Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Lleoliad:
Ystafell Bwyllgora 3 - y Senedd

Dyddiad:
Dydd Mercher, 16 Mai 2012

Amser:
09:00

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 gyrff proffesiynol (09.00 - 09.50) (Tudalennau 1 - 26)

HSC(4)-14-12 papur 1 - Coleg Brenhinol y Seiciatryddion
Dr Pauline Ruth, Coleg Brenhinol y Seiciatryddion
Dr Kathryn Williamson, Coleg Brenhinol y Seiciatryddion

HSC(4)-14-12 papur 2 - Coleg Nyrsio Brenhinol Cymru
Lisa Turnbull, Ymgynghorydd Polisi a Materion Cyhoeddus, Coleg Nyrsio Brenhinol Cymru
Sue Thomas, Ymgynghorydd Gofal Sylfaenol a'r Sector Annibynnol, Coleg Nyrsio Brenhinol Cymru

HSC(4)-14-12 papur 3 - Coleg y Therapyddion Galwedigaethol
Ruth Crowder, Coleg y Therapyddion Galwedigaethol
Eve Parkinson, Coleg y Therapyddion Galwedigaethol
Chris Synan, Coleg y Therapyddion Galwedigaethol

3. Ymchwiliad i ofal preswyl i bobl hŷn - Tystiolaeth gan undebau llafur (09.50 - 10.35) (Tudalennau 27 - 28)

HSC(4)-14-12 papur 4 - GMB
Paul Gage, Trefnydd, Rhanbarth y De Orllewin o'r GMB

Donna Hutton, Gwasanaethau Cymdeithasol Unsain

EGWYL 10.35 - 10.45

4. Ymchwiliad i ofal preswyl i bobl hŷn - Tystiolaeth gan gyrff staff (10.45 - 11.30) (Tudalennau 29 - 32)

HSC(4)-14-12 papur 5 - Cymdeithas Gweithwyr Cymdeithasol Prydain
Dr Catherine Poulter, Cymdeithas Gweithwyr Cymdeithasol Prydain

HSC(4)-14-12 papur 6 - Cymdeithas Gofal Cymdeithasol
Nick Johnson, Prif Weithredwr, Cymdeithas Gofal Cymdeithasol
Sue Davis, Dirprwy Reolwr
Sarah Owen, Rheolwr Preswyl

5. Papur Gwyn Gwasanaethau Cymdeithasol - Briff technegol gan swyddogion Llywodraeth Cymru (11.30 - 12.30)

Rob Pickford, Cyfarwyddwr Gwasanaethau Cymdeithasol a Phlant Cymru
Mike Lubienski, Uwch Gyfreithiwr, Gwasanaethau Cyfreithiol
Julie Rogers, Dirprwy Gyfarwyddwr Gwasanaethau Cymdeithasol Plant
Margaret Provis, Dirprwy Gyfarwyddwr, Gwella Gwasanaethau Cymdeithasol
Steve Milsom, Dirprwy Gyfarwyddwr, Polisi Gwasanaethau Cymdeithasol Oedolion

6. Papurau i'w nodi (Tudalennau 33 - 35)

HSC(4)-12-12 cofnodion - Cofnodion cyfarfod a gynhaliwyd ar 26 Ebrill

Health and Social Care Committee

HSC(4)-14-12 paper 1

Inquiry into residential care for older people – Evidence from the Royal College of Psychiatrists in Wales

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

For further information please contact:

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Mark Drakeford, AM

Chair, Health and Social Care Committee

National Assembly for Wales. 16 December 2011

Dear Mr. Drakeford,

Re: Inquiry into Residential Care for Older People

We welcome the Health and Social Care Committee's inquiry into residential care for elderly people and are keen to provide you with our response to your request for evidence based on the Terms of Reference outlined in your letter dated 24 October, 2011.

It is a pleasure to respond to this matter, which is close to our clinical hearts and of vital importance to our expanding elderly population. We hope the Health and Social Care Committee involve a broad range of professionals from different disciplines in Old Age Psychiatry in order to support and inform the ongoing process. We are prepared to provide the Committee with oral evidence to assist with the inquiry.

In drafting our response to the Committee's inquiry, we have consulted with the Association of Directors of Social Services Cymru and the Health Inspectorate Wales.

We have attached a response from the Learning Disabilities Faculty in appendix 1.

OUR RESPONSE

Introduction

We welcome the Health and Social Care inquiry into residential care for elderly people and are keen to provide you with our response to your request for evidence based on the Terms of Reference outlined in your letter dated 24 October, 2011.

There is a need for urgent reform in this and related care sectors as they have not delivered value for money. Also there have been numerous safeguarding issues over the years. We hope the Health and Social Care Committee conducting the inquiry involve a broad range of professionals from different disciplines including representation from Royal College of Psychiatrists in order to support and inform the ongoing process. The College is keen to provide the Committee with oral evidence in the spring.

Key Points

- We think that the Committee must use the opportunity to look at residential, EMI residential and specialist residential placements for the elderly.

- The inquiry must look at the specifics of the three categories as above and see whether they still need to be maintained. As care in the community has evolved the distinction between residential and EMI residential can be arbitrary. By custom and practice many patients in residential homes have cognitive impairment and dementia.
- The inquiry must look at the issue of domiciliary care in the community as it is critical to the transition of patients from their own home to a 24-hour care environment. Domiciliary care and related reablements has evolved by chance rather than design in various parts of Wales. There is very little regulation of this area of care.

A. 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

1. There is a **lack of transparency or consistency** around the process of entry into residential care homes. The process varies according to the client's circumstances and can appear to be arbitrary rather than follow a standard, consistent practice. This is particularly true in homes with waiting lists where clients are not always considered on a first-come first-served basis. Clients may be "preferred" over others and therefore offered a place. This practice is sometimes known as "cherry picking" where the patients with more needs are denied care. Not all homes assess clients directly themselves but will take a Case Manager's recommendations and information from clients' care plans, while other homes will come to assess and meet the client.
2. We would urge the committee to move away from the use of diagnostic categories as the primary influence in considering the type of care home a client should access. This process should be **person-centred** and consider the needs of the individual and how these needs can be met in a particular environment. Categorising care venues rather than focussing on the homes' ability to deliver person-centred care leads to difficult mixes of clients and the arbitrary moving of clients who are recategorised. Homes should ideally have all levels of care provision on offer to allow clients to remain in one home even as their needs change. For example, there are realistically many clients in ordinary residential homes who suffer from dementia and, provided their needs can be met, this diagnosis should not act as a trigger to a change of home per se. The National Dementia Strategy for Wales discusses the embracing of those with dementia in our community yet the process is such that those with a diagnosis of dementia are labelled, stigmatised and channelled towards an EMI environment.
3. It remains a cause of concern that the provision of homes, especially EMI, is very much a postcode lottery. There needs to be some guidance to local councils of need for adequate provision or alternatives if provision is not met.
4. The increasing practice of private and voluntary care homes to charge variable "top up" fees represents additional un quantified financial burden to families and carers. This segregates those families with greater finance, and thus denies choice for those who are unable to pay. In affluent areas this can divorce lower income families from their area of choice.

5. Discharges from General Hospital settings can sometimes lead to premature placement in residential homes often due to poor understanding of risk. There needs to be an emphasis on assessment of skills of general hospital staff in discharge planning for patients with dementia. There needs to be a common sense approach to risk when supporting older clients at home. Very often, the risks of going into care are either not understood or factored in. Telecare strategies are poorly promoted and could help people being maintained at home.
6. There appears to be no community-based model for reablement in patients with dementia. Current reablement teams often have dementia as an exclusion criteria.
7. Most EMI residential Care homes have waiting lists, and some clients can wait for months before they are admitted. This alone highlights that provision is inadequate in terms of demand. Strategies on demand reduction and adequate provision need to go hand in hand.

