



Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales

Cofnod y Trafodion The Record of Proceedings

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Chwaraeon](#)

[The Health, Social Care and Sport Committee](#)

19/10/2017

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynnddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd. Lle y mae cyfranwyr wedi darparu cywiriadau i'w tystiolaeth, nodir y rheini yn y trawsgrifiad.

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. Where contributors have supplied corrections to their evidence, these are noted in the transcript.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Rhun ap Iorwerth Bywgraffiad Biography	Plaid Cymru The Party of Wales
Jayne Bryant Bywgraffiad Biography	Llafur Labour
Angela Burns Bywgraffiad Biography	Ceidwadwyr Cymreig Welsh Conservatives
Caroline Jones Bywgraffiad Biography	UKIP Cymru UKIP Wales
Dai Lloyd Bywgraffiad Biography	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)
Julie Morgan Bywgraffiad Biography	Llafur Labour
Lynne Neagle Bywgraffiad Biography	Llafur Labour

Eraill yn bresennol
Others in attendance

Claire Aston	Nyrs Rhanbarthol/Pennaeth Gofal Cymhleth, Bwrdd Iechyd Lleol Aneurin Bevan Divisional Nurse/Head of Complex Care, Aneurin Bevan Local Health Board
Beth Bowen	Coleg Brenhinol y Therapyddion Lleferydd ac Iaith Royal College of Speech and Language Therapists
Steven Ford	Fforwm Gofal Cymru Care Forum Wales
David Francis	Prif Arolygydd Cynorthwyol, Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru Assistant Chief Inspector, Care and Social Services

Inspectorate Wales

Victoria Gimson	Fferyllydd Iechyd Meddwl Arbenigol, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Specialist Mental Health Pharmacist, Cardiff and Vale University Local Health Board
Sarah Isaac	Uwch Reolwr Fferyllydd—Gofal Sylfaenol, Bwrdd Iechyd Lleol Hywel Dda Senior Pharmacist Manager—Primary Care, Hywel Dda Local Health Board
Dr Chineze Ivenso	Seiciatrydd Ymgynghorol Hen Oed (Tîm Iechyd Meddwl Cymunedol Casnewydd), Bwrdd Iechyd Lleol Aneurin Bevan Old Age Consultant Psychiatrist (Newport Community Mental Health Team), Aneurin Bevan Local Health Board
Lisa Lane	Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Cardiff and Vale University Local Health Board
Melanie Minty	Fforwm Gofal Cymru Care Forum Wales
Karin Orman	Coleg Brenhinol y Therapyddion Galwedigaethol Royal College of Occupational Therapists
John Palmer	Cyfarwyddwr Gwasanaethau Sylfaenol, Cymunedol ac Iechyd Meddwl, Bwrdd Iechyd Lleol Cwm Taf Director of Primary, Community and Mental Health, Cwm Taf Local Health Board
Sue Stephens	Ymgynghorydd Rhagnodi, Bwrdd Iechyd Lleol Hywel Dda Prescribing Advisor, Hywel Dda Local Health Board
Dr Alison Stroud	Coleg Brenhinol y Therapyddion Lleferydd ac Iaith Royal College of Speech and Language Therapists

Kim Williams Seicolegydd Ymgynghorol Iechyd Meddwl Pobl Hŷn,
Bwrdd Iechyd Lleol Cwm Taf
Consultant Psychologist Older Persons Mental
Health, Cwm Taf Local Health Board

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

Amy Clifton Y Gwasanaeth Ymchwil
Research Service

Kayleigh Imperato Dirprwy Clerc
Deputy Clerk

Claire Morris Clerc
Clerk

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

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Dai Lloyd:** Bore da i chi i gyd a chroeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. O dan eitem 1, a allaf i estyn croeso i'm cyd-Aelodau i'r cyfarfod yma, a hefyd i'n gwsteion? Mwy amdany'n nhw yn y man. A allaf i bellach egluro bod y cyfarfod yn ddwyieithog, a gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1, neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2? A allaf i atgoffa pawb i naill ai ddiffodd eu ffonau symudol ac unrhyw gyfarpar electronig arall, neu eu rhoi ar y 'tawel', ac, yn

Dai Lloyd: Good morning to you all and welcome to the latest meeting of the Health, Social Care and Sport Committee here at the National Assembly for Wales. Under item 1, I'd like to welcome my fellow Members to this meeting, and also our guests—more about them in due course. I'd like to explain that this is a bilingual meeting, and you can use headphones to hear simultaneous translation from Welsh to English on channel 1, or amplification of the original language on channel 2. Could you please switch off your mobile phones and any other electronic equipment or switch them to silent? And you should follow the

bellach, hysbysu pobl y dylid dilyn cyfarwyddiadau'r tywyswyr os bydd larwm tân yn canu? A hefyd i'n gwsteion—nid oes angen cyffwrdd â'r meicroffonau; maen nhw'n gweithio'n awtomatig. Felly, rydym ni wedi derbyn ymddiheuriadau gan Dawn Bowden y bore yma, ac nid oes dirprwy, a hefyd rydym ni ar ddeall bod Lynne Neagle ac Angela Burns yn mynd i fod yn hwyr.

ushers if you hear the fire alarm. And also, to our guests—you don't need to touch the mics; they work automatically. We have received apologies from Dawn Bowden this morning, and there's no substitute, and also Lynne Neagle and Angela Burns will be late.

09:31

Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal: Sesiwn Dystiolaeth 9—Coleg Brenhinol y Therapyddion Galwedigaethol a Choleg Brenhinol y Therapyddion Lleferydd ac Iaith
Use of Antipsychotic Medication in Care Homes: Evidence session 9—Royal College of Occupational Therapists and Royal College of Speech and Language Therapists

[2] **Dai Lloyd:** Symudwn ymlaen i eitem 2, a pharhad o'n hymchwiliad i'r defnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal. Hon ydy sesiwn dystiolaeth rhif 9. O'n blaenau mae tystion o Goleg y Therapyddion Galwedigaethol a Choleg Brenhinol y Therapyddion Iaith a Lleferydd. Croeso i chi i gyd. Yn benodol, felly, croesawn ni i'r bwrdd Karin Orman, rheolwr arfer proffesiynol Coleg y Therapyddion Galwedigaethol; Dr Alison Stroud, pennaeth swyddfa Cymru, Coleg Brenhinol y Therapyddion Iaith a Lleferydd; a hefyd Beth Bowen, uwch-therapydd iaith a lleferydd, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro. Croeso i chi i gyd. Yn ôl ein

Dai Lloyd: Moving to item 2: a continuation of our inquiry into the use of antipsychotic medication of care homes. This is evidence session No. 9. Before us we have witnesses from the College of Occupational Therapists and the Royal College of Speech and Language Therapists. Welcome to you all. We welcome, therefore, Karin Orman, professional practice manager at the College of Occupational Therapists; Dr Alison Stroud, head of Wales office at the Royal College of Speech and Language Therapists; and also Beth Bowen, senior speech and language therapist, Cardiff and Vale University Local Health Board. Welcome to you all. As usual, we have received a

harfer, rydym ni wedi derbyn toreth o great deal of written evidence from dystiolaeth ysgrifenedig o bob cwr, all sides, and so, in terms of time, ac felly, yn nhermau amser, awn ni'n we'll go straight into questions, and syth i mewn i gwestiynau, ac mae'r the first question is from Caroline cwestiwn cyntaf gan Caroline Jones. Jones.

[3] **Caroline Jones:** Diolch, Chair. Good morning, everyone. The first question: could you please tell us what you think are the main reasons why patients in care homes with dementia are prescribed inappropriately with antipsychotic drugs? Do you think it's lack of staff training, or lack of resources, or lack of alternate therapies?

[4] **Dr Stroud:** Probably all three, I think. We know up to 75 per cent of the medication is overprescribed, and we are going to argue very much—all of us, really—for training to care home staff, from the allied health professional workforce on how to better manage people with the agitation that comes with dementia. That's because there is a lack of resource, and we need some positive action, really, to get some AHP workforce into those care homes to do the training and to do the modelling of how to manage people with agitation. We know that the challenging behaviour often arises because of the deteriorating ability to communicate needs and the frustrations that arise from that.

[5] **Caroline Jones:** That is an issue, isn't it?

[6] **Dr Stroud:** Yes.

[7] **Caroline Jones:** Does anyone want—?

[8] **Ms Orman:** Yes, I would fully support what Alison is saying. I think we're expecting care home staff to support people with the most complex needs, often in the very later stages of dementia, where they're more likely to experience distress and agitation, and they have very limited resources in terms of who they turn to for support, and understanding what lies behind that behaviour. So, by the time it actually comes towards specialist dementia services, the staff's resilience and ability—they're quite worn down. There may be a lot of distress to other residents, to family members who are visiting, and so people want a quick solution, and medication is often seen as that quick solution.

[9] **Ms Bowen:** Yes, I agree with everything that's said so far, that a lot of

the difficulties around behaviours that challenge stem from difficulties communicating, and not just communicating needs, but communicating establishing relationships, establishing rapport. One of the things I often do with staff who I work with is help them understand how communication changes as a result of changes in the brain with dementia. So—I'm not sure if anyone's talked about this yet here—when patients develop dementia, there are two main changes that happen in the brain. So, in the cerebral cortex, which is where our cognition, our thinking, our speech and everything is based, we get less white matter in the cortices, which means there are fewer connections. So, the brain is communicating less. Your processor has gone down in your computer. And then the other thing that happens is in the very primal part of our brain, in the limbic system, you have several different things that go on, but, in dementia, the main thing that happens is that an area of the brain called the hippocampus shrinks. And the hippocampus is important for storing memories, for spatial awareness—knowing where you are, where you want to go, how to get there—and, as that shrinks, other parts of that primitive part of our brain still work really well. So, the amygdala are still on fire, and our amygdala are what help us perceive threat: it's our fright, flight, fight mechanism. So, this shrinks so we're less able to remember and learn and know where we are and what we need to do, but this is still firing. So, it explains a lot about how people with dementia react quite primitively to a lot of things around them, and that's something that helps staff understand some of the processes happening so that they can then go on and do something.

[10] **Dr Stroud:** And use strategies, then, to manage that. Once you understand it, you can use strategies to manage that aren't medicating. And the issue with the overmedication, of course, is the falls risk increases and you have to put in one-to-one nursing then. You put in extra nursing to prevent the risk of fall because you've got your patient overmedicated, whereas if we replaced one nurse with an allied health professional we needn't have the medication but we could prevent so much more of this communication issues and the behaviours.

[11] **Dai Lloyd:** Yes, absolutely. Members will be having a test on neuroanatomy at the end of the morning. [*Laughter.*]

[12] **Caroline Jones:** Well, there's only three of us here, so take your time, please. [*Laughter.*]

[13] **Dai Lloyd:** Caroline, your next question.

[14] **Caroline Jones:** Diolch, Chair. My next question is: what do you think is the specific role of the occupational therapist and the speech and language therapist in reducing the need for medication, basically?

[15] **Ms Orman:** Okay. Perhaps I'll start with the role of the occupational therapist. I think there are two levels, really. We should be looking at delivering on prevention, so even within the care home sector there's a lot we can do. So, occupational therapists going in and doing general training—so, most care home staff will get dementia awareness, but it's actually understanding the impact of the environment, physical and social, on how somebody copes and manages, also thinking about approaches and communication, as has been said before. So, it's raising people's awareness, having some understanding of stock strategies that might help, but it's also looking at the care home as a whole and thinking about communication. Often, non-pharmacological approaches don't work, they fail, because there aren't consistent behaviours and communication across the care home team. So, it's about getting buy-in, building up trust and getting the staff to understand that this is worth investing the time because there will be benefits.

[16] If you've got two members of the care home team having to go in and delivering personal care because somebody gets very distressed, maybe lashing out, then that's very time consuming and wearing for staff. If they can understand that actually making changes to their approach, making changes to the layout of the room, making changes to how they might touch and handle somebody means that there's only one member of staff having to work with that individual—it has big impact. So you've got that prevention level, understanding the importance of stimulating people, keeping people active, having a sense of purpose to their day, but then you've also got the need for occupational therapists to go in and create bespoke training around individuals.

[17] **Caroline Jones:** I was just going to ask about bespoke—.

[18] **Ms Orman:** Yes. So, I think quite often what happens is you'll get AHPs and other professionals going into a care home, doing an assessment, making recommendations, coming back maybe a week, two weeks, later, and nothing's changed. So, assessment isn't just the key thing. It's actually thinking about, 'Okay, how can we train all staff to adopt those recommendations?', 'How can we think about—?', 'How—?', 'What's realistic

in terms of recommendations within that care home environment and with that staffing number and the needs of all the residents being met?’

[19] **Caroline Jones:** Okay. Thanks.

[20] **Ms Bowen:** From a speech therapy point of view, it’s about the same, communication, and how communication works, how normal communication works, what can go wrong, and strategies for supporting that. We’re also experts in—. It’s the same anatomy for talking as it is for eating and drinking, so we also have a role in supporting patients and people with dementia to maintain as normal eating and drinking as possible. We don’t yet have cures for dementia or strategies for stopping it completely, so dementia is there, but what we can do is provide staff with the skills to provide an environment to support patients with dementia and make them the best they can be with their dementia.

[21] **Dr Stroud:** Just by cutting down what you’re saying and chunking it, isn’t it?

[22] **Ms Bowen:** Yes. So, for example, I work on in-patient wards for people with dementia. I work with nurses, occupational therapists, physios, dieticians, all the time. Sometimes I notice, when I’m seeing a patient, that a member of staff, a nurse or a health care support worker, might go up to a patient and go, ‘Jean, it’s time for me to do your blood pressure now. Go and sit over there and I’ll come over and do it in a minute. Roll up your sleeve for me.’ And Jean is still standing there, looking. So the nurse then says, ‘Jean, I need to take your blood pressure now, go and sit over there; I’ll be with you in a minute.’ That’s a lot of information for Jean to take on board. And, when I see that happening on the wards, I’m able then to go up and say, ‘Hi Jean, how are you today? Love your top. That looks beautiful. Let’s go and sit down, shall we?’ And, hopefully, there’s a blood pressure cuff already there and I can say, ‘I need to check your blood pressure now. Can I put this on? Will you help me?’ Jean helps me. So, it’s how we communicate, and, speech therapists, we can help staff develop their skills to improve their communication, but we need to be in that environment to do it, not just be called in when there’s an emergency. It’s about having that constant support there to challenge people to improve their communication skills.

[23] **Dai Lloyd:** Océ. Cwestiynau **Dai Lloyd:** Okay. Rhun has the next nesaf gan Rhun. questions.

[24] **Rhun ap Iorwerth:** Adeiladu, Rhun ap Iorwerth: To build, really, on mewn difrif, ar feysydd rydym ni wedi areas that we've touched upon cyffwrdd arnyn nhw'n barod, rydym already, we've heard that there is a ni wedi clywed bod yna ddiffyg lack of access to occupational mynediad at therapyddion therapists. Your evidence is quite galwedigaethol. Mae'ch tystiolaeth striking and says that there isn't chi yn eithaf trawiadol yn dweud bod equal access to multidisciplinary yna fynediad anghyfartal i bobl hŷn services for people in care homes, mewn cartrefi gofal at wasanaethau even though they have the biggest amlddisgyblaethol, er mai nhw sydd needs. What are the barriers to older â'r angen mwyaf. Beth ydy'r residents getting access to allied rhwystrau sy'n atal y mynediad yna at health professionals? weithwyr proffesiynol perthynol?

[25] **Ms Orman:** Okay. What we find is that you've got in-reach services going in—either they're dementia specialist services or they might be reablement services, local authority—and what happens is they're around the individual, and we need to be, actually, as I said earlier, working with the whole staff team. There's no point in going in, doing an assessment for an hour and then leaving, if you haven't got the whole staff team on board in supporting that individual. The barrier is actually having the time and investing in working with the care home. Part of that barrier traditionally is that many of the care homes are privately owned, and so we'll go in and support that individual citizen, but we won't go in and support the whole care home; there's an expectation that the care home should be providing all the training and meeting all those needs. And I think those barriers really need to start changing because we can't support that individual citizen and give them the equality of access that they would have if they were living in their own home in the community if we don't work with the whole care staff team.

[26] **Rhun ap Iorwerth:** What about the universal issue of staff shortages? A shortage of OTs: is that an issue as well?

[27] **Ms Orman:** Yes, that's an issue as well, and it's thinking about—. We've got approximately 300 occupational therapists working in Wales in mental health services, and it's thinking about where they are sited. We would argue that, actually, people—. It's end-of-life care in care homes. People are there for, typically, two years. They're there because they've had a series of losses, they're there because their needs are so complex that, actually, they can no longer be supported in the community. And so, we

really should be seeing that as a priority and saying, 'Well, if they are the people with the most complex needs, why isn't there a multidisciplinary service going in routinely to support them?' Why can't care homes easily access those multidisciplinary teams? And what happens is we tend to be a tertiary service. Care homes will try and address and fix solutions internally. When that doesn't work, then they'll go their GP or the practice team, and when that doesn't work, finally, they go to the specialist services. By that stage, we are talking about crisis point, or actually they only get to see an occupational therapist or AHPs through admission to hospital.

09:45

[28] **Rhun ap Iorwerth:** A beth am brofiad therapyddion iaith a lleferydd? **Rhun ap Iorwerth:** And what about the experience of speech and language therapists?

[29] **Ms Bowen:** Mae'r rhan fwyaf o therapyddion iaith a lleferydd sy'n gweithio efo oedolion o fewn yr ysbytai a ddim yn y gymuned. O'm mhrofiad fy hunan, rwy'n lwcus achos cefais i fy rhoi mewn swydd o fewn wardiau i bobl efo problemau iechyd meddwl—henoed efo problemau iechyd meddwl—ac roedd *remit* gyda fi i hyfforddi a gweithio fel rhan o'r tîm cyfan, nid fel unigolyn yn mynd mewn i weld unigolyn. Felly, mae cael therapyddion iaith a lleferydd yn y llefydd y mae eu hangen nhw a bod yn rhan o'r tîm cyfan yn bwysig. Nid oes yna—. Mae yna therapyddion iaith a lleferydd mas yna i wneud y swyddi, ond mae angen i'r swyddi fod yn y llefydd iawn. A'r peth arall mae therapyddion galwedigaethol yn dda iawn yn gwneud, ac efallai bod angen i therapyddion iaith a lleferydd wneud mwy, yw defnyddio *rehab techs*, so ddim jest therapyddion ond **Ms Bowen:** Most speech and language therapists working with adults do so within hospitals and not in the community. From my personal experience, I'm fortunate because I was put in a post in wards for older people with mental health problems, and I had the remit to train and work as part of the whole team, not as an individual going in to see an individual. So, having speech and language therapists in the places where they are needed and as part of the whole team is important. There are speech and language therapists out there to do the jobs, but the jobs need to be in the right places. And the other thing that occupational therapists are very good at doing, and maybe speech and language therapists need to do more, is using rehab techs, so not just therapists, but people to assist us in the work that we do to carry things out.

pobl i'n cynorthwyo ni yn y gwaith rydym ni'n gwneud i gario pethau ymlaen.

[30] **Rhun ap Iorwerth:** Ac o ran y ffigurau rydych chi wedi'u rhoi i ni, rydw i'n meddwl eich bod chi'n dweud bod yna ddim ond 0.6 swydd llawn amser cyfatebol o therapi iaith a lleferydd mewn timau arbenigol yng Nghymru. Faint sydd angen? A oes yn ffigwr rydych chi'n anelu amdano fo?

Rhun ap Iorwerth: And, in terms of figures that you've given to us, I think that you say that there's only 0.6 full time equivalent posts in terms of speech and language therapy and specialist teams within Wales. How many are needed? Is there a figure that you're aiming for?

[31] **Ms Bowen:** Gwnaf i ofyn i Alison i ateb.

Ms Bowen: I'll ask Alison to answer that.

[32] **Dr Stroud:** Well, yes, I think the problem is Professor Deering talks about the two big tribes in the NHS, the doctors and the nurses, and then there's the AHP as a tiny little triangle in the middle going, 'Don't forget about us'. Speech and language therapists are even smaller. If there are 500 of us in Wales, that's about it, and more than half of those work within the children's services. The other chunk, then, are in the acute sector doing specialist work with people with cancer, people who have lost their voice, all that sort of stuff. And we need—. In this inquiry, and this is the most passionate one I've ever been passionate about because I think we've got a real opportunity to make a change, because there needs to be some positive drive to put that non-specialist, but that targeted training role into care homes and fund it specifically, almost as an invest-to-save, to—you know, you get the money back from reducing the medication, reducing the one-to-one nursing. We're only the same price as nurses, but we need some—. We're not big enough to be able to do the lobbying all the time. And, in terms of getting the workforce supply, we've been working with Workforce, Education and Development Services and the Royal College of Speech and Language Therapists. So, the numbers for training, the student commissioning, have been rising gently year on year. And then we've done some work now to cut the course from four years to three years and change the model of clinical placement so that more speech therapy students will be out in those less obvious student placements like Hywel Dda and up in Betsi Cadwaladr so that they will actually, hopefully, then remain employed in an area that they've trained in. It could give them that vision to carry on working here. But we do

need some specific push to fund this non-specialist but sort of targeted training model where people can be there modelling. It's no good just going in and doing a training package—as you said, you come back three weeks later and nothing has changed. Why isn't the AHP workforce actually there all the time doing that stepping in and modelling to improve things?

