Health and Social Care Committee
Inquiry into residential care for older people

RC66 – Wales Progressive Co-operators

National Assembly for Wales
Health and Social Care Committee
Residential Care Inquiry
into the residential care needs of older people

Evidence from Wales Progressive Co-operators

'The importance of Social Innovation:
What can older people in Wales learn from Quebec?'

Summary

- Long term residential care for older people cannot be viewed in isolation from its context, a context in which most care is provided by unpaid carers, often themselves elderly, and in which therefore home care and other sources of community support (and their absence) are fundamental factors in determining and preventing demand

- Existing prevalent models for the delivering of care for older people are difficult to sustain financially or to assure in terms of quality

- Existing models of care typically disempower the service user and weaken family and community capacity to care and to safeguard

- We need to find a more sustainable relationship between state, local authority and citizens, and for this, social innovation will be essential.

- There is strong evidence from other countries that the co-operative model of care service has enormous potential to address the deep problems we face, and merits earnest support for grassroots development in Wales

Introduction

Some older people will undoubtedly continue to need long-term residential care and the quality of that care, and access to it for those to whom it is appropriate, should be improved.

In the present situation, and for the foreseeable future, the traditional concept of residential care needs to be replaced by a vision based on new thinking, and on developments that are affordable, intrinsically empowering of the citizen-user, and receive public support.

This is a major issue in the advanced world. Markets have left a shambles and the State has real problems with growing elder care. Services are under pressure, mainly with target driven responses, not proving adequate to what is required. In Wales, we need knowledge of social innovation to break through and rethink models of care.

Long term residential care facilities represent a most costly type of intervention. Home care services, extra support housing clusters can delay or actually obviate the institutionalisation of individuals and help keep people at home. To discover how such services can operate effectively we should look to other countries, where co-operative provision is well established.

At the recent International Co-operative Alliance General Assembly in Cancun, Mexico, Ed Mayo, Secretary General of Co-operatives UK, commented that the UK has far more to learn from Co-operatives overseas than we have to teach. This is especially true of elder care co-operatives in Canada and social co-operatives in Italy.

This paper seeks to encourage international learning. See also the opportunity arising from a visit from a Quebec researcher in February 2011 (Appendix 4).

Background

There are important and basic matters to consider about elder care, and they become more urgent because of a rapidly ageing population and a limited amount of finance. Add to this the fact that many old people have limited capacity and may have no family available to advise them at a vulnerable time of their life.

Provision of residential care and home-based care is not as it should be in terms of either quality or quantity. Underfunding of some services still persists today. In Wales, despite increasing demand, the overall budget for these services has not increased much over the past few years. A new foundation is required to build future community care services that will replace in some measure the reliance upon residential provision, which is becoming more expensive for local authority and private provision, with the latter providing a financial return to the shareholder.

Loss of UK Care homes

The loss of the number of UK Care homes has doubled with 73 care companies going into administration in the year to the end of September 2011, compared with 35 in the previous 12 months. The number of smaller companies exiting the market is quite marked and included: - Southern Care Group, North Wales; Winnie Care Group, Cheshire; Argus Care Group, Scotland (500 residents) and Grosvenor Care, Stockport. Southern Cross is an example of how quickly the whole structure can disintegrate.

Extensive media investigations and from speaking directly with older people, all indicate an inadequacy in the quality and range of existing care provision,

including residential care. We provide a recent case study of Registered Social Landlord provision at Appendix 1.

A recent Equality and Human Rights Commission home care report in England, captures market dysfunction, which is unlikely to differ in other UK countries.

Home care services
For several years home care services have been receiving less attention from government. For example, the number of hour care hours has reduced from its peak of 12.8m in 2003/2004 to 11.2m in 2010/2011, with the proportion of local authority staff reducing from 62% to 32% from 2001/2002 to 2010/2011. Domiciliary service provision by local authority for those age 18 and over ranged from 10% in Cardiff to 78% in the Isle of Anglesey.
http://statswales.wales.gov.uk

Crucial role of unpaid carers

To put these statistics in perspective, we observe the crucially important role that unpaid carers play in Wales, upon which much of the current system is hugely dependent. In the 'Care at Home' report for the Care Council, Welsh Institute for Health and Social Care did some simple analysis about the proportions of care that are provided. Although it is not directly relevant to residential care, it is very important in the broader strategic context.