B. 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

8. There needs to be structured training for staff in dementia care. It is often the case that at the point of employment staff have only minimal training. We have found evidence where carers working with clients with dementia have reported to Case Managers not knowing what dementia is. And a domiciliary carer, when asked about training said, "Put it this way, last week I was a hairdresser". It is perceived that caring is intuitive and innate to all of us hence needs no specific training. This approach is wrong.
9. We suggest that all carers meet a national level of experience and training. There should be a qualification/NVQ that is mandatory at the point of entry for staff and also linked pay increases. There needs to be a recognisable career structure in the care sector. We strongly recommend that all care homes, EMI or otherwise, should have mandatory training in dementia care for the staff.
10. Each home should have the support of an in-reach specialist mental health teams which adopt a rehabilitative approach to care when care of patient is breaking down. Intensive support is needed by the local team for those clients where the initial period may be unsettling and thus drive down failed placements. The process of acceptance into a home should be carefully prepared with involvement of friends and family, visits to the home by the client and relevant meetings with the home manager, again trying to avoid failed placements.
11. Regarding resource levels, we are concerned at the high level of turnover in care staff and the number of staff working with clients in a one-to-one capacity who are poorly trained. Examples of good practice exist e.g. the Enhanced Dementia Care Project in Cardiff.
12. We would also urge the Committee to focus its inquiry on rural areas, which are experiencing an increasing elderly population coupled with the reduction in workforce as younger people migrate to urban areas where more work is available.

C. 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.

13. It is difficult to measure the "quality" of care services as experiences are subjective and personal. However, we believe that it is fundamental to quality of care that clients are able to exercise as much autonomy as possible over their own lives following admission to a care home. They should not be expected to follow the regimented pattern of life that is offered in so many. Clients should be provided with their own space as and when it is needed or wanted. Lack of privacy remains a problem.

14. We recommend that the provision of formal activities and access to outside services should be mandatory under legislation for all care homes to create a homely environment. Activities would include gardening, ironing, baking and should be according to the clients tastes and wishes. For the able clients, the home should provide day-trips away from the home, and assistance to maintain important interests in their life, such as Sunday church or going to the local pub. These issues are especially important to those who do not have a family nearby to fill gaps in this role to enrich their lives. Clients should be able to access any community service in the same manner as they would were they resident in their own homes.
15. Homes vary in their size, building, ambience and cost and it does not always follow that the most expensive homes are the best caring locally. Families of clients are unclear as to what the costs covers, especially when costs may vary by a few hundred pounds. The care settings can be very unimaginative and in some cases poorly planned environments. There should be minimums standards regarding building environments for people with dementia, particularly for new builds. The diversity of clients is increasing and the one-size-fits-all approach in the culture of care created can be very disappointing and inappropriate. Double rooms for couples or for those who prefer the company of sharing are not readily available.
16. Service user/ relatives groups should be encouraged within care homes to improve communication and influence of the client group.

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

17. There are no formal communications between healthcare staff and inspectorate bodies. Healthcare staff who often place clients in nursing homes are often not made aware of any concerns which arise in particular homes. In this climate of home closures/embargo there is then a panicked response to support the vulnerable elderly and as a result, personal choice is forgotten. We must give consideration to an improvement pathway, with a troubleshooting team from both Health and Social Services, nominated ahead of the critical situation. If emergency placements have to be made following a crisis, the client choices should be actively revisited thereafter. This would involve advocacy for those without support.

18. It is increasingly evident that if care begins to fail, the tolerance to support the acute issues varies greatly in some situations. As an example, where a residential patient develops some behavioural disturbance, Home Managers often say that their registration will be under threat unless such a client is moved on. It is not uncommon that "notice" is served upon these clients. With the development of Inreach Teams, We must allow for reasonable time to address these problems. The client has little personal rights in these circumstances and the Inspectorate needs to demonstrate a more supportive role. The Inspectorate should support Home Managers to responsibly engage with relevant professionals and attempt to sustain the placement which they consider to be their "home", without fear of adverse consequences. In such situations, we must still put the client first.
19. The relevance of the inspectorate's criteria in reports needs to be revised with consideration to less tangible but often more meaningful elements. The inspection often comes down to a tick box paper based exercise which is grossly inadequate. It should be based upon observation of care. The implementation of intelligent targets related to the care homes needs consideration.
20. The inspection arrangements should look at minimum staffing levels of appropriate staff, not just on the end of a phone but directing one-to-one care on the floor. They should observe care being delivered and assess the culture of care within homes by assessing individual care plans and their person-centeredness. They may look at financial viability. A number of Consultants have commented that they have never received any formal communication from regulatory authorities albeit they are key to the placement decision.
21. At the moment, there is no regulation of domiciliary care and quality varies. We would suggest this is looked at urgently.
22. The CSSIW and HIW need joined-up performance indicators because at the moment their indicators differ greatly.

E. New and emerging models of care provision

23. Extra care is in its relative infancy but to date it appears a positive experience for our client group, with a good balance between independence and support. We understand that the Welsh Government was looking into Extracare facilities, which are costly but very effective. We need to address who pays for it and who is responsible. The Committee must look into what has come of the Green Paper "Paying for Care".
24. Learning disability services also have an increasing burden of ageing population.
25. In LD there is a major thrust in new and emerging models of care, particularly in the prevention of further hospitalisation and prematurely putting patients into residential care homes. We have separately enclosed a feedback from the LD faculty in RCPsych (Wales) for perusal.

F. 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

26. We advocate planning new areas of care with supported living in either flats orbungalows with all levels of care in an on-site "home". These

should be provided by housing associations etc and ideally be not for profit set ups. In future we should provide older people the opportunity to move once, familiarise themselves with the area/neighbourhood and then be able to have their needs met as they change in this set of units. The model of provision offered by Southern Cross and the fiasco that came of it is too risky for very vulnerable individuals who may not be able to present their own objections or concerns. We must design safe and future proof solutions in the knowledge that we will be using these facilities ourselves too.

Appendix 1

INQUIRY INTO RESIDENTIAL CARE FOR OLDER PEOPLE

CONTRIBUTION TO THE INQUIRY FROM THE FACULTY OF THE PSYCHIATRY OF LEARNING DISABILITY OF THE ROYAL COLLEGE OF PSYCHIATRISTS IN WALES

INTRODUCTION

Services for People with a Learning Disability in Wales have their own distinct history and exist within a clear policy framework from the Welsh Government (Welsh Assembly Government, 2007). The core principles of this framework are based on the United Nations Declaration of Rights of the Disabled Person and include independence, person-centredness, community presence and fair access to general and specialist services. There is an obligation on Local Authorities to work together with partner organisations, including health services, to develop strategic plans for services for people with a Learning Disability, and particular emphasis is placed on periods of transition between different life stages.

The population of older people with a Learning Disability is growing rapidly (Emerson and Hatton, 2008) and so far there has been a failure of strategic planning to meet the needs of this group (Thompson and Wright, 2001). It is therefore vital that the needs of people with a Learning Disability are considered within this review of residential services for older people and we welcome the opportunity to contribute to this inquiry.

HEADLINE FACTS

- A rapidly increasing population: approximately 40% increase in the number of people with a Learning Disability aged over 60 years between 2001 and 2021
- A population with an increased risk of dementia and of physical and mental health problems
- A population at risk of entering residential care at an earlier age (Foundation for People with Learning Disabilities, 2002)
- A population requiring a substantial commitment of resources: comprising less than 0.25% of the general population but receiving 5% of the total personal care budget (Strydom *et al*, 2010).

THE PROCESS OF ENTRY TO RESIDENTIAL CARE

Older people with a Learning Disability may live in one of various models of supported community living, or in specialist residential care, or with family carers, who may be elderly themselves. When a transition to residential care is required this sometimes takes place through a planned process, but sometimes occurs as an emergency, for example when a family carer is suddenly taken ill. Planning is usually led by the Community Learning Disability Team, who may have little experience of the range of services available for older people. There are often obstacles to joint working with Older People's services and there can be a lack of clarity as to who is responsible for care planning and funding. LD services have a strong ethos of person-centredness, which may not be present in Older People's services, where there can be greater pressure on resources.

