Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 1 - Y Senedd

Dyddiad:
Dydd Iau, 23 Chwefror 2012

Amser:
09:15

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:

Llinos Dafydd
Clerc y Pwyllgor
029 2089 8403
HSCCommittee@wales.gov.uk

Agenda

1. Cyflwyniad, ymddiheuriadau a dirprwyon

2. Ymchwiliad i ofal preswyl i bobl hŷn - Tystiolaeth gan Gomisiynydd Pobl Hyn Cymru (09.15 - 10.05) (Tudalennau 1 - 14)

Ruth Marks, Comisiynydd Pobl Hŷn Cymru
Sarah Stone, Dirprwy Gomisiynydd Pobl Hŷn Cymru
Alun Thomas, Pennaeth Adolygu, Archwilio a Pholisi

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3. Ymchwiliad i ofal preswyl i bobl hŷn - Tystiolaeth gan raglen My Home Life (10.05 - 10.55) (Tudalennau 15 - 38)

John Moore, My Home Life Cymru
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Tom Owen, Cyfarwyddwr, My Home Life
HSC(4)-06-12 papur 3

Egwyl 10.55 - 11.05

4. Ymchwiliad i ofal preswyl i bobl hŷn - Tystiolaeth gan y Sefydliad Gofal Cymdeithasol er Rhagoriaeth a'r Sefydliad Gofal Cyhoeddus (11.05 - 11.55) (Tudalennau 39 - 51)

Prof John Bolton, y Sefydliad Gofal Cyhoeddus, Prifysgol Oxford Brookes
HSC(4)-06-12 papur 4
Julie Jones, Prif Weithredwr, y Sefydliad Gofal Cymdeithasol er Rhagoriaeth
HSC(4)-06-12 papur 5

5. Papurau i'w nodi (Tudalennau 52 - 56)

Cofnodion cyfarfodydd 2 a 8 Chwefror
HSC(4)-04-12 cofnodion
HSC(4)-05-12 cofnodion

5a. Blaenraglen waith - Gwanwyn 2012 (Tudalennau 57 - 59)
HSC(4)-05-12 papur 6

5b. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru - Gwybodaeth ychwanegol gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol (Tudalen 60)
HSC(4)-02-12 papur 7

6. Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 7 (11.55)

7. Goblygiadau iechyd cyhoeddus cyfleusterau toiledau cyhoeddus annigonol - Ystyried crynodeb o'r dystiolaeth (11.55 - 12.10)

Health and Social Care Committee
HSC(4)-06-12 paper 1
Inquiry into residential care for older people – Evidence from the Older People's Commissioner for Wales

Introduction

The Older People's Commissioner for Wales has four general statutory functions:

(a) to promote awareness of the interests of older people in Wales and of the need to safeguard those interests;

(b) to promote the provision of opportunities for, and the elimination of discrimination against, older people in Wales;

(c) to encourage best practice in the treatment of older people in Wales;

(d) to keep under review the adequacy and effectiveness of law affecting older people in Wales.[1]

The Commissioner is an independent advocate for older people in Wales. This response to the Consultation is in accordance with the Commissioner's general statutory functions. The Commissioner's position is that she will generally make comment relating to core principles. This approach is taken in order to avoid any potential compromise of the Commissioner's regulatory functions. Any practical suggestions made in this document are based on concerns and information brought to the Commissioner by older people.

United Nations Principles

The Commission commends the UN Principles for Older Persons as the basis for the provision of residential care services. Those which relate directly to care are:

1. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
2. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well- being and to prevent or delay the onset of illness.
3. Older persons should have access to social and legal services to enhance their autonomy, protection and care.

[1] Commissioner for Older People (Wales) Act 2006, s.2(1)

4. Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
5. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Observations related to some of the terms of reference set out for the Committee's inquiry are detailed below:

Entry into care

Admission into care is often preceded by a crisis or period of ill-health.

In our work, the Commission has seen evidence that the nature of decision making has a notable impact on older-people's adjustment to life in care homes.

When individuals do enter care, it is often in traumatic circumstances, for example admittance via hospitals, and there is a risk of being labelled with challenging behaviour.

Advocacy can be crucial in decision making about entry to a care home.

> 'Decisions about entry into care can all too easily be made by relatives and professionals whose interests and views may not concur with those of the older person. Such decisions might also be taken whilst the older person is in a particularly vulnerable position, such as at the point of hospital discharge. Similarly, in an evidence review of access to advocacy, Townsley et al (2009) acknowledge its potential benefits when entry into residential care is a possibility'
>
> A Scoping Study of Advocacy with Older People for OPCW by Andrew Dunning.

Access to information and advice services is variable. There remains anecdotal evidence of residents 'lost in care' especially when individuals have a cognitive impairment.

Much of our direct engagement with care homes suggests that older people have low expectations of care homes prior to admission and that they have low satisfaction thresholds once admitted. For example one man in his 90s told the Commission that he was assisted with

getting dressed and had his meals prepared and bed made and that was all that he could want in life at his age.

Capacity and staffing

During our various interactions with care homes, the prevalence of cognitive impairment amongst the older residents was notable. This was also a common theme during our first Review into dignity and respect for hospital inpatients. One of the recommendations of that Review called for better knowledge of the needs of older people with dementia, together with improved communication, training, support and standards of care.

Anecdotal evidence from our engagement with the care home sector is that staffing levels are being reduced. This can impact the amount of time staff can spend with residents for informal engagement and conversation. Residents have told us that they felt more staff are needed to enable time for more informal interaction.. We note that evidence received by the committee from older people and relatives expresses concern over the level of activity for residents. This theme also emerged strongly from our hospital review. The UN Principles refer to the importance of 'social and mental stimulation'. It is vital that people in residential care are able to engage in activities of their choice.

Role of Independent Mental Capacity Advocates (IMCAs) and Deprivation of Liberty Safeguards

Older people are the biggest client group to which IMCA services in Wales provide support.

IMCA services have identified a number of concerns to the Commissioner regarding the implementation of the Mental Capacity Act, although they were keen to recognise that a large number of older people have been adequately safeguarded by Mental Capacity Advocates (MCAs) and IMCAs.

Evidence provided to the Commissioner suggests that the Mental Capacity Act (MCA) is misunderstood by some professionals and its provisions and requirements are not entrenched into practise. There is a lack of awareness of the statutory duties under the MCA and particularly about what constitutes best interests, and whose best interests.

There appears to be inconsistencies around whether mental capacity issues are flagged and the IMCA services are not receiving the number of referrals they should. There are significant variations across different areas regarding the referral numbers.

The Commissioner has been informed by a number of practitioners that there is a lack of understanding regarding Deprivation of Liberty Safeguards especially in drawing distinctions between restricting and depriving liberty. In practice, we are concerned that the threshold of what constitutes a DOL may be set too high thus seriously reducing the number of cases registered. There are examples where temporary arrangements of restriction remain in place well beyond the threshold for triggering DOLS. There is also evidence of inconsistency in the application of DOLS. For example, it has been reported to the Commission that there is significant variation in the number of Deprivation of Liberty Safeguard procedures between the northern and southern parts of one local authority area

Reporting and monitoring is problematic. There is no all-Wales recording system.

Welsh Government Section 7 Guidance: 'Escalating concerns with, and closures of, care homes providing services for adults'

In 2010, the Commission was contacted by a considerable number of older people and their relatives who were affected by potential care home closures. These homes were under threat of closure due to a change in the local authority's policy about residential accommodation. The Commission spoke with the local authority to

express concerns about the uncertainty and worry that this threat was causing residents and relatives. We also contacted the Welsh Government and were told that the 'Escalating concerns with, and closures of, care homes providing services for adults' guidance should be applied by the local authority. However, a careful reading of the guidance indicated that the guidance as it stands does not provide a directly relevant framework for dealing with the threat of closure of local authority care homes as a matter of policy.

On 31 January 2011 the Commissioner wrote to the Welsh Government expressing concern. A copy of the letter is attached at Appendix 1. The main concerns were:

1. the lack of clarity in the 'Escalating concerns' guidance about how it applies where the threat of closure is as a result of a policy decision rather than due to concerns about quality of care or safety or financial viability;
2. the haphazard nature of any consultation process, the point at which it takes place and its, sometimes, indeterminable length;
3. the lack of independent advocacy for older people; and
4. the lack of Independent Mental Capacity Advocates for those older people who lack capacity.

The Commissioner received a response, dated 13 April, which responded in part to the issues raised (also at Appendix 1).

We raised the matter with the researchers from Swansea University carrying out the work on care home closure. We also commissioned a specific piece of work to look at the issue in more depth.

A draft copy of the Swansea University research findings and recommendations has already been submitted to the Health and Social Care Committee by the University as evidence (RC 72) and we would draw the Committee's attention to Chapters 6, 7 and 8 in particular. We will not repeat the issues here. The Commissioner strongly supports the recommendations made by the researchers in relation to updating the Welsh Government's guidance so it better protects the interests of older people in Wales.

In our view, the 'Escalating concerns' guidance and commissioning guidance fall short of providing a framework that ensures older people's interests are properly protected during home closures. Discussion with representatives from seven local authorities in Wales

showed that local authorities are not routinely using the 'Escalating concerns' guidance when they close homes as a result of a policy decision. The representatives saw the guidance as having been designed for a different purpose and did not see it as adequate guidance applicable to a policy based closure. They also did not think that commissioning guidance is directly applicable, viewing it as relevant mainly in a contextual sense. They would welcome the creation of bespoke best practice guidance.

Financial security of care home providers

The care sector is increasingly reliant on private sector providers, but a significant proportion of its income still comes from the public purse via local authority funded residents.

The Welsh Government and local authorities therefore have both the right and the responsibility to assess the financial stability of private companies who they entrust with vulnerable people's care. Financial stability should be a key consideration in the commissioning and awarding of contracts, and in the monitoring of care standards in homes in Wales.

Older people in a care home are not a commodity, they are human beings who have the right to be cared for properly and treated with dignity and respect. When care homes are run by businesses whose basic structures are less than robust, they are gambling with the wellbeing of the vulnerable older people who trust them with their care. It is vital that businesses which provide care are able to cope with difficult times as well as good.

The Commission would encourage the care sector in Wales to tell people what steps it will take to ensure that circumstances such as those surrounding the Southern Cross situation do not happen again. In particular it must look at how it manages risk, and consider ways of insuring itself against financial crisis, as other sectors do. Above all, residents must not become victims of financial crises which are not of their making.

Choice and Diversity of provision

With local authorities increasingly disengaging from providing care and a widespread move towards independent provision, it is important to address residents' fears about what impact these changes may have on their care. Independent provision is the subject of some myths, and these should be dealt with through clear and open communication, good information and advice, and the provision of advocacy where appropriate.

To ensure a robust care sector, and allow people a wide range of choice, the Commissioner believes it is important to maintain a diverse selection of private and publicly run residential homes. The One Wales document from the previous Welsh Government contained an undertaking to look into the viability of not-for-profit nursing care, and there is merit to considering a similar approach in residential settings.

Paying for Care

There is a general recognition that the current arrangements for paying for care are unfair and unsustainable. Any new system for care funding should be mindful of the UN Principles and of the need to end discrimination on the grounds of age.

Prior to the last UK General Election, the governments in London and in Cardiff held a consultation on paying for care. In Wales, the findings implied that there were opportunities for a differing emphasis in Wales. In reality the ties between care provision and benefit entitlement mean that developments in Wales are linked to developments in England and decisions made by the UK Government.

The report of the Dilnott Commission and its recommendations represent a real opportunity to address many of the inconsistencies and inequities in the current system. We have urged the UK government to act on the report's findings. We should do all we can in Wales to improve the current situation for older people.

The Commission is engaged in a range of activities which are pertinent to the subject matter of the Committee's current inquiry. These include:

- **Undertaking a Review into advocacy arrangements which safeguard the interests of older people in care homes**

This Review was first announced in September 2011 and will report in June 2012. The Review builds on two substantial pieces of research. The first was a scoping study on advocacy in Wales undertaken by Andrew Dunning from Swansea University (attached). Secondly the Commission funded Age Cymru to publish 'Advocacy Counts 3' in 2011(also attached). This report highlights the current state of advocacy provision in Wales and enables comparisons to be made with previous studies in 2007 and 2008.

The Review covers the advocacy arrangements of the following:

- Welsh Government (Minister for Health and Social Services and Deputy Minister for Social Services and Children),
- Local authorities in Wales,

- Local Health Boards in Wales where there are joint commissioning arrangements in place, and
- Local authority and independent care and nursing homes.

The initial phases of the Review have involved desktop research in the majority of local authority areas (13), where data applicable to four care homes per authority were considered in detail. The Review encompasses residential, nursing and 'elderly mentally infirm' care homes. It includes homes run by local authorities and the voluntary and private sectors. Visits were made to three care homes in each of five demographically distinctive local authority areas in Wales.