The 2001 Census collected information regarding the numbers of UK carers and the amount of caring they do for the first time. Based on returns, Carers UK recorded that there are nearly 6 million UK carers, with 340,745 in Wales – equivalent to 11% of the Welsh population. It is possible to analyse these figures and make an evidence-based judgement about the proportion of care in Wales that is paid for, and the amount that is provided by unpaid carers. Subject to a number of caveats, but based on these data, and using the most conservative estimates (i.e. the minimum values in the range) the analysis shows that at least 288.5 million hours of care were provided by unpaid carers in Wales in 2001. When compared with the most recent data of 11.7 million annual hours provided by local authorities (including services commissioned and delivered by others), this demonstrates that unpaid carers provide at least a hugely significant 96% of annual care hours in Wales, with the remaining 4% provided by local authorities and independent providers. This is an even greater proportion than reported in 'Fulfilled Lives, Supportive Communities' which states that 'at least seventy per cent of the care for vulnerable people is provided by family, friends and neighbours' (see p.19 in Llewellyn M, Longley M, Fisk M, Boutall T, Wallace C and Roberts M (2010) *Care at Home: challenges, possibilities and implications for the workforce in Wales* Care Council for Wales: Cardiff – ISBN: 978-1-906528-29-4).

Examining alternative methods

On current projections, public resources will be insufficient to meet demand at a time when people rightly value their independence and wish to have a say in how and what services are available. Therefore, we need to widen our approach to examining alternative methods and have an open mind to changes, which must involve older people within a process of 'co-production', and impact upstream on the development of policies and programmes that determine the conditions of production and the delivery of services (a process in Quebec called 'co-construction').

It is essential that we consider new and emerging models of care provision as a totality, with residential care as only one component of a complex and evolving picture. From a co-operative perspective we envisage the possibility of co-operators and the wider community being able to freely move between different forms of accommodation and levels of care depending upon their needs and circumstances, over an extended period of life, for example, including 'care villages' within urban communities: researched and seen in action forty years ago in Denmark.

Partnership working
A Co-operative approach fits well with the:

(a) Values and policies articulated by the Welsh Government, for example, co-operative approaches to housing and credit unions, and cross party support for the wider application of co-operative approaches to problem solving.

(b) Four themes of valuing older people, changing society, wellbeing and independence and making it happen, set out and approved by the Welsh Government Cabinet in the Strategy for Older People in Wales (2008-2013) and

(c) Principles set out in the Welsh Governments **'**Sustainable Social Services Programme Framework' (October 2011). A strong voice and real control, supporting each other, safety, respect, recovery and restoration, adjusting to new circumstances, stability, simplicity and professionalism.

Implicit in these themes and principles is an acknowledgement that traditional local authority, charitable and other models have encouraged dependency amongst service users rather than the reverse. This is well articulated in Appendix 2 as part of our evidence. What is needed now is an explicit commitment to support the development of new models in which the citizen-user is structurally empowered as a co-producing user-member.

Co-operation and 'Humanising the Economy'
What is missing is an understanding of positive contribution of co-operatives in improving the work conditions of employees, who are predominantly women; the role of multi-stakeholder co-operatives are able to make through their closeness to community; mutual support between individuals and democratic participation, which is able to reinforce values that are often missing in the private and public sectors.

With this in mind, we met John Restakis, the author of 'Humanising the Economy' at the Co-operative UK Congress in June 2011. We had an extensive discussion of co-operative elder care systems in Italy and Canada. Key messages from the social care chapter of his book have been summarised at Appendix 2. Significantly, 50% of older care provision in Quebec is co-operative and in Bologna 87%.

At about the same time we visited Sweden and learnt about how their highly successful consumer focused co-operative housing model is being developed to meet the care needs of their older members.

In August 2011, a co-operative care study visit was informally proposed to the Welsh Assembly Government. Alongside this we made contact with Jean-Pierre Girard, with a view to organising a study visit to Quebec *multi stakeholder co-operatives* to obtain a clear understanding of a good working model.

Regretfully, the visit to Quebec did not happen, but a further opportunity presented itself when we learnt that Jean-Pierre Girard, a leading co-operative researcher and practitioner and colleague of John Restakis, was due to speak at conferences in Paris and Belgium in the second week of February 2012.

Co-operative finance
One area that requires development and more explanation is how social care co-operatives would be funded. How should they raise funds? How is that done in Québec? One starting point could be Government action to bring resources and a policy priority to the effort.

As the fiscal settlement of the United Kingdom Government begins to affect the budget of the Welsh Government next year and beyond, discretionary and other public expenditure will be severely at risk. Although Wales does not have the ideological approach towards competition that the UK Government is currently imposing in England there are going to be hard choices for the National Assembly for Wales and the Welsh Government.