[33] **Rhun ap Iorwerth:** And one answer is—and this comes out in both your papers—that too few teams across Wales stipulate inclusion of speech and language therapy.

[34] **Dr Stroud:** Yes. If you don't know what you're missing, you're not going to—

[35] **Rhun ap Iorwerth:** That needs to be addressed at a national level.

[36] **Dr Stroud:** Yes. If you don't know what you're missing, you're not going to ask for it, are you? If there's no—. Well, there's Beth now as well, so one-and-a-half people. One's in a very specialist area in the memory clinic in Whitchurch, which isn't really what we're talking about here, and then there's Beth.

[37] **Ms Orman:** And I think we've got clear models in other areas. We've got liaison psychiatry teams in hospitals, which are often multidisciplinary, we can see how effective they are at delivering training and modelling and changing people's attitudes. Why aren't we applying that to care homes?

[38] **Rhun ap Iorwerth:** Diolch. **Rhun ap Iorwerth:** Thank you.

[39] **Dai Lloyd:** Symud ymlaen: **Dai Lloyd:** Moving on: Jayne has the Jayne, y cwestiwn nesaf. next question.

[40] **Jayne Bryant:** Alison, you firstly mentioned the importance of training in your first answer; you put it right up there. Some have suggested that we need mandatory national training and national standards. Do you think that's something that would make a real positive change?

[41] **Dr Stroud:** Yes, I think a patients' charter of what is to be expected in care homes would make a difference, and to have that expectation of a training element there. I think the culture of—. I'm exaggerating to make a point, but medication and looking after people needs to shift to being—.

[42] **Ms Bowen:** Empowering people.

[43] **Ms Orman:** Yes. We always talk about not thinking about what you need to do next, but it's thinking about, 'What do I need to do next with the care home residents?' So, it is changing that attitude of doing things for, and perhaps we should shift away from this term 'care' and talk about 'support'. You know, it should be care and support that we're delivering.

[44] **Ms Bowen:** I think a lot of what is perceived as care from a nursing point of view is very task orientated. It's about making sure people are clean, that they've had their food, that they've had their medication, and it's all about tasks. If we all live our lives just with all the tasks, we're not going to have very happy lives. It's about empowering and providing more holistic care that makes life enjoyable and makes the person the best person they can be, and therapies, because we come from a point of view where we look at—. We're very good problem solvers in therapies; that's what a lot of our training is around—understanding what the problem is, hypothesising, and 'How can we put it right?' That's something that therapies can bring to nurses by supporting nursing staff to do that, and it builds up resilience in our teams as well, to have that cross-section, not just relying on nursing to provide care, but to look at it more holistically. It benefits patients' quality of life; it benefits staff quality of life; and it's a nicer way of working.

[45] **Jayne Bryant:** And do you think it would take a lot to implement a national charter, as you suggest?

[46] **Dr Stroud:** One suggestion we've got is to look at what Scotland have done, which is a strategic allied health professional strategy for dementia that they—the Scottish Government—have funded but placed within Alzheimer Scotland, and they've been working on a strategy to take this forward.

[47] **Jayne Bryant:** Okay, thank you.

[48] **Dai Lloyd:** Océ. Caroline Jones, **Dai Lloyd:** Okay, Caroline Jones has y cwestiwn nesaf. the next question.

[49] **Caroline Jones:** Diolch, Chair. What is the current availability of alternative treatments, non-drug treatment options? Do you think these options are important? And have you seen examples of good practice or initiatives that we can take forward in a wider concept?

[50] **Ms Orman:** Yes—. I'm happy to start. We have got some good examples of overall training, and then I can give you an example of doing more bespoke work around an individual. So, we have Helen Lambert and Alison Turner, both occupational therapists, who work with the mental health nurse, Karyn Davies, and develop training at ABM and Bridgend county borough. That's a dementia reablement training package that they've rolled out across care homes, and also it's applicable to homecare teams as well. In Cwm Taf university health board, the mental health liaison occupational therapists have been delivering training to nurses and nursing assistants, again raising people's understanding around dementia awareness. Again, it's very applicable in the care home sector, and that service has been held up as an exemplar of best practice to be implemented across Wales. So, we don't have to look far at examples that we could actually apply in a care home setting.

[51] In terms of thinking about bespoke, if I can give you a little example of somebody whom I'm going to call 'Marjorie'. Okay, so Marjorie has severe dementia and there's high distress and aggression, particularly around times of personal care. It's taking three members of staff to get her washed and dressed and up in the morning or put to bed, and she was lashing out and staff were avoiding working with Marjorie. It was really felt that she needed to go into hospital and that the care home could no longer manage or support her. The occupational therapists went in and did an assessment. They had a look at how the staff were approaching her, and they thought a little bit—. They were thinking about Marjorie's background, who she was as a person, her interests, her previous routines and previous habits. They then set up a two-hour training package, which they delivered to all the staff in the care home, and it really challenged the carers' beliefs and their approach. Marjorie's behaviour still remained challenging, but it meant that they felt more resilient, more able to cope. Marjorie went down to one member of staff supporting her with her personal care, and she was also able to engage more with other aspects. She was able to spend more time in communal rooms and join in with the life of the home. So, it can be effective just working with one individual.

[52] **Caroline Jones:** Yes, so it's about understanding the individual cases, isn't it?

[53] **Ms Orman:** Absolutely: their personality, what were their previous routines, what are they trying to do, and how are they trying to

communicate? Yes.

[54] **Caroline Jones:** Yes, thank you.

[55] **Ms Bowen:** From a speech therapy point of view, I've got a—. I've been in my current post about 10 years. Before I was working on the mental health wards that I cover, there was no speech and language therapy, and when I started, I looked at how well patients there were eating and drinking. We found that about 20 per cent of the patients were eating and drinking a normal diet independently, and the other 80 per cent were on pureed diets, thick drinks, and needing full support for all their eating and drinking. Within two years of being in post, we had reduced that so that there were fewer than 10 per cent. So, this 80 per cent group dropped to fewer than 10 per cent needing modified-texture food, pureed diets, thick drinks—which, to be honest, none of us would ever want to live on—and most people were eating a normal diet. The difference we made with this support was that more patients were in this middle ground where they were having some support to eat and drink more normally. So, the patients were doing it more for themselves, but they needed some support from staff. So, things like hand-over-hand assistance. If I held Alison's hand like this, I could control her pen, I could do some of this, I could help her eat and drink, but—. I could load her food, give it to her and then—

[56] **Dr Stroud:** And then I'll start doing it—

[57] **Ms Bowen:** —she can start and carry on.

[58] **Dr Stroud:** —because my brain is remembering.

[59] **Ms Bowen:** So, that was training—individual and bespoke—understanding what's normal, what goes wrong, and then it was also individual for patients and using those strategies and showing it in real life in the environment where the patient is living, so that staff can then carry that on when we're not there. So, it's that combination that seemed to work and made a big change to the patients' quality of life, staff's quality of work life, and also it reduced cost, because pureed meals are much more expensive than normal meals.

[60] **Dai Lloyd:** Diolch yn fawr, ac **Dai Lloyd:** The final two questions are mae'r ddau gwestiwn olaf gan Jayne from Jayne Bryant.
Bryant.

[61] **Jayne Bryant:** Thank you, Chair. So, what do you think would have the greatest impact on reducing the use of antipsychotics in care homes? And who do you think should be the body or people driving that forward?

[62] **Ms Orman:** Do you want start anything off?

[63] **Jayne Bryant:** It's difficult to pick one, perhaps, but—.

[64] **Dr Stroud:** The strategy is perhaps an AHP consultant, possibly 1000 Lives—I know they do care home improvement work—and I'm not just saying this, but I seriously believe the MDT should include AHPs, and not just ones that come in and advise and go out again, but are there, modelling, doing and showing—and actually doing, not just coming in as an expert. They're only the same price as a nurse, but I think the savings that would come out of that—. We could do some pilot work, perhaps, with invest-to-save type things.

[65] The other way of changing could be considering the primary clusters. We've given evidence before about them considering having SLAs with speech and language therapists to come in, and there needs to be some funding to—. Because at the moment the whole workforce is managing a 14-week wait for the specialist end of everything, the cancer targets, so there needs to be some—. So, the primary care clusters could be another driver for change.

[66] **Jayne Bryant:** Thank you. Any other sort of—?

[67] **Ms Orman:** Yes. I would push for care home liaison teams, and that they are multidisciplinary. I'm aware that there are a couple in Wales, but they're not multidisciplinary; they're doctors and nurses. Those care home liaison teams can work with the GP clusters, but also the care homes. And it's about establishing relationships and trust so that you can do that preliminary training, getting care homes to think about their systems, their social environment, their physical environment, how they are supporting people with dementia, and then also they can more directly advise and intervene earlier, when the care home is saying, 'Well, actually, we're struggling to support this person. We're recognising signs of distress.' And just getting some advice on that early stage, rather than a referral much further down the line when, as we've said, staff have lost their resilience and they want a quick fix.

10:00

[68] **Jayne Bryant:** Okay, thank you. And just finally, one of the key aims of the Welsh Government's draft dementia strategy is to reduce antipsychotics in care homes. How do you think we can ensure that this becomes a reality?

[69] **Ms Orman:** Okay. With the dementia strategy, I think there's a real opportunity to push that agenda of enablement and person-centred care, and I think, from the strategy, that can be used for services to review their existing offer and consider, actually, how we can be more effective in providing an enabling ethos and environment for people to live—whether that's in their own homes or within care homes. So, I think it is about—. The overall strategy gives a guiding principle and a guiding message to services to say, 'Actually, this is about supporting the individual to live well.' Well-being is just as important as overall health, because it is so interlinked, and this is an opportunity for the whole of society to change its attitude to people with dementia.

[70] **Jayne Bryant:** Okay. No other comments.

[71] **Dr Stroud:** Possibly we need some further discussion with the regulators and the inspectorate bodies. Sometimes there can be unintended consequences of some of their targets.

[72] **Jayne Bryant:** Okay, thank you. Brilliant, thank you.

<p>[73] Dai Lloyd: Ocê. Unrhyw gwestiynau eraill? Na. Pawb yn hapus. Wel, dyna ni. Dyna ddiwedd y sesiwn. Diolch yn fawr iawn i chi. Fe allaf i ddweud wrthydych chi y byddwch chi yn derbyn trawsgrifiad o'r cyfarfod yma. Gallwch chi wirio'r ffeithiau i gadarnhau bod popeth yn ffeithiol gywir, gan gynnwys y niwroanatomeg ar y dechrau. Ond gyda hynny o eiriau, diolch yn fawr iawn i chi am eich presenoldeb, a hefyd am y papurau y gwnaethoch chi eu darparu ger bron ymlaen llaw. Felly, diolch yn</p>	<p>Dai Lloyd: Okay. Any further questions? No. Everyone content. Well, that's the end of the session. Thank you very much to you. You will be sent a transcript of this meeting to check for factual accuracy and make sure that everything is in place, including the neuroanatomy at the start. But thank you very much for your presence, and also for the papers that you presented beforehand. So, thank you very much. I can say to my fellow Members that there will be a break of</p>
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fawr iawn i chi. Gallaf i gyhoeddi i'm 10 minutes. Thank you very much.
cyd–Aelodau y bydd yna egwyl fer
nawr o 10 munud. Diolch yn fawr.

*Gohiriwyd y cyfarfod rhwng 10:02 a 10:14.
The meeting adjourned between 10:02 and 10:14.*

**Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal—Sesiwn
Dystiolaeth 10—Fforwm Gofal Cymru
Use of Antipsychotic Medication in Care Homes—Evidence Session
10—Care Forum Wales**

[74] **Dai Lloyd:** Croeso nôl i'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Rydym ni'n symud ymlaen i eitem 3 ar yr agenda y bore yma a pharhad o'r ymchwiliad i'r defnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal.

Dai Lloyd: Welcome back to the Health, Social Care and Sport Committee here at the National Assembly for Wales. We are now moving on to item 3 on the agenda and the continuation of our inquiry into the use of antipsychotic medication in care homes.

10:15

[75] Hon ydy sesiwn dystiolaeth rhif 10 ac o'n blaenau ni mae cynrychiolaeth o Fforwm Gofal Cymru. Yn benodol, felly, rydw i'n falch i groesawu i'r bwrdd Melanie Minty, ymgynghorydd polisi, Fforwm Gofal Cymru, a hefyd Steven Ford, cydlynnydd grŵp dementia a iechyd meddwl, Fforwm Gofal Cymru. Croeso i chi'ch dau. Rydym ni wedi derbyn y dystiolaeth ysgrifenedig o flaen llaw, ac, yn dilyn ein harfer, fe awn ni'n syth i mewn i gwestiynau. Mae gyda ni hanner awr, ac felly cwestiynau byr ac efallai atebion cryno hefyd. Caroline Jones i ddechrau.

This is the tenth evidence session, and before us are representatives from Care Forum Wales. I am pleased to welcome Melanie Minty, policy adviser, Care Forum Wales, and also Steven Ford, dementia and mental health group co-ordinator for Care Forum Wales. Welcome to you both. We have received your written evidence, and, as usual, we'll go straight into questions. We have half an hour, so short questions and, perhaps, some short answers as well, if you would. Caroline Jones to start.

[76] **Caroline Jones:** Diolch, Chair. Good morning. My first question: could you tell me what is your understanding of the main reasons why antipsychotic drugs are prescribed inappropriately to residents in care homes and do you think that it's a staff training issue or do you think there is a lack of resources or lack of alternate ways of dealing with these issues?

[77] **Mr Ford:** It's a very, very complex situation. I've been involved in nursing for 30 years, based in Colwyn Bay. I care for people with dementia. Sometimes, many residents have unwanted, difficult, challenging behaviour. One of the ways of managing that unwanted behaviour is by the prescription of various medications. Antipsychotic medications are particularly inappropriate. They were never developed for people with dementia; they were developed as long ago as the 1950s for people with bipolar and schizophrenia. There are horrendous side effects. So, there are a number of reasons why they are prescribed, but sometimes it's to protect other residents from service users, sometimes it's to get people to calm down and be more at peace with themselves, which is very, very important. But I think we've kind of lost our way, and it's become something of a national scandal, really—

[78] **Caroline Jones:** It's normalised now, isn't it?

[79] **Mr Ford:** There's far too much of it. I've been shouting about this for 30 years, and, really, there should be mandatory review dates in place. I'm not saying that we should never use an appropriate antipsychotic medication, because, in the exceptional cases, sometimes that's the only thing that works. But, as a general rule, we should try and avoid them. There's good research and an evidence base that the prescribing of antipsychotic medication for people with dementia has increased morbidity, there are cardiac toxicity problems with some of them, horrendous side effects, including chest infections and tissue viability problems. Generally speaking, on behalf of Care Forum Wales, we are delighted to be involved in the elimination or the reduction of these unwanted medications.

[80] **Caroline Jones:** Thank you.

[81] **Ms Minty:** I think, just to build on what Steve said there, there is probably a bit of a training issue there and I think there's no one way of best practice. So, whether it would help to have some sort of co-ordinated team looking at that, I don't know. But it is partly time, as well. People are very busy, and it's probably easy, sometimes, to keep someone quiet in the

corner when they should be dealing with the behaviours. There is training being developed, but I think there's a lot more that needs to be done to explain to people working in care homes what triggers behaviours, so that they can understand it and deal with it in different ways.

[82] **Caroline Jones:** My next question: we've received some written evidence, which includes from the Royal College of General Practitioners and the Welsh NHS Confederation, that there has been pressure put on clinicians to prescribe these drugs and also, some staff in care homes are reluctant to discontinue their use. So, what is your understanding of this, and do you think that care home staff need more training in this area? How can we all work together to eliminate the inappropriate use?

[83] **Mr Ford:** Absolutely, care home staff would benefit from increased training. That's something that I've been doing personally over the last year. It is absolutely essential to get this point across, really: whilst the GPs and the consultant psychiatrists are responsible for the actual prescription, the catalyst for that is the nurse or care home manager who picks up the phone requesting a GP visit and thereby requesting a sedative of some kind. I see my role as Care Forum Wales dementia care lead to stop that at that point. Rather than pick up the phone, let's provide some training to deal with unwanted behaviour in a creative manner, rather than always referring to the GP. The GPs are busy, so they're not going to come and just sit and chat about why somebody is behaving in an agitated way. They'll either give a prescription or not, but it could be so many things. I've actually done a paper called a champions document, which you can access if you wish. It could be somebody who lacks mental capacity, has communication problems, but, for example, has dental pain. They could be sat at the same table opposite somebody else and Mrs Green can't stand Mrs Jones, but yet Mrs Green sits with Mrs Jones three times a day at the meal table. It could be the tv blaring in the background. It could be somebody having bunions. It could be a whole host of things—hallucinations and things. So, what I'm saying is that we need to deal creatively with those solutions, and there's an excellent checklist in my paper. Rather than pick up the phone and request a GP visit, we want to eliminate that at source, if you like. Training and awareness of the possible causes of agitation that may lead to aggressive, destructive behaviour are absolutely imperative and, obviously, the Senedd can play a part in that.

[84] **Caroline Jones:** Thank you.

[85] **Ms Minty:** I think there's also a role here for bringing together best

practice and issuing perhaps some national guidance. We've got the care homes steering group best practice group, and Social Care Wales, so I'm sure that there's something that could be done to create a national group to bring some stuff together. The other thing that I think is very important, as Steve mentioned, is mandatory regular reviews. I think there's a major part that the community pharmacists can play in supporting care homes through that.

[86] **Caroline Jones:** Diolch, Chair.

[87] **Dai Lloyd:** Mae'r cwestiynau **Dai Lloyd:** The next questions are nesaf o dan ofal Rhun ap Iorwerth. from Rhun ap Iorwerth.

[88] **Rhun ap Iorwerth:** Just carrying on, really, we have heard calls for training to be mandatory and for that to include sections on antipsychotics. Do you agree that that should be pursued?

[89] **Ms Minty:** To me, it seems quite sensible for it to be mandatory. The only thing I would say as a cautionary addition is that, whenever you ask people to do mandatory training, if it's taking them out of the workplace, then it creates a problem with backfilling, so there's always the resource issue. But, yes, in theory, I think, absolutely, it should be.

[90] **Rhun ap Iorwerth:** Okay. Just picking up on what you said about you having been arguing the case for this for 30 years, you may be very, very aware of the risks and side effects of antipsychotic medication, but why has the rest of the care sector not been convinced in 30 years?

[91] **Mr Ford:** I've been involved in nursing for 40-odd years. I'm a registered mental nurse, registered general nurse, I've got a Master's degree in gerontology. So, this is my chosen subject, to be fair, and I do feel passionately about it. But there is a wide range of appreciations and knowledge out there. Not everybody is a nurse. There are many care home managers with some knowledge but not complete knowledge. It's underappreciated just how horrendous some of the side effects can be. It's definitely linked with increased morbidity, strokes and things like cardiac problems, chest infections, falls—increased falls—and a diminished quality of life for service users. So, it's a massively complex situation, but we've already started addressing this by doing—. I've done four or five sessions up and down Wales to our Care Forum Wales members giving them the information on how important this issue is and looking at alternatives to what can sometimes become a chemical cosh.

[92] **Rhun ap Iorwerth:** Is it the case that the care sector and care home managers or staff aren't or haven't been aware of the risks and side effects, or have they been turning a blind eye to them?

[93] **Mr Ford:** Probably both, to be fair. Don't forget that the responsibility is the clinician's; it's the GP who prescribes them, not the nurses. But as I say, we do need to bring everybody on board. The other thing to say is that—and it is part of this; forgive me, but it is important—when I bought Pembroke House, my first nursing home, 30 years ago, we were responsible to two agencies. There was the registration and inspection unit, which would register you and then inspect you against a set of quality standards in an unannounced fashion—fine, no problem with that—and then, the other one was the fire department so that the place doesn't burn down. Fine—that's reasonable. There are 27 agencies now—27—including the contracts monitoring officer, the legionella—. So, it kind of goes on. The reason I'm mentioning that is that, if mandatory training is imposed, that's another set of things that people will have to do. So, we need to get the care home managers on board, as a sense of ownership, to address this problem.