Alternative services which could prevent entry to residential care include extra-care housing, enhanced supported living schemes with integrated support and clinical services (including services

for individuals with epilepsy and who require PEG feeding), assistive technology and crisis intervention services.

Requirements:

- Protocols in each Local Authority area for joint assessment and care planning involving both Learning Disability and Older People's services
- Protocols in each Local Authority area for procurement of residential services for Older People with a Learning Disability
- Joint local strategy between Local Authority and NHS for prevention of entry of Older People with a Learning Disability into residential care settings

CAPACITY TO MEET DEMAND FOR SERVICES / QUALITY / SERVICE USER EXPERIENCE

Older people with a Learning Disability frequently present with highly complex needs, which may include physical and mental health problems, epilepsy, communication disorders, sensory impairment, feeding and swallowing difficulties, mobility problems and challenging behaviour. They are at risk of poor access to and a poor experience from health and social care services, including abuse. There is a need for generic residential services to access training and clinical services, and there is also a need for specialist residential services.

Within generic residential care the key issues include discriminatory attitudes from staff and other residents, a lack of meaningful daytime activity and a lack of opportunity to access the community and to build relationships with people who are not paid carers.

Requirements:

- Commissioning policies that include requirements for training for supporting people with a Learning Disability and the prevention of discrimination and abuse
- Quality measures that include social integration and daytime occupation
- The availability of independent advocacy
- Measures of service user experience that can include people with a Learning Disability and communication disorders (for example talking mats, patient stories)
- Availability of specialist clinical services and training through Community Learning Disability Teams (including training in the management of epilepsy, communication disorders, feeding difficulties, dementia and challenging behaviour)
- Joint planning groups between the Local Authorities and NHS for specialist services for people with the most complex needs, that avoid the need for repeated spot-commissioning through the Continuing Health Care arrangements
- Residential services for older people who have a Learning Disability and challenging behaviour that meet specifications for challenging behaviour services in Wales (Challenging Behaviour Community of Practice).

NEW AND EMERGING MODELS OF CARE PROVISION

Community Learning Disability services include diverse and innovative models of care and support that have arisen from the strong ethos of person-centredness and the historical political support for the resettlement of individuals with highly complex needs from institutionalised hospital care into community settings. Many of these models could also match the needs of older people, including:

- Enhanced supported community living (tenancy-based models with integrated clinical services)
- Extra-care housing including core-and-cluster arrangements

- Keyring schemes, comprising local community networks of support, that can provide support to both disabled and non-disabled people

CONCLUSION

The population of older people with a Learning Disability is a diverse and growing population of individuals who frequently have complex needs and are at risk of early entry to residential care and a poor experience of health and social services. There is a requirement for local strategies for commissioning, procurement, care planning and quality control. Individuals with the most complex needs require collaborative strategic planning between Local Authorities and the NHS. There are new and innovative models of community living which provide alternatives to traditional residential care.

Dr Jon Nash
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25th November 2011

REFERENCES

The Challenging Behaviour Community of Practice http://www.ldiag.org.uk/cbcop.html

Emerson E and Hatton C (2008) Estimating Future Need for Adult Social Care Services for People with Learning Disabilities in England (Centre for Disability Research).

The Foundation for People with Learning Disabilities (2002) Today and Tomorrow: The Report of the Growing Older with Learning Disabilities Programme.

Strydom A, Romeo R, Perez-Achiaga N, Livingston G, King M, Knapp M and Hassiotis A (2010) Service use and cost of mental disorder in older adults with intellectual disability (British Journal of Psychiatry)

Thompson D and Wright S (2001) Misplaced and Forgotten: People with Learning Disabilities in residential services for older people (The Mental Health Foundation).

Welsh Assembly Government (2007) Statement on Policy and Practice for Adults with a Learning Disability.

Health and Social Care Committee

HSC(4)-14-12 paper 2

Inquiry into residential care for older people - Evidence from RCN Wales

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15 December 2011

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Dear Mark

Thank-you for the opportunity to contribute to the Committee's Inquiry into Residential Care for Older People. Ensuring the highest possible standard of care in this sector is a significant issue and we welcome this Committee's Inquiry.

The Royal College of Nursing in Scotland contributed evidence in this Summer to a similar Inquiry by the Health and Sport Committee of the Scottish Parliament and we would draw your attention to the final report of this Committee which makes relevant and interesting reading.

The Royal College of Nursing in Wales has the following areas of concern:

1) The provision of primary and community healthcare in residential care.

   Older people in residential care require at least the same level of access to primary care services as people of any age living independently e.g. public health advice, preventative health checks, advice on self-management etc.

We would expect Care & Social Services Inspectorate Wales (CSSIW) to inspect arrangements and provision for this. We would also expect Local Health Boards to develop and oversee a primary care strategy that included residential homes.

We are concerned at the increasing pressure on community nursing services. This pressure may be reducing the availability of district nurses to support older people in residential care.

One particular issue is access to equipment designed to maintain the individuals' independence e.g. a hoist or wheelchair. Too often the address of a residential home is mistakenly understood by local authority social services as meaning the older person is not eligible to apply for such equipment (or perhaps that it is the sole responsibility of the home to provide such equipment). In fact a residential home is of course simply their home and the older person living here is as eligible as any other.

2) The availability and accessibility of alternative community-based services, including reablement services and domiciliary care:

   The increasing pressure on community nursing services that we refer to above also reduces the possibility of older people being supported in their own homes.

   Community nurses usually spend at least a third of their time assisting clients to request and be assessed for various forms of support such as domiciliary care or equipment to maintain their independence. The paperwork (and systems are not electronic) is extremely burdensome and difficult to navigate. Eligibility criteria and forms differ in each local authority adding to the complexity and time consuming nature of the process. In October 2010 RCN Wales responded to a Welsh Government consultation on this issue and we would urge the Committee to ask the Welsh Government for a progress update as part of the evidence gathering for this Inquiry.

3) Residential *Nursing* Care

   We are concerned that in some areas of Wales residential nursing care and in particular residential nursing care for people with dementia is very limited. This, combined with the intense pressure on bed space in hospitals (with bed occupancy across Wales running at around 90%) may be resulting in the dangerous situation of some older people being inappropriately discharged into residential care rather than nursing care.

The limited provision in some geographical areas is also causing some to fear that the ultimate sanction of CSSIW to close down a poor service is no longer realistic because of the dependence of the NHS. It is important this issue (including the perception) is addressed by CSSIW.

The legal separation of the two categories of care; nursing and 'personal' care has long been criticised by the RCN. This false distinction has created a time consuming and bureaucratic process of assessment which delays care and may also add to the risk of an inappropriate placement.

4) Regulation and other workforce issues within residential care

Too little is still known about the workforce in residential and nursing care. The RCN would expect CCSIW to be investigating numbers, qualifications and continuous professional development of staff. It is important to note that CSSIW is the regulator of the services provided rather than of the professionals. The Care Council for Wales keeps a register of some types of social workers. The Nursing & Midwifery Council regulates registered nurses.

It is regrettable that recently the Welsh Government has begun insisting that registered nurses working in care homes register a second time with the Care Council for Wales (in marked contrast to the mutual recognition arrangements of Scotland) this double layer of bureaucracy does not address the real area where public protection should be increased – the need to regulate health care support workers.

The services this workforce provide are essential to the operation of the NHS and if a particular area is vulnerable (e.g. a large proportion of nurses due for retirement at the same time or emigrating) it is important to forecast this.

Moreover the provision of residential care in the Welsh language needs to be addressed. Too often this issue is ignored by commissioners and planners.