In England we are seeing UK Coalition Government pressing to externalise social and health services under the guise of social enterprise (with questionable social component) at the same time as withdrawal of funds and continuing tightening of public budgets. Those actions affect the ability of the new organisations to survive beyond the next competitive tender round. One high profile body has already lost a renewed contract opportunity (to the 'well known' care provider Virgin! Or at least to one of its subsidiaries).

What the ingredients are for making it work, and specific advice for a similar sector in Wales.

We note that many charities and not for profit social enterprises do not have the democratic membership that crucially should define co-operative ownership, nor the structures for user control which people increasingly expect.

Definitions of social enterprise, mutual and co-operative are provided at Appendix 3.

Co-operatives are in essence enterprises owned by members, controlled by members, operating for the benefit of members. The co-operative starts from an active relationship with a bond of involvement being created by making use of services, investing, providing voluntary or paid labour to the co-operative. The user relationship may also refer to employment, and potentially address the adverse terms and conditions affecting a predominantly female workforce. Added value is primarily achieved by maximizing the user value rather than maximizing financial gains on capital.

Member input in co-operatives is of paramount importance. Sometimes a well meaning danger exists of 'putting the cart before the horse'. The point is that the co-operative is the members' local enterprise, and has to accommodate their needs and expectations, which they themselves are allowed to advance as part of the co-operative policy, and to which they personally, also with practical input, contribute.

A further aspect of care co-operatives worthy of note is the common practice of creating a network of small (even individualised) cooperatives who each become members of a bigger, secondary cooperative, which they in turn control, for example in order to realise economies of scale with shared back office functions, training, human resource management, financial feasibility and innovation**.** *Such arrangements inevitably take time to successfully evolve.*

Could the draft Canadian 'Principles for a National Co-op Elder Care Program' provide a useful baseline for adaptation in Wales? Service design and the designation of service needs should take place, as much as possible, at the community level of delivery, alongside an active programme of *co-operative education and community engagement*. This requires the creation of civil associations of public and community stakeholders to ensure the accountability of services and the flow of information necessary for effective budgeting, service design and delivery. This decentralisation of service delivery must include the democratisation of decision-making through the sharing of control rights with service users and caregivers.

In our experience of co-operative development, any programme will need to start small, develop organically and incrementally. For example, at an early stage we could look at encouragement and support being given to projects involving friends and people with like-minded interests, obtaining a mortgage through a co-operative structure and giving each other mutual support. This is in contrast to residential care where older people live with strangers not of their choosing, within a culture based upon dependency. In London we observe women who have co-operatively come together to provide shared home. We also see value in the Swedish model of locality driven Co-operative development to maximise the range of resources available, and the sustainability and ownership of this process.

We would propose that non statutory bodies seeking to benefit from government grants should sign a register to commit to providing ‘control rights’ to service users so they have a greater say in ensuing the needs of service users are central to delivering the service.

To support development, could a proportion of social care budgets that are not under the direct control of the state, be conveyed only to those organisations that provide control rights over the design and delivery of those services to users?

Advantages of a co-operative multi-stakeholder model: the Canadian experience

Social care services

“Consumer involvement....increases access to information, spurs innovation in service design and raises the level of transparency and accountability in the organisation”. John Restakis argues that social care services should be reciprocal in nature, with service users participating in the design of services and service delivery methods. Providers and recipients of services should be of equal status, leading to social cohesion and combining regard for the group. We agree.

Control and Service user satisfaction

Control rights means that service users have a greater say in ensuring that services are delivered in a manner that most benefits them as service users and not shareholders. The provision of control rights is the most cited benefit that the co-op model provides to members. It is perceived as essential to what makes the co-op model so attractive to those who have been exposed to it.

Service quality
This has been a key factor in attracting a growing number of older people to the co-op model. It is a direct result of the perception that member control can help ensure that service quality remains a paramount consideration. With profit making organisations, there will always be a tension between profit taking and the quality of care. With state-dominated services, the tension is often between local political priorities and the quality of care. There is no incentive in a co-op structure to shortchange service quality for considerations like profit maximisation, and the member control factor provides a buffer against collusion with government driven cuts.

Arguably, this user-centred form of internal organisation, will be more open to external regulation and inspection designed to promote safety and public protection.

Reduced Health Care Costs
One of the most compelling arguments for the use of the co-op model is the

reduced health care costs and hospitalisation rates for older people living in co-operative settings. John Restakis states the reasons for this outcome are complex and have much to do with the manner in which co-operatives help to nurture a sense of community among older people and others using this structure.

