ‘Please will the Welsh Government look at what is happening in the domiciliary care sector in the same way as it is doing with the residential care sector?’. If we lose domiciliary care provision in Wales, we will be far more at risk, with hospitals facing much more demand and stress than they do now. It is a pity that Kirsty has just left the room, because the last time we talked about domiciliary care in detail, she was also sitting on the committee. So, it is the same issue coming around again. The plea is for the Assembly and the Government to look at what is happening, please. We have no data for Wales that are complete and we have no data whatsoever about the services that are being provided outside local government. We need those to make sound policy.

[179] **Mark Drakeford:** That is a good note on which to end the session. We are grateful to you both for taking the time to come and help us with the inquiry. It has been useful and interesting for us.

[180] Diolch yn fawr iawn i chi’ch dau. Thank you, both, very much.

2.31 p.m.

Papurau i’w Nodi Papers to Note

[181] **Mark Drakeford:** Mae pump o bapurau am bethau sy’n codi o’r gwaith yr ydym wedi’i wneud yn barod. Gyda’r deisebau—papurau 6 a 7—nid oes dim inni ei wneud heddiw; maent yno er mwyn inni wybod beth sydd wedi’i fwrw ymlaen.

Mark Drakeford: There are five papers on matters arising from the work that we have done already. With the petitions—papers 6 and 7—there is nothing for us to do today; they are simply there for us to know what has been deferred.

Cynnig dan Reol Sefydlog Rhif 17.42(vi) i Eithrio’r Cyhoedd o’r Cyfarfod ar gyfer Eitemau 5 a 6 Motion under Standing Order No. 17.42(vi) to Resolve to Exclude the Public from the Meeting for Items 5 and 6

[182] **Mark Drakeford:** Cynigiau fod y pwyllgor yn penderfynu eithrio’r cyhoedd o’r cyfarfod ar gyfer y drafodaeth am eitemau 5 a 6, a hynny yn unol â Rheol Sefydlog Rhif 17.42(vi).

Mark Drakeford: I move that the committee resolves to exclude the public from the meeting for the consideration of items 5 and 6 in accordance with Standing Order No. 17.42(vi).

[183] Gwelaf fod yr Aelodau i gyd yn gytûn. I see that all the Members are in agreement.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 2.32 p.m.
The public part of the meeting ended at 2.32 p.m.*