Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

05/10/2017

Agenda'r Cyfarfod
Meeting Agenda

Trawsgrifiadau'r Pwyllgor
Committee Transcripts

Cynnwys
Contents

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

19 Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal: Sesiwn Dystiolaeth 5—Coleg Brenhinol y Seiciatryddion a Choleg Brenhinol yr Ymarferwyr Cyffredinol
Use of Antipsychotic Medication in Care Homes: Evidence Session 5—Royal College of Psychiatrists and Royal College of General Practitioners

39 Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal—Sesiwn Dystiolaeth 6—y Coleg Nyrsio Brenhinol
Use of Antipsychotic Medication in Care Homes—Evidence Session 6—Royal College of Nursing

50 Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal—Sesiwn Dystiolaeth 7—y Gymdeithas Fferyllol Frenhinol a Fferylliaeth Gymunedol Cymru
Use of Antipsychotic Medication in Care Homes—Evidence Session 7—Royal Pharmaceutical Society and Community Pharmacy Wales

70 Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal—Sesiwn Dystiolaeth 8—Cymdeithas Seicolegol Prydain
Use of Antipsychotic Medication in Care Homes—Evidence Session 8—British Psychological Society

86 Papurau i’w Nodi
Papers to Note

86 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

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi 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
Dawn Bowden Bywgraffiad|Biography	Llafur Labour
Jayne Bryant Bywgraffiad|Biography	Llafur Labour
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

Dr Victor Aziz	Coleg Brenhinol y Seiciatryddion Royal College of Psychiatrists
Dr Premini Balasekeran	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners
Helen Bennett	Nyrs Iechyd Meddwl ac Ymgynghorydd Iechyd Meddwl, Coleg Nyrsio Brenhinol Cymru Mental Health Nurse and Mental Health Consultant, Royal College of Nursing Wales
Alison Davies	Cyfarwyddwr Cyswllt Ymarfer Proffesiynol, Coleg Nyrsio Brenhinol Cymru Associate Director Professional Practice, Royal

	College of Nursing Wales
Mair Davies	Cyfarwyddwr, Cymdeithas Fferyllol Frenhinol Cymru Director, Royal Pharmaceutical Society Wales
Rhiannon Davies	
Wendy Davies	Fferyllydd Bwrdd Clinigol Iechyd Meddwl, Cymdeithas Fferyllol Frenhinol Cymru Mental Health Clinical Board Pharmacist, Royal Pharmaceutical Society Wales
Dr Jane Fenton-May	Coleg Brenhinol yr Ymarferwyr Cyffredinol Royal College of General Practitioners
Sam Fisher	Fferylliaeth Gymunedol Cymru Community Pharmacy Wales
Dr Ian James	Cymdeithas Seicolegol Prydain British Psychological Society
Dr Carolien Lamers	Cymdeithas Seicolegol Prydain British Psychological Society
Michaela Morris	Rheolwr Gwella Gwasanaethau Iechyd Meddwl, Iechyd Cyhoeddus Cymru Mental Health Service Improvement Manager, Public Health Wales
Steve Simmonds	Fferylliaeth Gymunedol Cymru Community Pharmacy Wales

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

Amy Clifton	Ymchwilydd Researcher
Claire Morris	Ail Glerc Second Clerk

Sarah Sargent | Dirprwy Glerc
Deputy Clerk

Dechreuodd y cyfarfod am 09:31.
The meeting began at 09:31.

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 yn y Cynulliad. A allaf i groesawu fy nghyd-Aelodau? Rydym ni wedi derbyn ymddiheuriadau oddi wrth Angela Burns, a hefyd mae Jayne Bryant yn mynd i fod yn hwyr, ond bydd hi yma yn y man. A allaf i bellach egluro bod y cyfarfod yn ddwyieithog? 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 pobl i naill ai ddiffodd eu ffonau symudol ac unrhyw gyfarpar electronig arall, neu eu rhoi ar y dewis tawel? Ac rydw i'n bellach yn hysbysu pobl y dylid dilyn cyfarwyddiadau'r tywyswyr os bydd larwm tân yn canu.

Dai Lloyd: Good morning, everyone, and welcome to this latest meeting of the Health, Social Care and Sport Committee here at the Assembly. May I welcome my fellow Members? We have received apologies from Angela Burns, and also Jayne Bryant is going to be running late, but she will be joining us soon. May I also now explain that the meeting is bilingual, and you can use headphones to hear the interpretation from Welsh to English on channel 1, and amplification of the sound in the floor language is on channel 2? May I remind people to either turn off their mobile phones and any other electronic equipment or to place them in silent mode? And may I further inform people that they should follow the instructions from the ushers should the fire alarm sound?

09:32

Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal—Sesiwn Dystiolaeth 4—Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru
Use of Antipsychotic Medication in Care Homes—Evidence Session 4—Public Health Wales NHS Trust

[2] **Dai Lloyd**: Felly, gyda chymaint

Dai Lloyd: Having said those few

â hynny o ragymadrodd, fe wnawn ni symud ymlaen i eitem 2, a pharhad o'n hymchwiliad i'r defnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal. Dyma sesiwn dystiolaeth rhif 6. O'n blaenau ni mae cynrychiolwyr o Iechyd Cyhoeddus Cymru. Felly, rwy'n falch i groesawu Michaela Morris, rheolwr gwella gwasanaethau iechyd meddwl, a hefyd Rhiannon Davies. Fel pwyllgor, rydym ni wedi derbyn y dystiolaeth ysgrifenedig gerbron, ac felly, yn ôl ein harfer, awn ni'n syth i mewn i gwestiynau, yn seiliedig ar beth rydym ni wedi'i dderbyn. Yn ôl y traddodiad, felly, awn yn syth i mewn i'r cwestiwn cyntaf, ac mae hwnnw dan ofal Rhun ap Iorwerth.

words, let's move on to item 2, and the continuation of our inquiry into the use of antipsychotic medication in care homes. This is evidence session 6, and before us we have representatives from Public Health Wales. So, I'm pleased to welcome Michaela Morris, the mental health service improvement manager, and also Rhiannon Davies. As a committee, we have received the written evidence, and so, according to our custom, we'll move straight into questions, based upon what we have received from you. And, so, as is our custom, we will move therefore to the first question, which is from Rhun ap Iorwerth.

[3] **Rhun ap Iorwerth**: Bore da iawn i chi, ac mi wnaf i ddechrau drwy gyfeirio at yr ymgyrch 1000 o Fywydau, a diolch, yn amlwg, i chi am y gwaith sydd wedi cael ei wneud ar hwnnw, achos mae e o gymorth mawr i ni wrth i ni wneud yr ymchwiliad yma. A allwch chi siarad efo ni am y cefndir, y cyd-destun, a arweiniodd atoch chi'n ystyried bod angen gwneud darn o waith ar ddefnydd o gyffuriau gwrthseicotig o ran ymgyrch 1000 o Fywydau?

Rhun ap Iorwerth: A very good morning to you, and I will start by referring to 1000 Lives campaign, and thank you for all the work that's been done on that, because it is of great assistance to us as we conduct this inquiry. Could you tell us a bit more about the background, the context, that led to you considering that there was a need to do a piece of work on the use of antipsychotic drugs as part of the 1000 Lives campaign?

[4] **Ms Rh. Davies**: Can I take my headphones off?

[5] **Rhun ap Iorwerth**: Yes, of course.

[6] **Ms Rh. Davies**: Since 2004, there has been an understanding of the harmful effects that atypical antipsychotics can give when used in dementia. But it really came to a head when there was a report written—an independent

report—by the Department of Health, by somebody called Professor Banerjee. That report was written in order to inform the English dementia strategy. And what Professor Banerjee actually identified is that there were significant negative issues in terms of quality of care, patient safety, clinical effectiveness and patient experience through use of antipsychotics. He examined the problem and made key recommendations. And on the findings of the report, just to give some broad figures, he estimated that 180,000 people with dementia in England were treated with antipsychotic medication at times. As I said, he reviewed the evidence on benefit and harm and he suggested that if the correct support was available, that prescribing could be reduced by two thirds. There's also somebody called Professor Clive Ballard, who felt that it could further be reduced by 90 per cent. So, just to give, perhaps, a bit of perspective on that: for every 1,000 people with dementia treated with an antipsychotic for six to 12 weeks, you would only see improvement in 90 to 200 people in psychosis and aggression. So, the efficacy is minimal. You'd see 18 cerebral vascular instances and stroke instances—50 per cent would be severe. You're likely to see 10 deaths within six to 12 weeks and other side effects to do with gait disturbances, et cetera.

[7] So, he made these lists of recommendations and it was very high profile. On the basis of the Banerjee findings, within England they managed to reduce the prescribing by 70 per cent and apparently that has been ongoing. The 1000 Lives project, I was part of the medicines management team in Powys Teaching Local Health Board, and we picked up on the Banerjee report very early and started work ourselves independently, but the 1000 Lives stemmed from that within the context of the whole of dementia care.

[8] **Rhun ap Iorwerth**: What would you say, so far, have been the main achievements? What are the bits of good practice that have emerged that hopefully can be replicated across our care sector?

[9] **Ms Rh. Davies**: This initiative—. Actually, it's more of a historical perspective if you like, because this initiative, 1000 Lives Plus, was set up in 2011, and I took the lead in 2012 and only worked on the initiative for a year. At that time, I was pharmaceutical adviser within the Powys medicines management team, but I always had a special interest in reducing inappropriate prescribing. Since then, I've gone on to become a volunteer and a social care rapporteur with the Older People's Commissioner for Wales, looking at the care home review.

[10] What happened was, I started the work within Powys, and what we did was we took 1000 Lives Plus driver 3, as it's called, which is the appropriate use of antipsychotics in accordance with guidelines that are available, and avoidance where possible. We sought to create good practice through that. That good practice was—. As I said, the work that I'm speaking about now was initiated in Cardiff, but it looked at the fourfold aim: reducing unnecessary use of antipsychotic medication and ensuring that all prescribing was in line with the guidelines; it was about developing a multidisciplinary team approach; and probably the biggest challenge and the most important aspect of the work was supporting carers in alternative approaches to managing and preventing challenging behaviour; and it was also about improving communication and transfer between healthcare settings.

[11] The work in Powys focused on two care homes. Firstly, we started by doing an audit of all the medical practices prescribing antipsychotics in care homes. That was quite difficult to do because the records were often quite patchy. But from that, as was recommended through 1000 Lives Plus, we were able to identify a GP practice and two care homes, as I said, one of which was for the elderly mentally infirm and one was residential and nursing.

[12] Through using a team approach, as recommended, we worked with care home staff, activities co-ordinators within the care homes where they had them, the GP, the community mental health team, the lead psychiatrist, and the pharmacist, which at that point was me, and with me as facilitator. What we did through that initiative was we identified the issues first and foremost, we looked at the audit criteria, we got the information through the audit that we needed, and then we put in a collection of interventions. They were: in-house training for care home staff and GP practices; we produced monitoring checklists; adapted behavioural charts, pain management and sleep charts; we also developed better review procedures, patient care information leaflets and staff posters; improved formal links between the community mental health team and care homes; improved communication generally; gave a clearer definition of who was responsible for what; and focused on the person-centred approach.

[13] Over 12 months, within that particular project, it started with—in the EMI care home, there were 49 patients, 30 of whom had a diagnosis of dementia and 16 were taking antipsychotics, so really quite a high proportion—putting in the interventions that we did, following it through this

cycle of audit, then after 12 months, we'd reduced that prescribing to six individuals. So, it had gone from 16 to six, and the same in the other care home as well.

[14] **Rhun ap Iorwerth**: So, an evaluation of that particular project seems to have brought results. Given that the inappropriate use of antipsychotics is still so prevalent, which is why we're conducting this inquiry now, what's been the problem? You've mentioned all the evidence and the expertise that has been put into this in England, and internationally I'm sure. Is it a problem with the initiatives that have been developed and difficulties with their implementation, or is it just a lack of whatever it might be, a lack of drive, leadership to scale up, if you like, these pilots?

[15] **Ms Rh. Davies**: I think it's about leadership, definitively. I think it is about making sure that it is a priority. There were health boards that worked on this initiative who really bought into it, and that was fantastic, and if you want more details of who they are then you can ask Les Rudd, but there were those who did not engage. Because the issue with 1000 Lives Plus is you cannot make a health board engage. What we need now, I believe, is to have initiatives that are totally embedded into the working practice. There is a lot of good working practice that can be drawn on, different health boards have different structures in terms of dementia care and support, so it might be different in each one. So, there were strengths within 1000 Lives in that it acted as a catalyst to bring it to the fore, but there were also weaknesses, without targets being set.

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

[17] **Dai Lloyd**: Okay, Lynne and Julie had supplementaries.

[18] **Lynne Neagle**: Thank you. In your opening remarks, you referred to Professor Banerjee's report and atypical antipsychotics. Are you drawing any distinction then in terms of the impact of using different types of antipsychotics?

[19] **Ms Rh. Davies**: Absolutely. There is only one atypical antipsychotic drug that is actually licensed for short-term use in the support and treatment of the behavioural and psychological symptoms of dementia. That is a drug called risperidone. You're nodding, so you've probably heard of that. There is not a huge amount of work that's been done in terms of clinical trials on this, but it is the only drug. But, it was interesting, when these audits were done,

that there was quite a variety of drugs that were used, and different psychiatrists would have different preferences. That work is still ongoing, but really, when an antipsychotic is prescribed for longer than six to 12 weeks, or is prescribed and is not risperidone, then it's really done at the discretion of the prescriber.

[20] 09:45

[21] **Dai Lloyd**: Okay. Julie.

[22] **Julie Morgan**: You said when you were talking that the records were patchy. Now, which records did you mean?

[23] **Ms Rh. Davies**: Sorry. I'm talking about medication. The records, when you go into a GP practice you can audit the medical records to actually look at what's been prescribed, who prescribed it, why it was prescribed. All of that is coded. Dementia has a particular code that can be used and it wasn't always being used appropriately to identify which patients actually did have a diagnosis of dementia. It's not only that—sometimes reviews were patchy, they weren't always being done on a regular basis. So, that work was looked at as part of this initiative and very much tightened up within those practices.

[24] **Julie Morgan**: So, things improved after you looked at them, but that is probably true of practices all over Wales.

[25] **Ms Rh. Davies**: I suspect it could be the case. Yes.

[26] **Dai Lloyd**: Okay. Lynne, probably your question 3 has been answered, I think, actually. Also your question 4 has been answered, Caroline. So, question 5.

[27] **Caroline Jones**: Despite promising to do so, local health boards are still not publishing audits of the use of antipsychotic drugs or evidence to say that their use is being monitored. The Welsh NHS Confederation speak out about the limitation of data available, so I wonder if you can give me your views on this, please.

[28] **Ms Rh. Davies**: I think it's an issue. Firstly, you've got the issue that actually to get that data, there isn't one place that you can go to. It needs to be drawn out manually for each health board. So, that's time-consuming and it might mean that it's often done through practice pharmacists and they

might not feel they had the capacity and the health board might not have prioritised it. But, it would be wonderful to think that it was possible to find a way of actually collecting this data more easily in order to ensure that it can be monitored in the way that is most appropriate. But, it's not there at the moment.

[29] **Dai Lloyd**: Michaela, have you got any views on that?

[30] **Ms Morris**: I think it comes back to the issues that Rhiannon discussed earlier as well. The problem with a lot of the 1000 Lives is that this target is really, really vital because there's everything in there that is still relevant today, having reviewed it. I've come into this post in the last 10 months and I've taken over one of the drivers that we're reviewing. I actually feel, the whole thing, we could connect together. Dr Les Rudd and the 1000 Lives team have done an awful lot of work in this area, with Rhiannon, with other health boards, and as Rhiannon has said, not every health board took it up, not every area within a health board took it up. There is nothing to make somebody actually take up any of this and the improvement methodology is exactly the same. The resource that's needed to actually try and intensify this, get it on the ground, embed it—maybe that's why people walk away.

[31] **Dai Lloyd**: Moving on, Dawn, you've got the floor.

[32] **Dawn Bowden**: Oh, I'm sorry, I have indeed. [*Laughter.*] I wanted to ask you about the Newport survey that we identified on your website. I think you answered a bit of it when you responded to Rhun's questioning early on, when you were talking about how antipsychotics are mainly initiated in secondary care, and whether you have found any further evidence on that and, if you have, what we can do to try to avoid that.

[33] **Ms Rh. Davies**: The thing about where antipsychotics are initiated is key, really, and you do well to pick up on it. What was identified through this work is that quite a number of the residents and patients that were started on antipsychotics had been done out of county, in secondary care, or even in county, the health board. There was very little information, and delayed information, coming to the care homes about that to know why it had been started and what the rationale was. So, really, this project I believe needs to be embedded on the general wards and on elderly mentally infirm wards. In fact, as part of the work that was done with this, that did happen, so that there was much clearer information coming from the health board, if they had it to start with, but also there was a lot of guidelines and support given

to actually prevent initiation. That's the key to it—the prevention of the initiation. It's the prevention in, as you say, hospital settings, started in secondary care. It's also the prevention of the initiation in care homes.

[34] **Dawn Bowden**: I was going to say that, because the converse of that is that the NHS Confederation's evidence to us was saying that, actually, it seems to be initiated in care homes to keep patients out of hospital. So, that's the opposite side of it, isn't it?

[35] **Ms Rh. Davies**: I think that it's a mixture of both, and I think that it really depends on the culture of the care home, in all honesty. There are some care homes where the culture of care is such that they know the patient so well that when there are issues to do with behaviours that challenge, rather than challenging behaviour, they know that it's an unmet need for that individual. So, they seek to address it, in a way. They know that antipsychotics are only used if it's really a severe case. I think that there are care homes that actually haven't got the capacity, the knowledge or the understanding, and so antipsychotics can be called upon because they don't have the training or the staff in place, or a culture of non-pharmacological interventions—

[36] **Dawn Bowden**: Which is the key to what we're talking about.

[37] **Ms Rh. Davies**: Which is absolutely the key.

[38] **Dawn Bowden**: It's about the appropriate or inappropriate use, or abuse.

[39] **Ms Rh. Davies**: It's absolutely key to it. I think that it was from this particular initiative—. I went in as a pharmacist thinking, 'Oh, this is all about the medicines', but, actually, what I discovered is that it's all about the culture of care—it's all about the culture of care—because it's about prevention.

[40] **Dawn Bowden**: Yes.

[41] **David Rees**: Michaela.

[42] **Ms Morris**: I was just going to echo that, really, because having come into this work, and reviewing driver 5, I'm finding that, with all of the health boards that are engaging, all we're talking about is the culture of care, the

non-pharmacological approaches, how we can upskill staff, how we link with things like good work and how we link, and hopefully link, to the dementia strategy—how it all links together. None of it matters in what setting you're in; it's across them all.

[43] **Dawn Bowden**: Sorry, I wasn't at the last session, so this may have been covered, Chair: is any of this, in your view, linked to the need to mask inappropriate staffing levels?

[44] **Ms Rh. Davies**: I think there could be aspects within that, definitely. I think that, as I said, the culture of care varies hugely from care home to care home. For those that have good and strong leadership, as I say, you will find that there's knowledge and understanding that working in a person-centred way is a natural way for them. But there are other care homes where I suspect, yes, there are staffing issues. The thing is, what I don't want to have is a blame culture on this, because it's not healthy. I think that it is about education, and it's about, I believe, the care homes actually being empowered, and recognising the important and valuable work that they do, and the staff the same.

[45] **Dawn Bowden**: I think, from our point of view, it's about understanding when, where and how these drugs are being used, really.

[46] **Ms Rh. Davies**: Yes, that's a valid point.