[94] **Rhun ap Iorwerth:** I have one other question. I don't know if Angela wanted to come in.

[95] **Dai Lloyd:** Yes, go on then.

[96] **Angela Burns:** It was just on this little bit. Thank you for explaining that to us—that there are 27 different registration bodies. I just wondered if I could explore that slightly, because some of the evidence we've heard says that there's a significant proportion of care homes that carry historical elderly mentally infirm or dementia registration classifications. So, when I read that—and I hope you're going to tell me I'm wrong—I thought, 'That means, then, that there might be people out there who've got care homes that are caring for people they're not actually appropriately ready to care for'. So, why, if there are 27 regulation bodies, do you think that we might still be in this situation where care homes are given an incorrect designation? Do you think that is something that we should be concerned about and be looking at—that care homes should actually be caring for the right level of person, with the right level of need, according to the ability or space capability and training within that care home?

[97] **Ms Minty:** There is a fundamental issue in that there is no agreed

definition of EMI for nursing, as far as I'm aware. Therefore, it is interpreted somewhat differently by different health boards, and, of course, by local authorities when it comes to funding in particular, which may sound cynical, but clearly, if there's a description of someone who has nursing or social care needs, then that will very much dictate what level of payment has to be made. So, I think that's part of it. And it's not just about the money, obviously; it's also about the fact that we don't have an acuity tool either, to determine what sort of level of care people need. It's all very much finger in the air, as far as I can see. And it's something that I think Sarah Rochira raised in her report into residential care—that we haven't really progressed on that in Wales.

[98] **Mr Ford:** If I could just add to that, the first thing to say is that, in every care home in Wales, and in every care home in the UK, even if it's not registered for people with dementia, there are service users with dementia in that care home. It's all just levels of. I'm one of those people; I have two care homes registered for nursing with services for people with dementia. The unwritten rule is: it's middle or later stages dementia, usually with associated problematic, challenging or unwanted behaviour. That's the kind of thing. So, for want of a better term, if people are just pleasantly confused without behavioural problems, if they can be safely managed in residential care, that's always been the case. It changes when the person with dementia—if their behaviour impacts negatively on the home in general, and other residents, then they might come to a place like mine. But I have to say that even in just regular residential homes, service users with dementia are absolutely everywhere. And the demographic explosion, as we know about, will not go away.

[99] **Angela Burns:** Could I just very quickly ask, then—? So the step beyond you, would that be what we would've thought of, perhaps, as an EMI?

[100] **Mr Ford:** No, we are an EMI.

[101] **Angela Burns:** You are an EMI.

[102] **Mr Ford:** Yes. You've got—

[103] **Angela Burns:** That's when you have to have nursing care, isn't it?

[104] **Mr Ford:** That's right. You've got residential care, EMI residential care with no nurses, general nursing care for people primarily with physical

problems, but with nurses, and then, at the top, EMI or EMH for people with advanced complicated dementia-associated problems, with nursing 24/7.

[105] **Ms Minty:** The categories will also be going, of course, under the regulation and inspection Act. So, Care and Social Services Inspectorate Wales, instead of asking people to register as being one of those categories, will now be asking people to say what people they are going to be looking after and how they're going to provide that service for them. So, it's going to be interesting—

10:30

[106] **Mr Ford:** So, you've got to provide your statement of purpose, and, whatever you put in your statement of purpose, you'll be measured by that. But I have to say I do have concerns about some of the changes that are going to happen.

[107] **Angela Burns:** So do I. Can I just have one more quick one? Because it is just on that. Sorry, Rhun. With the proposed changes, at what level do you not have to have a nurse? Or, to rephrase it, at what level do you have to have a nurse within your care home setting?

[108] **Ms Minty:** I don't think there's been any clear guidance on that. What CSSIW have said is that they wouldn't expect anyone providing nursing care not to have a nurse, and that's about as far as clarification has gone at the moment.

[109] **Mr Ford:** And the original definition was, where you don't have nurses in care homes, the care homes would provide care 'at a level of a caring, competent relative'—again, open to interpretation.

[110] **Angela Burns:** Wonderful areas of grey. Thanks, Rhun; sorry.

[111] **Dai Lloyd:** Rhun.

[112] **Rhun ap Iorwerth:** I was just going to ask one question, looking back at the evidence that we took from occupational therapists and speech and language therapists earlier, who said—I think it was the OTs that said—that they felt that there was no equity of access to multidisciplinary teams for older people in care homes, even though it's they that need that access most. Do you agree and what do you think are the barriers to that access?

[113] **Ms Minty:** What's your personal experience, Steve?

[114] **Mr Ford:** My personal experience of multidisciplinary teams is social services arguing that it's a health problem and health arguing that it's a social services problem when, in fact, it's all taxpayers-generated Government money. And the amount of money that's spent on manpower in these frequent multidisciplinary settings is unbelievable. But your original question—anybody should be able to access a multidisciplinary team meeting. That should be able to be requested by a service user, but, if they have dementia, that's unlikely; it would be the next of kin or, indeed, the service provider such as myself. So, there shouldn't be any difference in being able to access multidisciplinary meetings, but in reality there is.

[115] **Rhun ap Iorwerth:** Not access to meetings, but access to allied health professionals and occupational therapists.

[116] **Ms Minty:** Anecdotally, we believe there is and I think it's probably quite patchy and it depends which region you're in.

[117] **Mr Ford:** if I may, I'll give a perfect example of exactly what you're talking about. So, in terms of equality of opportunity for community services, I was at one meeting recently and somebody said, 'Well, of course we have equality of opportunity for community-based services for people in care homes'. And I said, 'Okay, get me a community chiropodist then, please'. I've asked for one for 25 years. You cannot access a community chiropodist in a care home, so we have to pay privately. So, that's just one example of exactly what you're talking about.

[118] **Rhun ap Iorwerth:** Okay, thanks.

[119] **Dai Lloyd:** Hapus? Reit, symud **Dai Lloyd:** Happy? Okay, moving on—
ymlaen—Jane Bryant. Jayne Bryant.

[120] **Jayne Bryant:** I think I'm okay, Chair. I'm okay, Chair.

[121] **Dai Lloyd:** You are? There we are. Angela, then.

[122] **Angela Burns:** Thank you. One of the key aims of the Welsh Government's draft dementia strategy is to reduce the use of antipsychotics. What do you think of the draft strategy as it stands now? Do you think it

would deliver that objective or that outcome?

[123] **Mr Ford:** It's certainly got the theoretical aspirations to do so, but in practicality that may not be—

[124] **Angela Burns:** I'm sorry, can I just flesh my question out and ask you what you think it should have extra, or what, you know—

[125] **Mr Ford:** In terms of the antipsychotic medication?

[126] **Angela Burns:** Yes.

[127] **Mr Ford:** It's already been mentioned, I think, that what should happen is we use maybe a pilot involving community pharmacists, some GPs—. It's already worked at Bryn Hesketh in Colwyn Bay, and they won a prize for reduction in local care homes' inappropriate prescriptions. So, yes, I think that it has to have the involvement of mandatory visits by community pharmacists to monitor the level of inappropriate prescriptions, and it doesn't actually mention that.

[128] **Angela Burns:** No, okay.

[129] **Ms Minty:** I would just add that I've actually been involved in the advisory group on dementia care for Welsh Government, and what I found at the meetings is that there's a very clinical viewpoint. Much of what we're trying to address through reducing antipsychotics is about the person's experience of living in a home, and that ties into how we deal with their behaviours and so on. I think, generally speaking, there needs to be a greater focus in our dementia strategy on the person's lived experience.

[130] **Angela Burns:** A slightly different subject, actually, still on how we achieve the reduction in the use of antipsychotics: do you think that most of the care homes are actually able to deal with—? In terms of their facilities, are they able to deal with people who might have sort of middling, maybe small to middling, dementia? Because my understanding is you need space and signing, and the ability to gather round and to help to guide and lead and so on and so forth. Because I have been in some care homes where you kind of think that, actually, there just isn't the room to breathe to be able to bring in all these services. And I just wondered if you had a view on that or—

[131] **Mr Ford:** I understand exactly what you're saying, yes. Bear in mind

that many of them are converted Victorian properties. The walls are not on casters; they are what they are. And, in terms of new build, the conditions for new build are so onerous that you could argue that it's not financially viable, frankly. But I know what you mean. But, even with limited space, it's what you do with that space. It's how creative you can be with that space, and the facilities and the fittings and fixtures within there can go a long way in creating a therapeutic atmosphere.

[132] **Angela Burns:** Can I just ask one more little question on that? In the care homes in your experience, do many of them have a physical division between those who, as you described earlier, are gently confused, and those who might be much further on down the path of dementia?

[133] **Mr Ford:** Some care homes operate several lounges. So, likeminded service users might be in one particular lounge, or people with cognitive impairment might be in another lounge. So, that usually works out quite well. The problem is when people go from stage 1 to stage 2, 3, with dementia, and then, their behaviour, as I said, negatively impacts on everybody else. Then they should really—. I know it's an awful thing, moving somebody that's been in a particular home for a number of years, but what about the other 30 people who are living there? So, you've got to then move that service user to a more appropriate location.

[134] **Angela Burns:** Thank you. That was the point of my question; it was about, if we reduce antipsychotics, the effect on other people. I'm sure we all know stories of friends and relatives who've been in a situation, and somebody's wandered into their room and done all sorts of things—

[135] **Mr Ford:** Absolutely. It can happen, yes.

[136] **Angela Burns:** —weed on their bed or whatever, because they're just not there. Thank you.

[137] **Dai Lloyd:** Océ. Jayne, **Dai Lloyd:** Okay. Jayne, questions. cwestiynau.

[138] **Jayne Bryant:** Thanks, Chair. Can you tell us about the current availability of alternative treatments, non-drug options, and how important do you think that is? We heard earlier of some evidence, and I just wondered if you could expand on that.

[139] **Mr Ford:** Yes, there are lots and lots of things that you can do. There is validation therapy, reminiscence therapy, reality orientation, relationship-centred care, all of which does not involve any medication. But I've always said it's about, first of all, the quality of the staff that's providing the care is absolutely—. Because not everybody's cut out for this. You've got to have empathy to begin with. Without empathy, I think people are going to struggle anyway, but it's about the connections and the relationships within the care home, which will go a long, long way in defining the level and the type of care and how compassionate and kindly that can be, but it's about the numbers of people, the right people, and fostering a positive ambience within the home. All of that can be achieved without recourse to an appropriate medication.

[140] **Jayne Bryant:** Have you got any good examples that you could share with us?

[141] **Mr Ford:** Yes, I've got one myself. I was the first care home in Wales to have a Snoezelen multisensory room from 1993, and it's got bubble columns in, and it's got images projected against the wall, with soft soothing music, and a number of things, olfactory things, smell, sense, and you can sit in that room on a one-to-one basis, holding somebody's hand, without recourse to PRN medications. Most people, not everybody, will chill and calm down after half an hour. It's a multisensory, called a Snoezelen room, and, as I say, we were the first care home in Wales to have one.

[142] **Jayne Bryant:** Do you know if that's being picked up more widely?

[143] **Mr Ford:** It's an expensive commodity, to be fair, and not everybody would be in a position to (a) have the room, but there are certainly elements of a multisensory room that could be brought in to lounges and things like that—fibre optics, holding fibre optics, and things like that. They started off being used with people with learning difficulties, but recent research-based evidence has shown that it's just as effective with people with a diagnosis of dementia.

[144] **Ms Minty:** One of our other members has just recently bought a new piece of technology that projects images across on tables so that residents can sit around and they can try and touch things or move things and play with them. So, there's a lot of stuff out there. A lot of it's very expensive, but there are cheap things and a lot of people will have memory boxes and it's the environment often, isn't it, the colours that you use and—

[145] **Jayne Bryant:** And music, perhaps.

[146] **Ms Minty:** Music, art.

[147] **Jayne Bryant:** It's all about stimulation.

[148] **Ms Minty:** Absolutely, yes.

[149] **Mr Ford:** And some other—. I've come full circle on this. It upset me to see, especially older ladies with a diagnosis of dementia, nursing a doll, and I suddenly realised whose problem it was—it was my problem because I was perceiving that it was infantilising, it was condescending, but, if somebody gets pleasure and comfort from that object, that in itself is enough. So, we can use things like that. And, just as a latest one, the latest one is a window and it looks like an old-fashioned steam engine. So, it's a tv and you can sit by the side of it and it looks as though you're going on a journey through Snowdonia, for example. I'm seriously looking at buying one of those. It's going to be about £6,000, but I might buy one. It's a cracking idea.

[150] **Jayne Bryant:** We'll all be encouraging you to do that, I think. [*Laughter.*] Do you think there's greater scope for the issue of antipsychotic prescribing in care homes to be considered by the commissioning and inspection process? I think you've touched a little bit on that.

[151] **Mr Ford:** The thing that bothers me mostly is, as I say, (a) most of it shouldn't be prescribed, but if it's necessary, and sometimes it is, there should be a mandatory review. I'd like to see the circumstance whereby people are not caught in this dreadful repeat prescription mechanism, whereby it rolls on and on and on, and you could go for two years and nobody refers to it. Some GPs, some practices, are better at reviewing than others. But, theoretically, because you're caught up in this repeat-prescription mechanism, it could carry on and on and on. I'd like to see—if you're prescribed an antipsychotic and you have a diagnosis of dementia, there should be a three-month mandatory review, with a second GP having to sign it off, rather than the responsibility of just one individual.

[152] **Jayne Bryant:** I think we've certainly heard that loud and clear today. Thank you.

[153] **Ms Minty:** And I also wouldn't think that CSSIW would have the

necessary skills to be able to look at some and audit to see whether it had been carried out correctly and whether people had been prescribed it in the right circumstances or not. So, it could become just a bit of a tick-box process rather than a meaningful exercise, I think.

[154] **Jayne Bryant:** Thank you.

[155] **Dai Lloyd:** Iawn? A oes unrhyw gwestiynau eraill? Na. Pawb yn hapus. Dyna ddiwedd y cwestiynu. Felly, diolch yn fawr iawn i chi am eich presenoldeb a hefyd am y dystiolaeth ysgrifenedig ymlaen llaw. Fe fyddwch chi yn derbyn trawsgrifiad o'r trafodaethau er mwyn i chi allu eu gwirio nhw i wneud yn siŵr eu bod nhw'n ffeithiol gywir, ond, gyda hynny o eiriau, a allaf ddiolch i chi unwaith eto am eich presenoldeb a hefyd am ateb y cwestiynau mewn modd mor fendigedig? Diolch yn fawr i chi.

Dai Lloyd: Okay? Any further questions? No. Everyone is content. That is the end of the questions. So, thank you very much for your presence and for the written evidence that you gave us beforehand. You will receive a transcript of the discussions so you can check its factual accuracy, but I'd like to thank you again for being here and for answering our questions in such a splendid way. Thank you very much.

[156] **Ms Minty:** Diolch yn fawr.

[157] **Mr Ford:** Diolch yn fawr iawn.

10:43

**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**

Cynnig:

Motion:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o'r cyfarfod yn unol â Rheol Sefydlog 17.42(vi).

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

Cynigiwyd y cynnig.

Motion moved.

[158] **Dai Lloyd:** O dan eitem 4, gallaf gynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer yr eitem nesaf. A yw pawb yn gytûn? Mae pawb yn gytûn. Diolch yn fawr.

Dai Lloyd: Under item 4, under Standing Order 17.42, we will exclude the public from the meeting for the following item of business. Is everyone content? Everyone's content. Thank you.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:43.

The public part of the meeting ended at 10:43.

Ailymgynullodd y pwyllgor yn gyhoeddus am 11:15.

The committee reconvened in public at 11:15.

Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal—Sesiwn Dystiolaeth 11—Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru

Use of Antipsychotic Medication in Care Homes—Evidence Session 11—Care and Social Services Inspectorate Wales

[159] **Dai Lloyd:** Croeso yn ôl i sesiwn ddiweddaraf Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Rydym ni'n symud ymlaen rŵan at eitem 6 a pharhad ein hymchwiliad o'r defnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal. Y sesiwn yma fydd sesiwn dystiolaeth rhif 11, ac o'n blaenau ni y mae cynrychiolwr o Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru. Felly, croeso i David Francis, prif arolygydd cynorthwyol Arolygiaeth

Dai Lloyd: Welcome back to the latest session of the Health Social Care and Sport Committee here at the National Assembly for Wales. We move on now to item 6, which is a continuation of our inquiry into the use of antipsychotic medication in care homes. This will be evidence session number 11, and before us we have a representative from the Care and Social Services Inspectorate Wales. So, welcome to David Francis, assistant chief inspector of CSSIW. Good morning, and thank you for

Gofal a Gwasanaethau Cymdeithasol Cymru. Bore da i chi. Diolch am fod yma. Diolch am y dystiolaeth ysgrifenedig ymlaen llaw. Ac, yn ôl ein harfer, awn ni'n syth i mewn i gwestiynau yn seiliedig ar y dystiolaeth yna, ac ar sawl darn o dystiolaeth arall yr ydym wedi ei gael hefyd. Felly, i ddechrau'r cwestiynau y mae Caroline Jones.

[160] **Caroline Jones:** Diolch, Chair. Good morning. The first question I'd like to ask, please, is: could you tell me what your understanding is of the main reasons why antipsychotics are often prescribed inappropriately to people in residential care with dementia? For example, do you think it's a lack of staff training, a lack of resources, a lack of alternative, non-drug treatments?

[161] **Mr Francis:** I think the important thing to begin with is to say that the effect of dementia on people is really critical and is very complex, and it results in people who are disorientated, who really struggle to cope with the reality of the world around them. Many of the behaviours that emanate because of the effects of dementia are very difficult for carers to care for. So, often, these things happen not because people are wanting to—. There is a real problem, and, quite commonly, there is a term that is used, and it's not necessarily—. It is 'resistive care'—not wanting to be changed, not wanting to be fed, not wanting—. And those are quite common issues facing carers, particularly if someone's been incontinent and doesn't recognise that and the carers have to do something about it. Similarly, you have incidents of people who are very agitated, or are wandering, or have become very aggressive towards staff or towards others. By and large, what's interesting is that those services that are well trained, are well supported and have good front-line staff actually manage those behaviours, because they really know the people they're caring for and they have a really good understanding of where the person with dementia is coming from, what's actually happening in their mind, how they feel, what it is that's causing them to feel anxious.

[162] So, where training is good and people are competent, then those sorts of situations are managed, but quite often, in many of our care homes, we have staff who really haven't got the depth of knowledge to actually tune into what it is that's causing someone to be anxious. And the natural response is to call for the GP, who will call on the psychogeriatrician, who will prescribe

antipsychotics, and then that is the response. So, I think that, in our written response to you, I think that a lot of it is because the care is not as sophisticated as it needs to be to meet the complexities of understanding the needs of people with dementia.

[163] **Caroline Jones:** I think you've partly answered my second question, but you've described training in dementia as variable.

[164] **Mr Francis:** Yes.

[165] **Caroline Jones:** And you say that, in a number of instances, neither the staff nor the manager have any specialist training in dementia.

[166] **Mr Francis:** Yes.

[167] **Caroline Jones:** So, how can we address this?

[168] **Mr Francis:** I think that Social Care Wales has already put in place a dementia care pathway ladder for people. We have a strong view, moving with the new regulations going ahead—the Regulation and Inspection of Social Care (Wales) Act 2016—that actually, for frail, older people, we need to move away from this classification of some services being for dementia and some services not being for dementia, but actually see that all services need to be dementia resilient, because many people who will be in residential care will have dementia. And it's a journey; it's not a thing that sits with you in the same way all the time. Often, with the complexities of managing people with behaviour and psychological symptoms of dementia, it's two or three years. Before that, you'll have the build-up of increasing forgetfulness, and after that you'll have very high levels of physical frailty. So, we think that actually we need to see dementia as part of one of the many conditions of frailty. So, I think that, as an action, all of our services, right across the piece, need to be strong.

[169] The other thing to say is that the services surrounding the care home that support the care home need to be smart and responsive, and those services that work well are those services that have a good relationship with secondary mental health for older people, or have good relationships with the GPs who have an understanding. Very often, the services themselves don't necessarily get the support from primary and secondary healthcare. So, the quality of the assessments is really important, and I think, very often when we look at dementia, if you look at the more sophisticated approaches

in terms of care planning—and I could talk about that if you wanted me to—we need to actually understand what the cognitive impairment arising from the dementia means for the person in terms of their residual abilities—what you can build on, their strengths—but also the difficulties that they’re having and how those can be compensated on. We tend to apply a sort of broad brush: someone’s got dementia, this is what we do—a lot of kindness and understanding. Actually, we need a more sophisticated approach, and the services that surround care homes need to be able to assist in ensuring that those assessments actually properly inform how care is delivered.