The Commission is currently analysing the findings of the Review before framing recommendations for a range of organisations. The bodies subject to the Review will be required to follow these recommendations. As the committee will appreciate, we cannot share much at this stage because the work is not yet complete but we would welcome the opportunity to share our detailed findings and recommendations with the Committee after the Review report has been published in June. Some of the general observations made during our visits do, however, strike a common chord with earlier work undertaken by the Commission in relation to residential care.

- **Undertaking a call for evidence on the experience of older people in receipt of domiciliary care**

The call for evidence commenced in September 2011 following some well-publicised concerns about commissioning processes for domiciliary care and the impact of change on service users, as well as the variability in quality and consistency of care provided. The Equality and Human Rights Commission inquiry in England also highlighted the need to begin developing a Welsh perspective on the experience of older people receiving care at home. The sustainability of domiciliary care is pivotal in off-setting the need to enter residential or nursing care.

The Commission has received over 200 responses and is developing this evidence base further by circulating questionnaires to home care users in 4 local authority areas to represent the breadth of older peoples experiences throughout Wales. The Welsh Institute of Health & Social Care has commenced the analysis of responses.

- **The Commissioner has commissioned research on whistle-blowing culture in Wales, together with a call for evidence which was launched earlier this month**

The Commissioner has specific legal powers to review arrangements for whistle-blowing in Wales. Before determining any future action on this issue we want to establish an evidence base about the culture that

surrounds whistle-blowing in Wales. This work is being conducted on our behalf by Cardiff University and will report in late Spring/early Summer 2012.

We have also commissioned a piece of work by Public Concern at Work which will be published in the Spring.

- **The Commission has been a partner in research carried out by Swansea University into care home closures.**

We are aware that Swansea University has shared a copy of this important report with Committee Members already and we would strongly advise the Committee to consider its recommendations in detail. Motivated by the volume and nature of calls on the poor management of care home closures, the Commission helped to initiate this work. We have identified the need either to enhance the 'Escalating concerns' guidance or produce additional guidance. This is discussed in more depth elsewhere in this paper.

- **The Commission conducted a series of seminars on frailty, one of which was held in March 2011. This was on the emerging findings of the care home closure research referred to previously and on the capacity of extra care housing to meet the needs of those with significant cognitive impairments and with deteriorating conditions**

The Commission's interest in extra care housing builds on a joint seminar held with the Joseph Rowntree Foundation in May 2009 and on research undertaken by the Centre of Innovative Ageing in Swansea University (Extra care – meeting the needs of fit or frail older people? – Burholt et al – July 2010). Whilst being impressed with many of the schemes which she and her staff have visited, the Commissioner was concerned to learn about differential approaches to residents whose health conditions worsen and the limited eligibility criteria of other schemes.

- **Taking a more coherent approach to meeting the information and advice needs of older people**

In January 2012, the Commission hosted a conference to consider a more coherent approach to meeting the information and advice needs of older people. A report into the state of information and advice provision currently is available on the Commission website. The report highlighted particular challenges in the health sector. The provision of information enabling timely informed choices to be made for future care options often at very short notice is of particular importance and was highlighted by the Institute of Welsh Affairs in its publication for the Commission 'Adding life to years' (Osmond, June 2010). The Commissioner is considering issuing guidance in this area.

Commission representatives will be happy to elaborate on these and any other initiatives when meeting the Committee.

Link to Advocacy Counts 3 – Report and Executive Summary
http://www.olderpeoplewales.com/en/news/news/11-03-01/Advocacy_Counts_3.aspx

Link to scoping study of advocacy arrangements in Wales and Executive Summary
http://www.olderpeoplewales.com/en/news/news/11-08-11/A_Scoping_Study_of_Advocacy_with_Older_People_in_Wales.aspx

Appendix 1

Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

Cambrian Buildings
Mount Stuart Square
Cardiff
CF10 5FL

Mr Steve Milsom
Head of Adult Social Services
Policy Division
Welsh Assembly Government

31 January 2011

Dear Steve,

Re. Statutory Guidance: Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults

In recent months, I have been contacted by older people who live in care homes facing potential voluntary closure because the care home is said to be no longer financially viable. These older people and their representatives have shared with me concerns about the uncertainty of the situation in which they find themselves. They have told me about the worry, and sometimes distress, they are caused by not knowing what their future holds.

Members of my staff have been looking carefully at this matter in order to promote awareness of the interests of these older people and encourage best practice when dealing with matters that affect their home life. We have also spoken with some Directors of Social Services, particularly about their use of the 2009 'Escalating Concerns' Statutory Guidance. This has led us to think that there is a gap in the guidance in relation to care homes where there are no concerns about quality of

care, no concerns about safety and where there has been no final decision about closure.

For example, there are an increasing number of local authority areas where the possibility of care home closure is announced and thereafter follows a long period of consultation and, sometimes, delay. In such scenarios, we have found that older people may be told that although no decision has been made to close the care home they must still visit other care homes with a local authority social worker so they can decide where they would like to go when the care home closes. If they express that they would rather wait until a final decision to close is made, they are told that if they wait until then they will 'miss out on a good place'. We are deeply concerned about what seems to be an insufficient use of Independent Mental Capacity Advocates in these situations. Local authorities and NHS bodies have a duty to instruct IMCAs where accommodation arrangements are being made on behalf of an older person lacking capacity without friends or family. Neither are we convinced that older people have access to independent advocacy services at an early enough stage to allow them to voice their opinions about the potential closure, for example, from the point when potential closure is first announced and then followed by a period of consultation. Local authorities do not seem to be sufficiently clear about the role of the statutory guidance and have expressed to us a need for further clarity.

The Older People's Commission is supporting research by Swansea University into the prevalence, process and impact of care home closure in Wales. We are holding a set of seminars to look at the emerging findings from this research and other research evidence on extra-care facilities. However, we do not want to wait until the final outcome of these initiatives before raising our concerns about the statutory guidance with the Welsh Assembly Government.

I would welcome a meeting to discuss these concerns more fully. I see this as an opportunity to make the statutory guidance even more widely applicable, which will in turn promote and safeguard the interests of older people in Wales.

Yours sincerely,

Ruth Marks

Older People's Commissioner for Wales

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Ruth Marks
Older People's Commissioner for Wales
Cambrian Buildings
Mount Stuart Square
Cardiff, CF10 5FL

Dyddiad/ Date: 13 April 2011

Dear Ruth

STATUTORY GUIDANCE: ESCALATING CONCERNS WITH, AND CLOSURES OF, CARE HOMES PROVIDING SERVICES FOR ADULTS

Thank you for your letter of 31 January concerning the above guidance. I must first apologise for the delay in replying but I understand that you met with the Deputy Minister for Social Services more recently and discussed this matter although I understand it was not covered in any great detail.

It is always a matter of regret when care homes providing good quality services are subject, for whatever reason, to proposals that could affect their future operation and I can appreciate the uncertainly and distress that such situations cause. From the information contained in your letter it would appear that representations made to you might have been from older people living in local authority owned care homes which could be facing "voluntary" closure.

As you will be aware, is it the statutory responsibility of each local authority to assess the social care needs of its resident population and to provide, or commission as appropriate, a range of social care services to meet those needs. As such the Assembly Government is not in a position to intervene in any proposals affecting service provision at a local level or indeed influence any decisions over service provision. However, in line with the Assembly Government policy, local authorities have been reviewing their social service provisions to ensure they meet the needs of their resident populations and can respond to future demands. As a result a number of authorities have reviewed their current residential provision to consider whether their homes are fit for purpose with a view to re-providing services in other settings. As a consequence this could lead to the closure of some homes.

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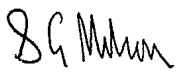
I can assure you that of paramount importance in any circumstance where the future of a care home is uncertain is the welfare of residents and to ensure appropriate steps are taken in a timely manner to safeguard each resident's future care. Local authorities and/or the LHB will need to ensure the welfare of residents is not compromised and that a full assessment of their long term care and accommodation needs is undertaken and full support is provided during any necessary move to new accommodation.

I hope I have been able to provide some further clarity on this issue and I can advise you that I will bring the specific issues you have raised to the attention of CSSIW. If as a result of discussions with my colleagues it is considered necessary to review any aspect of the guidance I will ensure you are advised accordingly.

Yours sincerely



STEVEN MILSOM
Head of Adult Social Services Policy Division, Health & Social Services Directorate General/ Yr Is-adran Polisi Gwasanaethau Cymdeithasol Oedolion, Cyfarwyddiaeth Gyffredinol Iechyd a Gwasanaethau Cymdeithasol

Y Pwyllgor Iechyd a Gofal Cymdeithasol
HSC(4)-06-12 papur 2
Ymchwiliad i Ofal Preswyl Pobl Hŷn yng Nghymru
Tystiolaeth gan My Home Life Cymru

Cyflwyniad

Mae rhaglen My Home Life ar droed yng Nghymru ers ail hanner 2008 ac yn cael ei hariannu drwy Grant Bach y Sector Gwirfoddol a hwylusir gan Her Iechyd Cymru. Nod My Home Life Cymru yw hyrwyddo gwella ansawdd bywyd y rhai sy'n byw, yn marw, yn ymweld ac yn gweithio mewn cartrefi gofal i bobl hŷn. Mae My Home Life hefyd yn anelu at ddathlu arfer da sydd eisoes yn bod a hyrwyddo cartrefi gofal fel dewis cadarnhaol i bobl hŷn. Ers diwedd 2008 hyd at yn awr, mae'r rhaglen wedi bod yn gweithio'n ddwys gyda 38 o gartrefi ar draws y wlad i gyd. Mae'r cartrefi hyn yn gynrychioliadol o'r sector cartrefi gofal yn ei gyfanrwydd yng Nghymru gan eu bod yn cynrychioli:

- 18 ardal awdurdodau lleol
- 31 o gartrefi'r sector annibynnol (yn cynnwys darparwyr bach a chenedlaethol)
- 3 chartref awdurdodau lleol
- 4 cartref y trydydd sector
- Cartrefi mewn ardaloedd gwledig, trefol a lled-drefol
- Cartrefi Cymraeg eu hiaith
- Cartrefi ffydd
- Cartrefi gyda'r niferoedd yn amrywio, o 7 i 100 o breswylwyr
- Cartrefi sy'n cynnig amrywiaeth o wasanaethau:
    - Gofal preswyl
    - Gofal nyrsio
    - Gofal seibiant
    - Gofal dydd
    - Gofal iechyd meddwl i bobl hŷn (Henoed Bregus eu Meddwl)

Digwyddiadau, hyfforddi ac adnoddau

Yn ystod y 3 blynedd diwethaf, mae My Home Life wedi cynnal nifer o ddigwyddiadau ar draws y wlad i godi ymwybyddiaeth am y rhaglen a datblygu Rhwydwaith Fy Mywyd Mewn Cartref o gartrefi:

- Cynadleddau blynyddol bob blwyddyn yn dechrau yn 2009. Cynhelir yr achlysur eleni yng Ngwesty'r Metropole yn Llandrindod ar 27 Mawrth. Ar gyfartaledd mae 113 wedi mynychu'r cynadleddau hyn.
- Cynhaliwyd Seminar Genedlaethol yng Nghaerdydd ym mis Tachwedd 2010, gyda chyflwyniadau gan lawer o'r enwau

blaenllaw yn sector cartrefi gofal y DU gan gynnwys David Sheard a'r Athro Mike Nolan. Denodd y digwyddiad hwn 185 o fynychwyr.

- Cynhaliwyd 8 seminar ranbarthol rhwng Mawrth 2010 a Mai 2011. Cynhaliwyd y rhain ar draws y wlad a rhyngddynt fe'u mynychwyd gan 175.
- Mae 7 diwrnod rheolwyr wedi eu cynnal ers mis Ebrill 2009. Targedwyd y digwyddiadau hynny at y 38 o gartrefi sy'n ffurfio craidd rhwydwaith My Home Life Cymru.
- Mewn ymateb i nodi rhai anghenion datblygu ymysg y cartrefi hyn, cynhaliwyd nifer o ddigwyddiadau hyfforddi ar hyd a lled y wlad:
    - Sicrhau hawliau dynol mewn cartrefi gofal
    - Ymagwedd cartref cyfan at weithgareddau mewn cartrefi gofal
    - Agorwch eich calon i ngweld i – cefnogi pobl gyda demensia
    - Dod i'ch adnabod – hanes bywyd a gwaith hel atgofion mewn cartrefi gofal
    - Hyfforddiant Gweithredol Effaith Isel (LIFT)

Mae datblygu adnoddau wedi bod yn rhan hanfodol o'n gwaith yng Nghymru. Mae'r adnoddau hynny yn cynnwys:

- Ein cylchlythyr chwarterol sy'n cael ei anfon i bob cartref gofal i bobl hŷn yng Nghymru
- www.agecymru.org.uk/mhlc Mae'r tudalennau hyn yn cynnwys y newyddion diweddaraf a dolenni at ddogfennau, cyflwyniadau a gwybodaeth werthfawr arall.
- Llyfryn 'Dod i'ch adnabod'. Cyhoeddwyd hwn i gyd-fynd â'r hyfforddi a fu yn 2011.
- Llyfryn 'Agorwch eich calon i fy ngweld i'. Cyhoeddwyd hwn i gyd-fynd â'r hyfforddi a fu yn 2011.
- Llyfryn Fy Mywyd Mewn Cartref. Mae'r llyfryn cyflwyniadol hwn yn helpu staff cartrefi gofal, y preswylwyr a'u teuluoedd i ddeall ymagwedd My Home Life.
- Canllawiau Arfer Da Fy Mywyd Mewn Cartref Cymru. Dyma gyfres o 8 o ganllawiau sy'n archwilio themâu My Home Life:
    - Cynnal Hunaniaeth
    - Creu cymuned
    - Rhannu gwneud penderfyniadau
    - Rheoli'r trawsnewid i gartref gofal
    - Gwella iechyd a gofal iechyd
    - Cefnogi diwedd bywyd da
    - Cadw'r gweithlu'n addas i'r diben
    - Hyrwyddo diwylliant cadarnhaol
- Mae My Home Life Cymru wrthi'n datblygu 'Rhestr Wirio Gofal Cartref', a fydd yn cefnogi unigolion a'u teuluoedd i gynllunio ymlaen llaw ar gyfer symud i gartref.