[47] **Ms Morris**: One of the things I would say is that, looking at all of the work, it was clearly evidenced that this was a change in culture, a change in practice. Through the 1000 Lives driver diagram, the plan-do-study-act cycles, the methodology was embedded in those homes in Powys. They were able to get spread, so they spread that out, which is exactly what the methodology is asking you to do, and had constant revisits of data. They could prove, as Rhiannon has said, that the reduction in antipsychotic prescribing happened, but it is coming back to what is stopping that spread from happening, and that may be one of the reasons, because of this skilling people up. We're looking at so many different approaches, like positive behavioural support that is used within learning disabilities. We've brought that into the older adults agenda. Good work is looking at the skills framework for a range of different practitioners. It's intensive to learn those skills and it'll take time, and it's about changing the culture, embedding those skills, shadowing those staff, working alongside them, coaching, having in-house training. That takes time and it takes resource, and that

could be why it's not sustained.

[48] **Dawn Bowden**: I understand. Thank you.

[49] **Dai Lloyd**: Okay. Lynne next. Some of the issues have been addressed, so I give you free rein, Lynne. [*Laughter.*]

[50] **Lynne Neagle**: Is that wise? [*Laughter.*] Thank you. You have answered some of my question in response to Dawn, and I think there are staffing issues, inevitably, but I wanted to ask about training. One of the recommendations of the older people's commissioner's report on care homes was that all staff should be trained in working with people with dementia, and we heard in the last session that we had on this that, actually, there may have been some progress but it's not enough. So, to what extent do you think a lack of training in providing that person-centred care is contributing to this problem?

[51] **Ms Rh. Davies**: I think that training is a very important part of it, but I also think it's to do with recruitment of staff and how you recruit staff, so getting the right sort of staff to work in a care home. I also think that, with the training, what seems to work really well is when there is a closer relationship between the health board and the care home so that it can guide them with the sort of training that is needed, and there are some really good examples of good working practice out there. That was one of the beauties of 1000 Lives Plus, that we were able, with those health boards that engaged, to share each other's good practice to come up with models that worked, and I think that that training aspect is crucial to it. It's where the training comes from, and if the training is somehow supported through the health board in some way, at least in terms of guidance, you know you've got equality—potential equality. Plus, it strengthens the links of people working collectively, which is so much stronger because of the communication. Does that answer your question?

[52] **Lynne Neagle**: So, you're saying, in some places there is that close link, then, between health boards, but not in all.

[53] **Ms Rh. Davies**: Yes, there are. There are, but not all, and then not with all care homes because of the resources and the capacity issue.

[54] **Lynne Neagle**: Can you just expand on the point you made about recruitment and how care home staff get those appropriate staff?

[55] **Ms Rh. Davies**: Yes. It's only some experience that I've had in the past when I was involved with care home work. I worked with somebody called David Sheard, who's led on this work, and he talked about the fact that not everyone can be a carer, in their capacity. Yet, the way that posts are often advertised is such that it appears as though anyone could come in. And, of course, the pay is not high either. So, really, it's making sure that the questions that are asked when you recruit people are the appropriate questions that actually really draw out, 'Is this person a caring, understanding person?' So, it's going right back there, and then, once you have the staff in post, making sure that they are supported appropriately through appropriate training and in whatever other way is thought appropriate.

10:00

[56] **Lynne Neagle**: Okay, thank you.

[57] **Ms Morris**: I was going to say, regarding the training, what we've been doing—. Before I came into post, Dr Les Rudd had been sourcing various different models of skilling up staff. So, looking at the Newcastle model around triggers, looking at least restrictive practice, looking at the positive behaviour support, the learning disability way of working. We've got occupational therapists who can deliver positive-approach-to-care training. All of this skills people up to be able to work with the person, and know the person—storytelling, my life. So, all of that has been shared, but actually, 'Good Work'—. I don't know if you are familiar with 'Good Work'. It's a document that's just been released. It's the dementia learning framework, and that actually talks about the skilled and the influenced—the influencer and the enabler. So, we're trying to join our work up to what they're needing to do next with this, to actually know what a training programme looks like and what skills need to be employed. We're trying to link that together at the moment, because it's vital. We won't achieve anything unless we have the right, skilled workforce.

[58] **Lynne Neagle**: We have had some written evidence that GPs and clinicians may feel under pressure to prescribe antipsychotics, and also that care home staff are then resistant to stopping that prescription. What is your experience of that?

[59] **Ms Rh. Davies**: I think that it's about education for families as well,

and understanding the risks that are associated with these drugs, and we made sure, as part of the 1000 Lives project, that that was there, and the same for the staff as well. I think that is and undoubtedly can be an issue, but, again, it goes back to the culture of that care home and how they see and respect the individuals that they work and support with, who are in their home.

[60] **Lynne Neagle**: Thank you.

[61] **Dai Lloyd**: Mae'r cwestiynau olaf o dan ofal Julie Morgan.	**Dai Lloyd**: The final questions are from Julie Morgan.

[62] **Julie Morgan**: I think you've mentioned some of the work in England, and it seems that the English dementia strategy hasn't succeeded in making a great deal of input in this field. I don't know whether you would agree with that. And I wondered why, perhaps, the Welsh one might make some inroads.

[63] **Ms Rh. Davies**: I think there were some inroads in the one in England. The figures that I read—. After the 2010 Banerjee report and recommendations, they did another national audit in 2012, and there was a 70 per cent relative drop. There was a drop, so I think there is learning to be had from them. They do say that it has sustained, and I think that, yes, as I say, there will be learning from that experience, but I don't have, perhaps, as in-depth a knowledge as I could, to answer your question as fully as I might.

[64] **Julie Morgan**: So, would you have one message as to how we should go forward in tackling this issue? What do you think is the key thing?

[65] **Ms Rh. Davies**: Okay, I think it needs to be prioritised. I think there needs to be good leadership for the initiative. I think that we need to make sure that there is good audit work that's done on a regular basis. I think it's about upskilling GPs in their knowledge and understanding, and also in perception and attitudes. There are a lot of really strange attitudes out there, and perceptions around people, even sadly within our GP practices. And we need, I think, crucially, care home training for staff, and tools and support with tools, and I think that we need more integration of services between health, social care, and working directly with care homes to support and empower them.

[66] **Julie Morgan**: So, that's quite a list, really.

[67] **Ms Rh. Davies**: Yes. Sorry. Should I—? [*Laughter.*]

[68] **Julie Morgan**: It doesn't matter. I just wondered: do you feel the impetus is here in Wales to make this happen?

[69] **Ms Rh. Davies**: Yes. I think, and—. As I said earlier, I was a volunteer on the care home review with Sarah Rochira, as one of the social care rapporteurs, and I think that, yes, it is here. But I think it has to be done well in that it needs to be done in a way that is a no-blame culture and it's just about support.

[70] **Dai Lloyd**: Okay. Michaela.

[71] **Ms Morris**: Yes, we really welcome the 1000 Lives—the opportunity that this committee has given us to sort of refocus this agenda. Obviously, we're looking forward to the dementia strategy that's due to be released, and really needing a lot of these links to tie together. There are lots of different parts of good work with the drivers; they need to link together—good work needs to link together. The dementia strategy should be the thing that holds it all together. So, we would really welcome this focus. To have a priority in this area, as Rhiannon said, is really, really important.

[72] **Dai Lloyd**: Grêt, diolch yn fawr. Dyna ddiwedd y cwestiynau, felly a allaf i ddiolch yn fawr iawn i chi'ch dwy, yn gyntaf oll am y dystiolaeth ysgrifenedig y gwnaethom ni ei derbyn ymlaen llaw, a hefyd am eich presenoldeb y bore yma, a hefyd am ateb y cwestiynau mewn ffordd mor fanwl ac aeddfed? Diolch yn fawr iawn i chi. Gallaf bellach gyhoeddi y byddwch chi'n derbyn trawsgrifiad o'r trafodion er mwyn i chi gael ei wirio hefyd. Ond gyda hynny, a allaf i ddiolch yn fawr i chi gyd? A gallaf gyhoeddi i'm cyd-Aelodau y bydd yna doriad byr rŵan, gan ddod nôl erbyn 10.15 a.m. Diolch yn fawr.

Dai Lloyd: Great, thank you very much. That's the end of the questions, therefore may I thank you both, first of all for the written evidence that we received beforehand and also for attending this morning and for answering the questions in so much detail? Thank you very much. I can now announce that you will receive a transcript of the proceedings so that you can check it. So, with those few words, may I thank you all? May I announce to my fellow Members that there will now be a short break—if you could return by 10.15 a.m.? Thank you very much.

Gohiriwyd y cyfarfod rhwng 10:06 a 10:16.

The meeting adjourned between 10:06 and 10:16.

Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal: Sesiwn Dystiolaeth 5—Coleg Brenhinol y Seiciatryddion a Choleg Brenhinol yr Ymarferwyr Cyffredinol
Use of Antipsychotic Medication in Care Homes: Evidence Session 5—Royal College of Psychiatrists and Royal College of General Practitioners

[73] **Dai Lloyd**: Croeso nôl i bawb i ail sesiwn y bore o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon, a pharhad ein hymchwiliad i'r defnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal. Hon o'n blaenau ni rŵan ydy sesiwn dystiolaeth rhif 7, ac o'n blaenau mae cynrychiolwyr o Goleg Brenhinol y Seiciatryddion a Choleg Brenhinol y Meddygon Teulu. Felly, rydw i'n falch iawn i groesawu Dr Victor Aziz o Goleg Brenhinol y Seiciatryddion, a hefyd Dr Jane Fenton-May o Goleg Brenhinol y Meddygon Teulu.

Dai Lloyd: Welcome back to everyone, to the second of this morning's sessions of the Health, Social Care and Sport Committee and a continuation of our inquiry into the use of antipsychotic medication in care homes. Before us now we have evidence session No. 7, and we are joined by representatives of the Royal College of Psychiatrists and the Royal College of General Practitioners. So, I'm very pleased to welcome Dr Victor Aziz of the Royal College of Psychiatrists, and also Dr Jane Fenton-May of the Royal College of General Practitioners.

[74] Rydym wedi derbyn tystiolaeth ysgrifenedig ymlaen llaw. Diolch yn fawr iawn ichi am hynny, felly yn ôl ein harfer, fe awn ni'n syth i mewn i gwestiynau gan fod amser ychydig bach yn dynn. Fe wnawn ni ddechrau'r cwestiynau efo Lynne Neagle.

We have received your written evidence beforehand. Thank you very much for that. And so, as is our custom, we will move straight into questions because time is slightly tight. So, we will begin those questions with Lynne Neagle.

[75] **Lynne Neagle**: Thank you, Chair. In your experience, how widespread is the use of antipsychotics in care homes in Wales?

[76] **Dr Fenton-May**: I think it's too wide is the answer, and there are multiple reasons for that. Obviously, sometimes there are problems with the

home; they feel that they can't cope with the patient. Some doctors feel that it is appropriate treatment, and, ideally, what we need to do is make sure the patients are reviewed there, if possible weaned off the tablets, and ensure that other management methods are put in place to help support the patient and their behaviour. And it's not only in care homes—I know that you're concentrating on that—there are also patients in their own homes who are being given antipsychotics, and the problems there, potentially, can be more difficult to solve.

[77] **Lynne Neagle**: Thank you. Dr Aziz.

[78] **Dr Aziz**: Sorry, they're my distance glasses, so I have to do that. Like last time, I provided you with lots of evidence, and also a couple of papers I'll talk about. I think the short answer for Wales is, 'We don't know'. There is no data. However, you have some evidence from the Welsh Government about the elderly population and about the complexity of the elderly population. For example, in the Welsh Government's priority for older people document, 'Living longer, ageing well: Making Wales a great place to grow old'—actually, there are more people aged 65 and over living in Wales than there are children. So, again, the older the people, the more older people you will expect, prescriptions are going to be higher, and also in the Welsh health survey 2015—on lifestyle behaviour—reported that 10 per cent of people 65-plus were smoking, 26 per cent were drinking alcohol above the guidelines. And, again, there's lots of this data in Wales, like, for example, two thirds of the population of Wales over 65 have chronic conditions. And, of course, the older you are, the more problems you have, the more polypharmacy comes into force. However, some of the UK studies—for example, Banerjee in 2009 said that between 20 per cent to 50 per cent of people with dementia in the UK are prescribed antipsychotic medications.

[79] There are a couple of papers, but there is local and international variation. All of these are referenced, and I'll leave that. There are also a couple of reports from the UK that have also been contradicted by other reports. So, the national dementia and antipsychotic prescribing audit in 2012—so, five years ago—showed a decrease of 10.25 per cent in the number of people with dementia receiving prescriptions for antipsychotic medication from 2006. There was a 51.8 per cent reduction in the number of people receiving a prescription for antipsychotic medication from 2008 to 2011. So, again, it's still out of date.

[80] The Prescribing Observatory for Mental Health-UK audit 'Prescribing

antipsychotic medication for people with dementia' suggests that the prevalence of antipsychotic use in mental health trusts or healthcare organisations for behavioural and psychological symptoms of dementia decreased between 2011 and 2012 by 23 per cent, and this decrease was maintained in 2016—19 per cent, down from 2011. However, other research said that that's not really entirely true—it has increased, and also some of the research looked at hospitals and care homes, and actually hospitals have been more aware of it so there might have been some decrease in hospitals, which is not consistent. However, in care homes, it has been on the increase.

[81] So, there is no really systematic way of knowing exactly what's happening in Wales.

[82] **Lynne Neagle**: Okay. We heard in the previous session that the only antipsychotic that is actually licenced to be used for people with dementia is risperidone but that a wide range of other antipsychotics are prescribed, depending on the preference of the prescriber. Is that a view you recognise, and have you had any feedback from any of your members that would help us with that?

[83] **Dr Aziz**: Again, there is evidence here as well. If you look at the British National Formulary—I actually just got it exactly out of the BNF for you here—if you look at the BNF recommendation about prescribing, the BNF identified two drugs—risperidone and haloperidol. So, the BNF is saying that risperidone is licenced as a

[84] 'Short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's dementia unresponsive to non-pharmacological interventions and when there is a risk of harm to self or others'.

[85] Haloperidol is licensed for agitation and restlessness in the elderly and for management of mental behavioural problems such as aggression, hyperactivity, self-mutilation, again in the mentally retarded and in patients with organic brain damage. That's the BNF.

[86] Lots of medications we use out of licence, and this is really a common practice. However, lots of research—and this is evidence-based—found modest evidence for risperidone, olanzapine and aripiprazole—and there is more evidence now about amisulpride, but it's not within the BNF. Quetiapine: all research was found—and quetiapine has been prescribed a

lot, including in Wales—. There is no evidence whatsoever in the literature about that. There has been lots of other research about some alternatives, if you want me to go on to that or—?

[87] **Lynne Neagle**: Maybe the committee could have a note on the—

[88] **Dai Lloyd**: The research notes would be good. All right?

[89] **Dr Aziz**: Yes.

[90] **Dai Lloyd**: Okay.

[91] **Lynne Neagle**: Okay. Can I just ask you to expand on what you think the main reasons are why we are seeing this level of antipsychotic prescribing in care homes?

[92] **Dr Fenton-May**: I think a lot of it is an ask from the care homes, and we need to try and change some of those cultures and ensure that there are activities in the care home that can stimulate the patients appropriately to stop them being bored or whatever it is that aggravates the behaviour. We need to ensure, obviously, that any underlying reasons for behaviour problems, such as pain or things like that, which are causing agitation for the person involved, are excluded. Dare I mention that GPs are overworked? And so visiting a care home can take a huge amount of time, and, in some areas, there are not designated doctors for each care home. So, in some places, where the nursing home or care home services are particularly good, there may be a doctor who will go in and get to know the residents, but in other areas, it may be whichever GP the patient is registered with. So, that can cause problems for the workload and the time.

[93] The other problem is that, sometimes, patients are discharged from hospital to a care home, they become a temporary patient of a local GP and the GP does not know that patient at all. They don't get any information about that patient. They might get a discharge note if they're lucky. So, all they have is what medication the patient came out of hospital with, they don't have any indications about why the patient is on that medication, and this makes life very difficult for them. We are hoping that the electronic discharge letters will help improve that situation, but there are all sorts of minefields out there that make care not ideal for patients in care homes.

[94] **Dai Lloyd**: Can I just interrupt for a minute? We've got a new additional

witness from the Royal College of General Practitioners in London who has just arrived to give evidence as well. So, if we adjourn for five minutes, we'll have another RCGP witness here as well. Thank you.

Gohiriwyd y cyfarfod rhwng 10:26 a 10:30.
The meeting adjourned between 10:26 and 10:30.

[95] **Dai Lloyd**: Croeso nôl wedi'r toriad braidd yn annisgwyl yna, ond rydym ni wastad yn croesawu tystiolaeth ychwanegol ar bapur neu mewn person yn y cyfarfod yma. Croeso nôl i bawb. I gario ymlaen efo'r cwestiynau, Lynne.	**Dai Lloyd**: So, I'd like to welcome you back after that slightly unexpected break, but, of course, we always welcome additional evidence, whether that is in a written form or in person in this meeting. So, I'd like to welcome everyone back, and we will continue the questions—Lynne.

[96] **Lynne Neagle**: Thank you. I asked the question; I'll just repeat the question. Just for clarity, we were just discussing what your understanding is of why antipsychotics are being used in care homes, and Dr Fenton-May had just answered, giving me her perspective on why we've got this problem. So, I don't know if anybody else would like to contribute.

[97] **Dr Aziz**: If I could contribute to that. Again, I did supply evidence for it. I think the issue is complex, and we are dealing with complex individuals and we are dealing with their needs. So, the issue is not just about antipsychotic medication; the issue is about everything around that person. We have an elderly population on the increase, while the workforce hasn't increased to cover that. We are dealing with chronic conditions and polypharmacy. We are dealing with under-resourcing, cuts to beds. Communication is a big problem—communication between not just primary and secondary, but even between secondary and secondary, between social services and health. Systems are not in place to address these issues. For example, in inspections: HIW, what are you looking for, CSSIW, what are you looking for? So, it's a complex issue.

[98] There is also the complexity about training, or lack of training; the lack of quality staff or good staff, because if you have good staffing and adequate staffing, very often you're not going to really need medication, you will try your best. There is a lack of alternatives. But with the individual—if you're talking about behaviour and psychological symptoms of dementia, out of research, the two most common, for example, reasons for prescribing

were verbal aggression or noisiness, more than agitation. But then, sometimes, you want an easy fix, a quick fix. Sometimes, families put pressure on you; sometimes, staff put pressure on you. But with the individuals, an individual actually might have depression, might have other challenging behaviour, they might have epilepsy seizures. So, sometimes—I actually put it down—a clinician often faces a dilemma: which one is which? It's really about that individual, about that balance.

[99] Jane doesn't know this, because I only got it yesterday, but I printed a copy for you here. Honestly, it only came yesterday—it's only been published—a lovely, lovely study from Australia, 'Prescribing of psychotropic medication for nursing home residents with dementia: a general practitioner survey'. So, they looked at GPs and they said,

[100] 'Results: A lack of nursing staff and resources was cited as the major barrier to GPs recommending non-pharmacological techniques for behavioral and psychological symptoms of dementia…and increasing staff levels at the nursing home ranked as the most important factor to reduce the usage of psychotropic agents.'

[101] So, people are trying. People are doing research. When you look at—I'm always happy to send it to you, but it's available online as well—the workforce report from the Royal College of Psychiatrists, Wales has the lowest number of consultants for the same number of population, compared to England, Northern Ireland or Scotland. So, when we are talking about 'we are overwhelmed', we are also under-resourced.

[102] **Dr Fenton-May**: Thank you. Can I just add on a little bit to what I was saying? I understand, in some areas, there are some nursing teams going in from the psychiatry of the elderly to the nursing home, and I understand that that is helping greatly. I think one of the main issues with some of the patients on the antipsychotics is somebody starts them and nobody goes back and reviews them and thinks about stopping them, because they're frightened of what had happened. The danger is that if we put a cap on the amount of antipsychotics that we give to patients, we'll go back to the old days where everybody was dosed up with benzodiazepines or other tranquilizers, which is equally not good for the patients. So, we need to watch that.