[170] **Caroline Jones:** And, of course, every patient has different needs and requirements, so how do you think that the need for individualism is to be put into the training—to treat a person as an individual, to be assessed and treated according to their needs, basically?

[171] **Mr Francis:** I think that there are a lot of materials around this, and I’m not sure whether you want me to go into this detail, but I’m very inspired by the work of Tom Kitwood, who is a psychologist. Some of you will know about his work, but he talks about what dementia is, the experience of dementia, and he talks about the importance of understanding the cognitive impairment, understanding the people’s personality—how they respond to anxiety, how they respond to stress—and understanding their physical health, and quite a few areas of complexity about behaviour actually are around physical health.

[172] There was a very good example in a west Wales case where someone actually had rotten teeth, and their behaviour wasn’t about dementia; it was about pain that wasn’t being managed through rotten teeth. So, physical health is really important, but, of course, biography is really important, and tuning people into things that make them feel comfortable, things that give them a sense of familiarity. So, there has been, in the past—. Many care homes, as you know, will have activity co-ordinators. There’ll be things like bingo or trips to garden centres. Actually, for many people, orientating them in an activity that gives them comfort and that gives them familiarity is really important.

[173] So, I think that the culture of care needs to be—and there’s a lot of talk about this—person-centred, which is actually designing an approach that recognises the individual, and many care homes do that. The way that they actually approach their care planning is around properly understanding the individual, and not trying to group, to deal with it across the board.

[174] **Caroline Jones:** Thank you very much. Thank you. Diolch, Chair.

[175] **Dai Lloyd:** Y cwestiynau nesaf gan Rhun. **Dai Lloyd:** The next questions from Rhun.

[176] **Rhun ap Iorwerth:** Bore da i chi, a mwy am hyfforddiant—jest un cwestiwn ar hynny. Mi ydym ni'n sic wedi clywed galwadau am hyfforddiant gorfodol ar gyfer staff cartrefi gofal ynglŷn â dementia, gan gynnwys adran ar feddyginiaeth wrthseicotig. A fyddech chi'n cefnogi hynny? **Rhun ap Iorwerth:** Good morning, and more about training—just one question on that. We've certainly heard calls for mandatory training for care homes regarding dementia, including on antipsychotics. Would you support that?

[177] **Mr Francis:** Yes, I think it must be part of the training package that people receive. It has to be a core component of the training they have. Also, I think an awareness of antipsychotics is really important, and I think that there are other things we can talk about in terms of medication reviews and other things. But, absolutely. The problem with training is that a lot of people have come 'to the market'. There isn't a single training provider. At one end, you've got things like the Butterfly projects and David Sheard's major programme. He's transformed many care homes, but his style is unique. And then you've got Alzheimer's training, you've got companies marketing DVDs that the staff can watch, you've got the Social Care Institute for Excellence online training. You've got so many different providers, and in trying to draw a line, one of the problems for us to say, 'Well, actually, what is the baseline here?' Personally, I would argue, in terms of dementia care, we're talking about a higher level than the QCF 2; we're looking at QCF 3 and need people around who really have an insight.

[178] I worked in England before I came to Wales seven years ago, and I was on the national dementia strategy, looking particularly at some of these aspects. One of the big programmes was in Gloucestershire, where they sent out—. They put a very high-quality training course to all of the care homes and identified just one person in each care home who had to be trained to be their dementia lead. It was a one-year programme, one day a week, reflective practice—all that sort of thing. The impact of that was quite astounding. First of all, the care homes often said—. I met these people who were doing this work and tracked the programme, and they were saying, 'We know more

about dementia than the GPs. We've been to hospital to see our residents, and you wouldn't believe how hospitals are handling this.' People don't know, and just that awareness of what dementia is and how it affects people—. You don't need to train all staff, but you really need to make sure that within homes, there are people who are giving strong leadership.

[179] There was a research project that I was involved with in England, looking at the quality of dementia care, using a tracking tool across 100 care homes. We looked at the most important thing that actually changed the quality of care, and that was front-line leadership. So, it's the support and direction and the culture that's established directly out there where people are living, by the staff. So, to cement it, everyone needs a base, but we do need leaders in our services who've got a strong understanding about dementia and how to respond.

[180] **Rhun ap Iorwerth:** Yes, because the impression that I have is that there would be support for everybody, because everybody would have that interaction—

[181] **Mr Francis:** Everybody needs it. Everybody needs it, but I have seen—. I did an inspection recently—well, about two years ago now—as an observation at a home in Bargoed. I was there and I observed a lunchtime, and it was the most brilliant quality of care I've ever seen. It was fantastic, and the staff were buzzing around the residents. They were keeping them stimulated. One of the issues for dementia is arousal levels, which is about how you keep people motivated and alive but not over-aroused so they get agitated and get anxious, but not withdrawn.

[182] **Rhun ap Iorwerth:** Why were—sorry to interrupt—these staff members so good? Do you know what training they had?

[183] **Mr Francis:** Yes. It wasn't them; it was that the home had sent their team leader on a course to Birmingham, and she had come back fired up and she had transformed the culture of care. So, I do think this question of front-line leadership is probably—. If we're going to invest money—and there is an issue of money, and resource and training staff, as all that side is expensive—if we're going to target, I would be suggesting that front-line leadership is very important.

[184] **Rhun ap Iorwerth:** We've also talked a lot about medicine reviews and calls for far more reviewing to be done. In relation to CSSIW, we have heard a

call for medicines to be a part of inspections done by CSSIW, and the Royal Pharmaceutical Society told the committee last week it had concerns that CSSIW hadn't mentioned medicines in an inspection report at all since 2007–08 and that nobody is inspecting what's going on with medicines. Do you accept that? If you do, should it be a mandatory part of inspections?

11:30

[185] **Mr Francis:** I've had a lot of contact with the Royal Pharmaceutical Society and a few discussions with them. They should fully understand how we undertake our inspections. You can put everything in writing, you can create all the standards you like, you can have care plans in place, you can have your staff training in place, you can have all the standards met, but, actually, what happens is that the last little bit doesn't happen and the experience of people living in care homes is poor. Quite often, we've moved away very much from a tick-box approach of going through checking this, checking that, checking the other, to actually centre our inspections, particularly for dementia, on the experience of people in care homes.

[186] So we use a tool, and we mentioned it, called SOFI, the short observational framework for inspection. It's a derivative of dementia care mapping. What this means is that we observe five people in the care service very closely, and then we track back. So, we then track back to their records, we track back to their medication, we track back to what staff training they have, and we look at what we see and we triangulate that with what we are told by staff, what we're told by relatives, and what we observe in the records. So, medication is very much part of our inspections. It's an area that we pick up on, but we are very interested—. We've moved to an approach that focuses on outcomes for people. So, we can go into the service and find everything perfect, but, actually, the experience of people is just sitting round the corner, withdrawn and whatever. But one of our lines of enquiry is medication reviews, so I actually don't agree with the RPS.

[187] **Rhun ap Iorwerth:** Could you perhaps give us an example? There is a lady—we talked about a Marjorie this morning, so let's reintroduce Marjorie—who is sitting very, very quietly in the corner probably because she has been given antipsychotic medication. How does your inspection look into what happened there and why she was prescribed that medication and whether it was the right thing? And if you have a feeling that, maybe, it wasn't the right thing for her or that there hadn't been a medicines review within a certain period of time that assessed whether it was appropriate for

her to have been given that medication, do you then cast the net a bit wider in that care home and look at whether there's a wider-scale inappropriate use of antipsychotics?

[188] **Mr Francis:** Yes, that's a perfect example. We have a sort of saying, which is, 'Smell the coffee, follow the smoke and then count the beans.' So, if we saw—and this is what we've trained our inspectors to do, and it's much more responsive and we've identified much more non-compliance and problems by taking this approach. So, if we see things that aren't right, and our inspectors are tuned into that sort of stuff, and this tool would pick up on someone like Marjorie—we then begin to follow the smoke. So, we then say, 'Hang on. Marjorie—can you tell us a little bit about Marjorie? How aware are you as staff of Marjorie's needs? Tell us about Marjorie.' And then we would look at the records and then we would start asking questions about the medication.

[189] One of the challenges that we have is who is right and who is wrong. We've got an example. We're talking about antipsychotics, but I think it's a bit wider than that. One of the drugs that is used, I think quite commonly for dementia, is Epilim, which is an anticonvulsant rather than an antipsychotic. It's used to prevent epileptic seizures. We had a report of someone who had weight loss in a home—significant weight loss—from a relative. So, we went in and we looked at it and they were being prescribed Epilim at quite high levels. Now, the question is: the home had sought that, the home had requested help and that was the response, so, who are we to say versus the psychogeriatrician? What was interesting about that story was that, because of factors that happened, that person moved to another care home where the care culture was actually a lot better and no medication was required and they could manage their behaviour. So, I think it's actually quite complicated who holds—

[190] **Rhun ap Iorwerth:** But do you ask in inspections what is a home's record on reviewing the medication of all its—

[191] **Mr Francis:** It's one of our lines of enquiry, yes.

[192] **Rhun ap Iorwerth:** In general, you were, 'Look, prove to us that you have been doing medicine reviews.'

[193] **Mr Francis:** It will pick out through the individual—. What we do is pick up, through individual—

[194] **Rhun ap Iorwerth:** Okay. Let me give you a scenario. There's a care home with 15 people. Five of them have been inappropriately prescribed antipsychotics. They are not among the individuals that you target, or you pick, randomly, however it happens, in order to be able to assess that care home. They've still been prescribed inappropriately, but you're not picking up on them. Could that happen?

[195] **Mr Francis:** That could happen. But I would suggest that those homes that—. In our work, there is a marked difference between those homes that are on the ball and those homes that aren't, and, very often, that will come out, because it'll be part of a whole host of things in terms of the care plan. Because we're talking today about antipsychotics, but there are a whole range of medical interventions, relationships with the GP—a whole range of things that we're looking at. So, by and large, that would get picked up. In terms of a full—

[196] **Rhun ap Iorwerth:** But it hasn't, has it? For decades, it seems. It just hasn't. That's why we're conducting this inquiry. I've been convinced. I didn't know about this before we started this inquiry. I have been convinced that this is a problem—that the inappropriate use of antipsychotics is a problem in care homes in Wales. For some reason, that hasn't been either identified, or perhaps it has been identified, but it hasn't been deemed worthy of an investigation into how this could be resolved. Now I can come, as a layman, to some of my own conclusions: wouldn't it be great if care home inspections sought out information on how many people in that care home were on antipsychotics, and then an explanation of what reviews had been done to assess whether that was appropriate or not? Why would that not be something that could've resolved this?

[197] **Mr Francis:** I think it is. I think that one of the things I mention in the return that we provided you is that we have an opportunity for homes to actually self-assess and to require—. But one of the pieces of information that we would be looking for is information on medication reviews and information on antipsychotics, so we can—

[198] **Rhun ap Iorwerth:** But only if you're—. Only in the case of people that you have chosen.

[199] **Mr Francis:** No, that would be general. That would be a general report back from the home. It allows us to monitor the home to see how well it's

doing. So, it would flag up to us if there was a high number of people on antipsychotics.

[200] **Rhun ap Iorwerth:** So, when the Royal Pharmaceutical Society says that nobody's inspecting what's going on with medicines, you contest that that is not true.

[201] **Mr Francis:** We don't go in and do medication audits in the way that RPS would like us to do. What we do is we look at the role of medication and how it's used around individuals. And that's how we track it.

[202] **Rhun ap Iorwerth:** Okay, thank you.

[203] **Dai Lloyd:** Jayne, did you have a supplementary?

[204] **Jayne Bryant:** Yes, just on the back of what Rhun was asking, really. You mentioned some of the tools available that would be able to investigate what happens to people like Marjorie, who Rhun had suggested. But do you keep any data on that, or statistics? How many Marjories do you deal with?

[205] **Mr Francis:** No, we don't.

[206] **Jayne Bryant:** So, it's very difficult, then, to understand how widespread this problem is and how we're able to support people like Marjorie, then, and how she's treated in the future.

[207] **Mr Francis:** At the present time, we—. This is one of the things that we think—. One of the opportunities that we have with new technology, with new computer systems and with going online is that we have an opportunity to actually collect data from care services in a way that we never have before. That's what's coming on stream. It's already started and it's being ramped up, so we can actually monitor this, and, in the future, we'll have the ability to answer these questions, provide data and actually monitor and put profiles of care services in. That is all planned for—. It's coming on stream now, slowly, in terms of—we're ramping up the information we're asking for from care homes.

[208] **Dai Lloyd:** Lynne, you had a supplementary.

[209] **Lynne Neagle:** Yes. I'm just struggling to understand how you can track it, really, especially as you haven't got any pharmacists on the team. So,

can you maybe give us an example of where you've gone in and you've done one of these generic looks at a care home, and looked at what the medication is? You know, some examples, maybe, of where you've picked up on problems and gone back and highlighted concerns—because somebody could be being prescribed an inappropriate antipsychotic on top of the general issue of prescribing. I'm struggling to see how your role in it all works, really.

[210] **Mr Francis:** Well, I tried to provide the example earlier of us picking up on someone who had weight loss where the care wasn't right, and we—

[211] **Lynne Neagle:** But that's not an antipsychotic, is it, Epilim?

[212] **Mr Francis:** Well, to some extent, it was used inappropriately for the same end. I'm trying to think of a case, a recent case, where we've done that. I can just assure you that it is something that is—in our inspection methodologies, we have lines of enquiry. Antipsychotics and medication reviews are one of those things our inspectors are expected to consider, and they fall out of that, and that is part of our methodology of doing inspections. But we do it by looking at the outcomes for key individuals in the home and seeing how they're cared for. A positive example—I was involved in an inspection in north Wales, and the people there all looked really positive and good. This was a home near Bangor. There were very positive interactions that went on. When we looked behind it, and asked why that was, we went to the records and there was evidence of regular reviews, regular medication reviews, regular oversight by the primary healthcare team. So, we do do that in terms of validating the care that people are having.

[213] **Dai Lloyd:** Angela, your question next.

[214] **Angela Burns:** I'm sorry to keep harping on about this, because I'm quite uncomfortable with this area. My understanding is that the role of CSSIW is to protect the best interests of the person, and, therefore, under the Mental Capacity Act 2005, the best interests of the person is something that you're going out there to judge these care homes on and decide whether or not they've got the appropriate, best interests of the person—. And yet we've heard evidence where the inappropriate use of antipsychotic drugs is called, basically, a chemical restraint. If it's a restraint, then it goes against that fundamental principle, 'in the best interests of a person', if it's inappropriate. So, I just don't understand why CSSIW don't already look at this as part of

your inspection process, or have I just missed something here?

[215] **Mr Francis:** I think, in our day-to-day inspections where we're going out to care homes, it's pretty evident to us, those homes where the culture and the care and the activity of profiles of the people are such that they're not having a good quality of life. So, how can I put it? It's that sense about smelling the coffee. You can go into homes where people are busy, they're proactive, people are engaged and life is good. You can go into homes where people are actually lethargic, where they're struggling, and then you begin to ask the questions, and we do ask the questions. But it's actually looking at the experience of people. So, we are looking at the best interests, but we're looking at them from the basis of the outcomes for people, rather than just going through a checklist, checking whether this has happened, that has happened or this has happened. So, that's how we currently do our inspections.

[216] **Angela Burns:** Sorry, how often do you do an inspection?

[217] **Mr Francis:** Currently, it's every 12 months, but—

[218] **Angela Burns:** Of every single care home?

[219] **Mr Francis:** Every single care home, and then we go out more often if we've got concerns, and we respond to concerns that come in to us. So, we are very keen that, if people raise issues with us, we will go out and respond quickly.

[220] **Angela Burns:** I tell you why this doesn't chime with me. It's because also in your evidence, and I'll read it to make sure, CSSIW states that:

[221] 'A significant proportion of care homes in Wales carry historical "EMI" "Dementia" or similar registration classifications. They also state in their Statement of Purpose/brochures that they care for people with dementia but in a number of instances we find that neither the staff or manager have had any specialised training in dementia.'

11:45

[222] What I just can't understand from the questions that you've answered to Rhun, to all of us, is this big gap about whether or not somebody is getting the appropriate medication, because my worry is that there are care

homes out there that say, 'Yeah, yeah, we can look after your relative with dementia', and actually the only way they can look after them is by keeping them subdued and not engaging with them in all of the other activities that might really enhance the quality of their life, particularly as this is end-of-life care. And where I don't quite understand the role of your organisation is in terms of finding out and really understanding whether or not care homes are trained adequately. You said earlier, 'well-trained, well-supported, good front-line staff', but in the same breath there's an awful lot of care homes out there that don't have that, that do use antipsychotic drugs inappropriately. As Rhun says, we've heard overwhelming evidence that this is out there, so why aren't CSSIW doing something about it? Why aren't you saying to those homes, 'What are you doing saying that you can do dementia-friendly when, actually, the only thing you can do is give them a bunch of drugs and stick them in a corner?' And I don't get any confidence that you as the regulator are going out there and saying, 'You shouldn't be saying you're dementia-friendly, you shouldn't be saying you're an EMI home, you don't have the appropriate staff', because, in fact, it's just easier, to be frank, just to pack them in and leave them to sit there, and I think it's horrendous.

[223] **Mr Francis:** I think we were quite open about this issue. We've put the problem on the table, and about four years ago we made a very strong move to get rid of all those classifications, and we pushed very hard. The trouble is that there were legacy holder registrations that took place in 2002 when the Care Standards Act 2000 came in, and there was a legal pushback against us. So, we're using the new Act as an opportunity to actually take away those classifications, and we are driving down now on our expectations that services set out very clearly in their statements of purpose who they're providing care for and how they do it, and we're going to be policing that. So, it's not something that we have been positive about in terms of these classifications, because we think that that is inappropriate, but it's been very hard for us to actually get rid of them because of the legal challenges that we faced from some of the care services when we tried to do that back in the past.

[224] But I just want to assure you that where we go out to services and people are, as you say, stuck in corners or whatever, we respond to it. If you look at our reports—I don't know whether you looked at some of our reports—we try to describe in a lay person's way the experience of people being cared for, what it's like and how that relates to staff training. It's very clear to me when I'm reading reports those services that, actually, are

sparkling and positive and those services where, actually, the experience for people is poor. We do take action with those poor services, and a lot of it is around staff training, around staff numbers, and those are the issues that come through. So, I absolutely understand your concern, and you're causing me to reflect on what we might do about that to give you assurance. But actually, by focusing on the outcomes for people and actually being very tuned in to the outcomes, I wouldn't expect any of our inspectors to walk out of a care home feeling comfortable if people were sitting down there and they were stuck in corners, and their medication hadn't been reviewed.

[225] **Angela Burns:** I'm afraid, though, that I am less comforted going forward with the new proposed system because it strikes me that, as the regulator and the registrar of businesses, if you can't dis-register or un-register somebody because you don't believe that they currently are fulfilling the criteria, which are laid out in a quite—you know, they've got boundaries, the current set of criteria, and we're going to move into a more unregulated or, not unregulated, but we're going to move into a system where there is much more onus on the care home saying, 'Yes, we'll do this and we can do that', then your ability to really regulate and have teeth on those that don't perform well is going to diminish. I've had concerns raised about this by other people, and I have to say that today I can tell you about care homes in Pembrokeshire and Carmarthenshire that I can walk into and I think, 'Yeah, I'd put my mum there', and there are other ones where I wouldn't put my dog.

[226] **Mr Francis:** You said there about the classification. The problem with these old classifications of EMI and dementia as they currently are: there were no agreed standards ever. There was nothing we could police against, and that was the difficulty, because there wasn't anything specific that—

[227] **Angela Burns:** But types of staff, you had to have, didn't you?

[228] **Mr Francis:** Types of staff?

[229] **Angela Burns:** Staff. Like you had to have nursing staff, or you know, there were regulations, I understood—.

[230] **Mr Francis:** Prior to 2000, for nursing homes, there were staffing notices, which allowed us to prescribe how many staff were on each shift. That was prior to 2000. Currently, there is nothing in there apart from saying you've got enough sufficient suitably qualified staff. Apart from that, there is

nothing we can do to actually specify the number of staff or who is there, other than if we think the staff is insufficient.

[231] The other thing that we can do, and what we do do, is we can take action to stop people admitting people. We could impose a notice not to look after people with dementia. We haven't done that very often. We've stopped services looking after people with complex needs, but the way that we would normally respond to that is to not allow services to admit places. And in the past—. You're probably aware, but in the past few years we have been instrumental in closing a lot of care homes. There have been a lot of nursing homes and care homes that have closed in Wales because of our new approach and because we've been quite rigorous and quite tough. When you come through to going to tribunal or providing evidence, what people will want is the evidence of the impact on people.