Several countries, including the United States and Canada, have commissioned extensive surveys of this sector using their equivalent of the Nursing & Midwifery Council's Register in order to inform their workforce planning processes and we would recommend this option be considered by the Welsh Government.

In Spring 2009 the Integrated Workforce Planning Implementation Board finished a report with recommendations for beginning the work of scoping the independent sector and utilising information already held by regulatory agencies such as the

CCSIW. The RCN would recommend the Committee follow up on progress on this work.

Finally we are concerned that cuts to the budget of CSSIW may be imperilling adequate and necessary inspections of residential care in Wales.

5) Whistle blowing

The Royal College of Nursing launched a whistle blowing hotline[1] for staff who were anxious about issues affecting patient safety. This initiative also has provided members with clear advice on how to raise issues with their employer and other appropriate authorities. We would recommend that CSSIW/Care Council for Wales consider how they could promote and provide opportunities for older people, professionals and members of the public to raise their concerns and have these concerns acted upon.

Kind regards

Yours sincerely

TINA DONNELLY
DIRECTOR, RCN WALES

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[1] http://www.rcn.org.uk/support/raising_concerns_raising_standards

16th December 2011

College of Occupational Therapists Coleg Therapyddion Galwedigaethol

Health and Social Care Committee

HSC(4)-14-12 paper 3

Inquiry into residential care for older people – Evidence from the College of Occupational Therapists

Introduction

The College of Occupational Therapists (COT) is pleased to provide a response to the consultation on 'Residential Care for Older People' which has been assisted by COT's Specialist Section in Older People and by occupational therapists working with older people throughout Wales. The COT is the professional body for occupational therapists and represents around 29,000 occupational therapists, support workers and students from across the United Kingdom and 2,400 in Wales. Occupational therapists work in the NHS, Local Authority housing and social services departments, schools, prisons, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapists are regulated by the Health Professions Council, and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties across the whole health and social care sector.

Occupational Therapy

Occupational therapists play a key role in supporting older people in maintaining health and well being; enabling them to continue to live independently at home and cope with daily tasks which can become more difficult with age. They offer solutions and options to enable older people to continue doing leisure activities that have become difficult and to get the most from life through maintaining social networks, helping with physical challenges and developing strategies to either prompt memory or adapt to memory deficits. (Craig &Mountain, 2007; Hay et al, 2002; Jackson et al, 1998; Mountain et al, 2008)

The philosophy of occupational therapy is founded on the concept that occupation is essential to human existence and good health and wellbeing. Occupation includes all the things that people do or participate in. For example, living independent lives in their own homes, caring for themselves and others, working, and learning, playing and interacting with others. Being deprived of or having limited access to occupation affects physical and psychological health. Therapy seeks solutions to barriers which prevent people carrying out valued occupations. It might include increasing capability through reablement, graded therapy and other interventions, analysing and amending the demands of occupations, developing alternative occupations or ways of coping and adapting the environment in which the occupation occurs, for example through adaptation or equipment provision.

1. Preventing dependence and keeping people at home

The decision to enter long term residential or nursing care is often made following an admission to hospital or other crisis. The profession supports the conclusion in 'Better

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Support at Lower Cost' (Social Services Improvement Agency {SSIA} 2011) that no-one should be admitted to residential care for a new long term placement directly from a hospital bed.

Home based occupational therapy for older adults leads to significantly lower mortality rates and hospital admissions (Gitlin *et al* 2006a) and can result in greater self efficacy, less fear of falling, fewer home hazards and greater use of adaptive strategies. Gitlin *et al (*2006 b.) found most outcomes benefits were persistent at 12 months. The long term outcomes of this can be a reduction in the need for care packages and support and a delay in admission to long term residential or nursing home care. Too often, there is insufficient early, preventative intervention from a multi professional team of health and social care practitioners to prevent admission or inconsistent access to services to truly rehabilitate people and return them to their homes.

There are key opportunities for supporting older people to maintain their lives which should be prioritised to ensure that the decision to enter residential care is made at the right time for that individual and their family, after all other alternatives have been explored. Those alternatives include:

- Access to a preventative community multi professional team which includes therapists
- Integrated enabling services which work across traditional health, social care and housing boundaries.
- Access to occupational therapy led reablement services.
- Access to a comprehensive Telecare/Telehealth assessment.

Preventative, early intervention, community services
Primary care based preventative services are only slowly developing following the publication of "Setting the Direction" (Welsh Assembly Government 2010). Community Resource Teams will be able to direct the right service to people very quickly, bypassing traditional referral routes. Community based therapists offer GPs an alternative to admission and can help prevent crises. They 'pull' people back home from hospital using their knowledge of that person's community and resources. Occupational therapists work across health and social care, across the statutory, independent and third sectors, and across mental and physical health services. Their core skills are key in preventative services and are underpinned by an evidence base that demonstrates clear cost benefits and successful patient reported outcomes (COT 2010). For example:

- Occupational therapists in accident and emergency departments, and 'turnaround teams' are able to prevent people being admitted from A&E, getting them straight home once their medical crisis is resolved. One 6 month pilot in 2000 concluded that even with set-up costs, the early intervention team had made a saving of 22.2 bed days, equating to a saving of approximately £25,000. There was also a difference of 21.2 days in length of stay between those seen and not by the early intervention team Howard 2010). In January 2010, the Queen Alexandra Hospital in Portsmouth found that following an occupational therapy assessment 81% of people returned home, 10% transferred to rehabilitation services, 9% admitted into hospital (Eckford et al 2010).

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- Elderly Care Assessment Services and other types of services such as social care short term intervention services can also prevent unplanned admission, offer rapid response to avoid admissions, keep people at home and resolve emergencies.
- Early Supported Discharge and specialist rehabilitation teams can provide complex specialist rehab in people's own homes.
- Integrated occupational therapy services work across health and social care, providing NHS and social services interventions to give a whole systems approach which reduces duplication and gaps.
- The assessment and provision of telecare/telehealth equipment, which in many local authorities is undertaken the occupational therapist, can be an essential aspect of enabling a person to remain in their own home.
- Creative and flexible use of respite beds can help with long term planning so that occupational therapists can facilitate a seamless transition into long term care. For example, being able to develop a relationship with a home for respite periods before a final commitment to a permanent move.

Occupational therapy enables older people to live their lives the way they want. Central to this is ensuring that they are able to maintain their skills and abilities through targeted individualised support. Occupational therapists are the only allied health profession working in significant numbers in social services organisations. They deal with between 35–45% of local authority referrals and yet only make up 2% of the workforce (Department of Health 2008). Occupational therapists work with older people to adapt their environment in order that they can carry out their chosen activities safely in their own homes thus reducing the need for complex and costly care packages or admission to residential care (DH 2008).

Integrated services
Integration is frequently used in reference to secondary health and social services; often in terms of facilitating hospital discharge. However, integration needs to be much wider to provide effective support for older people. Closer working between primary and secondary care is vital, as are improvements between specialities, physical and mental health services, hospital and secondary community services, housing and health services as well as statutory and non-statutory provision.

Equally important is the relationship between carers, families and statutory services. Families often struggle to access support for themselves where services are highly focussed only on the service user. Better support for carers will strengthen their ability to continue to support people in their own homes.

Issues around who pays for care can add a significant barrier and many policies identify the service user should not be able to see this interface. Yet this remains a major problem. Debates about continuing care, social services or hospital responsibility can delay and interrupt good quality services and lead to dependence on inappropriate packages of care- because that is the only solution available. At times, transfer to residential or nursing care before necessary is the simpler solution because it is too complex for organisations to support someone at home. This needs to stop if Wales is to achieve sustainable effective affordable services which enable people to also achieve their own wishes.

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Good quality housing support
Housing stock quality in Wales does not support older people or those with disabilities to remain at home. Far too little is built to lifetimes standards and the terrain around Wales often results in steps and steep slopes to approach or leave homes. Housing has a huge impact on health and better links between housing, health and social care will deliver sound outcomes for health and social inclusion. Occupational therapists are the only allied health professional to bridge these three areas.