[103] **Dr Aziz**: Can I just add quickly, very quickly—? For example, I did mention the Cwm Taf care home, but, actually, there is a gap here, because

they don't have a medic, which sometimes delays the prescribing of appropriate medication. So, you really need the balance of non-pharmacological and pharmacological. It's what is appropriate for that person, that's the most important issue.

[104] **Dai Lloyd**: Okay. And the view from London.

[105] **Dr Balasekeran**: I'll just say that perhaps the best setup is the one that I can see here where there's a model utilising prescribing a mental health pharmacist and a dementia care adviser. I'm not sure, if GPs are meant to be doing the reviews—. I'm not sure, first of all, are GPs meant to be doing the reviews. I'm not sure how comfortable they are, unless there are clear guidelines. If there are clear guidelines to doing them, I think the recommended number of reviews was five times a year: I think the initial one within four to six weeks of commencing the antipsychotics, and then every three months. So, I just wondered whether it was best coming from the mental health, because I'm not sure how confident GPs would be. But even if there were some GPs who are willing to do it as a shared care, I suppose it would be a funding issue, again, because the resources are already quite tight and these are complex patients, and they already have other comorbidities as well.

[106] **Dai Lloyd**: Particularly as the antipsychotic is usually started in secondary care.

[107] **Dr Balasekeran**: Yes.

[108] **Dai Lloyd**: Rhun, do you want to come in at this point?

[109] **Rhun ap Iorwerth**: Rydych chi wedi'n harwain ni ymlaen i drafod y system o gynnal adolygiadau meddyginiaethau. Mae yna gytundeb, rwy'n meddwl, bod angen cael system lle mae'r adolygiadau yma yn digwydd, ac mae'n ymddangos i ni fel pwyllgor, rwy'n meddwl, fod yna *barriers* i'r adolygiadau yma yn digwydd. Beth ydych chi'n meddwl ydy'r *barriers* mwyaf i roi system mewn lle sy'n gwneud yn siŵr bod yr

Rhun ap Iorwerth: You have led us on to discuss the system of medicines reviews. There is an agreement, I think, about the need to have a system where these reviews happen. It appears to us as a committee, I think, that there are barriers to these reviews. What do you think are the biggest barriers to put a system in place, and to ensure that these reviews do occur regularly enough?

adolygiadau yn digwydd yn ddigon rheolaidd?

[110] **Dr Aziz**: I think rather than looking at the barriers, the answer is to look at the individual. Again, I think passing the buck between primary care, secondary care or anyone is not going to solve the problem. I think we're all part of the problem; we're all part of the solution. If I mention the words 'shared care', we have reluctance of some areas to participate in shared care. Then you say, 'That's your responsibility, that's my responsibility', then you put barriers in the system. I made, actually, a recommendation there. If you look at, for example, the REACT team in Cardiff or this care home team in Cwm Taf, who are they working with? They are isolated and are working with themselves. In Cwm Taf, there is another team called the 'at home' team, which is for geriatrics and is focused on falls. Why are they not working together? This is a directorate, that's a directorate. Why are social services completely away from us? So, rather than focusing on the barriers, we may need to create maybe a locality-based team and maybe a cluster-based team to bring those people together, and those become a care home team or a specialised team that are supporting each other. Whether there is a pharmacist prescribing, a GP, a psychiatrist, a geriatrician, social services, occupational therapists, you have that team, one resource, who can go, give appropriate advice and they can monitor. That might be really the solution, rather than keep creating separate teams working together. And then, you'll have no barriers to communication: they are working together; they are under one set of management rather than different management. Communication, IT, whatever—you are not going to have any barriers.

[111] **Rhun ap Iorwerth**: You can call it passing the buck or you can call it looking for somebody to take a lead, and the RCP does actually say that community pharmacists should be dealing specifically with care home residents when it comes to medicine reviews. Explain more about the thinking there. Is that a clear leadership role that should be written into the system so that we know who takes the lead?

[112] **Dr Aziz**: It should be written in the system, because there is a role for community pharmacists, there is a role for nurse prescribers, there is a role for mental health named nurses, there is a role for physical health nurses, there is a role for occupational therapy—there is a role for everyone. Whoever is going to take that lead needs to have the skills of leading that team and providing that support. And support here is not just about having a team. The support also is about developing that team. That team has a very

important role in education and training others, because if I go and look at a patient in a care home, full stop, what really are the care home staff going to do? For example, one of the documents produced by the Royal Pharmaceutical Society, and, again, the National Institute for Health and Care Excellence, about medicine management in care homes—. What about the role of the care home staff? How can we train them about medicine? How can we make them identify that there is an issue? How can we make them think differently about managing this? Jane mentioned pain, but there are other things—constipation. How can we identify those things? Who is the best person to deal with this? You may identify a lead, but, unless you have that consistency and that development, and then expand—. We may start with care homes, but what about hospitals, what about patients' homes?

[113] **Rhun ap Iorwerth**: Sorry to interrupt: can I have the thoughts of you in the RCGP on this idea that perhaps it's community pharmacists in particular who should take the lead when it comes to medicine reviews and care homes, adding, of course, that they say that GPs and others should play a very clear part in implementing that system?

[114] **Dr Balasekeran**: Thank you. I think, having done care homes, there are so many reasons why a patient might be distressed. And so I think the primary role of the GP is as the first port of call when it's been highlighted that a patient is actually quite distressed. They don't know at this point whether it's dementia or otherwise. So, the role of the GP here would then be to establish if the issue is pain, is there an underlying infection, or whether, when everything's been ruled out, and that's what we're meant to be doing as GPs—then, you know, to be pretty certain that it may be a more mental health side of things. At which point, then, I refer to my colleagues. I don't start antipsychotics in care homes. I think it should come from secondary care, because the medications are pretty complex and they have all sorts of effects. So, I would then refer to mental health services, and then, I suppose, they would come and then establish. A lot of times, they are started on medications, but then there are scales and things like that. I think there are very clear guidelines as well on when to start them, if they are a risk to themselves, or if they are a risk to others. And I think there's also a behavioural scale that the care homes are meant to be doing.

[115] And, then, I think after that, the suggestion of a multidisciplinary team, consisting of a pharmacist who is particularly familiar with mental health medications, with a nurse as well—. But I think it should be led—. I don't know what Dr Aziz's view is on this, but it should be really led by a

consultant in mental health, so that you can always go to him. I just think that might be better.

[116] **Rhun ap Iorwerth**: Just one quick one on STOPP START screening. Tell us quickly—I know we're pressed for time—about the importance of that, and whether that actually is utilised as it should be.

[117] **Dr Aziz**: STOPP START is not a psychiatric tool. It was started by a geriatrician but it's for everyone. It simply tells you that this medication is appropriate to prescribe across all systems for that indication; the same medication isn't appropriate to prescribe in that, so you need to stop. So, start when it's appropriate, stop when it's not appropriate. It was never tried in psychiatry. I was the first one to try it. We published about it and it's really effective. We had—. When I did it in hospital, we just had the input of the pharmacists, the ward manager, 'Let's review the patient, let's review the notes, what is it that's prescribed?' Sometimes you have no clue—honestly, no clue—who prescribed the medication, and for how long the patient has been on those medications. No-one knows. Even on the GP record, no-one knows. So, we have no clue why these medications have been prescribed, by whom, and for what symptoms. Like, sometimes, some medication for urine incontinence: some of the medication is to prevent, but the patient is already incontinent. Why is the medication still there? It has some side effects.

[118] And the tool was a very well validated tool that can be used by anyone.

[119] **Rhun ap Iorwerth**: And it's relevant to what we're talking about—

10:45

[120] **Dr Aziz**: It's relevant because it has part of it about—[*Inaudible.*]—or mental health. So, benzodiazepines and antipsychotics—. So, for example, it identified—which is not relevant to psychiatry much, but, because of geriatric—that antipsychotics or benzodiazepines will become inappropriate in more than a month. Of course, our types of patients may need longer, but that needs to be monitored. If you are not doing it, how are you going to monitor it?

[121] **Rhun ap Iorwerth**: Okay. Thank you.

[122] **Dai Lloyd**: More on multidisciplinary working, Caroline.

[123] **Caroline Jones**: Diolch, Chair. Good morning, everyone. I was going to ask about the multidisciplinary teams, a more holistic approach. Speech and language therapists—what do you think their roles would be in this environment?

[124] **Dr Fenton-May**: I think that if we could get speech and language therapists into care homes easily, that would be wonderful, because the waiting time for them is great. Just picking up the point about the pharmacist being in the team, I think pharmacists do a great job, but their kind of medication review is not the same as a doctor would do, and I think we mustn't forget the importance of the holistic care that potentially somebody like a GP can do for a patient, that they can look at the mental health and the physical side of things, and we need to have the wider team—the speech and language therapist, the physiotherapist, the occupational therapists, and the pharmacist and the psychiatrist and the psychiatric nurses. We do have to remember that psychiatric nurses don't know very much about physical health because of the way that they're trained, so they may miss physical things, which are important for our elderly patients who've got lots of problems. So, yes, the multidisciplinary team is really good. It needs to be joined-up, we need to communicate, and we need to know who is pulling everything together and what is that team. The division between social services, private homes, secondary care and general practice needs to be pulled together and we hope, perhaps, that we will go some way in the next year or so in pulling that together, particularly for the elderly.

[125] **Caroline Jones**: So, do you see a distinction between care in a private home and care in a non-private home? Is there any difference?

[126] **Dr Fenton-May**: I think any home has got to—. Most care homes are private, so they are working to the manager's remit. So, if the manager says, 'We can't afford to have that many staff of this grade. We can't afford to have somebody who is trained in using the room, which is a quiet room, where there are stimulating activities for the patient', well, that's what the home decides. As the medical profession, we can only say, 'We don't think this is right'. I have been in homes where all the patients were kept in bed until after lunch. That is not right.

[127] **Caroline Jones**: So, do you think that cost is a barrier to using holistic therapies?

[128] **Dr Fenton-May**: I think probably it is and, unfortunately, the amount

of money that the local authorities—they come into this—can afford to pay for homes is restricted.

[129] **Caroline Jones**: Does anyone else want to come in on that or shall I go on?

[130] **Dr Aziz**: When you speak about speech and language, for example, which part of speech and language? You're always going to listen about swallowing in speech and language; you don't listen about communication or a speech component of it. So, sometimes we talk about the same person, but we're talking about the same person in terms of different things. So, sometimes, a swallowing assessment might be available, but the speech, the communication, which is very much needed, is not available. But also the role of OT, the role of physiotherapy—I think the issue is about complementing each other, working together, because then there will be no barrier because we'll have the same agenda.

[131] **Caroline Jones**: And understanding what the individual needs.

[132] **Dr Aziz**: Yes, that's the most important thing.

[133] **Dr Fenton-May**: And training for the carers as well.

[134] **Dai Lloyd**: Exactly. Right, Caroline, are you done or—?

[135] **Caroline Jones**: I'll go on to the next one now.

[136] **Dai Lloyd**: Right. Go on then.

[137] **Caroline Jones**: We know that GPs feel that there's pressure on them to prescribe antipsychotic medication, from both psychiatrists and staff at care homes. What are your views on this and how can we all work together to address this issue?

[138] **Dr Balasekeran**: I feel that, if you don't have the expertise and the experience in prescribing antipsychotics, then it wouldn't be a very safe thing for a GP to take on.

[139] **Dai Lloyd**: That's fair enough. Jane.

[140] **Dr Fenton-May**: I think some GPs are prepared to prescribe

antipsychotics without—and sometimes they're put on the spot, particularly GPs out of hours, and then sometimes there are questions, 'Why has this patient started it?', and it's difficult to get the patient off the medication. So, from my own personal experience, I used to argue with the psychiatrist not to give the antipsychotics to the patient, and they used to find this quite difficult. I'd say, 'Well, I'm sure there is some other way of managing this patient'.

[141] Particularly, I think of one lady who was living alone and was wandering around the locality. She was well-known in the locality but she was causing little problems. The psychiatrist wanted us to give her antipsychotics and there was no way we were going to give her antipsychotics because she would have got into even more trouble and caused even more—. She used to come into our surgery two or three times every day because she lived across the road. We knew her well. But she just needed more simulation. The one thing she wanted was actually more involvement from her family, and we couldn't control that, but antipsychotics definitely wouldn't help.

[142] **Dr Balasekeran**: I think also, coming from a hospital background with a lot of geriatrics, I think geriatricians really never like antipsychotics or the benzodiazepines, because of the increased risk of falls, which obviously increases co-morbidity and the risk of cardiovascular events like strokes and death and so forth. So, being aware of those risks—in becoming a GP, you're more aware of these things. If the need is really there, I just feel the most skilled person to do that might be a psychiatrist.

[143] **Dai Lloyd**: There we are. Continuing this theme, I think we'll move on to Jayne—alternatives to antipsychotics.

[144] **Jayne Bryant**: Dr Fenton-May, I think you mentioned about perhaps the need for a change of culture and the importance of stimulation to help behavioural problems. What's your view on the current availability of non-drug treatments in care homes?

[145] **Dr Fenton-May**: I think it's very poor. You go into some homes and the patients are all being stimulated by the television, and the only person that's actually following the programme is the carer who's chosen that particular programme because it's something they like to watch. From experience with my own father, he couldn't follow the complicated story on the television but he could follow a conversation. Yes, you might have the

conversation five times over in two hours, but it was stimulation, he was able to respond, he was able to talk, and that calmed him down. He liked doing things like that and doing physical things like going out for walks and enjoying sunny days like today. Those kinds of activities are much better than putting everybody around a television so that they are just quiet and subdued in front of the television and not watching it.

[146] **Jayne Bryant**: Have you got any examples of good practice around Wales where they are stimulating residents in care homes effectively?

[147] **Dr Fenton-May**: I think, in some care homes, they are looking at this and looking at patients' stories and trying to put in more activities. I think it's sometimes better in care homes than in the nursing bits of even the same homes. Sorry, I did retire three years ago, but there was a home that I used to go to occasionally, and, if you went to the care bit of that nursing home, there was always some sort of activity going on. Sometimes, it was a bit noisy and you could see that people didn't really like it, so sometimes it wasn't necessarily appropriate, but you went to the nursing bit and the patients were stuck in their own rooms and they were just there all day with people going in and out and not having those conversations. They could go to a central area but they weren't always encouraged to do that—some of that was due to their own problems with mobility. But some of those were—well, most of them were—demented, as well as the people that were physically seemingly active, who were in there just requiring care rather than nursing. So, I think that we need to do more. There are good examples, as I said.

[148] **Jayne Bryant**: Just thinking about priorities and how we can really make an impact here on reducing inappropriate antipsychotics, what do you think are the main priorities, the things that we should be doing, and who do you think should take responsibility for doing those things?

[149] **Dr Fenton-May**: I think the most important thing is education of the caring and nursing home staff about how to help support some of these patients and changing the culture. Yes, we need to educate the doctors and the nurses. There is a lot of education around these themes for them and we need to change their culture.

[150] **Jayne Bryant**: Are there any other views on that?

[151] **Dr Balasekeran**: I think education is key, I agree with Dr Fenton-May. On a very practical side of things as well, at the care homes, the staff there

are already very stretched. Even in the best care homes where they do the stimulation things—and I've seen that in Newport and I've seen that in the Cwm Taf area as well—then there are some care homes that don't have that. Sometimes, patients might even struggle to get continuous fluids and things like that, let alone stimulation. So, from a very practical side of things, I think a multidisciplinary team with regular reviews just to safety-net everything, from a safety perspective. Then at least somebody is taking responsibility for it. I think, yes, the care homes also have a responsibility. Everybody has a responsibility really. But, if we're talking about proper regulation and just from a safety perspective, perhaps a multidisciplinary team and regular reviews.

[152] **Dr Fenton-May**: Can I say, actually, public awareness is probably really, really important? Sometimes, you're so relieved that a home would take your elderly relative—I speak from my own experience, I was working full-time when my dad was demented and I had difficulty getting respite care when I needed it to do my job. I was so pleased that I found a home that seemed to be reasonable, but on the other hand I didn't like to complain that perhaps the care that they promised wasn't there. So, we need public awareness that they should be complaining and things should be better.

[153] **Dr Aziz**: In my paper, you'll find some recommendations, some priority points. I'm not going to repeat them, but one of the key issues that Jane mentioned is, for example, about care homes, which we see very often from social services. Nowadays there are so many panels for funding, which becomes a big barrier, because it's really not focused on the individual but it's focused on money and funding. I'll give you a typical example of a younger onset dementia patient I have—I had. I discharged her because she's not—for reasons, anyway. She needed a younger onset dementia unit. There are very few in Wales; very, very few. Then, you need top-up. Social services said, 'We cannot afford top-up.' The family couldn't afford top-up. So, that particular patient was discharged to a care home that's not meeting her needs and then you have behavioural problems, you have other problems. You have people prescribing medications and regardless, whether they're antipsychotic, benzodiazepines or other medication, that's really irrelevant here, but, you're not meeting the patient's needs. So, you also need places where they can appropriately meet that patient's need.

[154] I have a particular patient—I always give you some examples—a particular patient who has a very high risk of violence. Actually, he's really dementing, but when he goes he goes, in a second, and he will not

remember. He might kill you, but he will not remember that he's done anything. If you one-to-one him or he's—[*Inaudible.*]—between three and 10 o'clock in the evening, you'll prevent all incidents. You don't need medication. After four months of looking after him in hospital, that's what we decided: he just needs someone to look after him and then you can very easily distract him. You can see him, you don't need much medication. But, then you're faced with, 'Who's funding the one-to-one?' He's a big man, so whatever medication you prescribe, an antipsychotic or whatever might not touch him much, and then he becomes drowsy, falls on me or falls on the other person.

11:00

[155] So, I think the priority is about the individual—the individual as a whole individual—not just antipsychotics, not benzodiazepines and not mood stabilizers. It's about everything, including antidiabetic medication. So, it's about that individual. That's our priority.

[156] **Dai Lloyd**: Okay, moving on to the last two questions now—Dawn first and then Julie.

[157] **Dawn Bowden**: Thank you, Chair. I just want to come back on that because, Dr Aziz, you started to allude to this, I think, earlier, about whether there are similar inappropriate uses of these drugs in non-residential care settings, whether it's in hospital or whether it's in the home. Can you perhaps expand on that a little bit and express your concerns about that?

[158] **Dr Aziz**: I think the concern is—. What I'm talking about all of the time is about appropriateness, not inappropriateness. If I prescribe medication like the STOPP START, it's appropriate to prescribe for that patient. It might be the first thing that you need—that's really, really needed. For someone who's really aggressive, someone violent or someone at risk of self-harm, I need that; that's very, very appropriate. Because I'm keeping an eye on that individual, I'm reviewing it, that's very, very appropriate. But, if I have no indication—. Sometimes, I see patients being prescribed antipsychotics or any medication, and I think, 'Is the patient psychotic? No. Is the patient really in severe distress? No. Is the patient really aggressive? No. So, why are you prescribing this?'

[159] Sometimes, I had incidents—I'm not going to say that it was from primary or secondary care—where medication was being prescribed over the

phone without really seeing that individual. Sometimes, we'll have calls from the care homes, rather than from the GP, saying, 'We've got this; what can we do?' The first thing you think about is, 'Okay, as a community mental health team, we want to prevent admission,' but, however it might be, that patient really needs admission, because something else is going on.

[160] **Dawn Bowden**: How would you manage that in a person's home?

[161] **Dr Aziz**: In the person's home—. When I was talking about that multidisciplinary—. One of the papers I'm giving you today—again, I haven't read it all—but it's very close to my heart, because we have crisis teams everywhere. That paper from the UK said, 'Crisis teams aren't doing much for elderly people with dementia; they don't prevent admission and they don't really do much.' Why are we spending more money on crisis teams while taking some resources from community mental health teams? Community psychiatric nurses are overloaded with those patients everywhere—at home, in care homes and from hospital discharges.