[232] So, that is what we've been good at. That's what we've been strong at, and I think that we've actually taken out some of the very poor services in Wales and we've closed them, and I think that's very positive. There is an issue about how you drive up improvement for those services that aren't sparkling, that are grey, that are just about adequate, and we've always maintained that we would like to see opportunities for ratings, for us to give quality ratings and to build into that expectations about that to take services beyond where they are.

[233] I absolutely understand your concerns, and I respect them, and I think I will go away and think about them, because I think the questions you're asking are very valid. But, I would say very strongly that we have been very assertive, particularly in the world of dementia, where we are very involved with Margaret Flynn over 'In Search of Accountability' and the Flynn review, in terms of taking out those services where people really are suffering poor care. Sorry.

[234] **Dai Lloyd:** Okay. The supplementaries are stacking up but the time is not, so Rhun, happy? Caroline then Jayne. Caroline.

[235] **Caroline Jones:** Me, is it?

[236] **Dai Lloyd:** Yes, as a supplementary.

[237] **Caroline Jones:** Thank you. My question is basically around the storing of the data. In all the evidence, it says that this is very sketchy, that the

keeping of data and recording of data on the use of psychotic drugs is sketchy throughout.

[238] **Mr Francis:** Across the system.

[239] **Caroline Jones:** Yes, across the system. So, therefore, when people are suffering side effects and so on, nobody is taking note of any of this. There could be a lot of people suffering from side effects through these antipsychotic drugs, but if the data is, at best, sketchy, then we don't know how these people are affected by the use, do we, really? Because we haven't got proper records of it. That really concerns me.

[240] **Mr Francis:** As I explained earlier, where we have been is: every year we would send out to a care service a lengthy—. Because this area is just one aspect of caring for a home—you've got staff qualifications; you've got electrical testing; you've got all sorts of other things. We would send out a great big self-assessment for care homes, and that would come in and there was no way of actually entering that into any sort of computer system for us to crunch the numbers or do anything. I'm not trying to sort of sell myself, or sell us, but we have been a pioneer in Welsh Government in creating online—and across the UK—self-assessment for care services, and we now do that in our early years and childcare. We're now beginning to do it with older care and care homes. We've done two cuts at the data. We've got lots of information about environmental standards; we've got Welsh-language information. It's our intention to include antipsychotics as one of the traces—one of the things that we get—so that we'll have a regular audit each year of the use and prevalence across the service.

[241] **Caroline Jones:** But it seems to be such a lengthy process and, at the end, the individual person is the one who is suffering. So, it's not getting to the core of the problem here. We're not getting it; we're having a lot of information and data sent out online and so on, which is to be filled in by someone, but it can't be checked because of the volume of it. But I really do want something that—

[242] **Mr Francis:** I absolutely agree and I think it would be a tremendous benefit for us to be able to collect that data and be able to report on the use of antipsychotics across care services and identify those of high instance and identify geographically where there's a particular situation in one area because of the prescribing patterns.

[243] **Caroline Jones:** Yes, but who's going to be looking at the individual? It's all right to have a generic approach and say, 'This is happening there and that's happening there.' But it's the individual; we're not getting to the issue here. I'm looking at the individual and how the individual is suffering, but we're talking now about paper in different areas and collating information to see this and to see that, but it's the person that I'm looking at.

[244] **Mr Francis:** I'm trying to understand how the data—

[245] **Caroline Jones:** I'm not looking at a generic approach; I'm looking at a bespoke approach to see how an individual is affected by the inappropriate use or the prescribing of antipsychotic medicine.

[246] **Mr Francis:** You might be interested, in terms of positive solutions and things that might be done, that I've been talking to Four Seasons Health Care, which is one of the large care home operators. Their medical director has developed an app. This app means that the care workers put in each individual's medication profile into the app.

[247] **Caroline Jones:** Yes, and this is what we need to go forward.

[248] **Mr Francis:** The app actually analyses whether or not these medications are safe. There is a whole range of medications, and antipsychotics are part of it. The app will automatically generate a letter to the GP from the medical director—it comes out of their central office to say, 'You must review this person's medication, because of the following situations'. So, I think that is a practical solution in terms of the fact that it's something that—. I've spoken to them and I'm going to go and meet them and look at this in practice, but they've put that in place across their care services. So, that idea of having somebody who analyses and tracks individuals, I think, is a good thing.

[249] **Caroline Jones:** Yes, that's what I'm after.

[250] **Dai Lloyd:** Good. Some more agility is required in questioning, but I have full confidence in Jayne here.

[251] **Jayne Bryant:** Thank you, Chair. Just going back to a point in the answer that you gave to Angela just a little bit earlier, you mentioned that you've closed a number of homes in Wales. How many have you closed and what's the proportion of those in Wales? What happens to the staff then? If

there has been a culture of inappropriate prescribing of antipsychotics or a lack of understanding around dementia, I presume that some of them might find other roles in other homes and how do you follow up with that?

[252] **Mr Francis:** Actual numbers of homes we've closed, would be—. I'd have to go back and do some research for you. What happens is: when we decide to close a home, we issue notices; the home goes into free fall, and very often it might close or it'll be bought by another owner or it'll transfer on. So, the outcome of our decision to put pressure on them—. But you're talking about, I would guess, 30 or 40 in the last three or four years, which is quite a significant number that we've taken action on and closed. Half of the homes that we've closed or have moved to close actually improved and got out of that escape route, and the other half actually closed their doors and shut up shop.

[253] At the moment, our only legal relationship is with the registered manager. We work very closely with Social Care Wales, because they're registered with them as well. We will seek cancellation of their registration with Social Care Wales. We will cancel them.

12:00

[254] Our social care workforce isn't actually registered at the moment. You will know that there are intentions, perhaps, to consider that into the future, beyond 2020. But where nurses are involved, we will refer to the Nursing and Midwifery Council and we are involved in quite a number of NMC hearings. Often, on the nursing end—which is where this is and medication is part of the issues here—we will take evidence to the NMC and will pursue that hearing. So, quite commonly—you will have seen some of this stuff perhaps coming through in the press—nurses will be suspended, there will be NMC hearings and they'll either be restricted or they'll be struck off. So, the only route that we've got for—. We've got routes for the managers, we've got routes for the nurses, but at the present time we can't do anything about individual members of staff.

[255] **Dai Lloyd:** Okay. Lynne, your second question, 25, is to be asked.

[256] **Lynne Neagle:** Do you not want me to ask about the pharmacists because we've—?

[257] **Dai Lloyd:** I think you've already covered that, actually.

[258] **Lynne Neagle:** Yes, okay. Can you just tell us then what you think the priority actions that are required and what you think would have the greatest impact on reducing antipsychotic use?

[259] **Mr Francis:** Certainly, medication reviews are really important. There is research—you're probably aware that there's a programme in Cornwall called the STAR programme, where they've got homes to reduce it. One of the interesting things that came out of the barriers to reviewing medication was actually engaging the GPs. So, it's important that GPs are involved, are on board and are actually part of this in terms of collaborating to ensure this. So, it's not just homes; the GPs also have an active role. But there is this STAR programme that came out with very good results. There was also a programme with the Orders of St John Care Trust homes, which I've referred to, which has been researched.

[260] So, I think the medication reviews are the starting point. But if you do that and you haven't actually trained staff—. There was an incident that I was involved in in north Wales, where someone with quite severe dementia was placed in a care home and they then withdrew the antipsychotics without putting in place any other support and without any training to the staff, and it ended up with that person going out of control, getting very distressed and the person having to move on. So, what I'm saying is that taking away their antipsychotics is one thing, but actually you need a culture of care and you need training of staff, who are resilient to be able to care for them.

[261] We have homes that pride themselves on not using antipsychotics and that is one of their key performance markers—'We don't use antipsychotics here'. So, I think it's about the understanding of that. So, No. 1—the reviews; No. 2—the training of staff; but I also think that, thirdly, is the effective support from primary and secondary healthcare and the relationships that they have with those. It's interesting because the GPs that we have in Wales have an enhanced contract to provide support to care homes and maybe that could be looked at as part of this programme to see what their role is in terms of undertaking medication reviews.

[262] **Dai Lloyd:** Okay. And a short final question from Jayne.

[263] **Jayne Bryant:** Thank you, Chair. One of the key aspects of the Welsh Government's draft dementia strategy is to reduce the inappropriate use in care homes of antipsychotics. How do you think we can ensure that that

strategy does exactly what we hope it will do in terms of reducing the antipsychotics?

[264] **Mr Francis:** I think there is an issue about, going back to what I said earlier to Caroline Jones—I do think that you're right in that the data generally, across the piece here, is weak. I don't think we know how much is being prescribed. We don't know what is really going on in prescribing patterns. So, I would argue that we do need a baseline and I do think that we have a role in having that baseline. You will be able to see that going down and be able to identify the trends and identify the patterns. So, in terms of how you demonstrate that effectiveness, I think it's important that we do that.

[265] But I also think that it's—. We know the very harmful effects of antipsychotics, but the aim here is actually to improve the quality of life and the safety of people living with dementia. It just shouldn't be a goal in its own right, it has to be around the quality of life of people living with dementia in care homes and how we get measures on that. We would like to see, from our point of view, the opportunities, potentially, for using rating systems so we can demonstrate over a period of time the well-being of people in care homes, and we can actually say, 'In 2020, we rated this number, and in 2030—it's like that.'

[266] **Jayne Bryant:** Thank you.

[267] **Dai Lloyd:** Grêt, diolch yn fawr. Dyna ddiwedd y sesiwn, felly. Diolch yn fawr iawn i chi am eich presenoldeb. Diolch yn fawr iawn am y dystiolaeth ysgrifenedig y gwnaethom ni dderbyn oddi wrthyh chi ymlaen llaw. Diolch yn fawr hefyd am ateb y cwestiynau mewn ffordd mor raenus. Fe allaf hefyd gyhoeddi y byddwch yn derbyn trawsgrifiad o'r trafodaethau yma i chi allu ei wirio i wneud yn siŵr ei fod yn ffeithiol gywir. Gyda hynny o ragymadrodd, a allaf i ddiolch i chi unwaith eto am eich presenoldeb? Diolch yn fawr iawn.

Dai Lloyd: Great, thank you very much. That's the end of the session, therefore. Thank you for your attendance. Thank you very much for the written evidence that we received from you beforehand. Thank you also for answering the questions so splendidly. You will receive a transcript of our discussions to make sure it's factually accurate. With those few words, I'd like to thank you again for being here. Thank you very much.

[268] Fe allaf gyhoeddi mai dyna That is the end of the morning
ddiwedd sesiwn y bore i fy nghyd- session. There will be a break now
Aelodau. Bydd egwyl nawr am ginio a for lunch and we will come back at
byddwn ni'n dod nôl am 12.40 p.m. 12.40 p.m. Thank you.
Diolch yn fawr.

*Gohiriwyd y cyfarfod rhwng 12:06 ac 12:50.
The meeting adjourned between 12:06 and 12:50.*

**Defnydd o Feddyginiaeth Wrthseicotig Mewn Cartrefi Gofal: Sesiwn
Dystiolaeth 12—Bwrdd Iechyd Lleol Cwm Taf a Bwrdd Iechyd Lleol
Prifysgol Caerdydd a'r Fro
Use of Antipsychotic Medication In Care Homes: Evidence Session 12—
Cwm Taf Local Health Board and Cardiff and Vale University Local
Health Board**

[269] **Dai Lloyd:** Croeso ichi gyd i **Dai Lloyd:** Welcome back to you all to
sesiwn y prynhawn o'r Pwyllgor the afternoon session of the Health,
lechyd, Gofal Cymdeithasol a Social Care and Sport Committee
Chwaraeon yma yng Nghynulliad here at the National Assembly for
Cenedlaethol Cymru. Rydym ni'n Wales. We are now moving on to item
symud ymlaen i eitem 7 ar yr agenda 7 on the agenda, and the
heddiw, a pharhad o'n hymchwiliad continuation of our inquiry into the
i'r defnydd o feddyginiaeth use of antipsychotic medication in
wrthseicotig mewn cartrefi gofal. care homes. This, now, is evidence
Hwn rwan o'n blaenau ni ydy sesiwn session 12, and we have
dystiolaeth rhif 12. O'n blaenau mae representatives from Cwm Taf Local
cynrychiolwyr o Fwrdd Iechyd Lleol Health Board and Cardiff and Vale
Cwm Taf a Bwrdd Iechyd Lleol University Local Health Board.
Prifysgol Caerdydd a'r Fro. Croeso i Welcome to you, and welcome
chi, ac yn benodol, felly, croeso i'r specifically to the table to Mr John
bwrdd i Mr John Palmer, cyfarwyddwr Palmer, director of primary,
iechyd sylfaenol, cymunedol ac community and mental health, Cwm
iechyd meddwl, Cwm Taf; Mrs Kim Taf UHB; Mrs Kim Williams,
Williams, seicolegydd ymgynghorol consultant psychologist for older
iechyd meddwl pobl hŷn, Bwrdd persons' mental health, Cwm Taf
lechyd Lleol Cwm Taf; Victoria UHB; Victoria Gimson, specialist
Gimson, fferylllydd iechyd meddwl mental health pharmacist, Cardiff
arbenigol, Bwrdd Iechyd Lleol and Vale UHB; and Lisa Lane, senior

Prifysgol Caerdydd a'r Fro; a hefyd Lisa Lane, uwch-reolwr nyrsio, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro. Croeso i chi'ch pedwar. Rydym ni wedi derbyn tystiolaeth ysgrifenedig ymlaen llaw, a diolch yn fawr am hynny. A allaf jest ddweud hefyd: ni fydd angen cyffwrdd efo'r microffonau. Mae popeth yn gweithio'n awtomatig. Felly, ar sail eich tystiolaeth, a'r holl dystiolaeth arall rydym wedi'i chael yn yr ymchwiliad yma, awn yn syth i mewn i gwestiynau, ac mae'r cwestiwn cyntaf gan Angela Burns.

[270] **Angela Burns:** Thank you, Chair. Good afternoon. Thank you very much indeed for your written evidence. I'm going to leap straight into some detail, if I may. One of the things that struck us from both of your commentary was that the care home liaison teams have been making some effective reductions in the use of antipsychotic drugs in care homes, and we've been horrified at some of the evidence we've heard in previous sessions about how prevalent this is. So, we are very keen to hear about good practice, and I wondered if you could expand on that a little bit and let us know some more about why you think that those have been successful and also how you are going to be adopting that best practice throughout your own health boards.

[271] **Mr Palmer:** Shall I just kick off? I think colleagues will come in very quickly because they are the experts today, not me. I would say that, in both teams, there is very strong evidence of strong clinical leadership, and that you've seen small ideas adhere at an early stage. And then both health boards have been sensible enough to invest and build up a team. Again, I think that, in both instances, you see that there's a commitment to building up a multidisciplinary team, which is very, very needed for dealing with the kind of complexity we're seeing in the kind of cases that we're addressing. I think that the way forward is absolutely about continuing with that approach. I know that in the committee evidence that you've received, you've been probing around what the contribution is from primary care, what the contribution is in terms of the potential scale-up from clusters. I think we do start to see some interesting emerging evidence about things that can be

successful with primary care playing a very, very strong role in integrating into what have been probably previously quite strongly led secondary care initiatives. So, there's a good opportunity there. Really, my view is: clinical leadership is absolutely central, and then building on that with major depressive disorder approaches. I know colleagues will add to that in detail.

[272] **Dai Lloyd:** Good. Carry on.

[273] **Ms Gimson:** I could tell you about the piece of work we did in Cardiff and the Vale. I'm a mental health pharmacist, and I joined a dementia care advisor nurse with 30-plus years' experience of mental health and a specialist in providing dementia care advice—pharmacological measures. So, I joined the third stage of the pilot—myself and Candace, the dementia care adviser. She had been involved from the get-go. The Banerjee report came out in 2009. There was an audit done by primary care of the prescribing of antipsychotics, and a pilot was then set up in a single care home, with the care home liaison team at the time, with a consultant psychiatrist, and a nurse—a dementia care adviser—doing the reviews. They had really good results: 21 residents were identified as having dementia within this home and being prescribed an antipsychotic, and 56 per cent of service users had their antipsychotics withdrawn. The next stage moved on to just the dementia care adviser working on her own, and it didn't really get off the ground. So, where she was doing the non-pharmacological measures and providing support and training to staff, her recommendations to review the antipsychotics to the GP sort of fell on—not fell on deaf ears, but they weren't actioned or weren't actioned in a timely manner. So, by herself, it didn't work very well.

[274] Anyway, I joined pilot 3. Myself, as a prescriber as well, and Candace, we used a challenging behaviour scale, which I've got copies of if you want to have a look at, and we used that to identify patients that would be suitable for review. We worked jointly with primary care colleagues—pharmacist colleagues—who'd identified the people in this particular care home who were prescribed antipsychotics and had a diagnosis of dementia, and we went in every week and we saw about four patients. We did one day a week—one afternoon—and we saw about four patients in that afternoon, and we looked at the medication. So, I looked at more of a medical model and Candace looked more at a non-pharmacological model, providing support and how we would—because if we were reducing an antipsychotic, behaviours could emerge—then handle somebody without the antipsychotic. We were looking to support the nurses in giving the medication. It went on

for about three months, and out of 18 patients, we stopped the antipsychotics of 14. Fourteen patients had their antipsychotics stopped and two were reduced, so it was a good result. On the back of that, the idea was that we would upscale—

[275] **Angela Burns:** Sorry, could I just stop you there? Because the question I'm trying to really drive at is—. I think it's an excellent thing to have got those people off an antipsychotic, but you made the comment yourself: as you take them off the medication, other things will occur. So, I'm trying to understand, in the round, what you put in place so that when they came off the antipsychotics and were therefore more alive to their environment and their needs and all the rest of it—. You couldn't have just taken them off and said, 'Oh well, there you are. They'll be fine.' So, what else do you put in place?

[276] **Ms Gimson:** Well, we did, always. Out of the 18, 14 were stopped, and the only person for whom I made any changes at all to their meds was somebody who was on Trazodone—a small dose of Trazodone—and we increased that. The rest we managed to slowly reduce and stop without changing any other medication. It is possible.

[277] **Ms Lane:** I think the point you're getting at is what else happened, and I guess that is, in part, Candace's role.

[278] **Angela Burns:** Absolutely.

[279] **Caroline Jones:** The withdrawal symptoms and so on, from taking the drug away.

[280] **Ms Lane:** I suppose Candace's role very much, as a dementia care adviser, is about working with the staff in the care home to look at how they might manage things differently, so having a look at helping them to understand possible triggers for changes in behaviour and helping them to get to know the person. So, it's a lot more around the person-centred approaches, helping care staff understand that what they may view as challenging behaviour, actually, when you pick that backwards and understand it—what that means and why the behaviours are possibly there—there are alternative ways of managing some of that. That's about getting to know the person, getting to know their likes and dislikes, about environments, about approaches, about time, about understanding dementia, quite often, and actually why people behave in the way that they

do.

[281] So, Candace's role—. I think that's why the success of this pilot—. Having very much a pharmacist there to be able to make those changes at that time, rather than having to wait for that, and then actually working with the home around all of it, so the home is clear and understands what the possible changes might mean. They've got a team to contact if there's an urgent need for a review to take place before, but it's not, 'Well, we're stopping this medication and walking away'. As to the way the pilot was set up, they were there on a regular basis, so the home knew that it had the support there should it need it.

[282] **Dai Lloyd:** And the view from Cwm Taf, Mrs Williams.

13:00

[283] **Ms Williams:** Yes. I was going to say, we started from a rather different position. So, we started from providing the biopsychosocial formulation and interventions, rather than focusing on the medication, and it is exactly about helping the staff within the home to understand the person and get to know them, and I think the model works.

[284] The model that we've used is the Newcastle model, which I know you've already heard evidence about, and I think it works because the staff in care homes often have very, very little information about the people they're caring for, and so what our formulation does is it opens it out. We collect, with the staff and the relatives, any notes and records that we have. We collect a lot of information and sit down with the care home staff within a formulation meeting. So, everybody starts to talk about, 'Well, what does this behaviour actually mean?' We start to interpret that and then we put an intervention in place that's specific to that person. So, it's not about saying, 'Well, there's reminiscence available'. It's about saying, 'For this person, the need is for them to have that social interaction, for them to reminisce.' For somebody else, it might be a completely different need, and so it's about looking at the intervention specifically for that person, and what we've shown is that it's possible to prevent people going on antipsychotics using that model. It's actually very difficult to get people off once they're on.