Mutual assistance and wellbeing

The relationships that are generated by increased interaction among members for purposes of running the co-op are also a source of mutual assistance and social relations that have a direct impact on a person's sense of personal well-being, on their ability to live in their own communities, outside of institutional settings, and on the availability of assistance that would otherwise have to be supplied by professional care givers

More entrepreneurial and able to finance innovations in service delivery

One of the major advantages of co-operatives is that they "are not as limited in the distribution of profits as conventional non-profits, they are better equipped to raise capital from members, funders and other stakeholders. They are also able to provide a limited return on capital to investors and funders. These capital advantages make social coops more entrepreneurial and more able to finance innovations in service delivery or the development of new projects.

Care worker satisfaction

Without any doubt, in 1997, the setup of a network of 101 home care social economy enterprise of (SSEHC) in Quebec has helped to significantly improve the working conditions and terms and conditions of employment of thousands of employees, including social protection, annual holidays, and in some case, pension plan. Using the multi-stakeholder co-op model providing employee representation in the co-op governance arrangements has been a way to empower an active role of workers in the SSEHC instead of only receiving a wage.

Recommendations

That during United Nations International Year of Co-operatives 2012:

(a) Wales should take an international approach to the pursuit of knowledge and understanding of social innovations in relation to the provision of care services to an ageing population, and a vigourous approach to practical, local application.

(b) Co-operatives in Wales should urgently focus upon the importance of co-operative education to increase awareness and understanding of what is distinctive about co-operative approaches in this sector and increase their membership. Co-operative education should help to engage more people in the debate to build interest in the cooperative model and start to generate a commitment to doing things differently.

(c) Active consideration should be given to the drafting (as in Canada) of 'Principles for a National Co-op Elder Care Programme' to ensure older people have a democratic stakeholder model; as part of the Third Phase of the Older Peoples Strategy consultation, in April 2012, to give dignity in care.

(d) Older people, and others, establish a 'Council of Elders', as a source of wisdom, to provide mutual support and assistance in enabling the development of Co-operative Home Care Services drawing upon international experience.

(e) Non statutory bodies seeking to benefit from government grants should sign a register to commit to providing 'control rights' to service users so they have a greater say in ensuing the needs of service users are central to delivering the service.

Conclusion

User-controlled Co-operatives could fundamentally change our approach to the design and delivery of essential care services, complementing public provision, which will be under severe strain. These co-operatives would be run for and by members. This principle is already accepted with the development of credit unions and now needs to be extended to other services. Membership may represent a range of interests, including workers and family-carers, but would most crucially represent the citizen-user.

David Smith,
Wales Progressive Co-operators

Appendix 1

Registered social landlord case study

In preparing evidence we observed a material change in service quality provided by a RSL with the transfer of a purpose built local authority residential

care home, with 60 one-bed units. This arose because this large RSL was not registered to provide care, but relied upon at least four external care agencies.

This transfer made a significant difference to residents. Whereas previously care was an integral part of their housing arrangement, residents requiring care can now experience up to four different care workers. Not only is there a loss in personal service and human relations, it is inevitably more expensive to externally source in such a fragmented manner, and where care needs can vary from day to day.

Our observations are as follows:

(a) Would it not make economic and social sense to have care persons on duty at the residential home all the time, rather than relying on external agency care staff, unknown to residents, who may have to travel from the other side of a city?

(b) Is more pressure being put upon local health professionals, who previously could rely on a local authority trained care and support staff, to undertake small procedures, such as, administering eye and ear drops, or help with reordering medication?

(c) If bedding or clothing becomes soiled does it make sense to have a known 'in house' care worker to deal with the situation, rather than alternative, which cause more distress?

(d) Socialisation is important for wellbeing, with regular activities. Is it sensible to rely upon an external agency care worker to handle a wheel chair, to enable residents to participate in leisure activities?

(e) Why is the RSL not registered for care purposes? This would enable existing housing support staff to undertake care duties, for which they have been trained?

(f) How many more cases are there like this and how much money are we wasting? How is the RSL accountable it residents? If residents had any say in the design and delivery of services can anyone imagine this type of situation arising?