- ‘Datblygu Gwirfoddoli mewn Cartrefi Gofal’. Bydd y cyhoeddiad hwn o gymorth i gartrefi, gwirfoddolwyr a chyrff gwirfoddoli i weithio mewn partneriaeth i annog cefnogi a datblygu gwirfoddolwyr mewn cartrefi gofal.

Byddwn yn parhau i ddatblygu adnoddau mewn partneriaeth â chartrefi gofal er mwyn mynd i’r afael â’r gofynion sy’n newid yn y sector cartrefi gofal yng Nghymru.

Mae’r holl weithgaredd a grybwyllir uchod wedi helpu i sefydlu My Home Life Cymru ac mae’r sector cartrefi gofal wedi cynyddu ei ymwneud â ninnau yn unol â hynny. Hyd at y pwynt hwn, mae’r nifer o gartrefi sydd wedi dangos diddordeb gweithredol yn y rhaglen yn 225. Mae’r nifer bron yn 30% o’r sector yng Nghymru. Mae’r cartrefi wedi mynychu digwyddiadau, gwirfoddoli i fod yn rhan o’r rhaglen a hefyd wedi ymateb yn weithredol i’n hadnoddau.

Gwrando ar ddarparwyr, preswylwyr a pherthnasau

Mae fy ngwaith gyda’r 38 o gartrefi craidd wedi cynnwys ymweld â phob un ohonynt a threulio amser gydag aelodau o’r staff (rheolwyr, perchnogion a phob lefel o staff), preswylwyr a’u perthnasau/ymwelwyr â’r cartref. Mae hynny wedi rhoi imi gipolwg ar y persbectif unigryw sydd gan bob un o’r grwpiau hyn mewn perthynas â’r rhan a chwaraeir ganddynt yn y cartref gofal.

Ni waeth beth fo maint y cartref na nifer y preswylwyr, mae pob cartref yn cyflenwi gwasanaethau tebyg iawn i’w gilydd. Maent hefyd yn cefnogi grŵp cleientiaid sy’n galw am yr un anghenion. Mae’r grŵp perthnasau ac ymwelwyr hefyd yn edrych yr un fath ar hyd a lled y wlad. Mae tîm y staff yn wynebu’r un materion ac mae’r timau rheoli yn dod o dan yr un ddeddfwriaeth, rheoleiddio a chraffu gan awdurdodau lleol. Fodd bynnag, ni olyga hyn fod pob cartref yr un fath. I’r gwrthwyneb, mae gan bob cartref ei ffordd a’i bersonoliaeth ei hun. Mae ymagwedd pob un yn drwm gan ddylanwad cefndir tîm yr uwch staff, e.e. cefndir nyrsio/iechyd, gwaith cymdeithasol a phrofiad y grŵp cleientiaid. Rwyf wedi cwrdd â rheolwyr a staff sy’n dod o gefndir gwasanaeth anabledd dysgu. Yn yr achosion hynny mae’r unigolyn wedi dod â dealltwriaeth gryfach o ‘werth’ i’w gwasanaethau. Mae datblygu’r gwasanaethau anabledd dysgu dros y 25 mlynedd diwethaf wedi cynhyrchu llawer o bobl broffesiynol sy’n gweithio gyda seiliau gwerthoedd cryfion ac wedi mynd â’r rhain gyda hwy i’w swyddi presennol.

Mae’r sector cartrefi gofal yng Nghymru wedi ei wneud yn bennaf o ddarparwyr sector annibynnol bychain. Mae eu sefyllfa yn un werthfawr ond eto’n ansicr. Fel corff bychan, nid ydynt yn elwa ar y cymorth sy’n dod o fod yn gorff mwy e.e. darparwr cenedlaethol, awdurdod lleol. Golyga hynny’n aml iawn nad yw’r rheolwr yn cael y cymorth sydd

angen arno. Daw hynny ym meysydd datblygu'r gwasanaeth, addasu i ddeddfwriaeth newydd, gofynion rheoleiddio ayyb. Hefyd, mae maes cymorth gan gymheiriaid yn allweddol i ddatblygiad cartrefi. Mae gan reolwyr wedi'u cysylltu drwy gyflogwr cyffredin fel arfer rwydwaith cymorth i'w cynorthwyo wrth eu gwaith. Fodd bynnag, mae rheolwyr sydd heb y cylch hwn o gymorth yn tueddu i gael pethau'n anodd. Yr ydys wedi mynd i'r afael â'r ynysrwydd gosodedig hwn mewn sawl ardal drwy sefydlu fforymau darparwyr a rhwydweithiau eraill. Serch hynny, mae'r grwpiau hyn yn aml yn cael eu dal ym mater parhaus y ffioedd ac nid ydynt byth yn ymdrin â'r prif feysydd o gymorth sy'n allweddol i waith y rheolwr.

Mae My Home Life Cymru yn ymdrechu i ddatblygu ei rwydwaith yn rhanbarthol ac yn genedlaethol. Y 38 cartref gwreiddiol sydd wrth galon y datblygu hwn a byddwn yn edrych ar ymwneud â mwy o gartrefi yn ystod y misoedd a'r blynyddoedd i ddod.

Mae nifer dda o gartrefi yng Nghymru sydd o hyd yn gymharol fach mewn cymhariaeth â gweddill y farchnad. Po fwya'r cartref, po fwyaf ariannol hyfyw y bydd, ond mae'r cartrefi llai a hefyd y cartrefi wedi'u rhannu'n unedau bychain yn gallu cynnig amgylchedd sy'n fwy abl i ddatblygu awyrgylch 'cartrefol'. Pan fydd cartref/uned yn fach a bod dilyniant da yn y trefniadau staffio, mae'r awyrgylch yn ei gynnig ei hun i feithrin perthynas dda yn y cartref. Mae gan y preswylwyr lai o staff i ddod i'w hadnabod ac i'r gwrthwyneb. Ni ellir tanbrisio'r agwedd o berthynas mewn bywyd cartrefi gofal. Pan fydd aelodau'r staff, preswylwyr a'u teuluoedd yn gweithio gyda'i gilydd, gall hyn arwain at ddatblygu perthnasoedd sydd o gymorth wrth gyflwyno gwasanaethau sydd wedi eu mowldio mewn difrif o amgylch y preswyliwr.

Mae'r Fframwaith Synhwyrau (Nolan et al 2006), yn edrych ar fater ansawdd bywyd y rhai sy'n byw mewn lleoliadau gofal tymor hir i bobl hŷn, y rhai sy'n gweithio ynddynt a'r rhai sy'n ymweld â hwy. Mae'r fframwaith yn nodi'r Chwe Synnwyr sy'n hysbysu ansawdd bywyd i bawb. Mae gan bawb synnwyr o:

- Berthyn
- Diogelwch
- Dilyniant
- Pwrpas
- Arwyddocâd
- Cyflawni

Mae My Home Life yn annog cartrefi i ddatblygu'r ymagwedd perthynas ganolog sy'n annog staff i edrych ar sut maent yn gwneud yr hyn a wnânt. Gallant wedyn addasu'u hymagwedd yn unol â hynny i ganolbwyntio ar faterion ansawdd bywyd, ac nid y tasgau gofal mae'n rhaid iddynt eu gwneud. Yn aml iawn, bydd staff yn y cartref yn gweld eu gwaith fel mynd drwy restr o dasgau sydd a wnelont yn bennaf â

gofal. Mae cefnogi preswylwyr i gael y gorau o'u bywydau yn golygu mwy na dim ond bod yn gefnogol gyda'u gofal personol.

Mae ymagwedd y cartref at y gwasanaeth mae yn ei ddarparu yn hanfodol i ddatblygu a chynnal ansawdd bywyd da i bawb sydd a wnelont â'r cartref. Yn ystod f'ymweliadau â'r 38 o gartrefi ar hyd a lled y wlad, cwrddais â llawer o breswylwyr a'u teuluoedd sydd wedi cael y profiad o fyw mewn mwy nag un cartref ac o ymweld â hwy. Gall hyn fod am amrywiaeth o resymau:

- Preswyliwr yn symud o gartref preswyl i gartref nyrsio
- Preswyliwr y mae ei anghenion yn newid a bod amgylchedd arall yn well i gwrdd â hwy
- Mae preswylwyr hefyd yn gallu symud i fod yn nes at aelodau'r teulu
- Mae preswyliwr hefyd yn gallu symud am fod cartref yn cau

Roedd pawb y cwrddais â hwy yn crybwyll mai'r cartref roeddent yn byw ynddo/ymweld ag ef yn awr oedd eu profiad gorau o gartref gofal. Roedd eu profiadau blaenorol yn amrywio o iawn i wael i wael dros ben. Gan fod pob cartref gofal i bobl hŷn yn cyflwyno gwasanaethau tebyg iawn i'w gilydd, holais, 'beth oedd yn gwneud y gwahaniaeth yn eu profiad o gartref da?' Rhestrir yr atebion gan yr holl unigolion y siaredais â hwy isod:

- 'y bobl'
- 'ffordd y cartref a'r rhai sy'n gweithio yno'
- 'sut maen nhw'n gwneud yr hyn maen nhw'n wneud'
- 'sut maen nhw gyda chi'
- 'dim beth ydych chi'n ei wneud, y ffordd rydych yn ei wneud e'

Mae'r daith mae'n rhaid i deuluoedd a phreswylwyr newydd ei chymryd fel pobl newydd yn arena'r cartrefi gofal yn gallu bod yn un anodd, galed a phoenus. Gall fod gan y llwybr sy'n arwain at symud i gartref gofal ddechreuad mewn sawl lle:

- Mae claf mewn ysbyty yn methu â dychwelyd i'w gartref oherwydd faint o anghenion sydd ganddynt a faint o gymorth sydd ar gael
- Mae rhywun hŷn yn methu â gofalu amdano ei hun yn ei gartref bellach
- Gall teulu gyrraedd argyfwng am na allant bellach gynnig y cymorth sydd angen i ofalu am yr un sy'n annwyl iddynt
- Efallai y bydd rhywun hŷn a/neu ei deulu yn cael cyngor gan rywun proffesiynol e.e. meddyg teulu, gweithiwr cymdeithasol, mai cartref gofal yw'r dewis gorau er mwyn bodloni anghenion yr unigolyn hwnnw

Mae'r cyfnod hwn o drosglwyddo i'r cartref yn llawn anhawster. Wrth fynd drwy weithiwr cymdeithasol, efallai y bydd yr unigolyn hŷn neu ei

deulu yn cael rhestr o gartrefi i ddewis o'u plith. Fel arfer ni chânt ddim gwybodaeth am y cartref ar wahân i faint y gallai gostio iddynt. Yn aml iawn, dim ond cyfnod byr iawn o amser fydd ganddynt i ddod i benderfyniad am ba gartref maent am ei ddewis. Yn y sefyllfa hon, sut mae rhywun hŷn neu ei deulu yn gwybod sut mae adnabod y cartref sydd orau iddo? Sut mae adnabod cartref da ac un heb fod gystal? Pam cael eich cyfyngu i ddewis o blith dim ond ychydig o gartrefi? Mae'r cyfnod trosglwyddo hwn yn un trawmatig yn emosiynol i'r teulu a'r darpar breswyliwr. Yn gyson, dywedir wrthynt, 'Mae arnaf i ofn y bydd yn rhaid i chi/yr un sy'n annwyl i chi fynd i gartref'. Mae'r ffordd y rhoddir y neges honno yn cadarnhau'r olwg negyddol sydd gan y rhan fwyaf o'r boblogaeth ar gartrefi gofal.

Mae My Home Life Cymru wrthi'n datblygu adnodd ar gyfer y sawl sy'n dechrau ar eu profiad mewn cartref gofal, er mwyn bod o gymorth iddynt ar amser anodd.