A greater supply of well designed flexible housing which meets a range of needs through people's life will deliver greater independence for older people. In the meantime, high quality equipment and adaptation services can ensure that home does not become a prison. One study which explored the relationship between provision of equipment and reduction on care package costs and residential care found that over an eight week period cost savings to care packages through provision of equipment were over £60,000 (Hill 2007). Housing adaptations reduce or remove costs for home care. Heywood et al. (2007) found that savings range from £1,200 to £29,000 a year. Postponing entry into residential care by just one year through adapting peoples home saves £28,080 per person (Laing and Buisson, 2008).

Adaptations processes in Wales are improving, but more remains to be done. The profession believes a single tenure blind non- means tested process would deliver good quality adaptations in a timely and coherent manner. This would make the process more efficient, transparent and cost effective. For many older people repair and maintenance are overwhelming responsibilities and this is where agencies such as Care and Repair are invaluable in supporting people o remain at home. Telecare services offer highly effective support for older people, especially those with dementia and can make the difference between safe independent community living and institutionalised care.

Creative alternatives are being developed, such as extra care schemes, equity release and shared ownership which gives older people opportunity to find the right housing option for them. For many, these can be an important alternative to full residential care. However, the separation between housing and health means that few health workers are able to signpost people to these solutions.

Once admitted to hospital, older people frequently face a complex set of circumstances to get them back home. The inappropriate phrase 'bed blocker' is sometimes used when in fact health services are taking an overly medicalised approach, or are particularly 'risk-averse'. This can mean that older people and their families feel pressured to make a major decision too quickly in order to get someone out of hospital. Residential or nursing care could be perceived as a 'safer' or easier solution rather than the complexities of returning someone to their home. This is unacceptable and policies of no direct discharge to long term residential settings can help to focus services on solving problems for the individual. The development of community reablement and other enabling services will support people to return to and remain in their own homes.

Reablement
Reablement services maximise an older person's potential to recover. Reablement either prevents the need for hospital admission or post-hospital transfer to long term care, or

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appropriately reduces the level of ongoing home care support required and associated costs. Occupational therapists have a role key in delivering reablement services (Welsh Assembly Government 2011). They promote individuals' self-reliance and resourcefulness, engaging with them as active participants in their communities and services. 60% of older people who enter a reablement service do not require further services after a 6 week intensive period of help and assistance (SSIA 2011). The Welsh Reablement Alliance, of which the COT is a member, campaigns to promote the benefits of consistent, effective, integrated services which enable people to maximize their ability to live as independently as possible. The alliance identifies that enablement and reablement should be the starting point for all interventions.

Reablement has been shown to deliver cost efficiencies. A 2007 study for Care Services Efficiency Delivery Programme (CSED) found that following reablement up to 68% of people no longer needed a home care package and up to 48% continued not to need home care two years later (CSED Programme, Homecare Re-ablement Workstream 2007). The added expertise and involvement of occupational therapists in reablement teams contribute to successful reablement services (Rabiee and Glendinning 2010).

An effective reablement service can deliver between 10-20% reduction in demand for domiciliary care (SSIA 2011). Although this can vary, in Bridgend for example, members of the profession report far higher reductions with around 66% of those referred not needing any home care at all after occupational therapy led reablement. The occupational therapist's strengths in assessment and goal planning are integral to service users achieving personalised outcomes and a range of models exist for involving occupational therapists in reablement. Occupational therapists may be core team members or they could work collaboratively with a reablement service – an arrangement that could be aided through co-location (Scie 2011)

The Social Care Institute for Excellence (Scie) (Scie 2010, 2011) and Glendinning et al (2010) identify that a strong priority should be placed on the involvement of occupational therapy in planning and delivering reablement in order to achieve optimum outcomes for service users. Whatever model of involvement is established, it is crucial that occupational therapists' expertise can be rapidly accessed.

Occupational therapists are able to provide enhanced training to home care and other staff to deliver efficient and effective reablement services (Glendinning and Newbronner 2008). Advice on rehabilitation techniques from occupational therapists can assist the continuous reablement process for people with complex conditions and is particularly valued by care workers at progress reviews (Scie 2011). This particular point has been noted by occupational therapists across Wales. Reablement can be run alongside traditional domiciliary care where necessary, while the person recovers from an episode of care, but the skills and approach of staff are very different and care must be taken to maintain the reablement approach. If staff are very task orientated or are pressured to deliver within tight timescales; or are not trained to appreciate the principles of reablement they can begin to 'do for' instead of 'working with' someone. This can happen very quickly and once dependence on care is established it is very difficult to undo. Staff must maintain a rehabilitative and not a 'care' approach.

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Dementia
It is important for older adults to participate in mentally, socially and physically stimulating activities as this may postpone the onset of dementia (Fratiglioni et al 2007). Engagement of people with dementia in activities, graded to their capabilities increases their quality of life, preserves their own identity and provides them with a positive emotional outlet. This is a further supported by NICE guidance 16 *Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care* (NICE2008). Evidence to support a rehabilitation programme is cited by Graff *et al* (2006) Chard *et al* (2008) and McGrath and Passmore (2009).

> 'Ten sessions of community occupational therapy over five weeks improved the daily functioning of patients with dementia, despite their limited learning abilities, and reduced the burden on their informal care givers' (Graff et al, 2006a).

Telecare also enables a person with dementia to stay for longer in their own home; The CSED summary of evaluations of Telecare in England suggested a 37% impact on escalation of care to a care home setting. This would translate to an **average four and a half month deferment in going into residential care**, or could be viewed as **potentially preventing one in three prospective admissions**. This is achieved via such non-intrusive equipment as activity sensors, falls detectors, smoke/heat and Carbon monoxide detectors. In addition to maintaining the person in their own home, this has a significant cost saving of approximately £216 per person per week. (CSED 2007)

2. The process for entering residential care

Good quality preventative services with community support will lead to better decision making for older people and their families. Concerns about quality, cost and location to family all need to be balanced if the right selection is to be made. When a decision is forced at a crisis point it is extremely difficult for people to plan, select the right home or to psychologically prepare themselves. It often results in a move to wherever has space rather than where is right. Where partners have different needs it can be extremely difficult to find care to suit both so that life partners can remain together. New models of extra care housing and multi-level homes offer the opportunity for a single move which can support changes in the future.

Concerns about who will pay are inevitable and the difficulties of potential funders arguing about who is responsible for paying or how much they will pay makes this process even more stressful. Entering residential or nursing care has long term consequences and people need to be able to feel confident about their ability to continue to remain there, not only from a financial and safety perspective. Rarely are families aware of the need to consider financial or long term viability of the home and this is particularly so if they are making a decision at a time of crisis.

One concern for members of the occupational therapy profession is that homes and residents need to be recognised as part of the community: residents should still be able to access local services, such as reablement and therapy if appropriate for them. The COT is currently

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developing a position statement about access to occupational therapy for care home residents as it is recognised that this is not always prioritised. Residents also need to be able to access local services such as leisure and transport, library or social settings. If people move to homes in their locality, more needs to be done to ensure that they retain their local connections and networks- still going to the pub, church or shop if they wish too.

Good quality community services can maximise the person's ability, and create the space to make a planned, sustainable move to care when it is appropriate. There is a lack of open honest debate about care for older age. It is often reported that older people do not wish to enter care. This can means families have not had conversations about what might happen, what they might want, and may not have planned for ageing. This ranges from buying or renting housing that may limit their abilities, to thinking about when they might be very frail. It would be really useful for the Assembly to stimulate a national conversation about how to help yourself avoid difficulties as you age: For example, if people are going to retire to the sea or country: what kind of housing might be best? What happens when you can no longer drive? How will you develop networks friends if you move away from your family? Too often people move to new areas, buy dream homes with steps, down country lanes or away from any support. Then a crisis happens and they are left with great difficulties which a little forward planning would help avoid.