Appendix 2
Social Co-ops and Social Care:

Brief Summary of Chapter 6 of "Humanising the Economy" by J. Restakis (2011)

Public provision of services

The author begins by recounting the history of a Canadian couple in their 90s. The wife was dying in hospital from congestive heart failure. Her husband was in the same hospital exhausted from the worry and strain of caring for his wife, to whom he had been married for 70 years. Without warning, the wife was moved to a nursing home 100 miles away. She was wheeled in to say a brief goodbye to her husband, but could not embrace him as she was strapped to the chair. She died 2 days after the move and he died 13 days after that.

When the circumstances became public there was an outcry. The official explanation was that the wife had to be moved to the only palliative care bed available. The author cites this as an example of the often insensitive nature of care provided by state run institutions. In such a situation, he says, “patients are powerless to influence bureaucracies that serve institutional interests as opposed to the interests of those they are meant to help”. Because of this, he adds, “fears of isolation, maltreatment, neglect have remained a constant presence in the lives of the vulnerable, whether they be people living with disabilities or those whose life fortunes have left them stranded at society’s margins”. It also applies, he argues, to large numbers of elderly people.

“Universal access through state systems requires that services be designed for application to large classes of users, not individual cases. Inflexibility, remoteness and regimentation of care are a necessary consequence. This is the inevitable dehumanising and impersonalising effect of bureaucracy”.

Private provision of services

Although social support systems (in monetary, health and social care terms) have been extended to cover more and more people, centralised delivery systems were little changed until the 1980s – and then only by the introduction of free market ideas.

“With society awash in material goods people now expect that social goods and services will also recognise and respond to them as individuals”. Many hoped the privatisation of services would achieve this aim. However, free market competition for the provision of services has centred far more on driving costs down rather than driving quality up.

The author argues that commercial care providers almost inevitably regard service users as commodities, which generate financial returns. Even in the better run private services the ethos is profoundly paternalistic – as it is in the public sector. Some charity run services try to move beyond a paternalistic attitude, but most of them are becoming more and more financially dependent on public finances and are hence required to provide services public bodies deem to be appropriate and are forced to become more and more bureaucratic in nature in order to satisfy their paymasters.

The author argues that a third way is needed: “Neither state bureaucracies, which depersonalise social care recipients, nor private sector firms, which

instrumentalize recipients as a source of profit, can ever be suited" to the provision of services for individuals.

The co-operative approach

The author argues that social care services should be reciprocal in nature, with service users participating in the design of services and in service delivery methods. Providers and recipients of services should be of equal status, leading to social cohesion and combining regard for the needs of the individual with the overall good of the group. "Consumer involvement in particular increases access to information, spurs innovation in service design and raises the levels of transparency and accountability in the organisation".

Co-operatives are in the best position to develop these kinds of services because they are neither dependent on government funding nor on making maximum profits. "In those social co-ops where the service users are also members, the operation of control rights has the capacity to transform the user from being merely a passive recipient of care – an *object* of care systems, to being a protagonist in the design and delivery of the care – an active *subject* in the care relationship. Co-op models …have shown a remarkable capacity to provide new types of care at a cost and in a manner that blends the benefits of a public good with the choice and responsiveness usually associated with a private sector service".

The author cites experience in Bologna where 87% of social care services are provided by social co-ops. Throughout Italy there are 6,000 social co-ops employing 160,000 staff (including 15,000 disadvantaged people). The legislation enabling these services to be provided by co-ops specifies that they must "pursue the general community interest in promoting human concerns and the integration of citizens". Since these developments, quality of care has improved and overall costs declined.

Another initiative in the Bologna/Ravenna region has been the provision of vouchers for social care services for service users to make their own choices. This has led to competition amongst service providers concentrating more on the quality of services rather than cheapness. Local social co-operatives are often seen as the best providers and have therefore flourished in the region.

One major advantage of co-operatives is that they "are not as limited in the distribution of profits as conventional non-profits, they are better equipped to raise capital from members, funders and other stakeholders. They are also able to provide a limited return on capital to investors and funders. These capital advantages make social co-ops more entrepreneurial and more able to finance innovation in service delivery or the development of new projects".

In conclusion, the author argues "in partnership with service deliverers, caregivers and users, the state should regulate and monitor service delivery, establish service standards, license service providers and enforce legal and regulatory provisions". He also argues "Social services that receive public funding and are not under the direct control of the state should be conveyed

only to those organizations that provide control rights over the design and delivery of those services to users". In addition some funding should be available to users to select the services they wish to purchase from accredited organizations, which would have to provide for user control of their operations.

Finally: "funds must be made available for the organization of independent consumer co-operatives to assist users and their families in the identification, evaluation and contracting of care services to their members. This is crucial, especially in the case of users that haven't the means, or the capacity, to adequately select and contract services on their own".