Staffio

Mae llawer o'r staff mewn cartrefi gofal yn gwneud gwaith rhagorol yn cefnogi preswylwyr sy'n gallu cynnig sawl her iddynt. Mae heneiddio, llesgedd, salwch corfforol a salwch meddwl ac anabledd, poen emosiynol a rhwystredigaeth (o du'r preswylwyr a'u teuluoedd) a dod i ben yn gyson gyda marw preswylwyr maent wedi dod i'w hadnabod yn dda, yn gwneud y gwaith o weithio mewn cartref gofal yn un anodd eithriadol. Ar ben hynny, mae mwyafrif y staff yn ennill tâl nad yw fawr uwch na'r isafswm cyflog. Gall hyfforddiant y staff hefyd fethu â chyrraedd y safonau a ddylai, gyda llawer ddim ond yn cael y lleiafswm o hyfforddiant mewn meysydd craidd e.e. iechyd a diogelwch, codi a chario, cymorth cyntaf ayyb.

Casgliad

Mae'r sector cartrefi gofal yng Nghymru yn un amrywiol ac mae'r darparwyr yn wynebu sialensiau lluosog. Fodd bynnag, gall fod meysydd eraill maent yn wynebu sialensiau o'u herwydd fel bod yn wledig, wedi'u hynysu oddi wrth gymorth, a negyddiaeth gan y gymuned.

Mae'r gyrwyr gwleidyddol sydd wedi gweld pwyslais yn cael ei roi ar bobl hŷn yn aros yn eu cartrefi eu hunain am hirach, wedi golygu bod preswylwyr newydd sy'n dod i gartref, yn gwneud hynny gydag anghenion mwy cymhleth a lluosog. Mae hyn yn cynyddu'r pwysau ar ddarparwyr a'u timau o staff.

Mae barn y cyhoedd am gartrefi gofal at ei gilydd wedi bod yn un negyddol ac eto mae'r disgwyliadau sydd ganddynt ar gyfer y cartrefi yn dal i gynyddu. Mae'r cenedlaethau newydd sy'n symud i gartrefi gofal bellach yn dod â dulliau byw a disgwyliadau gyda hwy a fydd yn

herio'r gwasanaethau yn ddifrifol. Mae'r cynnydd mewn demensia ymysg y boblogaeth hŷn a'r boblogaeth iau yn gofyn am weithlu mwy ac arbenigol sydd â digon o gymorth a hynny'n barhaus.

Mae My Home Life Cymru fel rhan o Age Cymru yn anelu at weithio gyda'r sector i adnabod yr anghenion a'r meysydd datblygu sydd gan gartrefi, a'u cefnogi wedi hynny i gefnogi'r rhai sy'n byw, yn marw, yn ymweld ac yn gweithio mewn cartrefi gofal i bobl hŷn yng Nghymru.

John Moore, Rheolwr Rhaglen My Home Life Cymru
7 Chwefror 2012

My home life

Health and Social Care Committee

HSC(4)-06-12 paper 3

Inquiry into residential care for older people – Evidence from the My Home Life programme

Introduction

My Home Life (MHL) is a UK-wide initiative led by Age UK, in partnership with City University, Joseph Rowntree Foundation and Dementia UK; which has the support of the Relatives and Residents' Association and all the national provider organisations that represent care homes across the UK[1]. MHL seeks to promote quality of life for those living and dying, visiting and working in care homes for older people.

Summary of main points

The following messages have been synthesised from the emerging research on quality in care homes and from the lessons learnt from the more specific leadership support and community development work undertaken by the MHL team with care homes across the UK, over the last 6 years.

Research Message 1: Recognise, support and professionalise care home managers

Quality in care homes relies heavily on the skills, resilience and leadership of care home managers, many of whom work in isolation (care homes are often described as 'islands of the old'). The role of care home managers is complex (business manager; emotionally supporter; quality assurer; facilitator of best practice; change agent; workforce educator; organisational leader and expert practitioner in health and social care). They are caring for some of the most vulnerable citizens in our society, without real support to undertake the challenging and emotionally exhausting range of roles that are required of them. MHL has shown that regular monthly independently facilitated support through 'action learning' can help managers deliver quality and transformation.

- Care home managers should be enabled to form networks of support with each other.

[1] National Care Forum, English Community Care Association, Registered Nursing Home Association, National Care Association in England; Care Forum Wales; Scottish Care; and Independent Health and Care Providers in Northern Ireland.

- Care home managers should be required as a condition of their registration to demonstrate that they receive some form of professional supervision and engage in continuing professional development.

- Care home managers should be required to be members of an independent institute or body which represents their profession. This representative organisation should offer professional help and guidance (particularly in whistle-blowing) and work in their interests rather than those of the wider provider organisations who have many associations of their own. The organisation should represent care home managers, promote excellence in care home practice and help to shape health and social care policies

- Local commissioners should be required to contract only with those care homes where the Registered Manager is a member of the professional body, creating a lever for ensuring that managers are receiving professional supervision to deliver quality.

Research Message 2: Decrease the amount of paperwork
Over the past ten years we have seen a huge increase in the number of agencies and associated paperwork (regulation, fire risk assessments, business continuity plans, contracts and service specifications, employment law paper trail, resident care plans, risk assessments) that is pushed upon care home managers, taking them away from working with their teams to support quality.

- In line with the Government's desire to reduce red tape, an audit of paperwork required of care homes should be prioritised. MHL can help identify the sources of paperwork that care homes experience.

- Agencies should be required to work in partnership with care homes to co-create paperwork that is realistic, helpful and proportionate.

- A review of the respective roles of agencies responsible for fire, health & safety, commissioning, safeguarding regulation should be undertaken to reduce the burden placed upon care homes.

Research Message 3: Acknowledge the changing role of care homes
The role of care homes has radically changed over the past 5-10 years. Changes in policy have led to residents going into care homes later, sicker and staying for far shorter periods of time. Care homes are typically associated with end of life care and dementia. As a result of these changes, care home managers are making difficult clinical and ethical judgements with, and on behalf of, service users with little or no support from wider health and social care agencies. Where relationships with agencies exist, they are often based upon mistrust, suspicion, blame; and care homes are forced to deliver care from a position of fear and anxiety which can hinder

quality. There is often an inconsistency of message from the wider system about what is and isn't appropriate practice.

- Care home managers should be valued as professional experts in balancing rights and risks, and, through their national body, should develop evidence based briefings that offer clarity to the sector on key principles of good practice.

- Commissioners should recognise that care homes are seen as part of the portfolio of services in their local area, and actively support their professionalization through access to appropriate education and support.

- Government should recognise that a national star rating system delivered by the regulator has its advantages both to local authorities and to care homes themselves so long as there are sufficient resources for inspectors to properly assess safety and quality and an acknowledgement of the challenging work that care homes do often in isolation.

- Multi-agency and multi-professional national leadership should be promoted to support development and dissemination of good healthcare practice in care homes, supported by clinical guidance and quality standards. Messages need to be targeted in the right format

- Local authorities and PCTs should seek to create mechanisms to support care homes to deliver quality rather than simply reacting to problems and issues. There is some evidence that care home support teams can make a real difference both to care homes and in reducing unnecessary hospital admissions.

- Acknowledgement should be made in policy that given the multiple co-existing conditions that our care home residents experience, the needs of care home residents need to be seen as a priority group given the same range of access to health and support services to those younger and living in the community

- Policy should aim to outlaw the discrimination of access to services that is offered according to the likelihood of an individual resident being able to return home. Equal access should be provided to those who may still benefit from support even if ti will not mean a return to living independently

- Access to counselling services should be prioritised to our oldest citizens given the huge emotional upheaval and multiple losses experienced near the end of life

MHL recently worked with the British Geriatrics Society on a Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes[2] . The report the following recommendations:

- Local NHS planners/commissioners should ensure that clear and specific service specifications are agreed with their local NHS providers. These need to link with quality standards based on patient experience and appropriate clinical outcomes.

- Care home residents should be at the centre of decisions about their care. An integrated social and clinical approach should support anticipatory care planning, encompassing preferred place of care and end of life plans.

- Service specification for providing healthcare support to care homes should guarantee a holistic review for any individual within a set period from their move into a care home, leading to healthcare plans with clear goals. This will guide medication reviews and modifications, and clinical interventions both in and "out of hours".

- Healthcare services to support the achievement of these goals should be integrated. This should combine enhanced primary medical and nursing care with dedicated input from departments of old age medicine, mental health services, and other specialisms such as palliative care and rehabilitation medicine according to local needs.

- The UK nations" health departments should clarify NHS obligations for NHS care to care home residents.

- Statutory regulators should include in their scope of scrutiny, the provision of NHS support to care homes and the achievement of quality standards.

Research message 4: Encourage community engagement in care homes
Care homes are often isolated from the wider community and can benefit hugely in terms of quality by having better community engagement. Care homes typically do not have the capacity to identify or support volunteers and sometimes avoid opening their doors to the outside world for fear of criticism and poor press coverage. Greater community engagement leads to a higher quality therapeutic environment.

- Local authorities should work with local volunteer bureau to support the delivery of volunteer advocates to deliver a community presence in the home and receive training and support to offer real quality service to residents, relatives and staff.

[2] BGS (2011) *Quest for Quality: British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Quality Improvement*, London: British Geriatrics Society.

- Government may wish consider replicating the Long-term Care Ombudsman program developed in Massachewsetts which makes use of volunteer advocates to work within care homes (see paper1)

- A programme of better public understanding of the rules and workings of the long-term care system, what we can expect would help connect the public with the very challenging world of care homes.

- Funding should become available to support piloting work in care homes to offer more flexible range of services, in reaching out to those most vulnerable in the community, to offering a place for members of the public to learn more about ageing, frailty, dementia.

Research message 5: Open up new debate on funding.
While MHL cannot offer any conclusive evidence of the impact of funding on quality, the lack of equity between older people and other 'client groups' (e.g. learning disabilities) in terms of the level of state funding for individual placements must be addressed. Public opinion of care homes is varied, yet we know when properly funded and supported, the model of care homes can provide very positive outcomes for those who are highly frail and at serious risk of neglect at home even with regular domiciliary support.

- Policy should require funding levels for individual placements to be scrutinised in terms of the extent to which it is based upon ageist assumptions. Equity across client groups in terms of funding must be provided.

- Policy should begin with a frank discussion about the extent to which as a society we do want to properly invest in supporting our frailest citizens with dignity and quality care rather than pay lip service to it.

Care homes have the potential to respond to many of the issues that face us in supporting an increasingly frail population of care homes. There are now more care home beds than hospital beds. With support, encouragement and an injection of funding, care homes could potentially rebrand themselves to being viewed as experts akin to the hospice movement. Care homes could manage complex frailties thus avoiding the revolving door syndrome of older people facing on-going readmissions to hospital. Care home managers could act as advisors or consultants in supporting individuals living independently at home and offering flexible respite, intermediate care, counselling, physiotherapy etc.

This will not happen until we develop our workforce, particularly our managers, and support care homes to open themselves up to a more professional relationship with the wider health and social care system and wider community more generally.

My Home Life are at the heart of this thinking and are keen to continue to help shape future health and social care policy to better meet the changing needs of older people in care homes.

Research message 6: Need for an integrated vision for health and social care

Health and social care typically work in silos; however, the older person receiving care needs this work to be better integrated. The MHL vision is based on what older people 'want' from care and also 'what works' and provides an integrated vision of relationship-centred and evidence-based care. The care home sector are saying that the vision provides:

- Evidence of what customers (residents) want
- Articulates the expertise of the sector
- A framework for identifying evidence of good practice for self-regulation
- Accentuating positive (disassociating from bad press)
- Evidence base to inform commissioning and regulation
- Driven forward by the care home sector itself

A core component of this vision is the need to be relationship-centred. It is interesting to note that more recently, the importance of relationships and the need to move away from a 'tick box' culture to one that focuses more on relationships and the needs of individuals (users, carers and providers) is being highlighted as vital to ensuring dignified and compassionate care in acute care settings, where standards of nursing care are seen to be in need of improvement[3], [4] Other research has shown that older people in hospital find the relational aspects of care to be missing[5].

With this in mind, the Inquiry should consider recommending that a vision is articulated and shared at all levels of the health and social care system, so that all those working in the system can be singing from the same hymn sheet.

Factual Information

The MHL evidence base was developed by over 60 academic researchers from universities across the UK. The evidence identifies eight best practice themes which together offer a vision for quality in care homes[1]. The eight

[3] Patterson M, Rick J, Nolan M, Davies S, Musson G (2011) From Metrics to Meaning: Culture Change and Quality of Acute Hospital Care for Older People, SDO Project - 08/1501/93, Southampton: NIHR Service Delivery and Organisation R&D Programme.

[4] Tadd W, Calnan M, Bayer A (2011) Dignity in practice: An exploration of the care of older adults in acute NHS trusts, SDO Project - 08/1819/218, Southampton: NIHR Service Delivery and Organisation R&D Programme.

[5] Bridges J, Flatley M, Meyer J (2010) Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies, International Journal of Nursing Studies, 47(1)89-107,

themes can be grouped into three different types: Personalisation, Navigation and Transformation (see attached diagram). The first two groups (Personalisation and Navigation) are aimed at all care home staff; whereas the last group (Transformation) is aimed at care home managers alone.