[285] So, I think you need, actually, a bit of both of what we've been doing, but I think what we feel very strongly is that, as a biopsychosocial team—a multidisciplinary team—that medication review, that pharmacy overview,

needs to be there for every patient across the whole of the health board. We work very intensively with those people who have behaviour that challenges to such an extent that their placement is likely to break down, they're likely to come into hospital. That's a fraction of the people with a diagnosis of dementia within an area. So, you need that kind of overview, and you need a different system that works alongside.

[286] **Dai Lloyd:** Great. We have a stack of questions, actually, so make them short, team, and we'll see how far we go. The next question is Caroline Jones.

[287] **Caroline Jones:** Thank you, Chair. Good afternoon. Can I ask what your understanding is of the main reasons why patients in care homes with dementia are prescribed inappropriately, in some cases, antipsychotic medication? Do you think that some of the reasons may be a training issue or lack of staff resources, resources in any way, or lack of access to other methods, holistic methods maybe, as opposed to medication?

[288] **Ms Lane:** I suppose I think, training—absolutely. I think we're all very aware that the staff in care homes often are very transient, aren't they? I'm sure we've all provided a lot of training over the years, and you can go back to a care home two or three months later and actually not find the same staff there. So, I think there is a huge need for training and education, and actually our care home team have also developed a two-day training programme, which they've piloted, and that's very much about looking at the alternative ways—understanding people with dementia and what that is, in a very practical way. Because, quite often, people find those challenges—that people are resistive or very noisy or disruptive—as they're viewed, in their behaviours, so that medication is given, rather than actually getting to the bottom of things and trying to understand it. So, alongside the project, the care home team have also got training as well as going in to do reviews. So, I think training is a massive issue.

[289] I don't have the evidence, but my feeling is very much that people often arrive in the care home on antipsychotic medication, whether they've come from a district general hospital, from mental health services, or even from the community. Quite often, that has been the way to manage their behaviour prior to their care home placement, so I think it's not always that they're put on because of the failings of the care home; they sometimes come with that medication.

[290] **Ms Gimson:** They inherit medications.

[291] **Caroline Jones:** They inherit. So, do they analyse anything once they've inherited, then?

[292] **Ms Gimson:** No, this is the problem, I think. We have a huge problem with reviews not being done, so it's all about the appropriate reviews and the fact that there aren't any. Or, the review might be, 'Are they okay? Is everything fine? Then we'll do nothing. Then we won't look to reduce the antipsychotic', which is very easy to do. That's my big bugbear—that there isn't enough review going on.

[293] **Caroline Jones:** Okay. Thank you.

[294] **Dai Lloyd:** Kim.

[295] **Ms Williams:** I think there is an issue about training in that we don't have minimum standards for training for care staff in homes. And they are in a very difficult position because, if they have no training in de-escalation or physical restraint, they're often in a situation where they have somebody who's at risk or who poses a risk to somebody else. They've got no training in physical intervention, so what they turn to is the medication. What we would want them to do is to say, 'Okay, that might work now, but we need very quickly to review that and to put an alternative in place', and there isn't a mechanism for doing that. I think if we had some minimum training standards for care staff in homes, as they do in some areas of England, we would be in a much better position across Wales.

[296] **Ms Gimson:** I think it actually goes back—. You need to look at a step back before that. I work in liaison psychiatry as well one day a week, and I think the training is needed on the wards in district general hospitals—

[297] **Ms Williams:** Absolutely.

[298] **Ms Gimson:**—definitely, because if you can manage—and we are trying to address it—that behaviour on the ward before they actually get prescribed it in the first place, you've won the battle.

[299] **Dai Lloyd:** John.

[300] **Mr Palmer:** I think, from my point of view, there's definitely,

throughout all of the evidence that we've been looking at in preparation, an opportunity for improving and scaling up on training. So, the communication and interaction training is really the gold standard that we should be looking to—I think we do need to look at ways of rolling that out. But that's not all within the health board's gift or that of the wider public service; it's something that we're going to need support and help on from CSSIW as well, so there's a sense of regulation and the care homes can then respond. I'm sure that, as health boards, we'd want to put time and resources into supporting training in order that that could be taken up.

[301] I think it's an absolutely fair point that we need to look at psychiatric liaison services as well, not just in the in-patient hospital environment, but also what's the potential for applying that kind of approach in the community as well? I think we have had various conversations over the last couple of years about potential funding sources with Welsh Government for rolling out that kind of approach. I think the feeling so far has been, 'Let's concentrate, get the evidence base out of the in-patient psychiatric liaison services that we've put in', but I do think there's a moment now for us to really seriously consider community application.

[302] I think the final point is to say that, when we're talking about de-escalation or physical restraint as opportunities for mainstreaming, if you like, in terms of training, that's extant NICE guidance. So, it's not an unreasonable ask for that to be regulated and, I think, for care homes to be looking seriously at that.

[303] Very briefly—I'm sure it'll get picked up in other questions—but I think the review point is really important as well. So, we do have some opportunities around that at the moment developing. Some of us in health board land have had care home local enhanced services in operation that make sure that there is regular review in place and regular follow-up for complex polypharmacy medication reviews. We know that, in general, on average, if those are done well, then you can see in someone who's got a very typical polypharmacy presentation that they'll drop from 10 to seven medications. So, that's worth having. The directed enhanced services are going to be £4.4 million going in across all of the health boards, and it will mean that we'll get a more standardised approach. You add in to that the community pharmacy DES that's in preparation at the moment, and that starts to take a bit of pressure off the GPs taking the lead and it puts it on to the multidisciplinary team. So, again, I think that's an improvement that we should see happening over the next one to two years.

[304] **Dai Lloyd:** Yes. We'll be coming on to questions on those. Your second question, Caroline.

[305] **Caroline Jones:** My second question is: upon reading our written evidence from the Royal College of General Practitioners and also the Welsh NHS Confederation, it suggests that GPs, clinicians—there's pressure put on them to prescribe antipsychotic medication, and also some of the staff in care homes are reluctant to stop this medication. So, can you tell me are we not giving people enough support? You said about the training. So, how can we go forward with this? How can we prevent people being inappropriately and unnecessarily prescribed these drugs?

[306] **Ms Gimson:** We've got our care home liaison team, so we take referrals directly from care homes or from GPs for exactly that reason. If they're at the point where they think they're being asked to prescribe antipsychotics—

[307] **Caroline Jones:** Do you think they're pressurised? Would you go so far as to say—

[308] **Ms Gimson:** Are GPs pressurised?

[309] **Caroline Jones:** Yes. Are GPs pressurised to prescribe these drugs?

[310] **Ms Gimson:** I don't think so, no, because I think they should be coming to us. I think they're coming to us. I'm not aware of them being pressurised to do that. I know some GPs do prescribe them, and I know some GPs are comfortable to prescribe antipsychotics.

[311] **Caroline Jones:** They're comfortable, so you don't feel they're pressurised, on the whole.

[312] **Ms Gimson:** I don't, no.

[313] **Caroline Jones:** Okay.

[314] **Dai Lloyd:** Okay. Kim.

[315] **Ms Williams:** I think it would probably be variable from home to home. I think some homes do rely much more on antipsychotics than other homes, but I think what we've also seen is a shift from prescribing antipsychotics to

prescribing benzodiazepines, largely lorazepam, but a range of other things. So, people can be on several different medications because, sometimes, when antipsychotics are prescribed, they don't actually work. And so, then, somebody ends up on something else as well.

[316] What we've done in our health board is to change the referral pathway again, so that when GPs are referring in, or where care homes are referring in, for support for somebody with behaviour that challenges, that goes to our single point of entry allocation meeting and it goes straight to the dementia intervention team. The community mental health team doesn't go in, so it streamlines, and then we can prevent somebody going on an antipsychotic. I think the issue about taking people off is that people feel—. We get the comment a lot, 'Well, things are fine now. Don't rock the boat.' There's a fear that if we do something different, even if we're saying to them, 'Well, look, it was there before, it hasn't worked.' There's a fear for people.

[317] **Caroline Jones:** Do you come across staff who are likely to take people off it for those reasons that you said?

[318] **Ms Williams:** I think so. I think there's a kind of status quo, 'It's all great now. Just leave it alone.' I don't think they understand, really, what the complications can be if people are on it, either. So, I think it's about also educating people that there are consequences for people.

[319] **Dai Lloyd:** John.

[320] **Mr Palmer:** Just to build on the previous point, really. If you've got a system where the bulk of the workforce haven't got good training on de-escalation and haven't got training on physical restraint, then you're creating a natural pressure in the system that could lead to a line of least resistance, which is, 'Well, okay, prescribing looks like the best option that we have available.'

[321] So, there is a balance that we have to achieve, and back to the previous point I made as well, if we're doing the right level of medication reviews and we're getting into issues of polypharmacy properly—and a lot of the indications are that the system is realising it needs to purpose resource towards that—then, you will be taking some of that pressure away.

[322] **Caroline Jones:** But data has been patchy, hasn't it? The collation of data. Or are you saying not?

[323] **Mr Palmer:** No, I think that's absolutely fair. Again, looking through the evidence packs, data is a major issue, but I would say that one of the things that's on my mind is, we're going into the general medical services contract around now, so one of the things that we might be looking at is a review of the quality and outcomes framework. There's an opportunity to think about the data that we mandate to come back into the system. Alongside that, we've got a whole bunch of ICT improvements happening at the moment around the Welsh clinical portal. We've got trials at the moment where we've got GPs and secondary care consultants beginning to look at all of their data, collectively, around the medical record. That has to be an opportunity for us to improve shared understanding of patients' data, and, therefore, get much better to grips with the kind of complex presentations we're talking about.

[324] **Dai Lloyd:** Okay, we have to move on.

[325] Rhun sydd nesaf.

Rhun next.

[326] **Rhun ap Iorwerth:** Just a quick one from me on potential pressures to prescribe. The Welsh NHS Confederation is a bit of a worrying one. It says in its written evidence that

[327] 'the emphasis on the need to avoid hospital admission means that the likelihood of an individual being prescribed anti-psychotics to keep them at a care home invariably increases.'

[328] Do you think that's a fair assessment? And, if so, how can we prevent this?

[329] **Ms Williams:** The recommendations for why you would prescribe an antipsychotic—so, severe distress, risk to themselves, to the person and others—are probably the same as the admission criteria for a hospital. So, I suppose if you've got people who meet those criteria, it is better for them to be prescribed it in their own home. It's the least restrictive. Obviously, what we would like to be seeing is that, if it is required, under NICE guidance, for a short period of time, we offer something else to support.

[330] **Rhun ap Iorwerth:** Maybe this is integration between health and social care that we don't necessarily want, that one puts pressure on the other: 'Keep them away from us.'

13:15

[331] **Mr Palmer:** I would say I think you've reached the right word straight away. I think this is a challenge of integration. Very often, when we get into these conversations when we're talking about one specific service and one specific intervention, you can almost get into a conversation where you're playing different services off against the others.

[332] From my point of view, I'm trying to look at this—and I think my colleagues are—to look at all of this as an entire pathway. So, we invest a great deal into primary care, and I've talked about two national directed enhanced services that are going to come into place that should help us with this agenda. A lot goes into cluster-led community pharmacy as a result of the funding that's come in over the last couple of years, and there's a lot happening in memory assessment services as well. So, primary care's got a set of investments. In the community, a number of us in health boards run at-home services that have a bearing on this patient cohort. We're seeing more memory assessment investment at a more aggregate level around community hospitals, and we invest a lot in continuing healthcare and funded nursing care placements. And then, within the hospital system itself, we have a whole load of admission infrastructure: wards for admissions and wards for assessment, and they have a range, because you'll go from assessment wards for generic purposes through to acute stress wards, and then we have a whole bunch of dementia care wards for ongoing assessment that are in place.

[333] So, for me, it's about understanding where the patient needs to sit along that entire pathway and having the right balance of investment across that entire pathway. The future for us has to be that we're investing more in community, and I think that's what we are all looking for our medium-term plans to reflect at the moment. So, the recovery model in Cwm Taf has been about shifting away from ward infrastructure to supported community recovery. So, it's a long answer to your short question, but I do think we have to see this as an integrated whole-system pathway, not just one intervention by itself.

[334] **Rhun ap Iorwerth:** And one other short question: do you keep data, either of the health boards, on the prescribing of antipsychotics in the hospital?

[335] **Ms Williams:** I'm not aware that we do.

[336] **Mr Palmer:** I think we do audits on a fairly regular basis, but those audits are incomplete for the reasons that we've already referenced. Some health boards are better than others, and so it's a genuine challenge to pull that data together. But, the two improvements I've offered so far are the areas where we're going to go with that.

[337] **Rhun ap Iorwerth:** And the same for you?

[338] **Ms Williams:** I don't think we do keep records, no.

[339] **Rhun ap Iorwerth:** Okay, thanks.

[340] **Dai Lloyd:** Individual prescriptions are recorded, though, centrally, aren't they?

[341] **Rhun ap Iorwerth:** But not collated.

[342] **Dai Lloyd:** Obviously not collated, but they're there somewhere.

[343] **Ms Gimson:** Sort of linked to that, really quickly, is something we developed, which was an antipsychotic checklist, so that, at the point that they are prescribed for dementia patients, they—

[344] **Rhun ap Iorwerth:** In a hospital setting?

[345] **Ms Gimson:** In secondary care, yes. They fill this in, tick the target indication, tick who's reviewing and tick what should be the arrangement on discharge. It's a piece of paper at the moment, we're trying to get it in an e-form, so it gets pinged electronically to the GP on discharge, but then you've got somewhere to start. You've got somewhere that, if you're reviewing that patient, you know what indication—. You know the reason why they were prescribed it and you know what behaviour to look for.

[346] **Rhun ap Iorwerth:** Yes. And, will an alarm bell call when it's time to review? Will a timescale be set at the time of prescribing?

[347] **Ms Gimson:** Yes.

[348] **Dai Lloyd:** Océ, i symud **Dai Lloyd:** Okay, moving on, Jayne

ymlaen, Jayne Bryant.

Bryant.

[349] **Jayne Bryant:** Thank you. It's on the back of that last question, really, from Rhun. We heard evidence from the Older People's Commissioner for Wales that, despite promising to do so, health boards hadn't published audits of antipsychotic use or evidenced that they're being monitored. What are the reasons for that?

[350] **Mr Palmer:** I'll just be completely honest about it: I think it's about the fact that we haven't, until now, had a view about how we would deploy directed enhanced services or national enhanced services across Wales, previously. So, you've seen some variation. Within Cwm Taf, we have a local enhanced service that's allowed us to look at prescribing to an extent, and we're looking to roll out through the community pharmacy contract next year further data requirements. But, we haven't had a standardised approach across Wales. So, the two major opportunities are now the immediate two DESs that we have in front of us, where we will be able to mandate some data collection, and then the third element is that we're looking at the new negotiation of the GMS contract, which would allow us, again, to mandate some data collection.

[351] **Jayne Bryant:** Do you need a standard—? Does there have to be a standard process across Wales? Couldn't you just do that as a health board?

[352] **Mr Palmer:** Just to say, for some health boards like our own, we've been able to do some of that data collection because we've had a locally enhanced service in place, but not everybody across Wales has had that in place.

[353] **Jayne Bryant:** Not within the health board, even.

[354] **Mr Palmer:** Yes, so, within the health board, because we've had a locally enhanced service—

[355] **Jayne Bryant:** I see. So, you've been able to publish all of—

[356] **Mr Palmer:** —we've been able to collect some data.

[357] **Jayne Bryant:** But not all of it.

[358] **Mr Palmer:** As I said earlier, it's not been complete, and that's further

work to be done. I don't know if Kim wants to come in.

[359] **Ms Williams:** Can I just say, when we were putting together the briefing for this, and in looking at our annual reports for the specialist dementia intervention team, we had to look at about five different sets of notes, not all of which are very readily available, to follow through what's happened to a single person who's known to our team. So, they might start in the community, then they'll have a GP set of notes; we've got the care home notes, and then we've got the secondary care mental health notes. We have a whole series, so, it's really very difficult to pull that together, which is why, in the information that we've sent you today, there is missing data. Because, in order to track that, it's very difficult, but there's very clear NICE guidance about prescribing antipsychotics, and the kind of checklist that you've put together is based on NICE guidance. It would be relatively easy, I think, to have that review process on a single sheet of paper with a request that everybody does do it and a return for an audit, because that's what we need, really, isn't it?

[360] **Ms Gimson:** That IT aspect is a huge thing. Communication across teams, even within mental health—it's a challenge to get, sometimes, information across the same health board to different mental health teams. Trying to pick that data out from the GPs as well—it's a nightmare not having one single prescribing system that you can all access, where you can access the same notes. We really need it.

[361] **Dai Lloyd:** Okay. Jayne.

[362] **Jayne Bryant:** Thank you for that. The older people's commissioner also told us that, in general, health boards' responses to her care home review follow-up work was not good enough. That's what she suggested, and that there were still significant gaps in the data and that there was very little evidence, apart from some small pilot projects that were currently under way. What do you think is needed, then, to drive that cultural change to move away from inappropriate use of antipsychotics?

[363] **Ms Williams:** I think we've been very lucky in that we started this as a very small pilot, but, actually, we've collected a lot of data and presented that to our health board, and we've had investment as a result of that, because people can see it works. So, I think we've started small and grown at really quite a fast pace. You have to move—there is a limit to how fast you can move, because you're talking about culture change within the care homes,

and you're also talking about bringing people into teams. It takes about six months for them to get their head around the approach that we're taking and to really feel confident to go into homes and use this. So, there's a limit to how fast you can expand, but I think we've expanded in Cwm Taf really pretty quickly, and had a lot of investment on the back of the pilot that we did initially.

[364] **Jayne Bryant:** Do you want to—

[365] **Ms Lane:** I think part of that, for us, is considering, as we talked about before, the district general hospitals and the prescribing that happens there. I guess the way we've approached it is we're just on the cusp of using the recent moneys to actually employ healthcare support workers in our district general hospitals as part of our liaison service. The aim for them is to actually go in and role model different behaviours, different ways of managing people, and to start looking at much more of the psychological approaches to care. So, again, to try, at the possible point of source, where people are being prescribed them, to be going, 'Actually, there are alternatives here' and trying to demonstrate some of those. We're very early on in that. The anticipation is that once we've got the support workers, along with the dementia care advisers we already have in post across our liaison psychiatry services and the DGH site, we're hoping that's going to make a difference, because we do come across so many people who've been prescribed.

[366] Again, its environments and settings. There is, on the one hand, on an individual level—no, it isn't the right thing, but we know we all work within systems, and people manage people within systems, sometimes inappropriately, because of the other constraints they have. So, our aim is to hopefully move that way.

[367] **Dai Lloyd:** John.

[368] **Mr Palmer:** I was just going to say, on this particular initiative, it's very clear that there's been a significant impact. So, our story is scaling up from a single pilot, then we've got seven care homes that we're now rolled out to in the service. We've picked the areas with the highest volume of presentation. As a result of that, we've committed, through our last integrated medium-term plan cycle, and we'll be committing a bit more through this IMTP cycle, to further investment into the service. So, we'll more than double this service over the next year and a half. For us, that means that we can roll out to all 22

care homes that are affiliated with the health board, and another 16 that are affiliated with the two local authorities. So, we definitely think this is an important part of the answer in terms of antipsychotic drugs.

[369] But, to come back to the other point, which is about complex polypharmacy and ongoing medication reviews, I think there's an absolute fairness in the challenge that's come from the older people's commissioner around roll-out, patchiness and variation. But again, just to reinforce the point, I think we've seen a lot of cluster investment purposed towards community pharmacy that builds on a number of health boards investing in medicines management anyway in this area.

[370] If we really push through now and see good adoption of the directed enhanced service for care homes nationally and we follow up with the community pharmacy DES nationally and that runs out smoothly, that will guarantee that we've got medication reviews happening on a regular basis with guaranteed two follow-ups a year. Then, when we get to the community pharmacy local enhanced service, that means that there's a multidisciplinary team that's looking at that, so all the pressure is not on the GP.

[371] So, I think there's a balance for me between making sure that we're doing these types of interventions very, very well matched alongside interventions around complex polypharmacy.

[372] **Dai Lloyd:** Okay. Time is now marching on and I'm looking to the agility of experienced Members here to ask quickly and succinctly.

[373] **Angela Burns:** I think you've probably answered my question, but I just wanted to double-check. You were talking about when you managed to roll out your pilot, because at the moment we have heard a lot of evidence that it's very difficult for people within the care-home setting to access multidisciplinary teams, especially, I would imagine, non-affiliated care homes. Can you just tell us if that runs true within your two health boards at present, or do you feel that people do have the ability to access multidisciplinary teams? And, in the interest of brevity, could I also ask you to tell us how you might think that primary care clusters will be able to form part of this drive to improve the use of antipsychotic drugs within care-home settings?