[162] This is why I'm saying that the resources are there: you have the at-home care, for example, with geriatrics. So, you need that team to look at the community. If you have that team working together—physical, mental and social health—actually it doesn't matter. You may try it at a care home first, but, no matter what, care homes are going to be limited in numbers—I have, in my area, about 10. What about all of those patients? Why can't we provide the same at home? With the GPs now, a lot of GP surgeries have practice nurses, nurse specialists and nurse prescribers, and they've appointed pharmacists now. The role of the community pharmacist—. For example, if I'm prescribing medication and it goes to a community pharmacist, where is that alert, saying, 'Oh, it doesn't add up; they are interacting together. Who am I going to alert about this?' or, 'Actually, that's above the recommendation—who's going to alert them about this?' When you have that multidisciplinary approach, it's not just about care homes; it's really about community care. So, it's about spreading the message. You start somewhere and bring people together—'How can we spread that message?' Then, you'll have a team. Really, you'll have one team looking after patients in the community, because, in a way, that team means everyone—it means all of us.

[163] **Dawn Bowden**: Has anybody got any—? I think, probably, I'm trying to get my head around how this can be managed effectively. If you're trying to keep somebody out of hospital, and there isn't a place for them in the residential care home—

[164] **Dr Aziz**: —or in the hospital—

[165] **Dawn Bowden**: —or in the hospital, and they have to stay at home, does it become too easy just to prescribe an antipsychotic because it's easier to manage somebody in that situation?

[166] **Dr Aziz**: True, but this is why I'm talking about all of that. There are virtual teams, or virtual wards, prescribing antibiotics or prescribing fluids. You want that team to be together. You want that district nurse to be able to be part of that team. So, you have the elements, but you're just re-joining the elements. We have patients being monitored for international normalised ratio, for lithium, at home by district nurses. What if we develop something else? Whom can we alert? To whom can we have quick access? But if you are just waiting for a normal system and being put on the waiting list, you're not going to be seen until the situation's really, really worse. How quick—? That team, because they are working together, can go, 'Let's look at it from all aspects and sort it out.' Out—one person can keep an eye on that patient who, if needed, can come in. So, in and out, in and out, and then we are not exhausting our resources.

[167] **Dai Lloyd**: Dr Balasekeran.

[168] **Dr Balasekeran**: Can I just add that having a virtual team sounds excellent? They do this in other parts of the country, in England, in the north, where they have virtual teams for geriatrics. I'm not sure if that's happening with old-age psychiatry. So, essentially, it's a community-based team and it's consultant-led, and works very well.

[169] **Dai Lloyd**: Okay. Lynne, you had a supplementary here.

[170] **Lynne Neagle**: The virtual team sounds fantastic. I'm trying to visualise it actually happening, because, in reality, what you're going to have is a carer at home most of the time with someone with dementia, and it's one thing, giving them the drug, but how do you prevent that being prescribed at home, because that carer has to cope around the clock with those challenges? With the best will in the world, you're never going to get this virtual team providing that level of support that's needed.

[171] **Dai Lloyd**: Okay. Julie, last question.

[172] **Julie Morgan**: It was interesting listening to Dr Aziz earlier on, talking about how people should work. It just seemed to me what you're talking about is good practice, which is for every type of issue and every person, and that seems to be the message, really.

[173] **Dr Aziz**: Yes, it is the message. It's all our problem. It doesn't really matter if you are in geriatric medicine, if you are in palliative medicine. It doesn't really matter. It's identifying the problem and getting that help, because it involves all of us. You may start with antipsychotics, but then you'll have benzodiazepines, you'll have other medication, you'll have pain relief, and you have the patient who is in hospital with a very high risk of falling. He's on loads of pain relief, really loads of pain relief. It doesn't require an antipsychotic or anything because he's on loads of pain relief, and he's still in pain. How far can you go in that? But it's then looking at that individual. Is it really appropriate for him to be on our ward? We say 'no', because, actually, he needs proper, physical healthcare, rather than psychiatric care. So, he's inappropriately placed with us because we are not addressing his physical health needs.

[174] **Julie Morgan**: My last question, really, was to ask about what has happened in England with the English dementia strategy. I don't know whether you've got information about this, but we've been told that there hasn't been much development in reducing the use of these drugs, even though that was one of the aims. I don't know whether you have any information about this.

[175] **Dai Lloyd**: Dr Aziz has probably got a paper on it. [*Laughter.*]

[176] **Dr Aziz**: Yes, I did. I did. [*Laughter.*] Sorry, I'm prepared this time. Sorry. Actually, there has been research in England following the dementia strategy, and there was not much change. The reference is here in my evidence, but it didn't really make much difference.

[177] **Julie Morgan**: So, do you think we can do better here, then?

[178] **Dr Aziz**: I'll come back to what I said the last two times: we are a small country, we can do a lot if we are working together.

[179] **Dai Lloyd**: Good. Any closing remarks, Dr Balasekeran?

[180] **Dr Fenton-May**: Sorry, can I just say—? I think that we still have a

problem that we probably aren't diagnosing enough people with dementia early enough, because both the GPs and the public and the patients are not happy to have a diagnosis of dementia when there doesn't appear to be some of the care support for them when they have the diagnosis. So, a lot of GPs are reluctant to label people as 'dementia' until they are quite well-advanced in the condition.

[181] **Julie Morgan**: And I think there is a resistance in families as well.

[182] **Dr Fenton-May**: And there is resistance in families because you don't want that label, and it limits the sum of the support that you can get. If somebody's got physical problems, if they then get dementia, they may be excluded from some of the physical support.

[183] **Dai Lloyd**: Indeed. Final word, Dr Balasekeran.

[184] **Dr Balasekeran**: I was just thinking, if England hasn't done it yet, I don't see why Wales can't start the first multidisciplinary team, and then we could be used as an example for other services elsewhere.

[185] **Dai Lloyd**: Excellent. That brings the questioning to an end.

[186] Diolch yn fawr iawn i chi am eich presenoldeb. Diolch yn fawr iawn am y dystiolaeth ysgrifenedig ymlaen llaw. Diolch yn fawr iawn i chi am fod yma. Croeso arbennig i Dr Balasekeran. Diolch yn fawr iawn i chi am eich presenoldeb ac am ateb y cwestiynau mewn ffordd mor aeddfed a graenus. Fe fyddwch chi, yn ôl ein harfer, yn derbyn trawsgrifiad o'r drafodaeth yma i chi wirio ei fod yn ffeithiol gywir, ond gyda hynny o ragymadrodd, a allaf i ddiolch i'r tri ohonoch chi unwaith eto? Diolch yn fawr. I'm cyd-Aelodau, fe fyddwn ni'n torri am egwyl fer cyn y sesiwn nesaf—pum munud, nôl am 11:15. Diolch yn fawr.

Thank you very much for your attendance. Thank you very much for the written evidence we received beforehand, and thank you very much for being here. A particular welcome to Dr Balasekeran. Thank you very much for your presence and for answering the questions in such a mature and excellent way. As is our custom, you will receive a transcript of the discussion this morning for you to check for factual accuracy. Having said that, may I thank all three of you once again? Thank you. To my fellow Members, we will break briefly for about five minutes before the next session at 11:15. Thank you.

Gohiriwyd y cyfarfod rhwng 11:11 ac 11:16.
The meeting adjourned between 11:11 and 11:16.

Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal—Sesiwn Dystiolaeth 6—y Coleg Nyrsio Brenhinol
Use of Antipsychotic Medication in Care Homes—Evidence Session 6—Royal College of Nursing

[187] **Dai Lloyd**: Croeso nôl i sesiwn ddiweddaraf y cyfarfod yma o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Rydym ni'n symud ymlaen i eitem 4, a pharhad efo'n ymchwiliad i'r defnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal. Sesiwn dystiolaeth rhif 8 sydd o'n blaenau. Mae'n bleser i gyfarch Alison Davies, cyfarwyddwr cyswllt ymarfer proffesiynol Coleg Nyrsio Brenhinol Cymru, a hefyd Helen Bennett, nyrs iechyd meddwl ac ymgynghorydd iechyd meddwl, Coleg Nyrsio Brenhinol Cymru. Rydym ni wedi derbyn tystiolaeth ysgrifenedig ymlaen llaw, felly, yn ôl ein harfer, awn ni'n syth i mewn i gwestiynau ar y dystiolaeth. Fel rydw i'n dweud, hwn ydy sesiwn dystiolaeth rhif 8. Mae Aelodau felly'n dra arbenigol ar y pwnc erbyn nawr, felly, gyda chymaint â hynny o ragymadrodd, Rhun.

Dai Lloyd: Welcome back to the latest session of this meeting of the Health, Social Care and Sport Committee here at the National Assembly for Wales. We move on to item 4 and continue with our inquiry into the use of antipsychotic medication in care homes. This is evidence session No. 8, and it's a pleasure to welcome Alison Davies, associate director for professional practice at the Royal College of Nursing Wales, and also Helen Bennett, mental health nurse and mental health consultant, Royal College of Nursing Wales. We have received your written evidence beforehand, therefore, as usual, we'll go straight into questions on the evidence. As I said, this is evidence session No. 8. Members, therefore, have quite an expertise in this subject, so, with those few words of introduction, Rhun.

[188] **Rhun ap Iorwerth**: Diolch yn fawr iawn i chi. Mae fy nghwestiwn i, i ddechrau efo hi, yn eithaf syml: beth mae eich aelodau chi yn ei ddweud wrthych chi am orddefnydd meddyginiaethau gwrthseicotig?

Rhun ap Iorwerth: Thank you very much. To begin with, my question is quite simple: what do your members tell you about the overuse of antipsychotic drugs?

[189] **Ms A. Davies**: Bore da, diolch.

Ms A. Davies: Good morning, thanks.

[190] Thank you very much for this opportunity to give evidence. We've heard a lot about nursing this morning, and we're very pleased to be here as the Royal College of Nursing to explore some of that. As you may or may not know, our membership in the Royal College of Nursing covers the NHS and the independent sectors, and it includes nurses and healthcare support workers. Hence, we have a proactive and a reactive engagement with our members around this issue, the issue of working in care homes and quality of care. We engage in different ways, partly through our trade union arm and partly through our professional body arm, and our members tell us they are concerned about the quality of care that they're able to provide to people who live in care homes. And, of course, part of that is the use of antipsychotic medications and the opportunity to review and help provide the right level of care. We know this is the case because there are real concerns about the levels and types of staffing in care homes.

[191] You may be aware of a recent report the RCN has published, 'Safe and Effective Staffing: Nursing Against the Odds.' Some of that information was generated by healthcare support workers and nurses in care homes, and we're doing another bit of work around that, which we'll make available in due course. We know that the workforce profile in the care home sector is not always helpful to enabling that workforce to be properly educated, trained, skilled, and to have enough time to care for people appropriately. Our members have got growing concerns, as have we, around recruitment and retention within that setting, and, as somebody previously mentioned, where there is an opportunity to provide education and learning to assist people in managing people with complex needs in care homes, then the turnover in that staff group makes that something that's an ongoing and continual process.

[192] One of our challenges is that we've got no national data set on the care home sector workforce in Wales. So, although we have feedback from our members regularly around that—and I'm sure all of us around this table are aware of the need to secure that workforce—we haven't got any formal database to share with you or with us to make that discussion more alive, really.

[193] **Rhun ap Iorwerth**: Cwestiwn arall, ac nid wyf i'n gwybod a oes yna

Rhun ap Iorwerth: I have another question, but I don't know whether

ateb iddo fe, mewn ffordd, ond rydym ni'n clywed bod meddyginiaethau gwrthseicotig yn cael eu defnyddio er mwyn ei gwneud hi'n haws i edrych ar ôl rhywun sydd, o bosib, yn cael ei ystyried i fod yn anodd. A ydy'ch aelodau chi'n dweud rhywbeth wrthych chi ynglŷn â, 'Ie, mae hyn yn haws, yn aml iawn, os ydy person yn cael ei gadw'n dawel', neu a ydyn nhw'n fwy pryderus ynglŷn â'r ffaith nad yw'r person yna'n cael y gofal cywir oherwydd camddefnydd o feddyginiaethau?

there is an answer to it, really, but we hear that antipsychotic drugs are used in order to make it easier to look after someone who may possibly be considered difficult. Are your members telling you something about, 'Yes, this makes it easier, in many respects, if a person is kept quiet', or are they more concerned about the fact that that person is not receiving the right care because of the misuse of antipsychotics?

[194] **Ms Bennett**: There are a number of reasons why that might be the case, and members would be saying that there is a lack of time, there is a lack of skill within that workforce and you may only have one qualified member of staff; the rest would be healthcare support workers. And, the environments of care, often, aren't appropriate. You have a large mix of individuals. So, the individuals with mental health issues and behavioural problems may well be taking up an awful lot of time so that the other individuals don't get the appropriate care. So, that's what members are saying—that antipsychotics are often used to control behaviour rather than being in an appropriate environment.

[195] **Ms A. Davies**: I think time to care is fundamental in this, and time to provide person-centred care. We know that's where quality is and I know there's been reference previously this morning to the importance of keeping that person in the centre of what we do. It isn't essentially about which professional should lead; it's about what those needs are and who is best positioned to meet those needs.

[196] I think when you look at what time is needed for in care homes, you're looking at the need for robust assessment and review of that assessment, which includes the use of medication and other needs for care. We're also looking at care as fundamental as assisting people with nutrition, hydration and making sure people's pain and mobility are considered, as well as trying to enable the highest level of emotional and mental health and well-being. That agenda is enormous, and the time is so important—the resource to provide that.

[197] **Ms Bennett**: For individuals with dementia, they can't express verbally how they're feeling, and it's often understood, and their behaviours are viewed, as problematic and challenging, rather than an expression of unmet need. And if you haven't got the level of skill to understand that, then that's quite hard to manage.

[198] **Ms A. Davies**: There are two components that are worth linking into that, if I can, committee members. One is around the need to be able to accurately identify the level of need of people in care homes. We've got no national tool or measurement that helps us understand that. We need that to understand what level and type of staff we need to care for people there. That'll help us inform: meeting people's needs, providing quality of care and workforce planning for the future.

[199] Secondly: phase 2 of the Regulation and Inspection of Social Care (Wales) Act 2016. We really need to get that right. The implementation of phase 2 is going to be crucial for the quality of care given to people who are residing in care homes, particularly where that's with a nursing requirement attached to it. Those two are fundamental components. We've got some opportunity around the Nurse Staffing Levels (Wales) Act 2016 in terms of the requirements of health boards to commission appropriately. And I think we need to start to link these things together to understand how we can best meet these needs in Wales.

[200] **Rhun ap Iorwerth**: Ocê, diolch. **Rhun ap Iorwerth**: Okay, thank you.

[201] **Dai Lloyd**: Jayne nesaf. **Dai Lloyd**: Jayne next.

[202] **Jayne Bryant**: Thank you, Chair. You've mentioned already about concerning members around workforce issues, and also, Alison, you mentioned that it's really important that what matters is the needs of the individual rather than who is leading things. But, just in terms of the medicines monitoring and reviews, there's been some evidence to suggest that nurses should be the ones leading on this. What's your view on that and do you think that nurses would be willing and practically able to do that?

[203] **Ms Bennett**: Nurses do have the skills to do that, but I think it's what is right for the individual. So, working with community pharmacists actually gives nurses more confidence in recognising what they should be questioning, really, on the use of antipsychotics. It's about working together

with community pharmacists to provide the best for the individual.

[204] **Ms A. Davies**: So, part of the thing to think about in terms of what you suggested is, I think, that registered nurses do have quite an extensive skill set and knowledge base and medication reviews could fit into that. Nursing within care homes and more widely is a finite resource. So, we're here talking about nursing in care homes today. We could just as easily be talking about—we were, previously—nurses in primary care, community care; nurses in acute settings; nursing across the spectrum. So, we need to think how we best use that finite resource or expand that resource to be able to meet need appropriately, the answer being, I think, that, if we're looking at patient-centred care, then the lead clinician for that person's care might be a nurse, particularly an advanced nurse practitioner; it might be a GP; it might be a psychiatrist; it might be a community pharmacist. It's about who's best placed to meet that person's needs.

[205] **Ms Bennett**: This could be supported. Mental health liaison nurses—there are some areas where they do work in care homes and help manage behaviours, rather than using medication. So, that's a way forward really, but it's not everywhere.

[206] **Ms A. Davies**: The other component, I think, for older people with dementia is that it isn't that often that their only need, their single need, is around dementia. There are often comorbidities that exist and many other health concerns, so I think the needs and complexity of that patient should denote who leads that review.

[207] **Dai Lloyd**: Lynne Neagle.

[208] **Lynne Neagle**: I think that you've answered some of my questions about the reasons why antipsychotics are prescribed, and you've also referred to the Time to Care campaign. It's a no-brainer, isn't it, really? Nurses have got to have time to do the job. Can I just ask you about the skill mix in care homes? I've got experience of there being difficulties with managing challenging behaviour because of the ratio of care assistants to registered mental health nurses who have got that level of expertise to actually work with people with complex needs. Can you offer the committee any insight into that?

[209] **Ms A. Davies**: I think I mentioned previously the need for a nationally recognised means by which we can properly identify and therefore address

the level of need for people being cared for in care homes. We don't have that at the moment. There isn't a tool across the UK that I'm aware of that's used nationally. There are different pockets of research and small bits of anecdotal evidence that we can use, but it is a real key work stream for us in Wales.

[210] Just as we've got the evidence base to inform the nurse staffing levels in acute, general and surgical settings, we really need one for care homes because we know that people who live in care homes, their needs are complex. They're the type of people who used to be cared for in community hospitals, even five years ago. So, we know there's a level of need there. When we know what that level of need is then we can look at what we need in terms of the skill mix around registered nurses and healthcare support workers. Both bring an equally valuable offer to the table in terms of safe care, because that's our overarching aim: safe, quality care. That's what our members want; I would imagine that's what we all want.

[211] Registered nurses bring that level of assessment, evaluation, review, revision, as well as being able to provide nursing care, obviously. And with that knowledge comes safe delegation. So, we need to make sure that what we ask our healthcare support workers to do is right and proper for them, obviously provides a quality service and, as a nursing team, that that person's needs are managed appropriately.

[212] **Lynne Neagle**: Thank you.

[213] **Dai Lloyd**: Caroline.

[214] **Caroline Jones**: Diolch, Chair. Could you tell me please what the current situation is regarding access in care homes to, for example, speech and language therapists and other allied health professionals? Does this access differ in various parts of Wales for any reason? Thank you.

11:30

[215] **Ms Bennett**: It does differ and, again, it comes back to the way that services might be commissioned, and also the thought behind who you need within a team within a care home. So, some care homes actually have quite good multidisciplinary teams and employ OTs or physios, but access to speech and language therapy is quite hard. There is a lack of speech and language therapy. But, again, as I say, it's around the commissioning,

understanding what you need for that environment of care. But having OTs, physios, speech and language can make a big difference to the way that a care home and the environment might work, and also having good dietetic support as well for people in advanced stages of dementia.

[216] **Caroline Jones**: And understanding the individual needs—

[217] **Ms Bennett**: Definitely, yes—

[218] **Caroline Jones**: —of the patient and planning accordingly.

[219] **Ms Bennett**: Yes, so they would feed into the multidisciplinary team and have a really holistic approach for each individual.

[220] **Caroline Jones**: Thank you. Did you have anything to say on that before I move on to the next question?

[221] **Ms A. Davies**: Thank you, no. I think that was fine, thank you.

[222] **Caroline Jones**: We've had written evidence from the Welsh NHS Confederation stating that GPs and clinicians are under pressure to prescribe antipsychotic medicine. What we're asking is: do you think there is, perhaps, a lack of understanding among care home staff, nursing staff, about dementia? How can this be addressed, using a whole approach, involving everyone, with communication between teams, and training, obviously, of the staff to understand?