Personalisation themes (all staff)

Three of the themes for staff (Personalisation) are about an approach to care, which makes it more personal and individualised. These themes are commonly associated with Quality of Life and are drawn from an evidence-base often connected with best practice in social care. The Personalisation themes include:

1. Maintaining Identity (See who I am!): Working creatively with residents to maintain their sense of personal identity and engage in meaningful activity.
2. Sharing Decision-making (Involve me!): Facilitating informed risk-taking and the involvement of residents, relatives and staff in shared decision-making in all aspects of home life.
3. Creating Community (Connect with me!): Optimising relationships between and across staff, residents, family, friends and the wider local community. Encouraging a sense of security, continuity, belonging, purpose, achievement and significance for all.

Navigation (all staff)

Another three themes for staff (Navigation) are about what needs to be done to help residents, relatives and staff navigate their way through the journey of care. These themes are commonly associated with Quality of Care and are drawn from an evidence-base often connected with best practice in health care. The Navigation themes include:

4. Managing Transitions (Support me!): Supporting people both to manage the loss and upheaval associated with going into a home and to move forward.
5. Improving Health and Healthcare (Improve my wellbeing!): Ensuring adequate access to healthcare services and promoting health to optimise resident quality of life.
6. Supporting Good End of Life (Guide me to the end!): Valuing the 'living' and 'dying' in care homes and helping residents to prepare for a 'good death' with the support of their families.

Transformation (managers)

The remaining two themes are for managers (Transformation) and are concerned with the leadership and management required to transform care into best practice in service delivery and organisation. These themes are commonly associated with Quality of Management and are drawn from an evidence-base often connected with best practice in managing a business. The Transformation themes include:

7. Keeping Workforce Fit for Purpose (Educate me!): Identifying and meeting ever-changing training needs within the care home workforce.
8. Promoting a Positive Culture (Inspire me!): Developing leadership, management and expertise to deliver a culture of care where care homes are seen as a positive option.

What is Relationship-Centred Care?
Relationship-Centred Care (RCC) is at the heart of best practice and central to Quality of Life, Quality of Care and Quality of Management. In the MHL diagram, it therefore lies at the centre of the intersecting circles. RCC is different to the Person-Centred Care (PCC). PCC in policy tends to focus on individual patients, promoting their independence and consumer choice. It is argued that in long term care settings, positive relationships between residents, relatives and staff and interdependence matters more. For relationships to be good in care homes, we need to consider not just the needs of individual residents who live and die there, but also, the needs of relatives who visit and the needs of staff who work in care homes. RCC is represented by a star, made up of two triangles. One triangle depicts the importance of positive relationships between residents, relatives and staff. The other triangle depicts the importance of negotiating voice, choice and control between residents, relatives and staff.

Where does the Senses' Framework fit?
Based on empirical research in care homes in which older residents, their relatives and staff were asked what matters most to them in care homes, Nolan et al. highlight the importance of six senses (Senses Framework[ii]). Research has shown that each group (residents, relatives and staff) need to feel a sense of:

1. **Security** – to feel safe
2. **Belonging** – to feel part of things
3. **Continuity** – to experience links and connections
4. **Purpose** – to have a goal(s) to aspire to
5. **Achievement** – to make progress towards these goals
6. **Significance** – to feel that you matter as a person

In the MHL diagram, each tip of the star represents one of the six senses.

The handout of the Senses' Framework provides useful practical information of what residents, relatives and staff in care homes feel is important to them in relation to each of the six senses. For instance, in relation to feeling a sense of '**security**', residents suggest (amongst other factors) 'Staff being aware of your life story so that they really know you'; relatives suggest (amongst other factors) "Approachable teams/management"; and staff suggest (amongst other factors) "Effective teamwork and communication". The research has also been done on student nurses on clinical placement in

care homes and they suggest (amongst other factors) “Appoint a mentor”. For further information on the various factors for each of the six senses from the perspective of residents, relatives and staff, please see the Senses’ Framework handout.

What does the house represent?

Whilst relationships are important within the care home between residents, relatives and staff; relationships are also important between care homes and their local community and wider health and social care system. Quality of Life, Quality of Care and Quality of Management all depends on good partnership working. The roof of the house represents the need for health and social care policy to work in an integrated way to facilitate good partnership working.

Recommendations

1. **More funding** is needed to provide high quality care services, including care homes.
2. The **accountability** requirements for care homes need to be urgently simplified to streamline services.
3. **Integration of and an integrated vision for** health and care services would benefit care homes that work closely with both.
4. Increased **awareness and understanding of care homes** would help them become a more central part of local communities.

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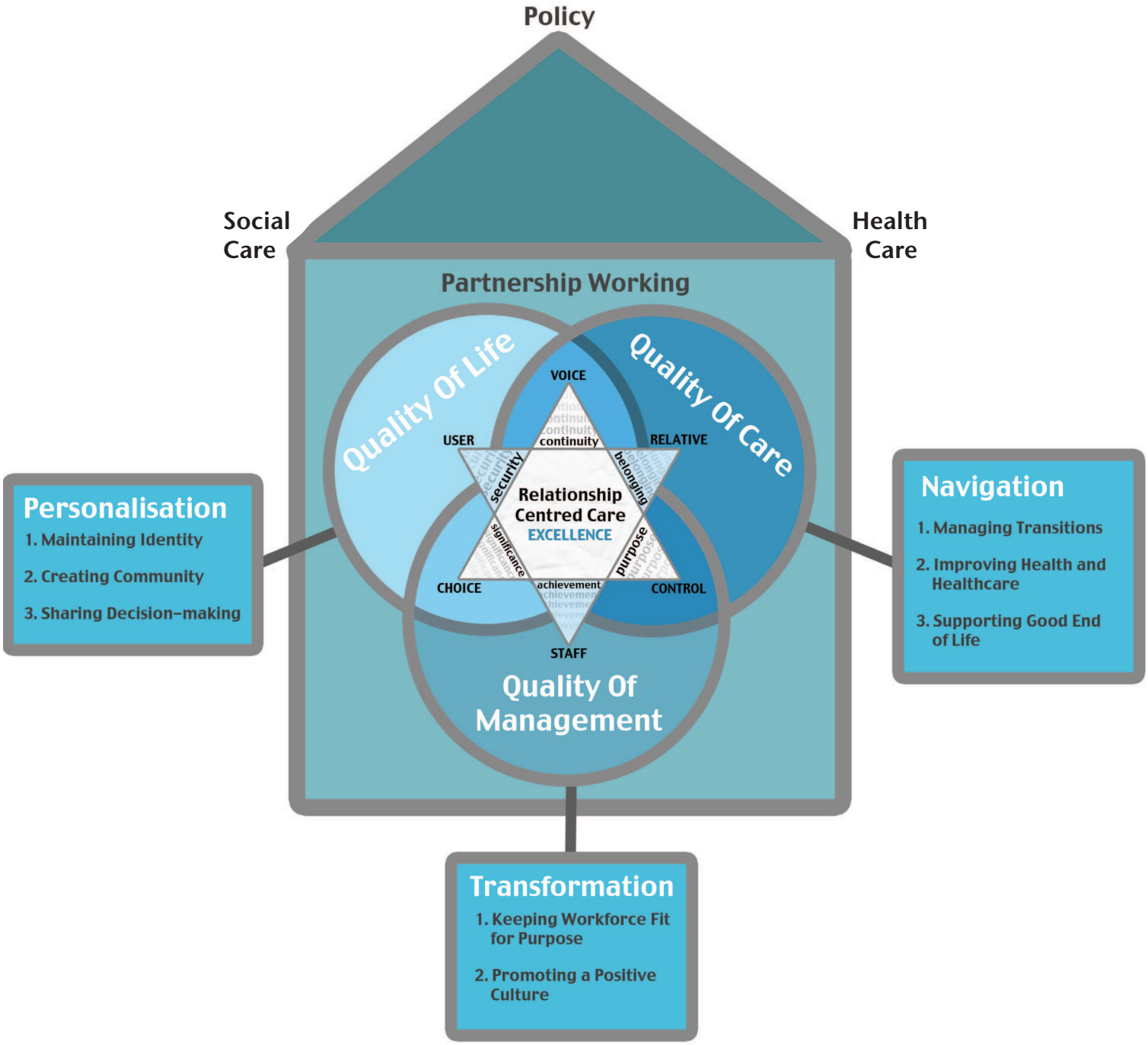
[i] NCHR&D Forum (2007) *My Home Life: Promoting quality of life in care homes, A review of the literature.* London: Help the Aged (now AgeUK). Downloadable from: http://www.myhomelife.org.uk.

[ii] Nolan, M., Brown, J., Davies, S., Nolan, J. and J. Keady. (2006). *The Senses Framework: Improving care for older people through a relationship-centred approach.* University of Sheffield. ISBN 1-902411-44-7


Policy
Social Care
Health Care
Partnership Working
Quality Of Life
Quality Of Care
Quality Of Management
VOICE
USER
RELATIVE
CHOICE
CONTROL
STAFF
continuity
security
belonging
significance
purpose
achievement
Relationship Centred Care
EXCELLENCE
Personalisation
1. Maintaining Identity
2. Creating Community
3. Sharing Decision-making
Navigation
1. Managing Transitions
2. Improving Health and Healthcare
3. Supporting Good End of Life
Transformation
1. Keeping Workforce Fit for Purpose
2. Promoting a Positive Culture

The Senses Framework:

Improving Care For Older People Through a Relationship-Centred Approach

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Factors Creating a Sense of Security

For older people

- Staff being aware of your life story so that they really know you
- Effective communication
- Introducing all staff so that you know who is who
- Encouraging visitors/people who know you really well, to be involved in your care
- Encouraging residents to bring in their own possessions – again to create a sense of familiarity
- Rearranging furniture if necessary
- Comprehensive assessment of needs on admission, including risk assessment
- Ongoing assessment and evaluation
- Allocation of key workers

NB *We do not always allow individuals to take appropriate risks due to legalities and possible recrimination*

For family carers

- Approachable teams/management
- Effective communication
- Feeling safe to complain without fear of recrimination
- Keeping appropriate people informed
- Advocacy
- Involving the multi-disciplinary team
- Staff being able to mediate between patients without taking sides
- Keep relatives informed of changes in care plan

For staff

- Effective teamwork and communication
- Effective leadership
- Accurate record-keeping
- Mutual respect – knowing you will be respected as an individual
- Appropriate staffing levels
- Adequate human and mechanical resources
- Training
- Open and approachable management
- Flattened management system
- Confidentiality
- Up to date records
- Compassion and understanding

For students

- Appoint a mentor
- Treat the student as an individual
- Clear aims and objectives
- Informing all staff of student's role within the home
- Comprehensive induction programme
- Allow student time to complete their own work (e.g. portfolio)

Factors Creating a Sense of Belonging

For older people

- Opportunities to visit the home prior to moving in
- Own room/belongings/privacy
- Wait until invited into resident's room
- Open visiting
- Own place in dining room
- Clarify expectations on admission
- Respect personal choice wherever possible
- Residents' groups with nominated chairperson

For family carers

- Make relatives feel welcome
- Encourage to take a more active part
- Ensure that staff are there fore relatives and residents, physically, mentally and financially
- Encourage involvement in all aspects of care and decision-making
- Value relatives' ideas
- Use appropriate terminology – avoid jargon
- Create care partnerships
- Educate relatives in promoting independence and optimising opportunities to enhance quality of care
- Make sure that relatives are informed of all changes
- 'Be there' for relatives and encourage them to talk
- Individual service planning to create social activities and opportunities

For staff

- Responsibility based on defined roles
- Opportunity to share
- Feeling valued, trusted and competent
- Thanking staff for their contribution
- Work towards common goals to deliver high standards of care
- Having a sense of camaraderie
- Not working in isolation
- Important for care assistants to have a sense of professionalism

NB *More important with big group companies*

For students

- Induction programme and booklet
- Explore student's expectations and objectives (possibly using a questionnaire)
- Value their new ideas
- Encourage students to realise that nursing home staff are progressive
- Involve all grades of staff in student learning
- Mentor relationship

Factors Creating a Sense of Continuity

For older people

- Life history sheet – developed with relative if possible/appropriate
- Consistency in key worker/associate nurse/support worker
- Visit hospital prior to discharge and ensure a familiar face on admission
- Comprehensive information on discharge from hospital and admission to hospital
- Involve activity co-ordinator in helping resident to continue with enjoyed past time

For family carers

- Residents/relatives meetings
- Being involved in care giving
- Involve relatives in reviews of care plans
- Update relatives with information regularly
- Opportunities to go on outing

For staff

- Monthly newsletter
- Regular staff meetings
- Clinical supervision and appraisal
- Audit
- Quality standards
- Follow policies/procedures

For students

- Good links with university
- Training for mentors to enable links with programme content
- Student induction pack