3. Maintaining capability and independence in residential care

Part of the above debate should include what life should be like in residential care. The best are truly homes, they are safe supportive environments which keep people active and engaged in their community. Sadly, some homes are not and leave people with little activity or role or ability to contribute to decisions about their life.

One of the key concerns around maintaining people's independence in residential care is the lack of power and control for residents about even simple decisions in their daily life. For example, too often 'health and safety' is held as a barrier to doing a simple everyday task. Homes could adopt a less risk adverse culture where appropriate, so residents can participate in and maintain their activity levels. Care staff could include residents in the functional tasks around the home for example, making their own cup of tea or a sandwich, setting the tables for all, ironing, or doing some dusting or gardening. Fine (2000) found that older adults who engage in leisure activity whether physical exercise or more sedentary activity were less depressed than older adults who did not engage in leisure activity. Maintaining opportunities for occupation and pleasure in care homes for older adults contribute to survival and mood state nine months after admission (Mozley C, 2001).

Reablement is rarely available for people in residential care. This might be among hospital staff who fail to prioritise rehabilitation for those they know to be returning to institutional care, or lack of access to community services for those who may have had a temporary drop in function, for example following an acute infection or small stroke. Access to the same therapy as would have been provided for someone living at home may not be available, so those in homes lose their optimal level of function and become increasingly dependent - because there is always someone there who could do it for them.

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In care homes the rate of falls is almost 3 times that of older people living in the community. Injury rates are also considerably higher, with 10-20% of institutional falls resulting in a hip fracture. 30% of people admitted to an acute hospital with a hip fracture coming directly from a care home. (Department of Health, 2009)

Appropriate use of telecare in residential/nursing homes can have a significant impact in the reduction of falls in these establishments, for example by immediately notifying care staff when a resident gets out of bed. Occupational therapists around Wales also report that the effects of the therapy received when someone is in active occupational or physiotherapy or via reablement is not continued as effectively when an element of care is required. Staff who work in a care model struggle to act therapeutically and people's skill level can then deteriorate. Training, supervision and direction for care staff is vital to help them enable people to maintain their level of ability and independence. Where occupational therapists are employed in residential and nursing homes they are able to influence activity and participation, continue rehabilitation and a reablement ethos, train staff and adapt environments to enhance independence.

Reablement and access to therapy should not end on admission to residential or even nursing care. Members report that community therapy may be limited to only one assessment and one further visit. This is not enabling people to access services they would have been done had they remained in their 'community' yet the benefit of such input is significant. It is vital that if someone in a care home has a stroke, for example, that they remain eligible and able to access therapy and rehabilitation to enable them to maximise their recovery. There should never be a presumption that they do not get therapy because they are already being looked after. Dignity and respect for people's independence must be paramount.

The way medication is used can also have an impact on activity levels. Research is currently underway examining the use of antipyschotic medication versus the use of social and physical activity. Care home staff need access to training and advice from therapists to help them use an alternative model.

The COT and National Association of Activity Providers (NAPA) have published activity benchmarks to help homes audit their activity levels and how they enhance residents' quality of life (COT 2007). These are currently being reviewed and COT is willing to discuss this if called to give oral evidence. It offers a framework of person-centred quality indicators and outcome measures to inform guide and encourage those who are responsible for and take part in managing, developing, providing, purchasing and inspecting activity provision within care homes.

The correct social and physical environment can also make a great difference to participation in occupation, and communal spaces in care homes can be evaluated by occupational therapists who can then use their knowledge to enable better care environments and improve quality of life for people with dementia (Morgan-Brown *et al.* 2011). Good accessible inclusive design in residential or nursing homes will help people retain their independence.

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4. Remaining Terms of Reference.

Support for people able to fund their own care.
Occupational therapists are also aware of the difficulties for people who are identified as being over the financial threshold for funding for residential care and who therefore totally fund their own care. They can be left to manage their own without advice and may then not be made aware of other alternatives to residential care (for example, use of telecare, reablement, environmental changes, disability equipment, and the provision of home care) which would facilitate a planned approach if the need for residential care remains.

Once people do enter residential care, expenditure on care home fees may reduce the individual's capital funds to a level that they then have to apply for funding from the local authority. This may result in disruptive change of home if the individual is in a care home with higher rates than the local authority will pay, a need for that local authority to assume a charge it had not planned for and a host of other issues which can inhibit good quality long term stability for people. Not least among these is the additional stress on family. Access to good financial advice and planning as well as awareness of options would help people protect or spread their care costs; potentially enabling them avoid running out of money and remain self funding so that there is no eventual long term cost to the public purse, nor disruption to their life.

The COT has restricted this evidence to areas within the scope of the profession and therefore is not presenting evidence on financial viability of homes at this time.

Conclusion

Moving to residential or nursing care is a major life event, and one that is widely reported to create anxiety for older people. While many homes provide excellent care, support, security and independence for older people we believe that more could be done to:

- Keep people at home longer by the use of appropriate occupational and other therapy and specifically by taking a reablement approach to all interventions
- Support people through their transition into residential care by ensuring older people have a greater awareness of alternatives, services and by discussing and preparing for greater frailty before crisis events occur
- Enable people to retain their personal control and responsibility for their life and their contacts outside the home environment by better use of reablement and rehabilitation within homes and by greater focus on activity and therapy for residents.

We hope this evidence is useful to the committee and are eager to support the inquiry in any other way. We would be very prepared to give oral evidence to the committee at any time. If you have any queries of require anything further please do not hesitate to contact the Policy Officer at the address below.

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References

Care Services Efficiency Delivery Programme, Homecare Re-ablement Workstream (2007) *[Homecare reablement] retrospective longitudinal study November 2007*. London: Care Services Efficiency Delivery. Available at: http://www.dhcarenetworks.org.uk/_oldCSEDAssets/longit-study-bc.pdf Accessed on 1.12.11.

Chard, G., Liu, L., & Mulholland, S. (2008). *Verbal cueing and environmental modifications: strategies to improve engagement in occupations in persons with Alzheimer disease*. Physical & Occupational Therapy In Geriatrics, 27 (3), 197-211.

College of Occupational Therapists (2007) *Activity Provision: Benchmarking Good Practice in Care Homes* COT. London Available from: http://www.cot.co.uk/publication/adult-social-care-workforce/activity-provision-benchmarking-good-practice-care-homes accessed 1.12.11

College of Occupational Therapists (2008) *Position Statement: The value of occupational therapy and its contribution to adult social service users and their carers*. COT. London

College of Occupational Therapists (2008) *Position Statement: Reablement: the added value of occupational therapists*. COT. London

Craig C, Mountain C (2007) *Lifestyle matters: an occupational approach to healthy ageing*. Bicester: Speechmark Publishing.

Eckford R, Bartrum S, Gargett K (2010) *Reducing unnecessary admissions*. OT News 5, 29.

Department of Health. (2008) *Occupational Therapy in Adult Social Care in England: Sustaining a high quality workforce for the future* Department of Health London

Department of Health (2009)Falls and fractures: effective interventions in health and social care London: Department of Health London

Fine J (2000) The effect of leisure activity on depression in the elderly: implications for the field of occupational therapy. *Occupational Therapy in Health Care* 13(1): 45-59

Fratiglioni L, Winblad B, Struass E (2007) *Prevention of Alzheimer's disease and dementia. Major findings from the Kungsholmen project*. Physiology and Behaviour, 92, 98-104

Gitlin LN, Winter L, Dennis MP, Corcoran M, Schinfield S, Hauck WW (2006a) *A Randomized Trial of a Multicomponent Home Intervention to Reduce Functional Difficulties in Older Adults*. Journal of the American Geriatrics Society. 54(5) p809-816.