[223] **Ms Bennett**: As was mentioned previously, some care homes have an allocated GP who gets to know those individuals within care homes. But that's not the same across Wales—

[224] **Caroline Jones**: So, do you think there's pressure on GPs to prescribe antipsychotic—

[225] **Ms Bennett**: Around environments of care, I think, as I said, the mix of individuals within environments can actually cause a lack of understanding. A lack of training may well lead to the prescribing of antipsychotic medication, but I think it's asking the question about what we want GPs to do within those environments and being very clear what we want them to do.

[226] **Caroline Jones**: Because understanding dementia is such a specialist

area that we need the right people and the right teams in the right places. So, what do you suggest regarding the training of care home staff regarding dementia?

[227] **Ms A. Davies**: You are right, one component of understanding and, certainly, diagnosing dementia is specialist and complex, but I think understanding what brings quality of life to a person with dementia probably isn't that complex. There are really good examples, which I can share a bit later, that are well established in Wales and in other areas. I think, having spoken to a healthcare support worker very recently myself, who works in a care home, a young, dynamic person who said, basically, 'If only I had time to care. If I only had time to listen.' Sometimes, it's as simple as that. So, I think in terms of education, training and learning, there's a whole spectrum, depending on what we're expecting, but to care sensitively for someone with dementia, I think, would be in all our capabilities; it's about the time.

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

[229] **Dai Lloyd**: Following on from that, Dawn.

[230] **Dawn Bowden**: I was just wondering if you could—good morning, both, by the way. I was just wondering if I could ask you a bit about the availability of alternative non-drug treatments. We saw from the previous evidence that we had, there was some very good practice in a particular care home in Cwm Taf, you might be aware of, in Tonyrefail. They do stuff around reminiscence, music therapy and doll therapy, whatever that might be. So, I was just wondering if you've got any experience of those kinds of non-drug alternatives, and perhaps you could tell us a bit about it.

[231] **Ms A. Davies**: Well, I think there are a couple of examples of good practice, Dawn. You might be aware of the RCN Wales Nurse of the Year awards that take place—due next month in fact. But, in 2016, we had two really good examples of caring sensitively for people with dementia. So, one, again, was in Cwm Taf health board, but in a mental health ward setting, which was about creating a dementia-friendly environment. These changes are about the environment of care, so enabling people to wake up and get dressed when they want to, having an environment that's more homely, having objects around that enable reminiscence therapy, using music, using dance, using things like bingo and other activities that people recall and are familiar with. There are a whole range of relatively straightforward interventions that can be made. It's sometimes challenging to fit in with

other requirements of being in a hospital or other care setting, but can be relatively straightforward and make an enormous difference. We know that some of the changes were brought into a ward by a healthcare support worker in Abertawe Bro Morgannwg, which was, again, a focus of our awards last year. Both projects have shown a reduction in falls, a reduction in anxiety and other behavioural representations, so that they can—

[232] **Dawn Bowden**: I think that they were doing something in Prince Charles—sorry, Chair—as well with a dementia wall, like a screen that they'd bring into A&E for dementia patients, and something to do with the floors as well, so that the colours were colour coded. But this isn't being done routinely, is it, this type of non-drug intervention?

[233] **Ms A. Davies**: It's difficult for me to comment on the routine nature of it; I can only comment on my personal experience of previously being involved in the commissioning of a new community hospital environment, and that was certainly something that was built into that planning.

[234] **Dawn Bowden**: And your members are telling you where this is happening, that it's a positive move and that it actually gets the outcomes that are needed.

[235] **Ms A. Davies**: Where there are changes introduced, good practice means audit is undertaken to evaluate those changes, or research, of course. And in both of the nurse of the year award winners' applications were references to the positive changes: a reduction in falls; better uptake of nutrition and hydration; and a more settled emotional and mental health environment for people to be cared in.

[236] **Dawn Bowden**: Okay. Thank you, Chair.

[237] **Dai Lloyd**: Cwestiwn olaf gan Julie.

Dai Lloyd: Final question from Julie.

[238] **Julie Morgan**: Diolch. We've heard quite a lot of the good practice that can go on, and you've just discussed with Dawn about how routine this is. What would you say is the priority action that would lead to a reduction in the use of antipsychotic drugs and better care?

[239] **Ms Bennett**: I think members would want—. It's looking at the environments of care, using non-pharmacological techniques before the use

of antipsychotics; the correct commissioning of environments as well, so staffing levels, the right skill mix of staff and a proper multidisciplinary team for holistic care for individuals, and reaching, obviously, staffing and workforce planning, so the data sets, so we've got a clear idea of what's happening within the care home sector; but, the importance of using the non-drug alternatives first, as the first line, rather than going straight into using antipsychotics; and GP training as well, and training for the care home staff.

[240] **Ms A. Davies**: Can I just add a couple to that, please, to reiterate, probably? Understanding the workforce profile and what we need is a must if we're going to get this right across the spectrum, so we need to understand what we've got in Wales and what we need in Wales. We need to make phase 2 of the Regulation and Inspection of Social Care (Wales) Act 2016 fit and work well within that. We do have some concerns about that juncture. We need to make sure that staff in care homes have appropriate access to education, training and learning. We know that where they're short-staffed and there's a high turnover, people don't get that access. So, to pick up on your point that you made around preparation of staff and making sure that they can be well placed, that's a key aspect. We need to have some way of identifying the level of need for people in care homes.

[241] **Ms Bennett**: And closer liaison with mental health—

[242] **Julie Morgan**: Who's going to make all this happen? Who do you see as being the lead in all this?

[243] **Ms A. Davies**: It's about having a commitment at a national level to look at this and actually address this need appropriately with all partners involved. I think it's about resource and understanding where that resource might be best placed in the system to meet need.

[244] **Julie Morgan**: Thank you. And then a final question about the dementia strategy in England. I don't know whether you have any information about this in your—

[245] **Ms Bennett**: I don't I'm afraid.

[246] **Julie Morgan**: You don't, no. Do you have any information? It was just we've been told that they had a strategy that was trying to reduce the use of antipsychotic drugs and it hadn't worked. I just wondered if you knew

anything about that.

[247] **Ms A. Davies**: I guess my offer would be, from listening to what's been tabled today, and looking at previous evidence, the issue is multifaceted. So, it's about identifying where those key bits that can be worked on are that would really make a difference.

[248] **Julie Morgan**: And that's what we should do in Wales.

[249] **Ms A. Davies**: I guess so.

[250] **Julie Morgan**: Thank you.

[251] **Dai Lloyd**: Grêt, diolch yn fawr. Dyna ddiwedd y cwestiynau, felly dyma ddiwedd y sesiwn arbennig yma. A allaf ddiolch yn fawr iawn i'n tystion ni, i Alison Davies, ac i Helen Bennett? Diolch yn fawr iawn am y papur a gafodd ei gyflwyno ymlaen llaw, a hefyd am eich presenoldeb a'ch tystiolaeth ar lafar. Diolch yn fawr iawn i chi. Mi wnewch chi dderbyn trawsgrifiad o'r trafodaethau yma, i wneud yn siŵr eu bod nhw'n gywir—ffeithiol gywir, ta beth. Felly, diolch yn fawr iawn i chi unwaith eto. Ac a gaf gyhoeddi i'm cyd-Aelodau y cawn ni doriad byr nawr am bum munud, a dod nôl am 11:45?

Dai Lloyd: Great, thank you very much. That brings us to the end of our questions and this particular session. May I thank our witnesses very much, Alison Davies and Helen Bennett? Thank you for the paper that was presented beforehand, and thank you also for your attendance and your oral evidence. Thank you very much. You will receive a transcript of these discussions to make sure that they are factually accurate. And thank you once again. May I inform my fellow Members that we'll have a brief break of five minutes and we'll return at 11:45?

[252] **Ms A. Davies**: Diolch.

Gohiriwyd y cyfarfod rhwng 11:40 a 11:45.
The meeting adjourned between 11:40 and 11:45.

Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal—Sesiwn Dystiolaeth 7—y Gymdeithas Fferyllol Frenhinol a Fferylliaeth Gymunedol Cymru
Use of Antipsychotic Medication in Care Homes—Evidence Session 7—Royal Pharmaceutical Society and Community Pharmacy Wales

[253] **Dai Lloyd**: Croeso nôl i bawb i'r adran ddiweddaraf o Bwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Rydym ni'n symud ymlaen i eitem 5 ar yr agenda rŵan a pharhad efo'r ymchwiliad i'r defnydd o fethyginiaeith wrthseicotig mewn cartrefi gofal. Hon ydy sesiwn dystiolaeth rhif 7 ac, o'n blaenau, mae'r Gymdeithas Fferyllol Frenhinol a Fferylliaeth Gymunedol Cymru. Croeso i'r pedwar ohonoch chi yn benodol. Mae gyda ni Mair Davies, o Gymdeithas Fferyllol Frenhinol Cymru, Wendy Davies, o Gymdeithas Fferyllol Frenhinol Cymru, a Steve Simmonds o Fferylliaeth Gymunedol Cymru, a Samantha Fisher o Fferylliaeth Gymunedol Cymru.

Dai Lloyd: Welcome back everybody to the latest section of this meeting of the Health, Social Care and Sport Committee at the National Assembly for Wales. We move on to item 5 on the agenda now and the continuation of our inquiry into the use of antipsychotic medication in care homes. This is evidence session No. 7 and, before us, we have the Royal Pharmaceutical Society and Community Pharmacy Wales. Welcome to the four of you specifically. We have Mair Davies of the Royal Pharmaceutical Society Wales, Wendy Davies, the Royal Pharmaceutical Society Wales, and Steve Simmonds, Community Pharmacy Wales, and Samantha Fisher from Community Pharmacy Wales.

[254] Croeso i'r pedwar ohonoch chi. Rydym ni wedi derbyn tystiolaeth ysgrifenedig ymlaen llaw ac, yn seiliedig ar hynny, mae Aelodau wedi'i ddarllen mewn cryn fanylder. Mae yna nifer fawr o gwestiynau mewn amser cyfyngedig, felly bydd angen cwestiynau cryno ac, os gallem ni, atebion cryno, ac nid oes yn rhaid i'r pedwar ohonoch chi ateb bob cwestiwn—fe allaf i ddweud hynny ymlaen llaw. I ddechrau, Dawn

Welcome to the four of you. We have received written evidence beforehand and, based on that, Members have read it in great detail. There are quite a number of questions in a short period of time, so there'll be a need for brief questions and if we could have brief answers as well, and the four of you don't have to answer every question—I can say that now. So, to start, Dawn Bowden.

Bowden.

[255] **Ms M. Davies**: Sorry, but my colleague can't hear the translation.

[256] **Dai Lloyd**: Reit. Wel, mae'n rhaid inni ddatrys hynny.	**Dai Lloyd**: Right. Well, we must solve that.
[257] **Ms W. Davies**: Mae'n ddrwg gen i.	**Ms W. Davies**: I apologise.
[258] **Dai Lloyd**: Popeth yn iawn.	**Dai Lloyd**: Everything's okay.

[259] However, that won't hold Dawn back.

[260] **Dawn Bowden**: No, absolutely not. Thank you, Chair. Good morning everyone. Can I just ask you about your views on non-pharmacological treatment options? I think you've all said in the evidence that this should be the first port of call when people are exhibiting challenging behaviour, but what's your experience of the current reality of that?

[261] **Ms W. Davies**: Yes, I think that non-pharmacological methods should be used first line. I always, when I come to things like this, say that I'm a pharmacist, but, actually, I don't believe that drugs are the answer to everything. So, I think that the non-pharmacological methods are really important. I think the most important thing, actually, in using those is actually knowing what the patient needs. We've got this booklet called 'This is me', and that, when people come into hospital, tells a little bit about them before they had their illness and what they liked doing and that sort of thing, and I think it's important to know that. We were just chatting about examples of that. There was somebody who, in the hospital I work in, had developed dementia but was a pharmacist and kept wanting to go and see the drugs trolley, because, in their profession, that's what they would have done—to check the drugs. Obviously, it was seen as interfering, but, actually, in terms of that person, because they were going back to their earlier memories—. So, rather than actually using medication in situations like that, we actually gave them some bottles and Smarties and things so that they could label, so they could channel that energy in a positive way. So, I think there are lots of things like that that should be done before we go down the pharmacological route.

[262] **Dawn Bowden**: Thank you for that. We have heard some examples of

good practice where different types of therapies are used—music therapies and so on. Have you got specific examples that you're aware of in Wales? Is it very common or is it something that we ought to be doing more of and pushing it more?

[263] **Ms W. Davies**: I think, certainly within the hospital setting, they try to do it as much as they can. Obviously, I work in the hospital sector, so I and my staff are much more involved with people who've just come into the assessment wards and then are on the treatment wards rather than being in the care homes, as such. Having said that, though, I have got a couple of members of staff who are non-medical prescribers, who actually work within care homes, doing care home liaison and looking at antipsychotics and other ways of dealing with the BPSD, the behavioural and psychological symptoms of depression.

[264] I think, as well as non-pharmacological, it's just not looking at the antipsychotics, because I think it's really important to look at the person as a whole. So, it's important to look at what is pushing that behaviour, what's generating that behaviour, whether it's that they want to do something that they feel frustrated and they can't do. But it's also important to look at their physical state, because it's often things like if they are in pain and they can't articulate that very well. It's really important to be able to assess that and put them on painkillers, paracetamol. If they're constipated, if they've got a urinary tract infection, all things like that, if they've got low sodium because of some of the other meds they might be on: it's really important to look at all those things to look at why they're presenting in the way they are rather than saying, 'This needs an antipsychotic'. So, it's taking that step back to look at the person as a whole.

[265] I know we're here to talk about antipsychotic prescribing, but I think it's also important to look at the other burden of medication that they're on. There's something called the anticholinergic burden, which is having a lot of drugs that a lot of elderly people are on, because they get urinary frequency, they need to go to the loo a lot, so you put them on something to stop that, and a lot of these medications can actually reduce cognition, so they can make the dementia worse.

[266] So, I think it's about looking at what they're on, looking at whether it's appropriate, looking at their physical state, looking at that non-pharmacological and then, if it is felt appropriate, the use of an antipsychotic, and I would say that—

[267] **Dawn Bowden**: It's the last resort.

[268] **Ms W. Davies**: As a last resort—but I think sometimes it is important at that moment in time. The important thing is whether it's appropriate then and whether it's reviewed. Those are the two important things.

[269] **Dawn Bowden**: Which is the next point I was going to make. Does anybody want to say anything else on that, because I wanted to come on to that?

[270] **Ms M. Davies**: Yes. I think one of things that we've noticed, looking at the responses to date, is that most of us are calling for the same things. Certainly, when somebody changes where they live, for instance—they're going into a home for the first time—there's a need for a full assessment. That needs to be a holistic assessment. Obviously, we talk about the medication part of that, but we would also enforce the need for using 'This is me'—what is the first thing we need to do, and this person is only moving home.

[271] I think the work of the older people's commissioner really needs to be listened to here. It is moving into a new home. So, medication review is very important as part of this, but it's part of the whole picture, and what is that home offering? You asked for examples of good practice—I don't know, I'm not aware of whether this whole holistic approach is taken, but I would certainly enforce that that's what it needs to be when they first move in.

[272] **Dawn Bowden**: Okay, fine. My second question is actually just to deal with that issue of medicines review and how effective you think it is—again, we're talking specifically in the residential care sector—how effective you think that is at the moment, from your experience and knowledge, and whether you feel that this should be led by pharmacists or other clinicians—you know, how you feel is the best way of dealing with that.

[273] **Ms M. Davies**: I've got a lot of evidence that I can send. There's a lot of cluster work going on with cluster pharmacists doing this, and I know Wendy can talk about some of the other work that's going on. I noticed in the past that some evidence came here of research done in 2002, actually—I think it was called the RESPECT trial, which is going back a long time. I just want to emphasise that things have moved on a phenomenal amount since then. I'll probably leave it to Wendy to talk about the current work, but, if you want us

to send evidence of how it's improving care, saving GP time, saving financial costs, we have that—we've collected some evidence. But it is patchy across Wales; there's not one model at the moment that I could talk about.

[274] **Dai Lloyd**: Okay, and CPW.

[275] **Ms Fisher**: Just to reinforce what Mair has said, there are pockets of great practice but there's not a consistent approach to medication review. So, that may vary considerably, depending on which home you're in and what health board you reside within. Over the last couple of years, we've seen decommissioning of community pharmacy services into care homes. I think there's a great opportunity to standardise that offering. Only three out of the current seven health boards actually now currently commission a care home support service, and some of those services are based around, I guess, the more basic elements of medicine administration, safe storage of medicines, and advice to carers, as opposed to medication reviews. There are really great elements of the contractual framework, medicines use review and discharge medication reviews, as Mair mentioned, that are more difficult to provide outside of the community pharmacy setting, because there isn't a framework to deliver that off site. I think there's a huge opportunity, if that were a standardised opportunity, which would give a more consistent standard of care.

[276] **Dawn Bowden**: And which three health boards use it at the moment?

[277] **Ms Fisher**: Abertawe Bro Morgannwg University Local Health Board have got a care home service. Aneurin Bevan—.

[278] **Mr Simmonds**: I'm not sure of the third. It could be Powys but I'm not sure.

[279] **Ms Fisher**: We can come back to you with the exact detail and the level of—. One of the things that we have done at Community Pharmacy Wales, though, is to scope out what a tiered service into care homes could look like. We would be really interested in working with Government and the NHS to understand how that may be fleshed out based on the recommendations that come out of your review.

[280] **Dawn Bowden**: Thank you.

[281] **Mr Simmonds**: I was just going to come in on that, because looking at

potential for community pharmacy to do more in terms of antipsychotic medication, there was a trial in a pharmacy chain in England where actually, over a two year period, the pharmacists worked with 463 care homes. So, it's quite well evidenced and quite well published. The end result was a 20 per cent reduction in doses, a 17 per cent drug discontinuation and a significant improvement in quality of life. That was involving elements like dementia awareness training, use of medicines use review and audit and elements like that. So, it's fairly clear that, given the right framework, community pharmacies can make a significant difference to this issue. It's just to add a little bit of weight to what my colleague has said.

[282] **Ms W. Davies**: I think you asked who should be responsible for the medication review. I think it should be a multidisciplinary process, really. I think it's really important. I've worked in mental health for about 35, 40 years, and pharmacy has been quite lucky in mental health in that we have always been part of the multidisciplinary team, so that a pharmacist would make a recommendation about what medication—. So, you look at the patient and it's not just the GP who says, 'Oh, we'll stop that', or the pharmacist who says, 'Oh, we'll stop that'. It should be a collaborative thing with the patient and with the patient's carers about what is best for that particular person.

[283] I think we do need a structure and I think community pharmacy is in an ideal place with support to actually provide those sorts of things. Because I work in a specialised service, I've got a couple of pharmacists—. One pharmacist, Vicky Gimson, who's had her work presented—she worked with a dementia nurse in a care home and they reduced antipsychotic prescribing by 70 per cent. The thing that they really showed with that was that it was having a prescribing pharmacist, because you didn't then have to get in touch with the GP to say, 'This is what I recommend'. She had the clinical skills to say, 'Actually, we'll stop that', and then would review them weekly, fortnightly and assess that it was appropriate. I think that's the way forward but I think there aren't enough of us. So, I think the training—we've been talking about what training is needed—I think it would be specialist mental health services supporting community pharmacy in this area so that we would work—.

[284] **Dawn Bowden**: But you can see community pharmacy is leading it with the multidisciplinary team.

[285] **Ms W. Davies**: I can see that they have a really important place to be

doing that. I haven't worked in community pharmacy for a long time so I would defer to people who were.

[286] **Mr Simmonds**: I think it's clear from all the submissions that everybody is saying that an integrated, multidisciplinary approach is the way forward. To me, I think it must start at community pharmacy level. The reason it should start with community pharmacy that actually supplies the medicines to the care home is because, if you think about it, they already have lists of all the care home residents and of all the medicines they're taking. So, they immediately can form a list of those taking antipsychotic medication. They're actually in a position where they're already supplying the care home, they've already got a relationship with the care home. So, it seems logical for them to get to know the patients more closely so they can continue to monitor their progress. It's been helped by the fact that our discharge medicines review service was changed by Welsh Government recently to actually cover off people moving from their home into a care home or moving from a care home to another care home. So, all of the building blocks are there, and there's a real opportunity to build on that.