Factors Creating a Sense of Purpose

For older people

- Create personal profiles including hobbies and interests
- Assess actual and potential abilities
- Identify targets and goals
- Residents committees
- Consider potential for discharge

For family carers

- Relatives' committee
- Involvement in care planning and delivery (based on relative/resident choice)
- Communication

For staff

- Team nursing
- Care plans
- Standing orders
- Induction and training available
- Assessments of quality of care

For students

- Team allocation
- Named resident(s)
- Involvement in decision-making
- Targets for achievement of agreed goals by end of placement

Factors Creating a Sense of Achievement

For older people

- Promoting independence (where possible) in relation to activities of daily living
- Promoting mental well being and motivation
- Setting individual goals and needs
- Recognising own capabilities
- Multi-professional approach

For staff

- Seeing clients improving and gaining confidence in their ability to achieve goals
- Keeping knowledge updated/sharing knowledge
- Regular appraisals/constructive criticism and practice development
- Written evidence of learning/acknowledgement of achievement
- Audit/quality control
- Support of manager/back up

For family carers

- Family carer interview on admission – identify expectations
- Open visiting
- Communication from care staff
- Opportunities to assist in providing care
- Support systems for relatives
- Acknowledgement of and help to deal with guilt
- Information about services and benefits
- Addressing conflicts and concerns

For students

- Clear objectives – asking what they want to achieve
- Overview of service provided and learning opportunities
- Spending time with different members of staff
- Encourage students to use their own initiative
- Regular feedback/planned evaluation sessions
- Set objectives for placement and review
- Provide adequate support and mentorship
- Encourage decision-making
- Give feedback on developing skills

Factors Creating a Sense of Significance

For older people

- Find out how clients wish to be addressed
- Involve fully in care planning
- Individualised care planning in identifying individual needs
- One-to-one/forming relationships
- Show an interest in the individual and their family
- Social care assessment identifying family relationships
- Use of photographs

For family carers

- Opportunity for family to give positive and negative comments about the service provided
- Annual quality control (opportunity to make comments about services anonymously)
- Service user forum
- Choices about involvement in the care of a resident
- Welcoming atmosphere

For staff

- Feedback from clients and relatives (either verbally or evidence of contentment)
- Feedback from the local community – knowing you have a good reputation
- Feedback via letters and carers
- Sense of pride in the quality of care provided
- Having opportunity to feedback to education providers

For students

- Time invested in orientation and induction
- Provide student with a mentor who they will see a lot of
- Ongoing support and encouragement to apply theory to practice
- Telling the student that we can learn from them too.
- Direct feedback from clients
- Encouraging students to give feedback and letting them know that their opinions matter

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-06-12 papur 4

Ymchwiliad i ofal preswyl i bobl hŷn – Tystiolaeth gan Yr Athro John Bolton

Gweler y linc sydd ynghlwm at yr adroddiad Gwell Cefnogaeth am Lai o Gost gan Yr Athro John Bolton, sydd wedi cael ei gyhoeddi ar wefan SSIA Cymru.

http://www.ssiacymru.org.uk/index.cfm?articleid=7067

Gwasanaeth y Pwyllgorau

social care
institute for excellence

Inquiry into Residential Care for Older People in Wales

Submission from the Social Care Institute for Excellence

Introduction

1. The Social Care Institute for Excellence (SCIE) is an independent charity that works across the United Kingdom to improve the lives of adults and children who use care services by identifying and spreading knowledge about what works in social care and by supporting the delivery of transformed, personalised social care services. We recognise the central role of people who use services and their carers, and we aim to ensure that their experience and expertise is reflected in all aspects of our work.

2. SCIE is pleased to have the opportunity to contribute to the Committee"s inquiry into residential care for older people in Wales. The Welsh Government has sponsored SCIE from its inception, jointly with England and Northern Ireland, and SCIE staff and managers at all levels have worked with colleagues from Wales. Both of the Welsh Government"s nominees to SCIE"s Board have been leading figures in the Welsh residential sector. Julie Jones, SCIE"s Chief Executive, was invited in a personal capacity to be a member of the Independent Commission on Social Services in Wales. SCIE is taking part in the Social Services Partnership Forum, working on the implementation programme for "*Sustainable Social Services".*

3. We have focused this submission on the quality and accessibility of residential care, and on how services can be developed and modernised. We have addressed the points raised by the Committee, and have taken into account some of the responses already submitted by national provider, commissioner, regulatory and training bodies in Wales. We have also noted the Minister"s announcement about the broad provisions in the forthcoming Social Services Bill.

4. A summary of our main points:

- There is a clear need for better information and advice for older people and their families, to enable them to understand what residential care and the alternatives have to offer. This should help to reduce crisis admissions to residential care, which often leave older people feeling they had little or no say in the choice of that type of service. There appear to be different admissions criteria for self-funders and local-authority funded residents, the former choosing to enter care at an earlier stage and the latter maintained at home until they reach an advanced stage of dependency. Home care has a role to play in avoiding unnecessary admissions, but to be an effective part of a prevention strategy it needs to be well tailored and targeted.

- The residential sector should be developing the capacity to meet a wider range of needs, including those of the growing number of people with dementia. Most homes are still at an early stage in exploring the scope to apply the principles and practice of personalisation in residential care, and to increase their ability to adapt care to the different choices and preferences of individual residents. Strategies are emerging for promoting the dignity of residents. However, many homes still operate traditional models of care, mainly focusing on the physical and some social needs of residents. Newer models of residential care offer personalised, outcomes-focused programmes for residents, often in conjunction with NHS professional services.
- The Care Council for Wales is leading an effective workforce development strategy, but training resources are limited compared with the rising expectations of staff capacity to support people with complex needs and their families. There are some ambivalent views on the desirability and reality of professionalising the care workforce in residential and home care settings. As the proportion of residents with significant health as well as care needs increases, ways should be found to equip NHS professionals and residential care staff for closer joint working.
- In Wales as elsewhere in the United Kingdom, the downward pressure on fees resulting from public spending restrictions is leading to concerns about the quality and sustainability of residential care provision. With the rising proportion of residents with dementia in many care homes, there may be a need for greater flexibility in application of registration categories to enable non-specialist homes to cater for their needs. CSSIW is focusing its inspections on residents‟ quality of life, staffing, leadership and the care environment. It may be necessary to give more attention, in inspections and monitoring by commissioners, to safeguarding approaches and financial viability.

1 - The process by which older people enter residential care and the availability and accessibility of alternative community-based services, including reablement services and domiciliary care.

Admissions in crisis situations

5. One of the consequences of tighter eligibility criteria for state funding is a rise in the number of people who are obliged to fund their own care, whether this is provided in a residential setting or in their own homes. Historical information on self-funders is sparse and there are significant regional and local variations. However, a study published in 2011 by the Putting People First Consortium, in conjunction with SCIE, [1] looks at the circumstances in which people enter the care system, and makes the case for better information and advice for people on their options at a time of crisis.

6. The Putting People First/SCIE study found that entry into the care system almost always takes place in crisis situations, such as the loss of a

spouse or a disabling fall: hardly any of the participants in the study felt they had chosen to accept care, or had been part of a genuine decision-making process. Pressure from hospitals for speedy discharge, and concern on the part of relatives about a person‟s fitness and ability to manage at home, adds to the sense of emergency and the demand for decisions at short notice.

7. Individuals and family members reported experiencing great difficulty in securing sound advice about service options, with local authorities often unable to give informed advice on the quality of independent sector provision or the range of choices open to people. Effective intervention and advice at such crisis points could increase people‟s confidence, options and scope for decision-making, and reduce pressure on the care system. SCIE is in process of developing a web-based Consumer Information Portal designed to bring together information on a range of issues which people seeking care and support, for themselves or their relatives, should find useful in aiding decision-making.

Self-funded and council-sponsored residents

8. Self-funders have more choice over whether and when to enter residential care than those requiring statutory funding. A study in England found the average length of stay in residential care of self-funders was 4 years, compared with 18 months for people supported by local authorities. This is taken to mean the latter group are not assessed as eligible for residential care until their needs are quite substantial and their level of dependency well advanced. This is consistent with the view of providers in Wales that council-sponsored residents are much more dependent and disabled than they were 10 years ago. It is an open question whether, as part of increasing voice and choice, more older people should be able to choose residential care as a positive option if they no longer wish to remain in their own homes. The other implication is that it may require complex and costly home care services to keep some very disabled and isolated older people in their homes until they qualify for residential admission.

Home care and prevention

9. There have been some increases in home care provision and extra care housing. Community services need to be tailored and targeted if they are to reduce or delay the need for residential or hospital admission. Intermediate care has been used successfully as an alternative for those who don‟t need to be in hospital, as well as a service for those leaving hospital. Both intermediate care and reablement services require close joint working and resourcing by the NHS as well as social care if they are to be effective and timely in restoring people to maximum independence.

10. Earlier intervention would avoid the situation that many people experience of being unable to access services until a crisis occurs. However, policy on prevention is not matched by levels of resource allocation. Whilst we know that preventative approaches, such as reablement services, can be cost-effective [2] , pressure on resources in many local authority areas

[7] Reablement – a cost effective route to better outcomes. SCIE. (April 2011).

inevitably means waiting until people are at, or near, crisis point before intervening. As a result, the health and wellbeing of family carers can also be put at risk.

2 - The capacity of the residential care sector to meet the demand for services from older people in terms of staffing resources, including the skills mix of staff and their access to training, and the number of places and facilities, and resource levels.

Sector capacity

11. The care sector is among the 10 fastest growing sectors in Wales. The numbers of places in care homes, approximately 23,300, has remained stable in the past year, although the number of settings is slightly reduced. Wales provides just under 5% of total UK residential care provision, estimated by Laing and Buisson at 481,100 places in April 2011.

12. It is generally agreed the market in Wales needs to supply a wider variety of services to meet different needs. This may involve encouraging a more diverse range of providers, including micro-services, personalised group living and a greater choice of supported housing models. In particular, the Inspectorate in Wales has noted a shortfall in homes, and staff, equipped to meet the needs of people with dementia. Given the demographic forecasts, this is a serious problem. The providers argue that this reflects a lack of incentives for expanding dementia care, and uncertainties in the market which make providers wary of investing in residential care for people with more complex needs.

Staffing, skills mix and training

13. The Welsh Inspectorate finds the majority of staff in residential homes it inspects are qualified to the requisite levels. The Care Council refers to a recently published research study which concluded that those residential care homes with a higher proportion of qualified care staff provide better outcomes for residents. The study found that where a greater proportion of staff had, or were working towards qualifications, resident outcomes were better. Structural issues such as how homelike is the environment, were also better where more staff had or were working towards a qualification.

14. The Care Council for Wales has introduced registration for managers in residential care homes, but plans to extend registration to care staff have been put on hold. Employers have expressed concerns about this decision, because it seems to run counter to moves to professionalise residential care services to cater for clients‟ more complex needs, and because it is taken to signal an undervaluing of the care staff workforce. They argue it makes it harder to improve terms and conditions, and to press for increased access to the training needed to improve quality of life for the highly dependent residents now looked after in residential care. Care staff turnover remains a significant challenge, as does safeguarding. More than one-third of those subject to abuse live in care homes.

15. The Care Council is leading a well-thought-out strategy to equip the social care workforce for rising demands and expectations. Developing a well qualified, confident workforce with the capacity to deliver citizen-focused, sustainable services is a primary driver in the Council‟s current work. The Care Council‟s work is focused also upon the concept of the professionalisation of the workforce in social care generally: “*We see the quality of professionals and their professionalism as central to responsive and sustainable social services”.*

Resources

16. Like their counterparts in England, care home providers in Wales argue that current levels of fees are not sufficient to meet reasonable costs, and risk making care services unsustainable. It is said that 40% of homes charge third party top-up fees as a way of bridging the gap. Two residential homes took Pembrokeshire Council to Judicial Review over the way fee levels had been set at figures below what they considered necessary to meet the required standards and costs of care; such legal action is becoming increasingly common in England as well.

3 - The quality of residential care services and the experiences of service users and their families; the effectiveness of services at meeting the diversity of need amongst older people; and the management of care home closures.

Personalisation

17. There is increasing agreement that the quality of residential care, as experienced by residents and their families, is strongly influenced by the extent to which the home and its staff have taken on board the principles and practice of personalisation. For too long, it was assumed personalisation did not apply in the communal living environment of residential care. This perception is now beginning to shift as positive efforts are made, in conjunction with residents and their families, to extend the aspects of residential care that can be personalised. Daily routines, times for getting up and going to bed, choice of meals and flexible mealtimes, the range of activities available, scope for taking on roles within the home, access to emails and the web, active engagement with the community, involvement of residents‟ families in the provision of care – these are some of the areas, once generally restricted, where many homes now offer greater flexibility.