Gitlin LN, Hauck WW, Winter L, Dennis MP, Schulz R (2006b) *Effect of an In-Home Occupational and Physical Therapy Intervention on Reducing Mortality in*

Functionally Vulnerable Older People: Preliminary Findings. Journal of the American Geriatrics Society*.* 54(6), p950-955.

Glendinning C, Newbronner E (2008) The effectiveness of home care reablement: - developing the evidence base. *Journal of Integrated Care, 16(4),* 32-39.

Glendinning, C., Jones, K., Baxter, K., Rabiee, P., Curtis, L.A., Wilde, A., Arksey, H. and Forder, J.E. (2010) *Home care re-ablement services: Investigating the longer-term impacts (prospective longitudinal study)*, York and Canterbury: Social Policy Research Unit and Personal Social Services Research Unit.

Graff, M. J., Vernooij-Dassen, M. J. M, Thijssen, M., Dekker, J., Hoefnagels, W. H. L., & Olde Rikkert, M. G. M. (2006). *Community based occupational therapy for patients with dementia and their caregivers: Randomized control trial*. British Medical Journal, 333(7580), 1196-1201.

Gutman SA, Schindler VP 2007 *The Neurological Basis of Occupation* Occupational Therapy International 2007 14(2):71-85.

Hay J, Labree L, Luo R, Clark F, Carlson M, Mandel D, Zemke R, Jackson J, Azen R (2002) *Cost effectiveness of preventative occupational therapy for independent living older adults.* Journal of the American Geriatrics Society, 50(2), 1381-88.

Heywood F and Turner L (2007) *Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations, improvements and equipment: a review of the evidence*. London: Her Majesty's Stationery Office

Hill S (2007) *Independent living: equipment cost savings.* [Research report identified through the COT Killer Facts Database].

Howard M (2010) *OTs in accident and emergency – a slightly different perspective* OT News 5, 27-28.

Jackson J, Carlson M, Mandel D, Zemke R, Clarke F (1998) *Occupation in lifestyle redesign: the Well Elderly Study Occupational Therapy Program.* American Journal of Occupational Therapy52 (5):326-36.

Laing and Buisson (2008) *Care of elderly people: UK market survey 2008.* London: Laing and Buisson

McGrath M, Passmore P (2009).*Home-based memory rehabilitation programme for persons with mild dementia.* Irish Journal of Medical Science.178 :(Supple 8): S330.

Morgan-Brown, M; Ormerod, M; Newton, R; Manley, D (2011) *An exploration of occupation in nursing home residents with dementia* residential care. British Journal of Occupational Therapy 74(5)217-225.

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Mountain, G., Mozley, C., Craig, C., Ball, L., (2008) *Occupational Therapy Led Health Promotion for Older People: Feasibility of the Lifestyle Matters Programme* British Journal of Occupational Therapy 71 (10) 406-413.

Mozley C (2001) *Exploring connections between occupation and mental health in care homes for older people.* Journal of Occupational Science, 8(3), p14-19.

National Institute for Health and Clinical Excellence (2008) *Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care*. London: NICE. Accessed on 1.7.10. Available from: http://www.nice.org.uk/nicemedia/pdf/PH16Guidance.pdf

Rabiee, P. and Glendinning, C. (2011) 'Organisation and delivery of home care re-ablement: what makes a difference?', *Health and Social Care in the Community*, vol 19, no 5, pp 495–503.

Social Care Institute for Excellence (2010) *Reablement: Emerging practice messages*, London: Social Care Institute for Excellence (available at www.scie.org.uk/files/EmergingMessages.pdf, accessed 24 January 2011).

Social Care Institute for Excellence (2011) *At a glance 46 Reablement: a key role for occupational therapists:* (available at http://www.scie.org.uk/publications/ataglance/ataglance46.asp , accessed 1.12.11)

Social Services Improvement Agency (2011) *Better Support at Lower Cost: improving efficiency and effectiveness in services for older people in Wales*. Social Services Improvement Agency, Cardiff April 2011.

Welsh Assembly Government (2010) *Setting the Direction: Primary & Community Services Strategic Delivery Programme*. WAG Cardiff

Welsh Assembly Government (2011) *Sustainable Social Services: A Framework for Action*. WAG, Cardiff

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Health & Social Care Committee

HSC(4)-14-12 paper 4

Inquiry into residential care for older people - Evidence from the GMB

GMB is a campaigning trade Union focused on protecting members in their workplaces and growing the number of GMB members in order to maintain strength. We are a general Union which means that we can represent any workplace. The GMB has almost 610,000 members and we are organised in 34 of the UK's biggest companies.

Staffing resources and training

The GMB welcomes the news that the Welsh government will formally launch the Academy of Care practitioners, which will hopefully raise the status of Care staff and ensure that in future Care staff will be looked upon as professionals in their areas of expertise, which we hope will raise the low wages and terms and conditions of this important workforce. In our experience the previous training of staff in some care homes has been nothing more than a paper exercise, that should the worst case happen, the Employer can pass all responsibility onto the individual.

Financial Viability

GMB has heavily criticised the statement made by the Care Quality Commission on the 30th March that "The large health and care organisations are not overseen financially by anyone. The Care Quality Commission requires that a provider is financially stable, but it is outside of our remit to carry out financial audits or financial background checking of any service provider that is putting the care of Service users at risk, whether they are large companies like Four Seasons and Bupa or are small one person one location. We can then request that the company gives us information about the state of their finances and future plans and concerns".

GMB questions how any organisation can be allowed to provide for the care of our most vulnerable people in our society without any financial viability.

GMB had been at the forefront of campaigning to highlight the plight of Clients, families and Care Staff which were involved in the downward Spiral of Southern Cross which was in the hands of the debt ridden company Four Seasons for a period of 6 months and who are now in the process of being taken over by the private equity company Terra Firma.

GMB call for the committee to consider that all organisations prove their financial viability, ensuring that they are able to provide and maintain a safe and long term environment for their clients.

GMB also call for the return of minimum care staff Client ratio as all too often in our experience homes are staffed at a dangerously low level, coupled that with the high use of agency workers being used to cover staff shortages, concerns need to be raised regarding the care that is provided.

Health and Social Care Committee

HSC(4)-14-12 paper 5

Inquiry into residential care for older people – Evidence from the British Association of Social Workers Cymru

BASW is the largest professional association for social work in the UK, with offices in England, Northern Ireland, Scotland and Wales. We promote the best possible social work services for all people who may need them, while also securing the well being of social workers.

By joining the Association, members commit to the values set out within the Code of Ethics.

BASW also comprises the BASW Social Work Trust, a registered charity; Venture Press Ltd, a publishing company and provides financial support to the Social Workers Benevolent Trust and Social Worker Educational Trust. BASW maintains strong international links through its membership of the International Federation of Social Workers.

The IFSW definition of social work:

The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

SUMMARY OF EVIDENCE.

1. Admission to residential care is often associated with hospital admission as policy and practice can reduce the possibilities of older people returning to their own homes.
2. Older people who appear to be self-funding may be denied an assessment of need despite the legal right under the 1990 NHS and Community Care Act.
3. People who are self-funding may find themselves placed in care homes by relatives with no access to independent advocacy.
4. The assessment framework focuses on deficits in order to evidence eligibility rather than assisting the development of person-centred solutions.
5. The pressure to complete assessments and move people out of hospital often leaves little time for exploring individual's choices and assisting them to make the best decisions.
6. There has historically been a view that social work skills are not required by older people. The replacement of social workers by care managers underlines this.
7. Once in care homes, there is little chance that residents with concerns about the care they receive will be able to share them unless they have supportive family or friends.
8. Although residents of care homes are referred to as living in their home, this is not an accurate description of the situation as residents have few rights.

9. Concern about the impact of home closure on residents has been raised but residents of care homes are often admitted to hospital and may have to move to specialist residential care or nursing care. The full extent of this has not been quantified.