12:00

[287] **Ms Fisher**: Just to build on that, one of the things that's critical is communication and transfer of information. We've been absolutely thrilled with the Welsh Government investment in the Choose Pharmacy platform. This has started to give the infrastructure to enable that integration. We always talk about integration, but we need the infrastructure and platform to do that. So, just over half of the community pharmacy network is now on the platform. This gives us electronic access to discharge letters, as well as access to the GP record. So, to truly deliver effective medicines reviews, we are at some point going to need read-and-write access to that record, but this is very much the start of that journey, and it's really, really positive.

[288] **Ms W. Davies**: I would second that, Chair. I think it's really important that as healthcare professionals, both in community pharmacy and secondary care pharmacy, everybody has access and is sharing information—you know, why they're on the medication. It's just about having that knowledge so you can then make a clinical decision, whether you're in secondary care or the community pharmacy setting. So, I would second that—it's really important.

[289] **Ms M. Davies**: There's one thing I'd like to come in with around what we're looking at today. You're looking at the use of antipsychotic medicines,

but I think that if you look at a holistic person-centred approach to this, it will be very difficult only to look at the antipsychotics. Doing a medication review, we would never think of only looking at the one drug—

[290] **Dawn Bowden**: Of course, I understand that.

[291] **Ms M. Davies**: We'd always look at the whole picture. That's why the generalist knowledge that pharmacists have is incredibly useful, because we don't go down—. We do need specialists—we really do need advanced practitioners, but this generalist knowledge that the pharmacists bring is absolutely essential.

[292] **Dai Lloyd**: Mae'n amser inni symud ymlaen at gwestiwn Caroline Jones.

Dai Lloyd: Let's move on to a question from Caroline Jones.

[293] **Caroline Jones**: Diolch, Chair. Good morning. What do you think the role of the speech and language therapist is in this field, along with the wider multidisciplinary teams?

[294] **Ms W. Davies**: I think that's really important. I was on the dementia taskforce, and, when we met, it was looking at—. Again, everything always goes straight away to the antipsychotic medication because of their behaviour, but, sometimes, it's something really simple, like they've lost weight and their teeth don't fit them, so we were working with a dentist. They lose their teeth, because they can't remember where they've put things, or you need to check their swallowing. It's really quite basic stuff like their glasses or their hearing aid—all of the stuff that we take for granted for communicating. If this wasn't working, if you carried on talking in Welsh, I wouldn't have a clue—I'd know some bits, but not an awful lot. So, I think that the speech and language therapists and the occupational therapists are part—that's why I'll keep going on about a multidisciplinary team. We are dealing with a person. Drugs are one bit, and social care, being cared for and loved are all part of that—that looks after that particular person. So, I think all of the therapy—. Within hospitals we work with the OTs, not so much speech and language, actually to give a whole package of care, which is what we're talking about, I think.

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

[296] **Dai Lloyd**: Okay, great. Moving on—Julie Morgan.

[297] **Julie Morgan**: Thank you very much. I think the Royal Pharmaceutical Society, in your evidence, has said how important it is to improve training for staff, and that there should be the development of national standards for staff training. Could you tell us a bit more about that and why it's so important?

[298] **Ms M. Davies**: I think we've got some good examples of training, but, actually, that training isn't accredited—we don't actually know whether it's the right training, whether it's the appropriate training or whether every carer, nurse or anybody working in these homes is having the same training. So, we would advocate for there to be some national standards for that training. We would also say that there needs to be uniformity across Wales—there shouldn't be different training in different places.

[299] There's also the issue around the inspection of care homes. We are really concerned that Care and Social Services Inspectorate Wales have not mentioned medicines since 2007-8 in their inspections at all. We look at the Care Quality Commission in England—the care home team there has over 40 pharmacists or pharmacy technician people involved just in care home inspections. So, we are concerned—we don't know what the training is, we don't know if it's accredited and nobody is inspecting what's going on with medicines.

[300] **Julie Morgan**: So, what you're saying is that, within Wales, if a care home is inspected, the issue of medicines is not looked at.

[301] **Ms M. Davies**: It's not reported.

[302] **Julie Morgan**: Not reported—

[303] **Ms M. Davies**: Not reported within their reports.

[304] **Julie Morgan**: Right. And has that been—?

[305] **Ms M. Davies**: And there is no pharmacist on that team at all. There is no pharmacy expertise being put into the inspection process.

[306] **Julie Morgan**: Right. And is that something that has been raised as an issue?

[307] **Ms M. Davies**: Absolutely, yes—on several occasions by us, and we've been told, 'Yes, we will put pharmacists in there', but nothing is happening.

[308] **Ms W. Davies**: I think there are probably two issues, aren't there? There's the storage and administration and then there's the clinical bit, so it's both aspects that need to be looked at. Yes, they have to comply with correct storage like we would in a hospital, and the fridge, but it's also looking—. It's not just medicines as how we're keeping them, it's medicines about how they're being given. So, I think it's important that pharmacists are involved, and I think, in terms of the training, that's vital. I think, if you're having healthcare assistants who are not necessarily qualified mental health nurses, they need the basic training of things like, if they're constipated, that's why their behaviour goes off. And I would totally agree with Mair and everybody here that we have to have national standards, and that needs to be reinforced everywhere.

[309] **Ms Fisher**: I think, whilst this is focusing on use of antipsychotics in care homes, there's care at home as well. So, there is a huge army of carers—paid carers—that extends beyond the care home setting that these standards would be equally applicable to ensure that there's the right standard of care being given.

[310] **Mr Simmonds**: It would also be very helpful to Welsh speakers. As part of the template service that Community Pharmacy Wales has created, it's actually one element of that. So, we always believe that we have to be really careful we don't develop services for Cardiff. We develop services for the whole of Wales where the resources are not always available and we need to make much better use of the resources within the smaller localities where some care homes exist. But the one thing that is common is the community pharmacies, and that's why we're saying that there is this specific role, and community pharmacies can and often do provide training to care home staff. But that training, as Mair said, is not as consistent as maybe it should be.

[311] **Julie Morgan**: And do you think that is one of the reasons—it's lack of training that's one of the reasons why antipsychotic drugs are used perhaps inappropriately?

[312] **Mr Simmonds**: I think there'll be a number of reasons why antipsychotics are used inappropriately, and having your awareness raised of medicines management or medicines issues as a grounding is really important. But as the trial in England showed, they specifically focused on an

additional element of dementia awareness training and the use of antipsychotics and alternative therapies. That was actually part of the training of the care home staff, so I think if we all pull together, there's an opportunity to get it right.

[313] **Dai Lloyd**: Rhun sydd efo'r cwestiynau nesaf.

Dai Lloyd: Rhun has the next questions.

[314] **Rhun ap Iorwerth**: Rydw i'n gwerthfawrogi'r dystiolaeth sydd gyda chi ac rydych chi'n ei rhoi, ac rydw i'n meddwl, wrth i ni fel pwyllgor feddwl ymlaen at argymhellion, fod yna gwpwl o bwyntiau sydd wedi dod allan yn y munudau diwethaf: un ynglŷn â hyfforddiant a'r llall ynglŷn ag archwiliadau gan CSSIW. Mae o'n fy nharo i'n od iawn bod yna ddim cyfeiriad at feddyginiaethau yn yr archwiliadau hynny. O ran hyfforddiant, rydych chi'n sôn am hyfforddiant ar sawl lefel: hyfforddiant dementia ac ymwybyddiaeth o ymddygiad sy'n heriol, yn ogystal â hyfforddiant ar ddefnydd o feddyginiaethau. Rydych chi'n sôn am yr holl rafft o hyfforddiant. A ydy hynny'n iawn?

Rhun ap Iorwerth: I appreciate the evidence that you are giving us, and I think that, as we as a committee look ahead to recommendations, a few points have arisen in the last few minutes: about training, in one case, and the other about inspections by CSSIW. It does strike me as being very strange that there is no reference to medicines in that work. But in terms of training, you mention training on several levels: dementia training and awareness of challenging behaviour, in addition to training on the use of medicines. You talk about this whole raft of training. Is that correct?

[315] **Ms W. Davies**: Can I just clarify? It is really uncomfortable listening to—. There's a whole raft of training, but looking at whether it should be just antipsychotic training or a whole raft or other training. Is that what you're—?

[316] **Rhun ap Iorwerth**: Yes, because you're talking about medicines training for care home staff, but you're talking medicines training also for clinicians and GPs, really, when it comes to appropriate prescribing.

[317] **Ms W. Davies**: Yes, and I think there are two issues, and I was going to just bring that up. The inappropriate prescribing, whether it is inappropriate or not, would be not so much the healthcare worker, but it's going to be the

GP, and I think that some work that's been done shows—. We did an audit of GP prescribing of antipsychotics in Cardiff. It was part of the quality and outcomes framework a few years ago—I haven't got the evidence, but I could certainly get hold of it—looking at what the prescribing of the antipsychotics was. Some were very good and some were not so good, but you can't just look at the prescribing. You've got to look at whether it's appropriate or inappropriate. So, I think there's a level of training and understanding for the GPs.

[318] I think there's a lot of work that needs communication between, say, secondary care consultants and GPs about how long that antipsychotic should be on, if they're discharged on it. And then I think the training that I would be thinking about for the nursing staff is much more of a generic training, because they shouldn't be making the decision about whether somebody's on an antipsychotic, but they should be making the decision about, 'This person is behaving in such a way', rather than just saying, 'Oh, they need an antipsychotic' and asking the doctor to write them up for it. What they should be thinking is, 'Are they constipated? Are they dehydrated? Have they got a urinary tract infection?' You know, things like 'Are they in pain?'

[319] So, I think there's that level of training for the healthcare assistants, who are not going to be qualified nurses. If it's a care home that's got an RMN, which sometimes they do—a mental health nurse and a physical nurse—you would expect a higher level of understanding of medications and needs there, but then you've got the doctor who's going to be doing this prescribing. It's about educating them as well. And certainly within the work that we've been doing, we've got non-medical prescribing pharmacists actually working in care homes, assessing the medication and advising GPs on that client group, but it's only a very small group that we're looking at, at the moment.

[320] **Rhun ap Iorwerth**: And with prescribing GPs and clinicians, what we're looking for is to make sure that they're all aware of the latest evidence, the good practice. Would you comment, though, on cases, perhaps, where a GP may be aware of the evidence, but there's pressure on them, still, to prescribe—inappropriately, perhaps—antipsychotics?

[321] **Ms W. Davies**: I suppose it's very difficult for me to comment on that, but—

[322] **Ms M. Davies**: Can I come in on this? I think we do ask that pharmacists who are delivering enhanced—I mean, that's one of our calls—should be able to access quality continuing professional development. This is not only about therapeutic knowledge; it's also about how you deal with that sort of patient. How do you deal? It's those soft skills, and we'd advocate for that to be multidisciplinary training, because the GP needs to be able to do that, the nurse, the pharmacist, and everybody needs to be saying the same message. So, that's what we're talking about—

[323] **Rhun ap Iorwerth**: So, the pressure's relieved, then.

[324] **Ms M. Davies**: It's not just about therapeutic knowledge and the latest—. It's actually: how do you deal with these difficult situations? Because they are difficult. How do you deal with a care home manager who's putting pressure on you to prescribe? So, it's bigger than therapeutic knowledge because, usually, the therapeutic knowledge is there, but it's these other softer skills, and you need to be part of that multidisciplinary team. Because you can play one against the other, so you're pressurised into making probably not the best decision.

[325] **Ms W. Davies**: And I think sometimes it's quite hard for carers. They know that in the past, if the antipsychotic has been stopped, then their behaviour—you know, it gets really hard to look after that person at home. So, their fear is that if they stop the medication, they're going to be wandering, they might hurt themselves. So, I would agree with Mair. It's that encouraging the parent—well, it's going to be the child, or the carer—that, actually, we will be there to support you. And also, if their behaviour becomes so unwieldy, that we would put you back on it, because that means it's appropriate, and I think that's really important. It's not that you shouldn't use antipsychotics; it's that you should use them appropriately and with a proper risk-benefit and with that being documented, and that being chatted through with the family. Because, you know, when the Banerjee report came out initially, everybody stopped everybody's antipsychotics, and people were so unwell. It's that knee-jerk reaction and we need to be careful that we don't get confused between inappropriate and appropriate.

[326] **Rhun ap Iorwerth**: Finally from me, just moving ahead to where this fits into a dementia strategy for Wales, we have a draft and it says that decreasing use of antipsychotics is going to be one aim. In England, it hasn't worked, even though they've tried to. How do we make sure we don't experience what they've gone through in England and really failed to make a

big difference in this? Because we know the therapies are there. You mention in your evidence the range of toolkits that provide alternatives, but in England it didn't work out in terms of the dementia strategy.

12:15

[327] **Ms W. Davies**: I'm not as up on the dementia strategy in England as in Wales. I think, certainly in England, when it first came out there was very much an idea about stopping antipsychotics and that it was not looking at appropriate use of antipsychotics. So maybe they took it from the wrong angle. As I say, I haven't read the evidence. Certainly all I can comment on is how I would like to see my service develop. And certainly what we're looking at within secondary care—and I know it's only a tiny bit—but what we're looking at is getting non-medical prescribing pharmacists working as part of the multidisciplinary team of the mental health services for older people team and the care home liaison team, the liaison LPOP, which is liaison psychiatry for older persons. The strategy over the next five to 10 years is to try—because they can't get speciality doctors—to get funding for non-medical prescribing pharmacists to provide input to the care homes. I think the more of those that we could grow, in a sense, in secondary care, the more ability we would then have to support community pharmacy, because community pharmacy have to cover all the drugs, and we're specialists. So, there isn't going to be an answer tomorrow, but if I were looking for my 10-year strategy, it would be to get more pharmacists funded so that they can do that, to provide the backbone that we would need then to provide the support for community pharmacy. We've got to do something. We can't let it fail, because it's a problem that's going to carry on. You know, we can't pretend it's not going to happen; more and more of us are going to be coming into that age group and are going to need care, so we need a plan.

[328] **Rhun ap Iorwerth**: Mr Simmonds, you were nodding there as well. Do you have anything to add from the community pharmacy perspective?

[329] **Mr Simmonds**: I think it's about looking at where each part of pharmacy fits in. I mean, we in community pharmacy are generalists, so we can take training and awareness raising out at scale to a certain level. On top of that, when pharmacists themselves are actually undertaking audits within the care home, you know, they'll become aware of particular issues, they can undertake basic assessments where they get those indications from, and at that point they will obviously pass on to other specialists, be that specialist pharmacists, be it the local community mental health team or local GPs. You

know? It's about looking at where each element of the profession fits in. So, yes, I'd completely support that.

[330] **Ms M. Davies**: If I could come in on this, I think one of the things that would certainly help—I mean, we advocate for there being at least one annual medication review, and for complex medication. Now, people with dementia would probably fall into the complex, so we would advocate that they should be having a medication review every three to six months because we'd need to be monitoring these people. It's not just about a medication review. We need to look at them again; maybe the appropriate prescribing is actually, 'We need to prescribe again' or deprescribe, and a lot of the work that's being done is deprescribing in medication reviews. So, certainly that would help, and I wouldn't just say it's medication reviews. It's also reviewing the patient and the symptoms.

[331] **Rhun ap Iorwerth**: And from what you were saying earlier, you would like to see the monitoring of whether those reviews are taking place as part of an inspection by Care and Social Services Inspectorate Wales.

[332] **Ms M. Davies**: Absolutely.

[333] **Dai Lloyd**: Lynne, you've got some questions.

[334] **Lynne Neagle**: Yes. I just wondered if, as part of these medicine use reviews, you ever raise concerns about the type of antipsychotic that's being prescribed, because we've had evidence that people are being prescribed not just inappropriate antipsychotic use, but inappropriate antipsychotics within that, such as ones that, you know, are not recommended at all for people with dementia.

[335] **Ms W. Davies**: I think the problem with all of the antipsychotics is that none of them—apart from risperidone, which is now licensed for short term treatment of BPSD for 12 weeks—none of them are licensed. And this is actually quite a problem within mental health, with lots of drugs actually, because the client group we're looking at you would never have in a clinical trial because, you know, of the comorbidities and because of their age. So basically, the drug companies aren't going to look at the use of antipsychotics for behaviour in this client group because they'd never get a clinical trial up, because it would just not fit within what clinical trial is. So, I think we are very cautious. Certainly, when all the evidence came out that risperidone, initially, and then all the other antipsychotics, increased the risk

of cardiovascular disease in dementia patients, there was a lot of concern and we looked at what else we could use. And then there was that stopping of everybody, and then lots of people became very unwell because we just stopped it. Then we went to look back at what else could be used. So, I think that when we do use the antipsychotics, none of them are licensed. I mean, the reality is actually that the one that would be licensed is haloperidol, because that's licensed for agitation in the elderly—that is the one that I wouldn't want to be giving anybody because that's the one that can give you more side effects; it will give you extrapyramidal side effects. So, you would caution that, whereas something like quetiapine, because there's evidence that the majority—. It's either risperidone or quetiapine that you would see elderly people on for behavioural symptoms. Even though there is not the research work there, there is, I suppose, a body of anecdotal evidence that you would use it.

[336] But we would certainly, you know, within secondary care, always challenge why they're on it, and we've got an audit checklist to see how long they've been on it and why they were prescribed it, which we're spreading out, really, within primary care as well and through the GP surgeries. Again, I could supply the paperwork that we've got. They are all not licensed, so it's a risk-benefit—. And that's the important thing, and that's about the appropriate use. Is it appropriate to use an antipsychotic? If it is appropriate that you need an antipsychotic, which antipsychotic should you be using? I always work on, 'What would I take?' or 'What would I have let my mum have, if it was felt necessary?' So, I think the two would be low-dose risperidone or low-dose quetiapine, which is normally what we would use.

[337] **Dai Lloyd**: Okay. Jayne—next question.

[338] **Jayne Bryant**: Thank you very much. I think you've given us a lot to think about this morning in your evidence, but what do you think would have the greatest impact on reducing the inappropriate use of antipsychotics? What are your priorities? What do you think we should be doing?

[339] **Ms W. Davies**: Well, I suppose I can speak for me. For me, it would be to have enough funding to train up pharmacists. We could do medication review clinics in care homes. As I said earlier, that is where we're going, and getting medical funding, but I suppose it's not going to be something that we can do overnight, because to get the training for community pharmacists to be able to do it and to get the training through to get specialist mental health pharmacists, you're talking about a few years, I think—well, a couple

of years, really—to get that. It's to get this communication and this idea that we all work in a multidisciplinary way with the patient and/or their carer at the focus of that care. I think that, if we worked a little bit more smartly, we could probably get there. Certainly, for me, it's about changing—my technicians doing stuff that pharmacists do now so that then we can release time for pharmacists to do things within secondary care.

[340] **Ms Fisher**: I think we touched on it earlier. I guess the key thing from a community pharmacy perspective would be having a consistent service framework that would offer a consistent input for patients, irrespective of wherever they may be. And, along with that, there'll be the professional training that Mair has talked about to ensure people are equipped with the skills to deliver that to a consistent standard. I think, bringing it back to the multidisciplinary piece, we have to have the interconnectivity and the communication that wraps around all of that. So, whilst we currently will start to have access to what we call the GP record, which would just be a list of medication, for these to be really effective, we need to understand what's going on behind that—so, what conditions. You can't really say whether something is appropriately prescribed until you understand what condition the patient has and the background, so, it will be full access to medical records in a read-and-write format to truly become integrated into the primary care team.

[341] **Mr Simmonds**: From a practical point of view, we need to start right at the ground and say that not every care home gets input from the community pharmacy that supplies the medicines to them. That input is not standardised. We need pharmacists to do their annual medication reviews, specific audits of patients with antipsychotic medication, undertaking simple assessments, flagging up when somebody hasn't had a review for a period of time or there are issues that we may be concerned at. So, if we at least start by putting some of those building blocks in place, that's a better foundation than we do have now.