18. The project *My Home Life Cymru* has been instrumental in promoting more responsive and stimulating environments in homes, and building up the confidence of staff and managers to work in these ways. Whilst policy and system issues, such as eligibility criteria and portable assessments, are of central importance to well-functioning social care, from the point of view of the individual user of such services and their family carers, what really counts is that they can choose and access high quality services which treat them with dignity and respect. As recent high-profile cases and reports into dignity and nutrition in health and social care settings remind us, this is unfortunately not always people‟s experience. Yet in some ways there is no excuse for this – SCIE‟s own work demonstrates how to safeguard people‟s dignity and respect

and we have defined clearly what makes for “excellent” care.[3,4]

Dignity

19. SCIE has carried out extensive work into the area of „Dignity in Care“. Our Dignity in Care guide is the main repository for information and resources on this subject:
http://www.scie.org.uk/publications/guides/guide15/index.asp
The evidence, recommendations, resources and practice examples relating to each of these areas are available on the Dignity in Care guide. It was agreed the main themes relating to the subject of dignity in care are as follows:

- Autonomy / Choice and control
- Communication
- Mealtimes, eating and nutritional care
- Pain management
- Personal hygiene
- Practical assistance
- Privacy
- Social inclusion

The SCIE Dignity in Care research overview explores both what protects dignity and what threatens it. See
http://www.scie.org.uk/publications/guides/guide15/selectedresearch/index.asp

20. What threatens dignity? These factors include not just the everyday incidents that dent self-esteem, weaken autonomy and remove privacy. They derive from the fundamental ways in which society is organised, and so require fundamental remedies. They include ageism and age and disability discrimination, the range of disadvantages and discriminations that can multiply the effects of ageism, and abuse - the violation of an individual's human or civil rights.

21. What protects dignity? Factors identified in the literature that support the dignity of older people in care settings include the inner strength and resilience of older people themselves, the range of rights which should protect them and the development of personalised care, which puts the needs and wishes of the service user at the centre of care planning and provision.
As an example, SCIE‟s work on minimising the use of restraint is available here:
http://www.scie.org.uk/topic/people/olderpeople/dignity/minimisingrestraint

22. Issues of service quality and effectiveness will in future be assessed within the National Outcomes Framework being developed with the Social Services Partnership Forum. Among the draft Outcomes, with associated performance indicators to monitor improvement, are

- Dignity
- Experience of care and support

[3] The Dignity Factors. Social Care Institute for Excellence. Guide 15.
[4] A definition of excellence for regulated adult social care services in England. SCIE. (October 2010).

- Carers‟ ability to balance their caring role and their own quality of life
- Freedom from abuse
- Being helped to lead fulfilled lives and reach full potential
- Less dependence on intensive services through early intervention
- Regaining health, wellbeing and independence
- Knowing what services are available
- Receiving services from a competent and qualified workforce

Integrated working

23. Finding ways of making integration a reality between health and social care (and other services) is central to delivering improved outcomes for people who use services and their families. This is particularly the case for older people in residential care, who often have complex combinations of care and health needs. We know from research that effective, integrated, multi-agency working is key to maintaining the health and wellbeing of people with multiple, complex and long-term problems. Strengthening the relationship between NHS and social services provision was one of the key themes in the Independent Inquiry commissioned by the Welsh Assembly.

24. There is a strong case for more medical, nursing, OT and physiotherapy input to residential care, both to improve the health of residents, and to enhance the ability of staff to care for residents‟ health needs. It is also important to bear in mind that a proportion of residents die in care and nursing homes each year, and better quality end-of-life care can make a big difference both to residents and their relatives. SCIE‟s Guide on end-of-life care in care homes is being updated, and other Information and links for professionals who support people and their families at the end of life can be accessed at http://www.scie.org.uk/adults/endoflifecare/index.asp

25. In the context of an ageing population, with a growing number of people living with long-term conditions, better co-ordination and information sharing between acute, primary and community-based NHS staff, and between health and social care and support services, is crucial to achieving good outcomes for people and making best use of scarce resources. Preventing unnecessary hospital admissions and avoiding delayed transfers of care are better for individuals as well as for the system as a whole. It is important for health and social care to work closely with people needing support, and their families, to ensure that they get the most out of all available resources. SCIE‟s work, for example on supporting black and minority ethnic older people's mental wellbeing[5], shows that when health and social care work well together, people‟s health and wellbeing improves. When health and social care fail to collaborate, people are burdened with closing the gaps for themselves – if they can. The ongoing divide between health and social care makes little sense to people using services.

[5] Supporting black and minority ethnic older people's mental wellbeing. SCIE report 38. (December 2010).

Care home closures

26. The Welsh Inspectorate considers homes closures in Wales have been well-managed. At the same time, the large-scale failure of Southern Cross caused concerns in Wales as well as England, and Directors of Social Services, providers and the Welsh Government have taken steps to learn the lessons from the action taken to safeguard the welfare of residents in Southern Cross homes and maintain continuity of care. In the light of the Southern Cross situation, SCIE prepared guidance for commissioners and others on dealing with short-notice homes closures, available at http://www.scie.org.uk/publications/homeclosures/

4 - The effectiveness of the regulation and inspection arrangements for residential care, including the scope for increased scrutiny of service providers' financial viability.

Regulation

27. Figures from the Welsh Inspectorate show a small increase in the number of nursing homes registered, and a similar drop in the number of care home places. This is consistent with the picture of increasing disability, dependency and long-term health conditions including dementia amongst residents. A case has been put forward for greater flexibility in the application of registration categories by the regulator, so that where appropriate, residents whose health and care needs increase, particularly those with dementia, can continue to be looked after with additional support in the home where they are placed, rather than having to move to another home because it falls into a different category. As in England, the growing proportion of people with varying degrees of dementia in the care home population poses questions about whether designated specialist dementia care homes should be the only places able to accommodate a person with dementia. Instead, the principles and practice of effective dementia care should almost certainly become part of the core skills and training of most care staff working with older people.

Inspection

28. Care providers argue that inspection should focus on the experience of people living in residential care and their families, that it should be proportionate, and that it should be taken into account in commissioning decisions. They are concerned to contain the regulatory burden, and to avoid duplication in the monitoring of care quality carried out by the Inspectorate and commissioning authorities. It is important to ensure good information flows between the Inspectorate and local (and health) authorities. Concerns about the performance of a home, and anxieties about poor quality care, neglect or abuse, are likely to be picked up at local level before the Inspectorate is necessarily aware of them. It is worth bearing in mind that the growing numbers of people paying for their own care do not have a commissioner to monitor the quality of the care they are receiving. This is a gap that should be addressed.

29. The Inspectorate has indicated that its inspections will focus on 4 themes: quality of life for residents, staffing, leadership and management, and

the care home environment. Given the safeguarding figures quoted above, it might be worth checking how well safeguarding policies and procedures are covered in the inspection framework. SCIE has produced guidance for social care and NHS commissioners on taking account of safeguarding issues in commissioning decisions. Guide 45 is on *Safeguarding and quality in commissioning care homes* (http://www.scie.org.uk/publications/guides/guide45/) and Guide 46 on *Care homes: common safeguarding challenges* (http://www.scie.org.uk/publications/guides/guide46/)

Financial viability

30. Private sector providers, who deliver the great majority of care, report that some banks are changing their lending terms, and demanding higher levels of occupancy. With the increasing concerns about financial viability of residential homes, it would be timely for the Inspectorate to discuss with provider interests, service users and carers, and the Welsh Government how, and how far, it should build a financial and economic assessment into the registration and inspection process.

5 - New and emerging models of care provision.

Traditional residential care

31. A good deal of residential and nursing home care is still very traditional in its approach. It is focused on the physical and some medical care needs of residents, and is geared to the group rather than the individual. It doesn‟t take very much account of the psychological or spiritual needs of older people. Practical and recreational activities are integral parts of the residential experience in some homes, and tailored to people‟s individual interests and backgrounds. In others, the role of activities coordinator is tacked onto the job of one or two staff, and becomes operational only on the odd occasions when they have time to spare.

32. Although isolation, loneliness and anxiety are among the factors that lead people to choose residential care, not enough is done to meet the social needs of residents. Others living in the same home can be a source of anxiety, concern and stress, particularly some of those with dementia, or unpredictable or disturbed behaviour. Some residents find the atmosphere in their home is quite restrictive and even oppressive, and may choose to spend most of their time in their rooms away from other residents.

New approaches.

33. Personalised care As already noted, some homes are being transformed by serious attempts to implement the philosophy and practices of personalisation and co-production. This is partly a matter of shifting staff attitudes, increasing their understanding of older people‟s feelings and behaviours, and fostering a culture in which they can listen and respond to what residents are saying and thinking. It is also about managers and staff consciously sharing power with residents, becoming more aware of how, without realising it, they maintain institutional and impersonal practices, and deny residents opportunities for control and choice. Individual support and

care plans may be a vehicle for person-centred approaches, but so is enabling residents to access their care plans, record their own views and experiences, and engage as equal partners with staff in drawing up the plans and determining the priorities and objectives they wish to have included.

34. This model can be reinforced by the allocation of personal budgets to individuals in residential care, and in due course, subject to a change in the law, access for some residents to direct payments. The present disjunction between the several hundred pounds a week many residents are paying, as self-funders or through charges, and the amount of say this gives them over how the home is run for their benefit, is quite stark.

35. Outcomes-based support and care Another area of development is the adoption of outcomes-based approaches in residential and nursing homes. Until recently, both social workers and care providers might have found it alien to talk about the outcomes residential care was striving to achieve. People went there when they couldn‟t cope at home or elsewhere, and the home‟s job was to provide them with care and attention, usually until they died. Work is now under way to formulate outcomes statements and frameworks applicable to residents in care homes.

36. One of these is found in the ASCOT (adult social care outcomes toolkit) model, developed by the Personal Social Services Research Unit at University of Kent and LSE. This identifies social-care-related quality of life (SCRQoL) factors, using 8 domains:

Domain	Definition
Control over daily life	The service user can choose what to do and when to do it, having control over his/her daily life and activities
Personal cleanliness and comfort	The service user feels he/she is personally clean and comfortable and looks presentable or, at best, is dressed and groomed in a way that reflects his/her personal preferences
Food and drink	The service user feels he/she has a nutritious, varied and culturally appropriate diet with enough food and drink he/she enjoys at regular and timely intervals
Personal safety	The service user feels safe and secure. This means being free from fear of abuse, falling or other physical harm and fear of being attacked or robbed
Social participation and involvement	The service user is content with their social situation, where social situation is taken to mean the sustenance of meaningful relationships with friends and family, and

	feeling involved or part of a community, should this be important to the service user
Occupation	The service user is sufficiently occupied in a range of meaningful activities whether it be formal employment, unpaid work, caring for others or leisure activities
Accommodation cleanliness and comfort	The service user feels their home environment, including all the rooms, is clean and comfortable
Dignity	The negative and positive psychological impact of support and care on the service user's personal sense of significance

The Framework offers different ways of measuring outcome, and different versions of the measure, one of which is designed for use with residents in care homes. Additional guidance explains the scoring method for arriving at SCRQoL scores for individuals, the expected score in the absence of services and support, and the positive (or sometimes negative) impacts of service provision on their quality of life.

Integrated care models

37. Despite the fact that one is free and the other means-tested, it is likely that the boundary between NHS and social care provision will continue to become more blurred in the interests of providing a more seamless response to people and their families. This process is already visible in the case of nursing homes, where the input from qualified, registered nurses is now funded by the NHS. In other settings various forms of joint and mixed professional teams have been set up to bring together, and often co-locate, health and social care specialists in fields such as mental health, disability, support for older people and dementia.

38. Further steps in this direction could involve much closer working between residential and nursing homes and integrated multi-disciplinary teams. Intermediate care and reablement provision have already demonstrated roles for residential services in enabling people to return home better able to cope, and with different degrees of independence restored. Working with multidisciplinary teams, it may be possible for residential and nursing homes to develop much more dynamic, stimulating and outward-looking environments. This could include promoting more positive approaches to residents with dementia and depression, the latter going often undiagnosed. As noted earlier, end-of-life care for residents is another area where joint working between health and residential care staff would be valuable.

39. As in other services, residents in care and nursing homes often conform to the expectations of the institution and the staff. If they, like some GPs, attribute every decline in physical and mental functioning simply to the

effects of ageing, it is likely the home will miss opportunities to maintain people‟s capabilities at a higher level, and will regard all apparently strange and restless behaviour as the effect of dementia. With help and advice, as Professor Tom Kitwood showed, it is often possible to make sense of the behaviour and distress of people with dementia, and take effective steps to alleviate them. SCIE‟s resources on dementia can be found at: http://www.scie.org.uk/topic/careneeds/dementia

40. A variety of new extra care housing schemes are beginning to offer different forms of integrated care. This may take the form of care staff based at the housing complex; care agency staff going into the extra care scheme to supplement the personal care for individual residents; home nurses visiting to look after the health needs of some tenants; and residential care, and in some cases nursing home care, located on the same campus. The explicit purpose of some schemes is to provide flexible care, which can be adapted up or down if people‟s needs increase temporarily or long term, and which avoids people having to move around to other services and sites if they become increasingly dependent. Another aim is to widen the range of choice available to older people who become more dependent and disabled. One or two schemes are being designed to act as community hubs, offering telehealth and telecare support to some people living in the community as well as those at the scheme. The funding of these schemes varies, and they offer different kinds of tenure and ownership according to residents‟ previous housing and financial circumstances.