[374] **Ms Lane:** I think, for us, we have a very open referral system. Any care home, any GP, district nurses or anybody can refer into us for anybody in a

nursing or residential home right across Cardiff and the Vale. So, that's probably where we then struggle with the amounts of referrals and such, but it is an open referral system. Anybody can make that referral to us. People understanding that that's available to them is sometimes where we struggle more. People don't always remember or think about us, et cetera. We are a degree of a multidisciplinary team, in as much as we have medics, we have nurses, we have a dementia care adviser, we have sessions from pharmacies, speech and language, and dietetics, but we don't have physio and we don't have occupational therapy. So, we're a degree of a multidisciplinary team. We don't have psychology either, at the moment. So, there are elements of that within our service. I forgot the second part of your question.

[375] **Angela Burns:** GP clusters. Do you think they have a role to play in this gateway?

[376] **Ms Gimson:** I can help with that. GP clusters, cluster pharmacists—this whole new cohort of pharmacists is an untapped resource. It should definitely be the way forward. They've been asked to do these sorts of reviews already. I've actually got a training plan to do with cluster pharmacists to help support them to do this sort of work. Yes, they're an untapped resource and they should be part of the plans to do these reviews, because they're doing polypharmacy reviews and they're more than capable of doing antipsychotic reviews with a little bit of support. It's the way forward—some more funding for people like that, cluster pharmacists, and dementia care advisers at the front end.

[377] **Angela Burns:** And it would take the pressure off the GPs enormously. So, what you're basically saying is that the pharmacists will go out to each care home and review every patient on a regular basis, which is exactly what's missing at the moment.

13:30

[378] **Ms Gimson:** It doesn't need to be a GP. This is pharmacist work. This is bread-and-butter pharmacy work as well.

[379] **Ms Lane:** And I think the benefit has been the join-up with the dementia care adviser to provide the other side of that.

[380] **Dai Lloyd:** Okay—Kim Williams.

[381] **Ms Williams:** We've taken a different approach, because we've looked at people with very high-end needs—very challenging behaviour. So, we've focused on areas of highest need, because we want to change the culture within those organisations. The organisations we've gone into are largely privately owned—they're owned by companies—and some Rhondda Cynon Taf homes. So, we've chosen on the basis of need. So, we aren't available to everybody in Cwm Taf, although, hopefully—that is our goal.

[382] But, I think there's a need for a stepped approach here as well. You don't need the intensity of the work that we do for everybody in every care home, but I think what you do need is access for all of those homes, then, to have a dementia adviser, or to have a link person within a community mental health team, who can then say, 'Look, this has got to the stage, now, where you do need to have more intensive support'.

[383] Our multidisciplinary team has been growing. We have an occupational therapist who's coming on line. We don't have psychiatry, very deliberately, because it's a psychosocial intervention team. We would love to have things like a speech and language therapist—and a music therapist, too, because we had one as a student who came on a placement and was phenomenally useful in our team. So, there are lots of areas we would like to expand into. Hopefully, we'll be able to do that.

[384] **Angela Burns:** One tiny, tiny question, which is in all of the discussions about MDTs that we've heard across our evidence: very few people have mentioned the words 'palliative care'—do you have that as part of your—? Because, to be frank, care homes tend to be the end-of-life journey.

[385] **Ms Williams:** We have a palliative care specialist nurse.

[386] **Angela Burns:** But they're not part of the MDT when you're looking at taking someone on a journey and they're getting worse and worse in their dementia travel.

[387] **Ms Williams:** We don't work specifically with that brief, but we have helped people stay in the care home that they're living in to the end of their life, and supported the staff to do that, where there's been some pressure, perhaps, for them to move into a hospital setting. So, they have died in their own homes.

[388] **Angela Burns:** Yes. Great, thank you.

[389] **Ms Lane:** And we have nurses who've got a special interest in palliative care. We do feel that's quite an important part of the role within our service and what we provide. We're looking to do some research shortly with Cardiff University around that too.

[390] **Dai Lloyd:** Good. Final question, Jayne.

[391] **Jayne Bryant:** Thank you, Chair. There are lots of things that we've discussed today, but what do you think are the priority actions that are required that should have the greatest impact on reducing inappropriate use in care homes? What would you say the main thing and the priority would be?

[392] **Dai Lloyd:** Help us out with some recommendations.

[393] **Ms Gimson:** I think it's a two-pronged attack. You'd be looking at training for healthcare support workers on medical wards in the district general hospitals at the point where you're pre-empting the point when you need antipsychotics—looking at managing that behaviour on the ward—so more funding needs to go into that. And, I think the review needs to be looked at. We need to sort out who is going to do these reviews, whether they're cluster pharmacists—take it off the GPs if they're too overloaded to do it. We're looking at reviews, I think, and we're looking at training beforehand and during their stay in care homes.

[394] **Ms Williams:** I would say training as well, but training within care homes and a minimum standard of training for care home staff, so that they, in fairness to them, have the skills to manage what is extremely difficult behaviour from their point of view, and to understand it. And I think it needs to be training that's very specific and very hands-on, about: how do you approach somebody if you're needing to take them to the bathroom? What is the comfortable interpersonal distance between you and another person? All of those very practical things, because those are the things that help them manage, day to day. It's a different kind of training, perhaps, from that which we would offer our qualified nursing staff in DGHs. Some of it would be the same, but—yes.

[395] **Dai Lloyd:** Okay. John.

[396] **Mr Palmer:** I thought the Royal Pharmaceutical Society's submission to you was very good. I would support the recommendations that came in there.

Their last one was on palliative care, actually, as well, and I thought that was a good set. I do think, going back to some of the themes we've picked up, communication and interaction therapy—CAIT—training, an effort at standardising that and an expectation from the regulator, CSSIW, that that would be standardised I think would be really helpful.

[397] I think, as health boards, we need to keep generating very clear guidance on dementia-specific training. You see a number of health boards doing a lot for dementia-friendly environments now, but we probably need to push harder and see more standardisation. I'd like us to be forcing the issue on NICE so that we are seeing standardisation around de-escalation or physical restraint training, to avoid some of the issues that we've talked about.

[398] I saw some points around independent review to help us look at proper audit and proper data. I think that may well be helpful, but I think I would be tracking that onto what we're going to do on the care home DES and the community pharmacy DES and hold us to account on those to make sure that we track through to antipsychotic prescribing.

[399] I think the final point would be the general medical services contract. We ought to make sure that there's an expectation around that, if we push on with the quality and outcomes framework, that we have the right data collection there.

[400] My final point would be we have to continue to support clusters in the work that they're doing around community pharmacy, but we shouldn't park all of the expectations on them—they are still largely experimental and developmental spaces. I know that we all want them to move on and push on into delivery, but actually it's core budgets around mental health, core budgets around prescribing across the integrated pathway, and core budgets around primary care that ought to be repurposed towards making sure that we can serve this patient cohort properly.

[401] **Dai Lloyd:** Okay, Jayne.

[402] **Jayne Bryant:** Just finally, Chair, one of the key aims of the Welsh Government's draft dementia strategy is to reduce the inappropriate use of antipsychotics in care homes. How do you think that we can assure that that happens and is delivered?

[403] **Dai Lloyd:** As part of the dementia strategy, specifically.

[404] **Ms Williams:** I think there needs to be a very clear statement in that strategy that these approaches work, because if you've not had any of this before and if you're used to relying on medication, it's sometimes quite difficult to convince people that this is effective. That's one of the reasons why we've been so strict in collecting outcome data—so that we can go back and show people, 'Look, this is a very effective approach'. So, there needs to be support for that in the strategy, as well as the other things that were mentioned.

[405] **Dai Lloyd:** Grêt. Mae'r amser ar ben, yn sylfaenol. Diolch yn fawr iawn i chi am fod yma yn y lle cyntaf, am eich presenoldeb. Diolch yn fawr iawn am eich atebion doeth, a hefyd am y dystiolaeth ysgrifenedig rŷch chi wedi'i gyflwyno ymlaen llaw. A gaf i hefyd ddweud y byddwch yn derbyn trawsgrifiad o'r drafodaeth yma er mwyn i chi ei wirio i wneud yn siŵr ei fod yn ffeithiol gywir? Gyda hynny, a allaf i ddiolch i chi'ch pedwar am eich presenoldeb? Diolch yn fawr iawn i chi.

Dai Lloyd: Great. Time has come to an end, basically. Thank you very much for attending today. Thank you very much for your wise answers, and for the written evidence that you've presented beforehand. May I also say that you will receive a transcript of this discussion for you to check for factual accuracy? But, with those few words, may I thank the four of you for attending? Thank you very much.

[406] Cawn egwyl fer o ryw ddwy funud cyn i'r tystion nesaf ddod i mewn. We'll now have a short break of about two minutes before the next witnesses come in.

*Gohiriwyd y cyfarfod rhwng 13:38 a 13:42.
The meeting adjourned between 13:38 and 13:42.*

**Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal—Sesiwn
Dystiolaeth 13—Bwrdd Iechyd Lleol Aneurin Bevan a Bwrdd Iechyd
Lleol Hywel Dda**

**Use of Antipsychotic Medication in Care Homes—Evidence Session
13—Aneurin Bevan Local Health Board and Hywel Dda Local Health
Board**

[407] **Dai Lloyd:** Croeso nôl i'r sesiwn ddiweddaraf o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Rydym yn symud ymlaen nawr i eitem 8 ar yr agenda a'r parhad i'r ymchwiliad i'r defnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal. Hwn o'n blaenau ni rwan ydy sesiwn dystiolaeth rhif 13. O'n blaenau ni mae tystion o fwrdd iechyd prifysgol Aneurin Bevan a bwrdd iechyd prifysgol Hywel Dda.

Dai Lloyd: Welcome back to the latest session of the Health, Social Care and Sport Committee, here at the National Assembly for Wales. We are moving on to item 8 on the agenda, which is a continuation of the inquiry into the use of antipsychotic medication in care homes. This now is the thirteenth evidence session. Before us we have witnesses from Aneurin Bevan and Hywel Dda health boards.

[408] Croeso i chi, yn benodol, felly, Claire Aston, nyrs ranbarthol a phennaeth gofal cymhleth, bwrdd iechyd prifysgol Aneurin Bevan; a hefyd Dr Chineze Ivenso, seiciatrydd ymgynghorol henoed, tîm iechyd meddwl cymunedol Casnewydd, bwrdd iechyd prifysgol Aneurin Bevan; Sarah Isaac, uwch-reolwr y tîm fferyllwyr, gofal sylfaenol, bwrdd iechyd prifysgol Hywel Dda; a hefyd Sue Stephens, ymgynghorydd rhagnodi, bwrdd iechyd prifysgol Hywel Dda. Croeso i'r pedair ohonoch chi.

Specifically, we have Claire Aston, divisional nurse and head of complex care, Aneurin Bevan UHB; Dr Chineze Ivenso, old age consultant psychiatrist, Newport community mental health team, Aneurin Bevan UHB; Sarah Isaac, senior pharmacist manager, primary care, Hywel Dda UHB; and Sue Stephens, prescribing adviser, Hywel Dda UHB. Welcome to the four of you.

[409] Rydym ni wedi derbyn tystiolaeth ysgrifenedig ymlaen llaw. Rydym ni hefyd wedi derbyn toreth o

We have received your written evidence beforehand. We have also received a great deal of evidence

dystiolaeth o bob man hefyd ymlaen llaw. Fel rwy'n dweud, hon ydy sesiwn dystiolaeth rhif 13, felly mae'r Aelodau yn byrstio efo'r holl wybodaeth yma, felly mae gyda ni res o gwestiynau i'w gofyn i chi dros yr hanner awr nesaf. Heb oedi dim rhagor, fe wnawn ni ddechrau efo Lynne Neagle.

from elsewhere. This is the thirteenth evidence session, as I said, and so Members are bursting with information, and we have many questions to ask you over the next half hour. Without further ado, we'll start with Lynne Neagle.

[410] **Lynne Neagle:** Thank you, Chair. Can you just tell us about any work that's going on in your health board areas to reduce the use of antipsychotics in care homes, please?

[411] **Ms Aston:** Shall I start? We're doing quite a lot of work across Aneurin Bevan health board. We're working with the care homes and the community mental health teams, with the in-reach service model. That is proving quite successful at this moment in time. That is assisting and educating some of the care home staff. It's something that we wish to spread further. We're starting in smaller areas and then growing it, but it actually has been working now for some considerable years and we've got some evidence behind that.

[412] There's a lot of work that we do need to do. Some of our care homes have been able to put their care staff through dementia training. Many of our staff in the health board have also done their dementia training. We've started with trying to capture many people doing Dementia Friends, and then growing it into some of the three-day models that are provided by some of the other providers out there.

[413] I have to say, perhaps the pace is not the pace that we would want, but there is so much to do and there are so many people to educate. We've been talking this morning—we do believe that the education around this and the training and development is absolutely key. I'm not sure if you'd like to talk about the Caerphilly experience.

13:45

[414] **Dr Ivenso:** Yes. In Caerphilly borough, we have a behavioural support service that is providing brief behavioural interventions to people who have behavioural disorders in care homes. We hope that, by the end of this

project—because it's the pilot—we'll have an evaluation of the resources that are needed by the carers and the mainstream services in gaining skills to manage people who have behaviour problems with dementia.

[415] **Dai Lloyd:** Okay. Hywel Dda.

[416] **Ms Stephens:** In Hywel Dda, we have a medicines management team that inputs into medication reviews in care homes. As part of the medication reviews, we have been looking at antipsychotic prescribing and linking in with the community psychiatric nurse linked to that particular care home. We've had pockets of work where we've had some success in reviewing and reducing antipsychotic prescribing. We're also looking to link in with the community mental health team. I'm aware that they're having multidisciplinary meetings in GP surgeries in some areas where they discuss the case notes of some of the dementia patients in care homes, and I believe that's having a positive impact. I also know that there are referrals from the GP practices to the community mental health teams, so that the community psychiatric nurse will go and review particular patients that the GPs have requested because they've got complex needs. Do you want to add to that as well?

[417] **Ms Isaac:** When we were asked by the older people's commissioner whether we were publishing data, we realised that we didn't really have an understanding of how many patients were on antipsychotics. So, what we've done locally is developed an audit to generate data on the use of antipsychotics across primary care, but we've also got a subsection where we're recording how many of those patients are also in care settings. What we're going to do then with that information is make sure that we can publish it, and obviously then we're able to benchmark and understand the scale of the issue. Obviously, we're working with our different teams across the health board, with the mental health teams and our cluster pharmacy teams, to see the best ways within those localities of how we address—because there's different service provision in different clusters, different hospital provision. So, we're working with those locality teams to see how we can best address any information.

[418] **Ms Stephens:** To build on that as well, in one of the clusters, I'm aware that there's a GP frailty service, which is a multidisciplinary service that is GP led, but they've used the cluster pharmacists for extra support in the care homes, and they are looking at antipsychotic prescribing as part of the medication review process as well.

[419] **Dai Lloyd:** Great.

[420] **Dr Ivenso:** If I might add, if this is okay, within Aneurin Bevan university health board, we have data across all of the health board regarding the use of antipsychotic medication in the care setting. Across the health board, we have a database that tells us exactly how many people are on antipsychotics living in the nursing care home setting. In the last year, we've noticed that we have 341 patients across all localities in our health board on antipsychotics living in nursing home settings. Since 2012, within Newport borough, we've been able to carry out audits on the use of antipsychotic medication with patients who have dementia living in care home settings. If you're interested, I could share with you some of the findings, so far, of our 2017 audits. I don't know if this is the time to go ahead and share that.

[421] **Dai Lloyd:** Yes, pass us a note, subsequently—that'll be fine.

[422] **Dr Ivenso:** Okay.

[423] **Ms Stephens:** We also have, in Hywel Dda, conducted an audit in our mental health in-patient wards, using the Prescribing Observatory for Mental Health UK audit, and it specifically addresses antipsychotic use in dementia patients. It's been approved by the College of Psychiatrists, and it's that very audit that we've adapted for use in primary care to look at care home patients.

[424] **Dai Lloyd:** In similar fashion, if you liaise with the clerks, we'll have them as papers to pad out our review.

[425] **Dr Ivenso:** Because since we've been conducting these audits since 2012, we've been able to establish what the prevalence and patterns of the prescribing of antipsychotics within our care homes have been. As a health board, we are in the process of collating information from other boroughs in this respect as well.

[426] **Dai Lloyd:** Good. Well, that's very useful because one of the pieces of evidence we've had is that data is in short supply and patchy, so it's reassuring to hear that. Caroline.

[427] **Caroline Jones:** Thank you, Chair. Good afternoon. Could you tell me, please, what you think the main reasons are as to why antipsychotics are

often prescribed inappropriately to patients in care homes with dementia? Do you think there are staffing issues, or is it lack of training? I wonder if you could give me your view on this please.

[428] **Ms Aston:** Shall I start?

[429] **Dai Lloyd:** Who wants to kick off? Go on then, Claire.

[430] **Ms Aston:** Thank you. I'm not sure that we are actually overprescribing at this moment in time. We are seeing a decrease in possibly what was overprescribing in the past in nursing homes in the Aneurin Bevan area. They are still prescribing antipsychotics, as you heard from my colleague. I think training is an absolutely huge issue. We tend to focus on a problem and need to solve that in the quickest mechanism that we have. Often, that is reaching for a pill, or, certainly, if you look over cases from previous years, that would be the mechanism. But, we are not actually getting underneath it and using the soft nursing skills and caring skills that the carers need in the nursing homes to be equipped with. So, we need to be thinking about nutrition, pain, mobility—all those sorts of things around activities of daily living—and the behaviours and also the history that that person has presented with, not from a clinical point of view but from their personal life. We are not, in my experience, awfully good or consistent at doing that. We tend to focus on, 'There is a medical problem and we need to solve it', and we don't get into the issue that is driving that person's behaviour, which then may lead them into that antipsychotic medication cycle.

[431] We are wanting to do some training with a multidisciplinary focus, and we're just beginning to have those conversations about how we do that and extend it into the nursing homes. We've got 48 nursing homes in the Aneurin Bevan health board, and half of those are our EMI nursing homes. But, there are roles for occupational therapists, and there are roles for speech and language therapists. All of our allied health professionals have skills that can help us in the management of these patients without looking at pharmacological solutions. We've got to spread that message. Our GPs and our clusters also need to hear that.

[432] We have got a lot of good examples of where things are happening and changing in our nursing homes. One of the nursing homes in Newport has done a lot of work on need and alternative provision of care. They've turned one of their units in that home into a very dementia-focused unit. Talking to the registered manager of that home yesterday, they have seen

falls come down and they have actually seen antipsychotic medication on those in the past who would have been having antipsychotic medication reduced. We need to replicate that more and be given some drivers to actually do that.

[433] **Caroline Jones:** You stated that you don't think there is overprescribing. The collation of data is patchy, and people are not writing up records correctly regarding this, so I don't think that's a fair assumption.

[434] **Ms Aston:** I was basing it on discussions that we have been having with—

[435] **Caroline Jones:** I was just going to ask what you were basing your—

[436] **Ms Aston:** Yes. It is to do with the reviews, and the six-month reviews, that are being done and the annual reviews of those individuals.

[437] **Caroline Jones:** So, you are looking at it purely from a short-term point of view.

[438] **Ms Aston:** Yes. As my colleague said, it's sort of going back to 2012, where big improvements have been made.

[439] **Caroline Jones:** Right, okay.

[440] **Dai Lloyd:** Okay. Any inappropriate prescribing in Hywel Dda?

[441] **Ms Stephens:** Because antipsychotics are largely initiated in secondary care, I suspect there may be some hesitancy with GPs maybe to stop the antipsychotics for fear of the behavioural symptoms returning and causing harm. So, I think there probably needs to be a care pathway to support the GPs to review and stop the antipsychotics.

[442] **Ms Isaac:** Certainly, the feedback we've had when we've been discussing with GPs about reviewing antipsychotics is that it's not always an area they've had any training in. So, we've been in discussions about making sure that it's possibly on the GP training scheme, and in the educational sessions we deliver to GPs. We've recently had some of our mental health consultants attend those meetings and give GPs an overview, because it's not something that they're perhaps familiar with reviewing.

[443] **Dr Ivenso:** I suppose in Aneurin Bevan health board, because most of our prescribing of this kind of medication to that group of patients is done from secondary care, we feel that, actually, we do have a system that allows us to prescribe the medication as appropriately as is needed, because before such medication is initiated, it has to be through an in-reach nurse who then has a discussion with the psychiatrists. So, because GPs aren't the main prescribers, we feel we're monitoring the people who have to be on this medication reasonably well.

[444] **Caroline Jones:** Individually monitoring.

[445] **Dr Ivenso:** Yes, within our in-reach services.

[446] **Caroline Jones:** Okay.