[342] **Dai Lloyd**: Ocê. Y cwestiwn olaf gan Lynne Neagle.

Dai Lloyd: Okay. The final question from Lynne Neagle.

[343] **Lynne Neagle**: Thank you. Are you aware of whether there's a similar problem with inappropriate prescribing in other care settings, such as hospitals or even in the community?

[344] **Ms W. Davies**: To be honest, I don't know. Certainly, we try, within

hospitals, we audit what we prescribe in terms of antipsychotics. We've got a pharmacist on all of the ward rounds and we've got paperwork that, as I said, I can send to the committee that whenever we start an antipsychotic, it'll be, 'Why?', to make sure we've done things like electrocardiogram and then, 'When is the review date?' So, I would hope, and I don't think we've audited it recently, I would hope that there isn't inappropriate use, but I think the problem is we don't do it across—. We may do it in mental health. I think we're starting to do some work in the medical gerontology wards, really, which maybe don't have the same sort of input, but they're supposed to be filling out these audit forms, so we actually know why they're starting antipsychotics. I don't know, I wouldn't like to comment on GP.

[345] **Ms M. Davies**: I have no evidence either, but we do have evidence—. Obviously, people will be admitted to hospital with an acute episode and we have the evidence around discharge medication reviews that, on discharge, there's a transfer of care. So, if somebody has been prescribed an antipsychotic for, for example, and it should be only for 12 weeks, we do need to make sure they have this discharge medication review, because it very often goes onto the repeat medications and it carries on. So, that DMR is some really good evidence that we can send to you, not particularly around antipsychotics, but if I just give you some figures, you'll see: on the evaluation—that was external evaluation—of 252 judgments—they did sort of a panel of experts who came in to judge the DMRs—there were 148 discrepancies out of 252; 82 were deemed to be errors, 31 minor, 21 significant, 27 serious and eight with the potential to be fatal. So, that is something that can certainly stop—. We know there's a problem with that, not particularly with antipsychotics, but if something is prescribed acutely for 12 weeks, you would think that would certainly be something that needs a DMR on discharge.

[346] **Lynne Neagle**: Thank you.

[347] **Dai Lloyd**: Sam.

[348] **Ms Fisher**: Sorry, I was going to say I'm not aware of any specific evidence available from a community perspective around inappropriate prescribing. I think the difficulty is the data that we have is largely prescribing data, which is not necessarily linked to morbidity and clinical conditions. However, within the contractual framework, there's a number of opportunities for audit, whether that be multidisciplinary audit or practice-based audit, and I think this is a really interesting area that some—. If the

right audit were constructed, we could attempt to gather some of that data, but I'm not aware of any specific studies that could give you data.

[349] **Dai Lloyd**: Okay. Rhun.

[350] **Rhun ap Iorwerth**: Just to dig down a little bit more about what happens in a hospital setting, can you tell us what happens if somebody who has previously been inappropriately prescribed antipsychotics in a care home setting comes to a hospital? Is there a review at that point of the appropriateness of continuing with antipsychotic prescribing? And what happens, question 2, to somebody who is quite appropriately prescribed an antipsychotic in hospital, then moves on to a care home setting, and that might turn into, if that medication continues, being something inappropriate at a later stage?

[351] **Ms W. Davies**: When they come in, we would do a medicines reconciliation and medicines review, and the pharmacist would be in part of the ward round and we would look to see why they were on it, why they'd come in, whether it was appropriate or not, and actually, when they came in, they probably came in because they weren't very well. It might actually be you might need to increase the dose or something like that, or see what was wrong, really. So, it would be reviewed then. I couldn't—

[352] **Rhun ap Iorwerth**: It could be somebody who had fallen because they were sedated and drowsy because they were on antipsychotics and they—

12:30

[353] **Ms W. Davies**: It could be. The reason that they came in would be reviewed, yes, and I think antipsychotics can cause sedation and they could fall. I think it's really important to realise that, actually, an awful lot of other meds do as well, which is why it's really important to think of it as a whole. If somebody's got high blood pressure and the meds they're on—. If their blood pressure goes down because they lose weight or something, and they're still having their high blood pressure tablets, they would then be pretty likely to fall. I think the problem from my point of view is that they wouldn't necessarily come into an acute mental health ward; they'd come into an acute medicine bed.

[354] **Rhun ap Iorwerth**: Yes. I think that's what I mean.

[355] **Ms W. Davies**: And I think, at the moment, I think about communications and I don't think there is enough communication between the two caring bits. I know, certainly, Annie Procter, the clinical board director, wants us to have more input into the medical bit, because where you end up, if you've got dementia, depends on how you present. You might end up in mental health services for older people or you could very well end up on East 6 in Llandough, which is a medical gerontology ward.

[356] They certainly are supposed to be doing it and I can look at the audit whether they've been doing it there. I think it would be hard to say that, yes, everybody is then reviewed adequately. I think, again, it is a problem of how we get that information to them, because the mental health—. Our patient admission system, when we admit patients, doesn't talk to the Welsh clinical portal. So, we can't do medicines transcribing and e-discharge. I don't know if you're familiar with MTeD, but that's where the discharge letter gets pulled across. We can't do that in mental health, because we have a different—. So, the GP won't get the discharge medication with any advice that should be on the bottom of that, like, 'This medication should be stopped; this is why we stopped it when they came in; this is how long we want them to be on it.' That is in the letter that the doctor will write eventually to the GP, rather than coming from pharmacy. So, we've got that lack—. Community pharmacy can't get it, we haven't got that follow-up so that we can follow them through.

[357] **Ms Fisher**: One of the areas where we could be much smarter, though, is if we were aligned with activity across care settings. For instance, Community Pharmacy have recently done a falls awareness campaign as part of one of our public health campaigns in our contractual framework. Linking in with that, we would do a focus on medicines use reviews in cohorts of patients who would be liable to be at an increased risk of falls. What we don't then necessarily do very well is tie that in with any targeted activity within general practice, or likewise within hospital, so that, over a given period, we're all giving similar messages to the same cohorts. So, I think there is much room for improvement in us undertaking similar messaging right across the system.

[358] **Dai Lloyd**: Grêt. Diolch yn fawr. Dyna ddiwedd y cwestiynau. Felly, dyna ddiwedd y sesiwn am y bore. A allaf ddiolch ichi unwaith eto am y dystiolaeth ysgrifenedig y

Dai Lloyd: Thank you very much. That brings us to the end of our questions and our session for this morning. May I thank you once again for the written evidence that you gave us

gwnaethoch chi ei chyflwyno ymlaen llaw, sydd wedi bod o gymorth mawr i ni, a hefyd am eich presenoldeb y bore yma? Diolch yn fawr iawn ichi am ateb y cwestiynau mewn ffordd mor raenus a defnyddiol. Diolch yn fawr iawn ichi. Mi fyddwch chi'n derbyn trawsgrifiad o'r trafodaethau hyn i chi allu gwirio ei fod o'n ffeithiol gywir. Gyda hynny, diolch yn fawr iawn ichi. Gallaf gyhoeddi i'm cyd-Aelodau fod sesiwn y bore, felly, ar ben. Byddwn yn torri am ginio nawr a bydd pawb yn dod yn ôl yma erbyn 1.15 p.m. Diolch yn fawr.

beforehand, which has been of great assistance to us, and also for your presence this morning? Thank you very much for answering the questions in such an excellent and useful manner. Thank you once again. You will receive a copy of the transcript of the discussions so that you can check that it is factually accurate. With that, thank you very much. May I let my fellow Members know that the morning session is therefore finished? We will now break for lunch and everyone will return by 1.15 p.m. Thank you.

Gohiriwyd y cyfarfod rhwng 12:33 a 13:18.
The meeting adjourned between 12:33 and 13:18.

Defnydd o Feddyginiaeth Wrthseicotig mewn Cartrefi Gofal—Sesiwn Dystiolaeth 8—Cymdeithas Seicolegol Prydain
Use of Antipsychotic Medication in Care Homes—Evidence Session 8—British Psychological Society

[359] **Dai Lloyd**: Croeso nôl i bawb i sesiwn y prynhawn o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. Awn yn syth ymlaen i eitem 6 a pharhad efo'n hymchwiliad i'r defnydd o feddyginiaeth wrthseicotig mewn cartrefi gofal. Y sesiwn prynhawn yma ydy sesiwn dystiolaeth rhif 8. O'n blaenau mae Cymdeithas Seicolegol Prydain, ac rwy'n falch iawn ac mae'n bleser i groesawu i'r bwrdd ddau aelod sy'n cynrychioli Cymdeithas Seicolegol Prydain. Mae gyda ni Dr Ian James a Dr Carolien

Dai Lloyd: Welcome back, everyone, to this afternoon's session of the Health, Social Care and Sport Committee meeting here at the National Assembly for Wales. We will proceed immediately to item 6, a continuation of our inquiry into the use of antipsychotic medication in care homes. This afternoon's session is evidence session 8. Joining us we have the British Psychological Society, and it is my pleasure therefore to welcome to the table two representatives of the British Psychological Society. We have Dr Ian James and Dr Carolien Lamers.

Lamers. Croeso i chi'ch dau. Rydym wedi derbyn eich tystiolaeth ysgrifenedig ymlaen llaw. Mae Aelodau wedi darllen rheini mewn manylder, ac felly yn ôl ein traddodiad yn y fan hon rydym yn mynd yn syth i mewn i gwestiynau, ac mae'r cwestiynau cyntaf o dan ofal Jayne Bryant.

Welcome to you both. We have received your written evidence beforehand. Members have read that in great detail, and so as is our custom here we will move directly into questions, and the first questions are from Jayne Bryant.

[360] **Jayne Bryant**: Diolch, Chair. In your briefing paper you mention and describe well the stepped care model. Perhaps you could outline why you feel it's so effective.

[361] **Dr Lamers**: This will be the double act. [*Laughter*.]

[362] **Jayne Bryant**: That's fine.

[363] **Dr James**: I guess one of the issues was we produced it because, at that point in time, there was a lot of confusion in the area because there was, I guess, a push to reduce antipsychotics, but there wasn't any clear structure or organisation as to how we would do it. So, that was a way of looking at how we could do it in an organised and cost-effective way, because there were some behaviours that are just behaviours. They're not particularly problematic—we all behave—and there's no point in giving them a very comprehensive formulation step 4 type of approach.

[364] **Jayne Bryant**: Did you want to add anything?

[365] **Dr Lamers**: I think it's right. I think we need to use the expertise that we've got amongst our colleagues, and, like Ian was saying, sometimes somebody. like us all—if we have a headache, we all get a bit grumpy and a bit unpleasant. So, sometimes we just need to start at the basic level where our colleagues or GPs or nurses just begin to exclude some of the basic stuff, and then start working our way up and use our expertise appropriately, rather than, as Ian says, there is a behaviour where somebody gets perhaps less co-operative, or slightly more agitated, and we immediately need to go in with a whole team. I think it's just building it up and using our resources and our expertise to the best of our ability.

[366] **Jayne Bryant**: So, how far do you feel that, in Wales, we need to travel

to make these models so consistent across Wales?

[367] **Dr Lamers**: I think probably a decent way—. In preparation for today, I was just canvassing, because I'm from Betsi Cadwaladr University Local Health Board, talking to our colleagues in the other health boards. I think some health boards seem to be moving very slowly towards this, but I think, in other places, just by sheer shortage of staff, the very high level of demand with a lot of the paperwork that needs to be done, I think it's actually very hard to do that in a very structured way. As health boards, perhaps we haven't adopted the model, as such, to actually say, 'This is the way we're going to be working'. It's on-the-ground clinicians who will try and implement these things, but perhaps it's not quite driven from the top level, to say, 'This is the way we're going to be working'.

[368] So, I think it varies, like you would expect, but I think there is a way to go to make sure this is embedded, and people understand this collaborative working.

[369] **Jayne Bryant**: Okay. You note in your paper as well that most behavioural difficulties will stop after four weeks without pharmacological treatment. Perhaps you could add a little bit more to that to tell us a bit more about it, and whether you feel that antipsychotics should be prescribed for people with dementia.

[370] **Dr Lamers**: Well, obviously we're here to present you another alternative way of looking at things, and I think our concept of dementia and behaviours that might be associated with this is not that it's coming out from a pathological perspective. Some behaviours might be driven by some damage in the brain, but, with a lot of it, you are dealing with people who are going through a very scary time in their lives, and who will respond, like all of us would be responding, if we were taken into a small room and our clothes would be taken off by a total stranger, and perhaps in a language, again—we need to be aware of different cultures, the Welsh language—that you wouldn't understand. I bet you all of us would start hitting out, because that would be a real violation of our privacy. Now, obviously, if you then have complications like, perhaps, earlier sexual abuse, you can just begin to see that, actually, dementia is only a small bit, but all of us will behave in exactly the same way. So, that's why I think we need to take the pathology out of it. You wouldn't prescribe antipsychotics for that behaviour, which actually comes from a very normal, human response to a situation that might be very difficult for people to understand.

[371] So, obviously, our perspective is: we need to start understanding this person in its fullness, including the environment, the noise levels, the training of the staff, all of these bits, to try and address this emotional need that, quite often, is being expressed in these very challenging behaviours for people. So, for us, I think antipsychotics would be—. We need to try the other stuff first before we start with something that is actually a very narrow and pathologising way of saying, 'We've got almost a diagnosis of challenging behaviour and there is this medication for it.' Well, actually, no. It doesn't match up that easily. It's not like, 'You've got pneumonia and here's an antibiotic'. It just depends, because sometimes it is about privacy, sometimes it is about connection with people, sometimes it's about just wanting to be active, because there's nothing to do in care homes. You might think that you're a postman still, because you're up at 4 o'clock every morning. So you might just want to be walking up and down the corridors, knocking on doors and checking on people, because that's what you used to do. That doesn't require medication, but it requires a great understanding of the staff, and we think that, if you can begin to change the understanding of the staff, because sometimes the behaviour can be tricky to change, but if staff understand it and reframe it—rather than challenging behaviour, this is John doing his morning rounds—the staff can begin to respond to it in a different way, rather than, 'This is a difficult resident.'

[372] **Dai Lloyd**: Mae'r cwestiynau nesaf dan ofal Rhun ap Iorwerth.

Dai Lloyd: Rhun ap Iorwerth has the next set of questions.

[373] **Rhun ap Iorwerth**: If I could turn to the issue of reviewing medication, how effectively is it done? We know it should be done.

[374] **Dr James**: What do you mean by 'reviewing medication'?

[375] **Rhun ap Iorwerth**: Making sure that people in care homes are on appropriate medication and they haven't been given medication for the wrong reasons and reviewing that at regular intervals, as I think every other witness has suggested should be the case.

[376] **Dr Lamers**: I think it's certainly probably best practice. We know that our colleagues in psychiatry are mainly responsible for that, and perhaps some GPs but not all. I think there's probably a whole range of issues, because it's almost like we've got to the antipsychotics too early. Obviously, if you go in with an antipsychotic, it's almost like a hammer and a nail. If

you've only got a hammer, you'll see everything like a nail. We need to start looking at it in a different way.

[377] I suspect, quite often, perhaps the MDT is not called in early enough to look at it as part of that review, to look at, 'We've got behaviours that are difficult. We've tried everything else and nothing works. Is antipsychotics the required treatment here or not?' So, that's one bit. If you don't have the team around you to have other perspectives in that review, there's obviously a danger. If it's just the medic doing the review, then you'll just get this. So, that's one bit.

[378] I think, sometimes, having done some audits of case notes, the decision-making process is not clearly documented. So, it would just be—we've talked about this before—changed from one medication to another without the rationale as to why that change has happened or whether other approaches have been tried out: were they effective, what else has been happening? So, we get a change of medication and reviews without the rationale.

[379] Again, talking of my clinical patch, and again, talking to my colleagues in Cardiff, we actually have a huge shortage of psychiatrists. We tend to operate with locums at the moment in Betsi, as you might be aware of. So, what you get is one locum will start somebody on an antipsychotic, they disappear again, and another locum starts. We need to get the admin system up to speed to know where they need to go and look for people, and then they have a different approach. Again, it goes back to the point that we haven't got a steer that actually dictates how we need to do this. It seems to be personal preferences of clinical practice.

[380] **Rhun ap Iorwerth**: Certainly, we are hearing very clearly that there's a belief that it should be a multidisciplinary approach to conducting reviews, with suggestions from others about who should lead that—perhaps community pharmacy taking the lead. What is the nature of the review that should take place for somebody on antipsychotic medication and deciding whether that is appropriate or inappropriate? Is it a matter of taking them off it and seeing how they respond or—I don't know; I'm a layman.

[381] **Dr James**: There's been lots of studies that have done that by Clive Ballard in Exeter—he's a Welsh psychiatrist; you probably know him—where they have done that and just taken people off the medication, and that's been problematic. He's just done a study called WHELD where they reviewed

people's medication, mainly antipsychotic but psychotropic as well. They saw that if they just take people off the medication without supporting them with some kind of package of care, people get worse in terms of their well-being.

[382] I guess, just going back to the earlier bit, the reason I queried the views is because—. So, I work in a team up in Newcastle and I've got a UK perspective. The people who review the medication in the team we run are nurses—community psychiatric nurses—who are very knowledge and have been trained in the use of psychotropics. The problem when you have teams is that the model starts to change, and that becomes highly difficult when you've got very complex people.

[383] The other big thing about reviewing medication is it's not just about taking people on and off antipsychotics; it's also because there's lots of misdiagnosing, there's polypharmacy, which is a huge problem, certainly in care homes, and there's misprescribing. So, I guess psychiatrists and our medical colleagues are good for some of those, but in the day-to-day running, if you're running a service, we've found that the CPNs are better if they're doing a full package of care.

13:30

[384] **Rhun ap Iorwerth**: And also, you need an element of consistency to be able to track from one review to the other. You shouldn't be starting afresh every time you conduct a review.

[385] **Dr Lamers**: You have a new—

[386] **Rhun ap Iorwerth**: You should be able to trace back.

[387] **Dr Lamers**: And again, I think we probably need a particular model that will start approaching these difficulties in a systematic way. So, when the psychiatrist arrives at the care home, it doesn't depend—. Again, that's my own clinical experience. One day, you talk to staff nurse X who says, 'Mr Y is perfectly fine.' You go back four weeks later and they say, 'Oh, Mr Y has never been fine', when you talk to somebody else. So, you need to start collecting data in a more systematic way. Staff need to be trained to collect this, so you are at least, when you come as a new locum, familiar with the quality of the data that you're presented with, and if you were to decide that antipsychotics are the right way forward, you make that as an informed choice, rather than just ending up with a nurse who's tearing her hair out

because there's no staff, or whatever, and there's been yet another incident this morning with Mr Y that colours her views. Our experience quite often, when you ask staff to start recording, is what seems to be a tremendous problem might happen five times in a month. Now, that can still be a big problem, but when you hear it in the first instance, it sounds like it is happening five times a day, but when you start recording it in a very systematic way, you get a much better insight.

[388] It tends to happen, like I was saying earlier on, in intimate care. That's usually when stuff happens, and then you get a member of staff saying, 'I never have any problems getting Mary dressed.' Well, that's interesting. Why is that? What are you doing that Mary finds acceptable that, when Julie does it, goes wrong? So, how can we also help staff to support each other? Because, quite often, my experience is the staff have a lot of the answers to how to manage this, and I think, as clinicians, we will facilitate conversations amongst them, where they'll begin to say, 'I never have that problem because I lower the light in the bathroom', or, 'I give her advance notice' or, 'I show her the flannel', or whatever it would be, or, 'I speak to her in Welsh'. Whatever it might be, staff quite often know. I think the other bit is that this is tough work. This is really tough work for staff—very low paid, with a population that has no voice. How can we support these people to feel good about the stuff that they do, and they quite often are in the firing line?