6 - The balance of public and independent sector provision, and alternative funding, management, and ownership models, such as those offered by the cooperative, mutual sector and third sector, and Registered Social Landlords.

41. The independent sector already provides the great majority of residential and nursing home care for older people, and this is likely to continue. In order to cater for the needs and preferences of a wider range of individuals, it is important that the local market is encouraged to offer a vibrant range of provision, in different formats and with a variety of governance structures.

SCIE
February 2012

Eitem 5

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Iau, 2 Chwefror 2012**
Amser:	**09:30 – 11:30**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_400000_02_02_2012&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**David Worthington, Welsh Government** **Chris Brereton, Welsh Government** **Chris Humphreys, Welsh Government** **Rob Wilkins, Food Standards Agency**
Staff y Pwyllgor:	**Sarah Beasley (Clerc)** **Llinos Dafydd (Clerc)** **Meriel Singleton (Clerc)** **Stephen Boyce (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Ni chafwyd unrhyw ymddiheuriadau na dirprwyon.

1.2 Yn unol â Rheol Sefydlog 17.49, croesawodd y Cadeirydd Joyce Watson AC i'r cyfarfod. Roedd Joyce Watson yn bresennol ar gyfer eitem 2 ar yr agenda ar ran y Pwyllgor Menter a Busnes.

2. Y Bil Drafft ynghylch Sgorio Hylendid Bwyd (Cymru) – Briff technegol gan swyddogion Llywodraeth Cymru

2.1 Bu swyddogion yn ymateb i gwestiynau gan Aelodau'r Pwyllgor ar y Bil Drafft ynghylch Sgorio Hylendid Bwyd (Cymru).

2.2 Cytunodd y swyddogion i ddarparu'r wybodaeth ychwanegol a ganlyn, yn unol â chais y Pwyllgor:

- ffigurau ynghylch nifer yr ymweliadau â thudalennau gwefan yr Asiantaeth Safonau Bwyd sy'n ymwneud â sgorio hylendid bwyd;
- dadansoddiad o nifer yr ysbytai yng Nghymru sydd ymhob categori hylendid bwyd;
- nifer yr ysbytai yng Nghymru sy'n arddangos eu sgôr hylendid bwyd ar hyn o bryd; a
- ffigurau cywir ynghylch nifer y busnesau bwyd yng Nghymru sydd wedi cael eu sgorio ers mis Hydref 2010, fesul awdurdod lleol, a dadansoddiad o nifer y busnesau sydd ymhob categori sgorio.

2.3 Cytunodd y Pwyllgor i gynnal sesiwn debyg unwaith y bydd yr ymgynghoriad ar y Bil Drafft wedi cau.

3. Ymchwiliad i ofal preswyl i bobl hŷn – Trafod y gwaith o ymgysylltu â'r cyhoedd

3.1 Bu'r Pwyllgor yn trafod ei waith ymgysylltu allanol ar gyfer yr ymchwiliad i ofal preswyl i bobl hyn.

3.2 Cytunodd y Pwyllgor ar weithgaredd ymgysylltu arfaethedig a chytunodd i benodi Age Cymru a Gofal Croesffyrdd i weithio ar y cyd er mwyn hwyluso'r gwaith hwn.

4. Blaenraglen waith – Trafodaeth ynghylch sesiynau tystiolaeth un-tro

4.1 Bu'r Pwyllgor yn trafod pynciau ar gyfer cynnal pedair sesiwn dystiolaeth un-tro yn nhymhorau'r gwanwyn a'r haf.

4.2 Cytunodd y Pwyllgor i geisio cynnal ymchwiliadau undydd mewn perthynas â'r materion a ganlyn:

- Amseroedd aros ar gyfer cadeiriau olwyn yng Nghymru: gwaith dilynol ar yr argymhellion a wnaed yn adroddiad y Pwyllgor Iechyd, Lles a Llywodraeth Leol yn y Trydydd Cynulliad ar wasanaethau cadair olwyn yng Nghymru;
- Atal thrombo-emboledd gwythiennol; a
- Lleihau symudiadau ffetws a marwenedigaeth yng Nghymru.

4.3 Cytunodd y Pwyllgor:

- i benderfynu'n ddiweddarach ar y pwnc i'w drafod yn ystod ei bedwaredd sesiwn, gan benderfynu rhwng trafod gwasanaethau cyd-ymatebwyr,

mynediad at feddyginiaethau ag amseroedd aros ar gyfer gwasanaethau orthopedeg;

- i aros am adroddiad Pwyllgor Materion Cymreig Tŷ'r Cyffredin ar ei ymchwiliad i anhwylder straen wedi trawma, sy'n mynd rhagddo, cyn ymgymryd ag unrhyw waith ar y mater hwn; ac
- y byddai angen mwy nag un diwrnod i drafod anghydraddoldebau iechyd, ac felly y dylid cynnwys y mater hwn ar restr o bynciau posibl ar gyfer ymchwiliadau yn y dyfodol.

5. Papurau i'w nodi

5.1 Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 19 Ionawr.

6. Cynnig o dan Reol Sefydlog 17.42(ix) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 7 ac ar 8 Chwefror

6.1 Cytunodd y Pwyllgor ar y cynnig i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 7.

6.2 Cytunodd y Pwyllgor hefyd i wahardd y cyhoedd o'r cyfarfod a gynhelir ar 8 Chwefror, ac eithrio'r sesiwn dystiolaeth lafar a gynhelir gyda Jean-Pierre Girard ar yr ymchwiliad i ofal preswyl, a gaiff ei chynnal yn gyhoeddus.

7. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru - Trafod y prif faterion

7.1 Bu'r Pwyllgor yn ystyried y materion allweddol mewn perthynas â'i ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru, a chytunodd i ddychwelyd er mwyn trafod ei gasgliadau ac argymhellion allweddol yn ystod ei gyfarfod nesaf ar 8 Chwefror.

TRAWSGRIFIAD

Gweld trawsgrifiad o'r cyfarfod.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Mercher, 8 Chwefror 2012**
Amser:	**09:15 – 10:30**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200000_08_02_2012&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle**
Tystion:	**Jean-Pierre Girard, arbennigwr ar ddatblygiad a rheolaeth sefydliadau cydweithredol, di-elw a cilyddol (enwebwyd gan Gydweithredwyr Cynyddol Cymru)**
Staff y Pwyllgor:	**Llinos Dafydd (Clerc)** **Catherine Hunt (Dirprwy Glerc)** **Stephen Boyce (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Cafwyd ymddiheuriadau gan Kirsty Williams. Nid oedd dirprwyon.

2. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Trafod y prif faterion

2.1 Bu'r Pwyllgor yn ystyried y prif faterion yn ei ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru.

3. Blaenraglen waith – Trafodaeth bellach ynghylch sesiynau tystiolaeth un-tro

3.1 Bu'r Pwyllgor yn trafod ei flaenraglen waith. Yn dilyn ei seminar anffurfiol ar fynediad at feddyginiaethau, cytunodd y Pwyllgor y byddai'n cynnal ymchwiliad byr i fynediad at driniaethau yng Nghymru.

3.2 Cytunodd y Pwyllgor na fyddai'n trefnu pedwerydd sesiwn dystiolaeth un-tro, a hynny er mwyn caniatáu digon o hyblygrwydd yn y flaenraglen waith fel y gall y Pwyllgor ymateb i faterion a allai godi.

3.3 Cytunodd y Pwyllgor i ystyried ei flaenraglen waith eto cyn toriad y Pasg.

4. Ymchwiliad i ofal preswyl i bobl hyn - trafodaeth â Jean-Pierre Girard mewn perthynas â thystiolaeth ysgrifenedig a gomisiynwyd gan Gydweithredwyr Cynyddol Cymru

4.1Ymatebodd Jean-Pierre Girard i gwestiynau gan y Pwyllgor ar fodel cydweithredol gofal yn y cartref i bobl hŷn yn Québec.

5. Papurau i'w nodi

5.1 Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 25 Ionawr.

TRAWSGRIFIAD

Trawsgrifiad o'r cyfarfod.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-06-12 papur 6

Blaenraglen Waith y Pwyllgor Iechyd a Gofal Cymdeithasol: Chwefror– Ebrill 2012

At: Y Pwyllgor Iechyd a Gofal Cymdeithasol

Gan: Gwasanaeth y Pwyllgorau

Dyddiad y cyfarfod: 23 Chwefror

Diben

1. Mae'r papur hwn yn gwahodd yr Aelodau i nodi amserlen y Pwyllgor Iechyd a Gofal Cymdeithasol, sydd wedi'i atodi fel Atodiad A.

Cefndir

2. Yn Atodiad A, ceir copi o amserlen y Pwyllgor Iechyd hyd at doriad Pasg 2012.

3. Fe'i cyhoeddwyd i gynorthwyo Aelodau'r Cynulliad ac unrhyw aelodau o'r cyhoedd a hoffai wybod am flaenraglen waith y Pwyllgor. Bydd y Pwyllgor yn cyhoeddi dogfen o'r fath yn gyson.

4. Gall yr amserlen newid a gellir ei diwygio yn ôl disgresiwn y Pwyllgor pan fydd busnes perthnasol yn codi.

Argymhelliad

5. Gwahoddir y Pwyllgor i nodi'r rhaglen waith yn Atodiad A.

ATODIAD A

DYDD IAU 23 CHWEFROR 2012

Bore yn unig

Ymchwiliad ar ofal preswyl i bobl hŷn
Sesiwn yn cyflwyno'r cefndir

- Comisiynydd Pobl Hŷn Cymru
- Rhaglen My Home Life / My Home Life Cymru
- Y Sefydliad Gofal Cymdeithasol er Rhagoriaeth / Sefydliad Gofal Cyhoeddus, Prifysgol Oxford Brookes

Goblygiadau iechyd cyhoeddus o gyfleusterau toiledau cyhoeddus annigonol
Ystyried y crynodeb o dystiolaeth (preifat)

DYDD MERCHER 29 CHWEFROR 2012

Bore yn unig

Ymchwiliad ar ofal preswyl i bobl hŷn
Sesiwn dystiolaeth lafar – Defnyddwyr, eu teuluoedd a'u gofalwyr

DYDD IAU 8 MAWRTH 2012

Bore a phrynhawn

Gwasanaethau cadair olwyn yng Nghymru: adolygu'r cynnydd a wneir o ran gweithredu'r argymhellion yn adroddiad y cyn Bwyllgor Iechyd, Lles a Llywodraeth Leol ar Wasanaethau Cadair Olwyn yng Nghymru.

DYDD MERCHER 14 MAWRTH 2012

Bore yn unig

Ymchwiliad ar ofal preswyl i bobl hŷn
Cyfarfod gyda'r grŵp cyfeirio – i'w gadarnhau

DYDD IAU 22 MAWRTH 2012

Bore a phrynhawn

Ymchwiliad ar ofal preswyl i bobl hŷn
Sesiwn dystiolaeth lafar – Cyrff yn y sector cyhoeddus

DYDD MERCHER 28 MAWRTH 2012

Bore yn unig

Ymchwiliad ar ofal preswyl i bobl hŷn
Sesiwn dystiolaeth lafar – Darparwyr yn y sector preifat

ATODIAD A

Bydd amser hefyd yn cael ei ddyrannu i ystyried adroddiad y Pwyllgor ar yr ymchwiliad i gyfraniad fferylliaeth gymunedol i wasanaethau iechyd yng Nghymru.

Eitem 5b

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Mark Drakeford AM
Chair of the Health and Social
Care Committee
HSCCommittee@wales.gsi.gov.uk

16th February 2012

Dear Mark,

ENQUIRY FROM THE HEALTH and SOCIAL SERVICES COMMITTEE RE THE FUNDING OF ADDITONAL COMMUNITY PHARMACY SERVCIES

Thank you for the opportunity to comment on the funding of additional services delivered by Community Pharmacies. The question that has been sent to my office from the Committee Secretariat is reproduced in bold below for ease of reference.

"What would be the implications for the Community Pharmacy Contractual Framework of a change in the way that community pharmacies in Wales are remunerated for certain additional services. For example if payments for Minor Ailments Schemes were to be made on a capitation basis?

In asking this question, the Committee is only referring to the way in which community pharmacies are reimbursed for additional services and whether they should be on a capitation rather than a fee basis".

Payment on a capitation basis, underpinned by a patient registration system, is one of the options being explored as part of the development phase to establish a minor ailments scheme in Wales delivered by community pharmacies. You may also find it useful to know that we already fund other additional services such as Enhanced Hormonal Contraception, Medicine Use Reviews and Discharge Medicine Reviews on a type of capitation basis, i.e., payment is triggered by delivery of the service to an individual.

We will in due course consult with stakeholders on the most effective and cost effective mechanisms for funding this service but we do not consider a capitation based approach to have any significant implications for the contractual framework.

Kind Regards
Lesley

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
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