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Appendix 3
Definitions of social enterprise, mutual and co-operative
Extract from the NHS Alliance (England) 'The semantics of the 'Big society' Social enterprises, mutuals and co-operatives '
By Geraint Day and Mo Girach, August 2010.

"i. A **social enterprise** is an enterprise that is intended to fulfill a social purpose. It may use market-based mechanisms to operate. But its aim is to fulfill a social end. A social enterprise may be a so-called 'not for profit' organisation. ('Not for profit' is usually meant to indicate that there are not distributions to external shareholders.) It may be a 'for profit' body, where the business profits are applied to achieve one or more social aims. The key thing to bear in mind is that the main intention of a social enterprise is to not solely to operate commercially but to achieve other goals, such as specifically social or environmental aspirations. Examples of social enterprises

include *The Big Issue*, the Divine Chocolate Company, Hackney Community Transport, co-operatives and The John Lewis Partnership. According to the Social Enterprise Coalition there are around 62000 social enterprises in the UK, collectively employing about 800000 people.

iii Perhaps sounding somewhat circularly defined, a **mutual** is an organisation that operates according to the principles of mutuality. A mutual has *members*. The intention is that the members benefit in some way as a result of the activity of the mutual. Examples of mutuals include housing associations, building societies, credit unions, friendly societies, co-operatives, employee-owned enterprises (such as the John Lewis Partnership), NHS foundation trusts, football supporter trusts and mutual insurers. According to the policy body Mutuo there are some 20000 mutuals in the UK, collectively employing over 900000 people. Mutuo reckons that about 35000 people in each UK Parliamentary constituency who are members of mutuals; about half of the electorate in each.

iii. A **co-operative** is an organisation with *members* who have a democratic say in what is done with any profits (usually called surpluses). Co- operatives conform to a set of internationally agreed principles, which are: voluntary and open membership; democratic member control with each member having an equal say; member economic participation; autonomy and independence from the state; education training and information for members; co-operation with other co-operatives; concern for community. Examples of co-operatives include The Co-operative Group, Midlands Co- operative, and The Phone Co-op. According to Co-operatives UK, there are nearly 5000 co-operatives in the UK owned by 11 million members (about a fifth of the total population) employing over 200,000 people in all. They operate in sectors including from housing, agriculture, energy, retailing, credit unions, and healthcare. Although they need to conform to the seven principles listed above, they need not contain “co-operative” in their title.

What's in a word? The reader may have noticed that some of the words have cropped up under each of the three categories of organisation. For instance, credit unions have been mentioned as both mutuals and co-operatives. Co- operatives themselves have been mentioned under all three headings. Without going any further into semantics or setting hares running, the term social enterprise may be taken to include mutuals and co-operatives. Yet not all social enterprises are either co-operatives or mutuals. Nor are all mutuals co-operatives. When it comes to co-operatives, as has been mentioned, they are a particular type of organisation with a form and purpose that is understood internationally. The origins of co-operatives go back to seventeenth century Ireland, eighteenth century Scotland and the nineteenth century England. Their principles and values have been agreed by an International Co-operative Alliance comprising organisations having a total of over 800 million members”.

We would add, although much praise is rightly given to Robert Owen, of Newtown, equal merit is due to Dr William King of Brighton who wrote several dozen practical newsletters, which enabled Owen’s ideas to become a practical reality.

Appendix 4

Learning from Quebec – an opportunity in February 2012

Wales Progressive Co-operators, alongside the national care organisation Cartrefi Cymru, with financial support from Wales / Cymru Co-operative Membership, Public Health Alliance Cymru and the Welsh Food Alliance, enabled us to invite Jean-Pierre Girard (JPG) to participate in a two day programme of activity in Wales as part of United Nations Year of Co-operatives 2012.

New and emerging models of care provision and alternative co-operative models

Care Co-operatives are not new, and internationally are well established. To assist the Inquiry, and help inform public discussion, we have:

(i) Arranged a number of public events with JPG, including one being kindly hosted by Rosemary Butler AM, in Ty Howell, Cardiff Bay on the 7th February 2012;

(ii) Commissioned JPG to present evidence to the HSCC Inquiry using questions related to the Inquiry Terms of Reference, including Co-operative Home Care Services in Quebec;

(iii) Offered to make JPG available should the Health and Social Care Committee wish to take oral evidence on 8th February 2012;

(iv) Provided a facility for Ministers, Officials, NGOs and others to meet with JPG during his short visit.