[389] **Rhun ap Iorwerth**: You said that what we need is a system. You gave us one example of a system where the nurses are taking a lead. It might be that there needs to be a different approach elsewhere. Are you confident that it is possible to develop a system that's flexible enough—?

[390] **Dr James**: There are systems developed. I think one of my concerns is that the big answer in many of the documents, including our own document—that would be updated—is that we talk about teams: 'Teams should do this, teams should do that.' What is very rarely specified in all the European dementia strategies is what you actually do. We have very vague statements: 'Let's do person-centred care. Let's do this type of communication. Let's do—', but until we get the idea of, 'A team does this, this is the function, this is how they do it, and this is how we train them to do it', we're really going to get stuck. So, there are at least four examples: there is our own example that we've been using since 1999 up in Newcastle; there's the example that is being used in Belfast at the moment, which is a really good example called CLEAR; there's the one in Dumfries and Galloway, which is called Interventions in Dementia, Education, Assessment and

Support; and there's one in the Tees, Esk and Wear valleys trust, which is the Yorkshire area, top of Yorkshire, and that's what they focused on.

[391] They recognised that you just can't throw teams or specialties and different professionals at things. You've got to have a very clear—. As Carolien was saying, you have to have a structure and a function, and that needs to be audited and measured by the different measures, so that we can say, 'It is working. It's not working', and also that draws in, in our case, the NHS. That has to work the same way. It's no good the NHS having a different way of working. And the third sector can then work in the same way. The GPs are helped because, certainly when we first set up our team, everything came through psychiatry. If we got a referral that said 'behaviour that challenges' or 'challenging behaviour', it went to the psychiatrist. The first thing we had to do was stop it going to the psychiatrist because the psychiatrist would prescribe. Then, because of the nature of tranquilisers and sedatives, the person became much more dependent, and any possibility of doing activities or psychological work was reduced because the person was then, as I say, sedated. So, you need the whole system, and, when you first set up a whole system, it's a bit like a rabbit warren: if you think you've dealt with something here, the weakest link will pop up over here. So, if the GP will not go via a psychiatrist, they'll go through the care home, and then the care home will go through the psychiatrist; it just moves around. So, in our service, if something has challenging behaviour—care home—it automatically comes to the behaviour support team, and that's the system.

[392] **Dai Lloyd**: Okay.

[393] **Rhun ap Iorwerth**: Why does misprescribing happen usually?

[394] **Dr Lamers**: Again, it depends. There's probably a whole range of things. Some of the work that carers do is difficult, they do get hurt and injured, so obviously care home managers want to protect their staff—one bit. I'm also aware of some care homes that get really anxious about their registration, protection of vulnerable adults inspections. Because, obviously, sometimes when we're dealing with behaviours that are challenging, and before we start getting this psychological approach implemented, it takes a bit longer than perhaps giving a pill that might just sedate people straight away. So, some people want quick fixes. So, care homes get anxious about perhaps the slightly longer term intervention that you might need to put in and then get really worried about what happens with POVA. I've just been working with a lady who was on the list to be evicted from the care home

because of her difficult behaviour. Because she didn't want to have private care, her skin was breaking down, so this was now moving into POVA, and the home gets really nervous. So, what they want, they just want a quick fix, because the last thing they want is to get a POVA referral, the inspectors come in, and their name being associated with poor care. So, it's a very fine balance, and I think quite often when I, myself, get involved, we're already running on the latter end of the—you know, every other bid's already been tried, and, quite often, even when antipsychotics are being given, because the intervention is so aversive to the person, it still doesn't stop that. They might be sedated, but every time you need to change them—and you can begin to imagine, if your skin's broken down, it's painful, it's unpleasant—that behaviour still doesn't go away despite this medication, so you need to work really hard with the care home to then create the trust that this can be tackled in another way. And we did—and, again, just to make the appropriate use of the Mental Capacity Act 2005—you know, this residential home very much felt like, 'I ask the lady, "Do you want to go to the bathroom?", the lady says, "no"'. And then she sat in her own urine and faeces for hours, because the lady had said 'no'. So we needed to just, again, look at the mental capacity Act and what can we do in an effective way to make sure we look after this lady—that this is not the informed choice of her sitting in her excrement. So, again, there's lots of components to it, which an antipsychotic is the plaster on the wound, but it doesn't resolve—.

[395] **Rhun ap Iorwerth**: Yes, and there's one of the things that we've discussed in other sessions here: what is the pressure that prescribers find themselves under to make this prescription? It might not be pressure from some individuals or, 'Go on, go on, give them some antipsychotics'. It could be just purely circumstantial.

[396] **Dr Lamers**: It's bigger. And I think that's why there's other systems at play in this whole thing, like Care and Social Services Inspectorate Wales, like POVA. Again, I'm just thinking about my colleagues who are doing the mental health Measure paperwork: it takes up a lot of time, it's not dementia-specific, but, you know, they again feel their time's taken away from where they would benefit from being in the care home doing work with the care staff, but, again, partly because—. I can speak about Betsi; we're under special measures, so we're being scrutinized about having our paperwork completed, but it takes us away from the real clinical stuff that needs to be done.

[397] **Rhun ap Iorwerth**: So, training: dementia training, training in

challenging behaviour, training in all medicines.

[398] **Dr James**: There are a number of studies. There's the Barber study, which talks about misprescribing, and I guess misprescribing is all—. Again, what do we mean? So, once you start prescribing, you have to dispense it, you have to administer it, you have to follow it up. There's all sorts of—. So, Barber was saying that, if you look at any care home, within a 12 month period, 70 per cent of those residents will be misprescribed something, and some studies say it's even higher. So, there's all sorts of stuff when you start prescribing medication that you need to be very careful of. And, again, it's under pressure. Now, people are under pressure, they're, poor staff, again dispensing medication in very difficult circumstances, and the polypharmacy, the amount of medication one has to get, is staggering at times. So, you're wondering how they cope, how they don't misprescribe. So, I think, as you say, there are all sorts of things where training is required. But what we do know from the Barber work is that misprescribing rates can be reduced significantly through training. We do know that.

[399] **Dr Lamers**: And I have to say again, part of my work would be to go into the care homes and do some training with the staff. The problem—. Again, I think we all know it. You go to a training day, you're really beamed up about—this is a fantastic approach—and you arrive back at work and there are piles of stuff. You know, that would be my bit, and, before you know it, you've forgotten all these new innovations.

[400] So, again, in north Wales, we've been trying to work with a coaching model, just to try and help the care home managers to develop skills, so that, when a problem arises, they can begin to help their staff to implement the training. That's one model, but you can envisage that, actually, if you've done training, ideally, you need to have staff on the ground with them, on the shop floor, to try and model, coach, support—you know, just be there and show them how to do this. So, I think training itself is useful. You need to have a basic bit of knowledge. But then it's how do you implement this, because it's not always text book.

[401] **Rhun ap Iorwerth**: And it's a change of culture. You know, through—

[402] **Dr Lamers**: Culture is people, so we need to change people, and that's a big ask. But we can start somewhere, can't we?

[403] **Rhun ap Iorwerth**: Thank you.

[404] **Dai Lloyd**: Ocê. Lynne Neagle sydd â'r cwestiwn nesaf.	**Dai Lloyd**: Okay. Lynne Neagle has the next question.

[405] **Lynne Neagle**: All right. Well, I think you've touched on some of this, really. Can you tell us a bit more about the availability of alternative non-drug treatments for people with dementia?

[406] **Dr James**: Availability—it's huge. The issue is: what's required? I could give you at least 10 different non-pharmacological treatments now, ranging from reminiscence to dance therapy, music therapy, all sorts of things, but the issue, really, is: what needs aren't being met; why are we actually doing these things? This is one of the things that we need to be careful about, as professionals—we can throw things at people. There's no direct substitute for a pill. There's no therapy, or very few therapies, that we can say, 'Let's take the medication away and give them that therapy.' It's a different model altogether.

[407] Most behaviours that challenge occur because someone's needs aren't being met. They can be biological needs, can't they, they can be psychological needs, they can be social needs. Many behaviours that challenge are a mixture of those. What we need to do is find out what the person requires and then a package of care. But the crucial thing that we've found is that we've been doing these fancy formulations for years, since 1999, but it's the way we deliver them that is crucial.

[408] Most behaviours that challenge happen around intimate care activities. Because someone's slightly confused, and I say to the client, 'Unfortunately, she's wet.' I have to then change her. How do I do that in a way that she doesn't feel attacked? And that's the skill we need to do. That's why, when we talk about training, it's these hands-on nuts and bolts things. It isn't, 'Why don't we do reminiscence work? Why don't we do memory work? Why don't we do this type of work?' The crucial bit is how we get that interaction, that communication, in a way that you're okay about whatever intimate activity you need to do to make you feel safe and improve your wellbeing. And that's what we're—. In terms of psychology, that's what we're looking at at the moment, and that's where we've been developing our training programmes, at that level.

[409] **Dr Lamers**: Dare I say, there aren't many psychologists that work on Anglesey. Two days a week—that's my clinical patch, two days a week. So, I

deal with anybody who's been diagnosed. The memory clinic does the diagnosing, but I pick up anybody in two days a week. You can just begin to imagine—there are 26 care homes in that area, or 24 or something. So, we're beginning just to—. There aren't enough hands on deck to do the work. We're trying our best to work through different routes in Cefni hospital; we're trying to work—sorry, it's the hospital in Llangefni. It's not a care home, but I think there is translation possible where we're working with some applied behavioural analysis students.

[410] So, again, just to try and broaden our psychology presence with other people because we just haven't got enough of us to help think with our colleagues as to how we can tackle this in a different way. There are lovely examples in pockets, but it's not there, rolled out.

13:45

[411] **Lynne Neagle**: Both I and Julie sit on the children and young people's committee, where we've been looking at perinatal mental health, and the issue of the shortage of psychologists has been very prevalent there, really. So, you seem to be saying that there's a wider issue there. Is that to do with the Government not training enough psychologists in the first place, not funding them?

[412] **Dr Lamers**: The other bit of my job is I'm the admissions tutor for the north Wales clinical psychology programme, so I'm aware of the recruitment issues. So, Welsh Government funds 27 training places; that's slightly up from what we had before, but I'm aware in older adults we've had two vacancies, 8A vacancies, probably for the last year and a half, and this is in Wrexham, so you'd think we would be able to pick up people from Liverpool, Manchester. We cannot recruit. So, there seems to be a shortage in the UK of training people, let alone in Wales.

[413] One big driver—sorry, going slightly off thing here, is we also want to ensure that we train more Welsh-speaking clinical psychologists, and that's a huge problem, because, nationally, only 1 per cent, which equates to about 15 to 25 people in the UK, are Welsh speakers. So, again, we need to do a lot more work on marketing, getting into the young generations to see psychology as a career, because I think, traditionally, that's perhaps not quite the way that young people—I think it's much more teaching and media that, perhaps, young people would want to do in Wales. We just need to do a lot of work to bring Welsh speakers in, because, again, the area I work—as you

know, I'm Dutch, so I'm aware of what it's like not to be able to express yourself in your mother tongue. We need Welsh speakers. We need Welsh speakers to work with people who are in distress, and then, again, I think, there are posts. We're trying, but we can't even fill them, so it's very difficult to ask for more posts when you can't even fill the ones that you've got, and it seems to be across Wales that we can't fill posts.

[414] **Dr James**: Can I pick up on that, as well? I'm always a bit careful about professions and—. I always look at functions. So, what we need is someone who can develop formulations, who can train people, who can coach people, who have got an appreciation of different theories, and that routinely is psychology. But it doesn't have to be. If that's what's the function, we can train people to do those things, because what we need to do is just meet the needs of the people. Psychologists are the obvious people at the moment, but, if we're struggling to do that, then—. In some of the services up and down the UK, it's nurses who take on that role. They have been trained by psychologists, but they run teams. The psychiatrists come in for half a day a week to advise on the medication and prescribing, but the teams are run by nurses, very experienced nurses, who can do the supervision, who can do the coaching. They also have the credibility that they know a lot about medication, that's the credibility above OTs or psychologists.

[415] **Dr Lamers**: And they give the hands-on care.

[416] **Dai Lloyd**: Okay. Rhun, you've got a supplementary, briefly.

[417] **Rhun ap Iorwerth**: Just to dig down to a bit of information that might clarify things in my mind about good practice and use of alternative therapies—. You mentioned Anglesey. In somewhere like Plas Crigyll, which has a specialist dementia unit, I assume things would be better there than in other homes in terms of use of alternative therapies for people with dementia.

[418] **Dr Lamers**: I get referrals from Plas Crigyll as well, and we try and help them with their behaviours. So, I think it really varies. Some staff are, perhaps, better skilled. I think the other component is leadership. I think the manager of Plas Crigyll is really quite psychologically minded. She very much sees it as the residents' home, so it's a very different outlook. Rather than seeing it as a place where you care for somebody and, if it doesn't work anymore, you move them on—Plas Crigyll is a local authority home, in contrast with some of the private homes where there could be a slightly

different outlook of, ‘These clients are getting too difficult, they’re creating a bad reputation for us. We’ve done our stint, let’s move them on’. And, again—

[419] **Rhun ap Iorwerth**: But, even in somewhere that’s seen as dementia specialist—not Plas Crigyll perhaps, but other places that you’ve been—there are issues of understanding what difficult behaviour means and what you can do to deal with that.

[420] **Dr Lamers**: And sometimes you need more heads, just to try and work it out. You just need to get more heads together to look at it from different angles, and that is psychology, OTs, speech and language therapy and family—crucial, family, because they’ll know that, I don’t know, mum always got out of the bed that way, and now you’ve put the bed the other way, and it actually makes her really confused and anxious because she’s trapped. You know, it’s the little things that we just don’t know.

[421] **Dr James**: One of the difficulties is that we haven’t got—. And, as I say, my experience is that, across the UK, there are very few good in-patient services that use models we know work—very few—and the staff aren’t trained to good levels, and I’ve got to say that’s the same where I work too. It’s difficult, but we know what we need to do; it’s just that we’re struggling to do it.

[422] **Dai Lloyd**: Okay. We’re sort of out of time, but Julie can wrap up with a final couple of questions.

[423] **Julie Morgan**: Yes. In terms of equal access to treatments, do you think age discrimination operates in terms of the types of treatments that are offered to older people? I mean in terms of the non-pharmacological—

[424] **Dr James**: Yes. I think that, from the document, when we set up the document—. So, the package of care that we offer is 12 weeks of care, going in occasionally, developing a formulation and producing a care plan that we then coach people to deliver. When we first set up that service, our manager said, ‘That’s far too much. We can’t be giving care homes this amount of work.’ And then he had to stop a second and say, ‘Hold on. If this was a younger person and they had depression, we’d give them 12 weeks of therapy—cognitive therapy or interpersonal therapy.’ Even at that time we were giving people three years of psychodynamic therapy. So you’re saying that, with these far more complex folk, we can’t give 12 weeks into the

setting? So, yes, there was this discrimination; there still is.

[425] **Dr Lamers**: I think one other—. Again, a practical example: I'm working with a lady at the moment where we've managed to address some of the behaviours that were challenging, by working with the staff, and the staff have adopted another approach to dealing with her. But there are ongoing issues with this lady: abdominal pain and, excuse my language, but vaginal discharge; she's clearly in discomfort. The matron is excellent. We've been trying to get the GP to investigate this—my goodness: 'Why do we need to do blood tests? We've done a blood test.' 'But you didn't check for cancer markers; can we please send them to gynaecology; can we please—?' We're still waiting. So, there is another age discrimination that, sometimes, if you've got a patient with behaviours that are difficult, everything is being put down to the behaviour. Perhaps, again, if this was a person without dementia who would have gone to the GP with abdominal pain and vaginal discharge, they might have had slightly better service. Now, in terms of the treatment, that's a different kettle of fish, but at least we might want to try and find out, because we might need to manage her behaviour differently if we know that there could have been a palliative component to her condition. So, it works at different levels—part of the service, but sometimes—. Again, not all GPs are like that—don't get me wrong—but it can be hard to persuade colleagues to investigate other stuff that, if they were younger, they probably would have been checked out for. It's ageist.

[426] **Julie Morgan**: Yes, so it is there. It does operate—

[427] **Dr Lamers**: Not always, but there are examples.

[428] **Julie Morgan**: And the example you gave, Ian, about the scepticism about giving the longer treatment, is that now sort of sorted? This doesn't happen now or—?

[429] **Dr James**: It's hard; it's hard work.

[430] **Julie Morgan**: Okay, thank you. I wanted to ask about the dementia strategy in England, which we are told hasn't resulted in a reduction in the use of the drugs. I wondered whether you had any comment or information about that and whether there's something we should be doing more in Wales that might have more effect.

[431] **Dr James**: So, in patches, it has. By auditing, it has, but I guess it's a

system change you need. You can't replace a pill with a therapy. No-one has really taken the bull by the horns and said, 'We need to change the system. We need to support it. Everybody needs to have a formulation. Everybody needs to have their needs assessed.' Until we start doing that, we're not going to get major change because, ultimately, if someone is a problem in a care home, they'll need to be dealt with some way and, ultimately, it'll be through a sedative or a tranquilliser, and we'll make them more dependent and we'll increase costs and care costs, but it's a quick fix.

[432] **Julie Morgan**: Right. So, what do you think is the most important thing to be done?

[433] **Dr James**: I think it requires training, but the right sort of training. I think—. And it's happened in Scotland—they threw a lot of money at training and they had large sections, and NHS Education for Scotland put a programme together that I helped them put together, but people just attended. They didn't get the supervision. They didn't get the training around one-to-one skills. As I said, we know where most of the behaviours that challenge happen, about those intimate care activities, about the communication, and we also confuse preventative strategies with acute strategies. So, we can prevent people becoming aggressive by increasing well-being through some of the strategies, but once someone is in your face and shouting at you or trying to hit you or trying to get out of that door, they're the skills we really need, and a lot of professionals haven't got those skills. Some psychologists struggle with those skills, and that's what we need to develop, and there are a couple of programmes around at the moment that help do that. Some are nurse-led, some are psychology-led, and in terms of the BPS, we've been developing some of those, and it is those sorts of things: when someone's really upset, how do you de-escalate the situation?

[434] What we've done, we've gone to Marks and Spencer, we've gone to John Lewis, and we've got their customer care skills, because all of their staff get trained in that and none of our staff get trained in that, so that's an obvious one—the 19 principles of Marks and Spencer. And then we've gone to the police. So, how do police de-escalate situations? People don't want to get arrested. So, we've gone to them. There's a thing called 'verbal judo' they use, by George Thompson, and that's got some instructions—things not to say when someone's upset—and we've taken those and we've packaged those into a treatment called CAIT—communication and interaction training—and that's the level we're at, and I think that would make a big

difference, but that's another system change.

[435] **Dr Lames**: No quick fix, I'm afraid. Lots of ideas, but—.

[436] **Dai Lloyd**: Well, we're out of time. Very interesting, thank you.

[437] **Dr Lamers**: Diolch yn fawr.

[438] **Dai Lloyd**: Excellent session. Thank you very much indeed, and for the written evidence beforehand. Obviously, you'll receive a transcription of this session as well, so that you can verify that it is actually what you meant to say.

[439] **Dr Lamers**: What we said. Thank you very much.

[440] **Dai Lloyd**: Thank you very much indeed. Diolch yn fawr.

13:57

Papurau i'w Nodi
Papers to Note

[441] **Dai Lloyd**: Troi yn syth nawr i eitem 7 a phapurau i'w nodi.

Dai Lloyd: We turn now to item 7 and the papers to note.

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:

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

Motion:

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

Cynigiwyd y cynnig.
Motion moved.

[442] **Dai Lloyd**: Ymlaen i eitem 8: cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod. Pawb yn cytuno? Ydyn. Awn ni i sesiwn breifat, felly.

Dai Lloyd: On to item 8, which is a motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting. Does everyone agree? I see you do, so we move to private session, therefore.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 13:57
The public part of the meeting ended at 13:57.