[447] **Dai Lloyd:** Great. That's answered your second question as well, I assume.

[448] **Caroline Jones:** Yes, I was going to say. Thank you.

[449] **Dai Lloyd:** Moving on—Rhun.

[450] **Rhun ap Iorwerth:** Os gallaf i Rhun ap Iorwerth: If I could eich llongyfarch os nad oes yna congratulate you if there isn't ragnodi amhriodol yn eich ardaloedd inappropriate prescribing in your chi, achos mi ydym ni wedi clywed area, because we've heard quite tystiolaeth eithaf sylweddol bod significant evidence that rhagnodi amhriodol yn broblem ac inappropriate prescribing has been wedi bod yn broblem dros undertaken and has been a problem flynyddoedd mawr. Rydym ni wedi for some years. We've heard a clywed sawl rheswm posib yn cael ei number of reasons why incorrect roi pam bod rhagnodi anghywir yn prescribing is happening. I'll bring digwydd. Gwnaf i ddod â hwn i'ch this to your attention, by the Welsh sylw chi gan Gonffederasiwn NHS Confederation. There's written Gwasanaeth Iechyd Gwladol Cymru. evidence that Maen nhw'n dweud mewn tystiolaeth ysgrifenedig fod

[451] 'y pwyslais ar yr angen i osgoi 'the emphasis on the need to avoid derbyniadau ysbyty yn golygu bod y hospital admission means that the tebygolrwydd y bydd unigolyn sy'n likelihood of an individual being

derbyn meddyginiaeth wrthseicotig prescribed anti-psychotics to keep
i'w gadw mewn cartref gofal yn them at a care home invariably
cynyddu'. increases.'

[452] Hynny ydy, rhowch That is, if you give antipsychotic
feddyginiaeth wrthseicotig iddyn nhw medicine to someone to keep them
i'w cadw nhw'n dawel yn y cartref—ni quiet in a home, there'll be no need
fydd angen eu symud nhw i ofal to move them to secondary care,
eilradd drudfawr. A ydy hynny'n deg? which is expensive. Is that fair?

[453] **Dr Ivenso:** I suppose—if I can take the question first—within our health board, again, we do not see that this is frequent practice, the pressure of prescribing antipsychotic medication to people with dementia in the care setting. We don't see that as very common, and I think this might be in part because we have an in-reach service, in which the nurses are quite well trained, and they're able to establish first whether there's a physical cause for the behaviour and if there are other non-pharmacological means that can be used before antipsychotics are prescribed. So, I take the point that the Welsh federation has said that this may be practised in some health boards, but from our experience in our own health board, that's not usually the case.

[454] **Ms Aston:** If I may add also, supporting that, we provide quite a lot of one-to-one provision in nursing homes so that if a person is demonstrating an excessive need to walk and to pace, with that behaviour, and maybe wanting to interject with other individuals in the home, there is somebody there to supervise that person, and it is something that we take very seriously. So, we're trying to look at the alternative ways of delivering care to everybody in that care environment, but without going to reaching for drugs that can cause harm to individuals as well, and certainly not to quieten them down but to actually let them go through that period of needing to pace, and eventually they need to sleep and then we can try to re-establish a pattern with those people, and we've got some care homes that are very experienced in doing that—some of our nursing homes. We need to start sharing their good practice.

[455] **Rhun ap Iorwerth:** Ocê. A **Rhun ap Iorwerth:** Okay. And Hywel Hywel Dda? Dda?

[456] **Ms Stephens:** I think in Hywel Dda there's possibly an element of that happening—some pressures—but we are, as Sarah mentioned, in the process of collating data to establish the scale of inappropriate prescribing of

antipsychotics. So, once we do have findings from that audit, maybe we'll have a better idea of the scale of inappropriate prescribing that's going on. We do recognise that, obviously, the challenging behaviour might be attributed, as you mentioned, to certain triggers, like pain and anxiety, and depression, and we do have a care home support team in Hywel Dda that is multidisciplinary, so we have a tissue viability nurse, we have a dietician, and we have pharmacists as well. So, it's a multidisciplinary approach that we would like to think helps to address any possible triggers that would give rise to these challenging behaviours.

14:00

[457] **Rhun ap Iorwerth:** Sarah.

[458] **Ms Isaac:** I think it's very difficult for me to say there's no inappropriate prescribing or to discuss that patients have been given excessive amounts to prevent hospital admissions, but certainly, as Sue has said, once we've been able to collate that information—. I think, as a result of the audit, we've got much better working relationships now with our mental health colleagues and we are putting together a plan of how we're going to address this. So, whatever the outcome of the audit, we're looking to develop care pathways. Our consultants—. We've had discussions between GPs in primary care and our consultants, discussing the transfer of information between the two settings, and our consultants have said that they're going to make sure that when a patient is initiated now, if they're initiated in secondary care, that that information is transferred in a timely way to the GP, so they have that information, and they're clear why it's been started, and they've got a clear review date. They also, then, are able—if they have any concerns at all—to go back and discuss those with secondary care.

[459] **Rhun ap Iorwerth:** Just one quick question: when did the current review that you're conducting begin, and what triggered that review?

[460] **Ms Stephens:** When we were addressing the older people's commissioner's report, we recognised that we weren't publishing information on the use of antipsychotic medication, so we liaised with the mental health pharmacist and established that there had been prescribing audits done in secondary care in the mental health in-patient unit, so we wanted to bring that into primary care so that we were able to provide that information and drive forward some improvements in addressing any inappropriate use.

[461] **Rhun ap Iorwerth:** Thank you. Diolch.

[462] **Dai Lloyd:** Okay. Lynne, I think your first question has largely been answered, on audit, so moving on—okay?

[463] **Lynne Neagle:** Yes, thank you. The older people's commissioner told us that, in general, she didn't think that the health boards' responses to her care home review follow-up work were generally good enough, and

[464] 'that there are still significant gaps in data'

[465] and

[466] 'little evidence of activities taking place across whole health boards (as opposed to the small-scale pilot projects currently underway'

[467] in order to drive the cultural change needed. What is your response to this, and what further work are you planning in this area?

[468] **Ms Aston:** In Aneurin Bevan tomorrow, actually, we have a very large workshop. We've got over 250 or 260 participants to engage in discussions and a programme of events around meaningful activities that can take place in care home settings, particularly in nursing homes. It is the journey that we're on at the moment. There's a lot of appetite for this, and we have got a great deal of involvement from other organisations, non-statutory organisations, who are willing to help us with this. You may have seen it—it's called 'Bingo and Beyond', because this isn't about just playing bingo in a nursing home, this is about doing something that's meaningful, that's a meaningful occupation. Some of our—. And that is for that person to be involved in it on a regular basis, and we've got the befriending volunteer scheme as well, called 'Ffrind i Mi', and that is growing, and we're very grateful that that is growing and that the volunteers are coming forward.

[469] Again, there is a resource issue, both in terms of the ability to do this in terms of persons as well as the finances. The fact that we've got buy-in from so many people and from the nursing homes, rather than it just being a care home thinking, 'If we invested in an activities co-ordinator, we could tick the box and say that we've done something.' It's not about that. Every person who works in a nursing home needs to be able to engage and actually do something with an individual, be it just to sit down, touch their arm, or

say, 'You seem to have a lot of frowns today. Have you got pain somewhere?' That sort of thing. And, again, some of the nursing homes that we work with and that we commission services from are very good at utilising the skills of their kitchen staff, their domestic staff who also work in that care environment, so it doesn't just become a carer's role. So, as I said at the beginning, you know, it is the start of a process and, again, getting speed into these things and getting it to grow is something, so I couldn't disagree with what the OPC said, but we do have some opportunities to develop things further and differently. Thank you.

[470] **Dai Lloyd:** Okay. Hywel Dda.

[471] **Ms Stephens:** I think with Hywel Dda, we're looking to develop primary care pharmacist roles and embracing the primary care pharmacist to undertake medication reviews in care homes and targeted medication reviews addressing polypharmacy and antipsychotic prescribing. We're also looking to have more mental health specialist input in the nursing homes and possibly providing mental health pharmacist input to work with the community psychiatric nurses as they have the specialisms and skills to address inappropriate antipsychotic prescribing. Do you have anything to add?

[472] **Ms Isaac:** I understand that some of our colleagues, perhaps, who have spoken to you earlier mentioned about the new care home directed enhanced service that's been introduced across Wales, and also there's a new community pharmacy enhanced service that's in place. So, you know, we're quite confident that, with the introduction of the enhanced services and the resource that's being put in from the health boards through the medicines management teams and through the cluster pharmacists, we have a plan in place and that those patients will receive medication reviews and they will be done to a much higher standard, and any inappropriate prescribing will be—.

[473] **Dai Lloyd:** Good.

[474] **Dr Ivenzo:** If I may add to what Sue said, our vision for our in-reach services in ABUHB would be for us to have a more multidisciplinary approach, to have more skill mix within this team, because currently what we have is in-reach nurses who work quite closely with our psychiatrists, and we would love to have old-age and mental health specialist pharmacists who could lead on these medication reviews. And the in-reach nurses will conduct some of the reviews as well as the education and training, and that might be

needed around the non-pharmacological methods of managing behaviour. We also would like to see, if possible, some other allied professionals like our speech and language therapists, some of our occupational therapists, as well as physiotherapists, being able to join this in-reach team in a more multidisciplinary way to provide the care.

[475] **Dai Lloyd:** Good. Moving on to Angela, seamlessly.

[476] **Angela Burns:** Seamlessly. I'm really cheered up to hear you say that, both sets of health boards, because you talked a lot about the involvement of primary care clusters, you've talked an awful lot about the involvement of the multidisciplinary team, because that all centres around the question I want to ask, which is that if we manage to reduce the use of antipsychotic drugs in care homes, what are we putting in their place? What non-drug interventions do we need to either put into place or train into place in care homes? What role are the health boards, primary care clusters and multidisciplinary teams playing in the provision of that? Perhaps you could just give us a quick overview. Would you like to go first?

[477] **Ms Stephens:** Okay. Well, I think the non-pharmacological interventions that you're referring to—we do have a care home support team, which is multidisciplinary, which I've mentioned, and we have speech and language therapist input in that team, which would address any communication problems that may be triggering the challenging behaviour, and we also have dieticians and wound nurses—TVN nurses. So, if there's, obviously, pain—it's well known that pain can be a major cause of the challenging behaviour. So, they'd be able to help to manage any pain associated with wounds, for instance. So, we have got this supportive team, then, which can address various factors. I think as well it would be important, maybe, to look at the person holistically and look at their medication overall because polypharmacy is a big problem and there may be issues relating to polypharmacy. So, having pharmacy input in that team and addressing other problems, such as depression or anxiety—any behaviours that might be attributed to anxiety or the environment, so addressing any environmental problems as well. I think all of these interventions are important before using antipsychotic medication, which should be, obviously, a last resort really. So, looking at the triggers behind the behaviour.

[478] **Ms Aston:** Adding to that, environment is key, and we've learned quite a lot from the Scottish system with what they've been trying to do with their dementia strategy over recent years and certainly the work of Stirling

University, where they've done so much on environment, you know, from the black floor with a sparkle in it where, if you've got dementia, you see the black hole that you're walking into—. We can do so much more on the decorative part of the area that the persons are living in and also in their bedrooms and so forth to take away that clinical environment. We've made many of our nursing homes such a clinical environment that they don't feel so homely. Some of that is tied up with the regulation from—and I'm not knocking CSSIW; they're a partner of ours. But some of that regulation doesn't sometimes help the freedom of a provider to address some of the environmental issues. If we could enable them to invest, rather than us investing in antipsychotics and other medications, we could actually possibly achieve more within the resources that we've got.

[479] **Angela Burns:** Could you just give a quick example of a barrier—one of the barriers that you might face?

[480] **Ms Aston:** For instance, Mr Jones likes to garden, has gardened all his life; a care home has got a nice garden that's secluded; it's safe, by our accounts of being safe; he's not going to be able to wander onto a main road because there's a lock on the other side that he can't use to get out; there's a carer within the garden but not overseeing him, because maybe they have two or three other people in that home that like to garden; and the carer has given him a pair of gardening gloves, he's got his seeds or whatever and a little pitchfork and, that day, the inspector comes into the nursing home and goes out and says, 'I see you've got four residents in the nursing home', and picks up on the fact that Mr Jones has a fork that's got prongs on it—'What if Mr Jones were to fall on the fork? Have you risk-assessed this? Have you done this, have you done that? If he were to stab himself with it, the risks are high. You haven't got a risk assessment.' So then that escalates into, 'Should it be a protection of vulnerable adults—a safeguarding situation?' And the carer is only trying to get them to enjoy the environment of the outside atmosphere. And that's where we seem to lose common sense in these situations. And it isn't appropriate to have one-to-one for Mr Jones just to plant his seeds or his little pansies into the pot, because he's been doing that all his life—he's probably going to be as safe as we are in this room if we were doing it. So, we don't always have the common sense side from an inspection. That's a sort of hypothetical example for you.

[481] **Angela Burns:** It's the home element. Got it. Thank you.

[482] **Dai Lloyd:** Okay. Final question—Jayne.

[483] **Jayne Bryant:** Thank you, Chair. We've talked about quite a lot of priorities really today, but what do you think the main actions are that are required that would have the greatest impact on reducing the over-prescription of antipsychotics in care homes?

[484] **Dai Lloyd:** Help us with our recommendations, in other words.

[485] **Jayne Bryant:** And really an idea of who should be driving these forward.

[486] **Ms Aston:** I think we've all said the same, both Hywel Dda and us, regarding the multidisciplinary approach—the community pharmacists particularly with mental health experience to take a lead on that. We know that the pharmacists supplying the medication know what's going on in the homes in their area. I don't think it's fair to lay it all in the lap of a primary care cluster or in the lap of secondary care. There's that partnership pathway that we must all take responsibility for and having the opportunity here to talk about education—we can't just leave this to the NHS to be the ones receiving and delivering education. There's got to be a lot more education for everybody in the nursing home sector, including their relatives.

[487] One of the things I wanted to mention was about 'This is me' and enabling relatives, or the individual before they get to that stage, to use the 'This is me' document. I have personal experience of using it for my mother-in-law, and it was a very powerful tool when she was in hospital in England. I updated it when she came into a care home in Wales, and it was very useful for the carers when we weren't there to be able to understand her previous life and to talk to her about her pets, her animals, those sorts of things, because they were documented.

14:15

[488] We don't always give carers the time to read these documents, though, and to go back, or the time to chat. So, we can't make time, but perhaps we can make the system a little bit easier for people to actually stop doing, but, actually, when you're talking, you are doing and you're caring. It's not all about the tasks that we've suddenly become acquainted with with care.

[489] **Dai Lloyd:** Okay. Hywel Dda.

[490] **Ms Stephens:** I think we've already touched on it. I think dementia training would be a priority, and I'm not aware that it's mandatory for care home staff to have dementia-care training, and maybe consideration of making it a mandatory requirement. And also, perhaps, development of national standards for dementia-care training as well, so that care home staff have the necessary skills and knowledge of risks and benefits of antipsychotic medication.

[491] And also, what they can do to address the behavioural and psychiatric symptoms before resorting to antipsychotic medications. So, I think training would be a high priority. Also, recording and review of medication, maybe make it a formal requirement for them to record and have timely reviews for the antipsychotic medication. And I think we also touched on perhaps having a care pathway for behaviours and psychiatric symptoms of dementia, so that GPs in primary care are supported to feel more amenable to reducing and withdrawing antipsychotics. So, embracing networks as well, so the mental health pharmacist, psychiatric team, mental health team, so that it's a multidisciplinary approach to addressing antipsychotic prescribing.

[492] **Ms Isaac:** And we were also looking at working with third sector providers with some of the training needs, and, obviously, looking to our GP training schemes and working with our primary care colleagues—so, nurse prescribers and GPs and pharmacist prescribers—to ensure that they've had adequate training as well.

[493] **Dai Lloyd:** Great.

[494] **Dr Ivenso:** Can I add one more? So, I suppose, just in relation to the Commissioner for Older People in Wales's concerns about the lack of audits around this area, I suppose it would be helpful if we could consider spreading some good practice across our health board and across different health boards, because if you have data, you can see if you're improving. If you don't have that data, then, whatever you're doing, you can't really measure it. So, I would suggest maybe that's something to prioritise as well.

[495] **Ms Aston:** If I may add one more? There is something about our IT systems that don't talk to each other. So, the discharge information from an acute episode may not get to the GP or to the nursing home. Communications get lost—those sorts of things. We're using CWS, a pharmacy digital system, there's a different IT system for something else,

and one day, to have them all connected, would be marvellous, and at the push of the button, you could see that latest history and that sort of thing. And some actual targets from yourselves—though some people may not like me saying that—but to give us a push to actually do things that we've all been talking about.

[496] **Ms Stephens:** Yes, I think it would be great to have some kind of national mechanism for collecting data for antipsychotic prescribing.

[497] **Ms Aston:** So we're all collecting the same data that is useful for self-government.

[498] **Ms Stephens:** So that we could benchmark against other health boards and against the NICE standards as well.

[499] **Rhun ap Iorwerth:** Could you tell us what data that should be? You can write to us, by all means, and give us a design for what data you'd want collected.

[500] **Ms Isaac:** We try to use that data to develop our local audits.

[501] **Ms Stephens:** The data would be in line with the NICE guidelines.

[502] **Dr Ivenso:** The data we have actually shows quite a reference to the NICE guidelines, as well as what other things need to be monitored, regarding whether medication is being reduced, stopped, continued or switched. So, there are established outcomes we could look at.

[503] **Ms Stephens:** I think the Prescribing Observatory for Mental Health UK, which has been approved by the Royal College of Psychiatrists, they have very good standards for the audit that have come from NICE guidelines, and that's what we've adapted for our audit, so we can share that.

[504] **Dai Lloyd:** Okay. Jayne, happy? Yes.

[505] **Jayne Bryant:** Just finally, then, it might be some of the things you've mentioned, actually, because, in the Welsh Government's draft dementia strategy, one of the key aims is to reduce the inappropriate use of antipsychotics in care homes, so how do you think we can ensure that the strategy really delivers for older people? I've stunned you to silence again, there.

[506] **Ms Aston:** We need to all take ownership of that, and we need to ensure that our nursing homes are brought into that strategy with us, and one of the things that we've started to talk about—. Our discussions today in the car coming over were around what might need to go into a contract with nursing homes in the future, and some Assembly Members in the room will, perhaps, be aware that we've been trying to work to an all-Wales contract for a long time, and we haven't got there. And we do need to consider some of these in our contracts with each health board and local authority, and where we're going with the social care Act, giving us an opportunity to do that. I have a list on my board in the office of all the things I want to put into the contract at the moment, and one of those is antipsychotic medication reviews and dementia training strategies, as well. I'm sure other health boards would be similar in that.

[507] **Ms Stephens:** Yes, I agree with what you're saying. It should probably be included in the quality statement of the health board. And maybe also the inspectorate, CSSIW, could include some formal regulation as well, within its inspection process.

[508] **Ms Isaac:** Certainly, from our health board perspective, this work has been given priority—the number of suggestions that were raised by the older people's commissioner.

<p>[509] Dai Lloyd: Grêt. Mae'r cwestiynau ar ben. Diolch yn fawr iawn ichi gyd am eich presenoldeb y prynhawn yma, ac am ateb y cwestiynau mewn ffordd mor ddoeth, a hefyd, diolch am y dystiolaeth ysgrifenedig cawsom ni ymlaen llaw. Felly, diolch yn fawr iawn i'r pedair ohonoch chi—diolch yn fawr.</p>	<p>Dai Lloyd: Okay, thank you. The questions have come to an end. Thank you for your presence here this afternoon, for answering the questions so wisely, and also, thank you for the written evidence that we received beforehand. So, thank you to the four of you—thanks very much.</p>
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14:22

Papurau i'w Nodi Papers to Note

[510] **Dai Lloyd:** Nawr, pwyllgor, **Dai Lloyd:** Now, committee, we move
rydym yn symud ymlaen i eitem 9: on to item 9: papers to note. There

papurau i'w nodi. Mae yna dri llythyr are three letters there. Any yn fanna. Unrhyw sylw? Nac oes. Da comments? No. iawn.

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

Cynnig:

Motion:

bod y pwyllgor yn penderfynu that the committee resolves to gwahardd y cyhoedd o weddill y exclude the public from the cyfarfod yn unol â Rheol Sefydlog remainder of the meeting in 17.42(vi).

accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.

Motion moved.

[511] **Dai Lloyd:** Symud ymlaen i eitem 10: cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod. Pawb yn cytuno? Pawb yn cytuno.

Dai Lloyd: Moving, then, to item 10: motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting. Is everyone content? Everyone is content.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 14:22.

The public part of the meeting ended at 14:22.