ENTERING RESIDENTIAL CARE

Admission to residential care often occurs after a crisis at home or, more frequently, an admission to hospital. Research shows that hospital admission negatively affects older people and prompt discharge is in their best interests. However, prompt discharge can mean that decisions are not optimum for the individual. The Commission for Social Care Inspection found that following the introduction of the Community Care (Delayed Discharges) Act in 2003 rates of discharge to residential care ranged from 5% to 33% of older people requiring support. The research also found that once in a care home, there was very little chance of leaving.

The process of decision making when planning discharge from hospital is affected by a number of factors. Of major importance is access to information in order to make informed decisions. This information may not be available. Medical or nursing staff are known to inform relatives that the patient has to go into residential care, despite having little understanding of alternative care options in the community. Patients who are obviously going to be self-funding may be denied an assessment, ignoring their right under the NHS and Community Care Act 1990. Instances of relatives being given a list of care homes and left to choose are not unusual. The choices made, which usually do not actively involve the older person, may not be based on the needs of the individual It can also mean that people are forced into a care home against their wishes with no advocacy available. The force is not physical but the desire not to be a burden can be very strong.

THE IMPACT OF POLICY AND PRACTICE ON OLDER PEOPLE

The policy of reducing Delayed Transfers of Discharge rightly aims to reduce the inappropriate use of hospital beds and the damage an extended stay can cause older people. However, efforts to reduce delays because there are no beds available in the residential home of an individual's choice by encouraging the selection of other homes can result in people moving to homes that are difficult for relatives to visit or where the care is known to be poor. While moving to the home of choice is possible, this will involve further upheaval for the older person.

When an individual does have an assessment of their needs, the focus is often on their deficits as the Unified Assessment Framework evidences eligibility for services. The hospital environment accentuates individual's difficulties, particularly when people have dementia. The result can be that decisions are made without an understanding of how a person would function if they returned to their own home. The relentless pressure to complete assessments and arrange care packages do not allow time for the development of creative solutions.

The contrast between services to children and those for older people is rarely commented on. Children who have to leave their homes are 'looked after' whereas older people are 'placed'. It is considered good practice for social workers to carefully consider the future plans for children and help them to adjust to the changes. Social work with older people has historically had a low status. In fact the

necessity for qualifications has at times been thought to be unnecessary. The role of 'care manager' was created to implement the care management cycle of assessment, arrangement of care and review. There is little connection with the IFSW definition of social work above.

Once in a care home there are few safeguards for residents. Those people who are on local authority contracts should have their needs reviewed annually, but this may not happen because of the need to prioritise new referrals. The CSSIW inspectors talk to residents when inspections are carried out. However, residents may be reluctant to share concerns with people that they have not met previously and don't know they can trust. In addition many residents may have limited communication because of cognitive or physical impairments.

Residential homes are referred to as the 'home' of residents. This is misleading as residents have few rights associated with living in their own homes. Choices about furnishings and behaviour are limited by considerations of safety and routines. The manager of the home has to ensure that the individual resident's needs can be met in the home. Once this is no longer the case, the resident will have to move. The owner of the care home may decide, or be forced, to close the home and residents have no option but to move out.

Concern has been expressed about the impact of home closures on the residents. However, the residents of care homes frequently move. Admission to hospital is common, sometimes on a number of occasions. This may be associated with the high levels of physical frailty of residents but it can also be the result of inadequate skills within the staff team or fears that failure to send someone to hospital may be seen as neglect. Residents also move onto nursing care or into specialist dementia care. The full extent of these movements has not been quantified.

RECOMMENDATIONS.

1. No one should move to a care home without the opportunity to consider the possibility of alternative options, preferably out of a hospital environment.
2. Advice should be available that will inform choices about the selection of a care home.
3. Older people should be entitled to a skilled social work service that will promote their rights and choices.
4. Investment in the prevention of avoidable hospital admissions will benefit older people by maintaining them in their own homes.
5. Support for residents in care homes should be improved to protect their rights and promote well-being.

Health and Social Care Committee

HSC(4)-14-12 paper 6

Inquiry into residential care for older people – Evidence from the Social Care Association

Briefing for Assembly Committee on the Care of Older People

Social Care Association is a membership organisation for social care workers devoted to promoting best practice through the workers from across the client spectrum and all UK countries. Our founding secretary Kathleen Lewis worked for National Children's Home in Cardiff in 1949

- The Registered Manager
  We are keen to discuss with the committee the critical role of the manager in delivering high quality care. To this end we have published a Registered Manager's Guide and will bring hard copies to the meeting for member but I attach an electronic version of a late draft for convenience and preparation purposes.

- The Front line worker
  It is our view that the key measure of service quality is the interaction between the worker and service user in whatever setting or service this happens. This view is widely accepted and we are interested in discussing how, if this a widely held view, we transfer the values of the statement into strategic and policy practice

- Supporting the delivery of Best Practice
  We would also like to discuss the systems and practices that underpin this – recruitment, conditions, induction, training and registration as well as equivalent support and resources given to organisations established to help social care workers themselves as those directed to employers or the social work services.

- Practice Methods
  If there is time, we are also interested in talking about practice techniques and challenging issues, for example the integration of people with and without dementia conditions in care environments.

Nick Johnson and Sue Davis will attend for SCA and we hope to bring a Registered Manager with us but yet to be confirmed

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Iau, 26 Ebrill 2012**
Amser:	**13:00 – 15:00**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_700000_26_04_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:	**Yvonne Apsitis, UK Home Care** **Ed Bridges, Gwasanaeth Brenhinol Gwirfoddol y Merched** **Philippa Ford, Cymdeithas Siartredig Ffisiotherapi** **Francis McGlone, UK Home Care**
Staff y Pwyllgor:	**Llinos Dafydd (Clerc)** **Meriel Singleton (Clerc)** **Catherine Hunt (Dirprwy Glerc)** **Stephen Boyce (Ymchwilydd)** **Victoria Paris (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1Nid oedd ymddiheuriadau na dirprwyon.

2. Ymchwiliad i ofal preswyl i bobl hŷn – tystiolaeth gan sefydliadau a darparwyr y trydydd sector ac ar fodelau amgen

Ymchwiliad i ofal preswyl i bobl hŷn - tystiolaeth gan Gynghrair Ailalluogi Cymru

2.1 Ymatebodd y tystion i gwestiynau gan aelodau'r Pwyllgor ynghylch gofal preswyl i bobl hŷn.

2.2 Cytunodd y tystion i ddarparu gwybodaeth ysgrifenedig ynghylch a fyddai eu haelodau yn cefnogi rhaglen beilot ailalluogi yn benodol ar gyfer y rhai sydd â dementia.

Ymchwiliad i ofal preswyl i bobl hŷn - Tystiolaeth gan UK Home Care

2.3 Ymatebodd y tystion i gwestiynau gan aelodau'r Pwyllgor ynghylch gofal preswyl i bobl hŷn.

3. Papurau i'w nodi

3.1 Nododd y Pwyllgor gofnodion y cyfarfodydd a gynhaliwyd ar 14 a 22 Mawrth.

Blaenraglen waith - haf 2012

3.2 Nododd y Pwyllgor y papur.

Y Bil Sgorio Hylendid Bwyd (Cymru) Drafft - gohebiaeth oddi wrth y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

3.3 Nododd y Pwyllgor y llythyr.

Ymchwiliad i ofal preswyl i bobl hŷn - papur gan yr Athro Andrew Kerslake

3.4 Nododd y Pwyllgor y papur.

Deiseb P-04-329 rheoli sŵn o dyrbinau gwynt sy'n peri diflastod

3.5 Nododd y Pwyllgor y papur.

Deiseb P-04-375 rhoi terfyn ar system eithrio ar gyfer rhoi organnau

3.6 Nododd y Pwyllgor y papur.

4. Cynnig o dan Reol Sefydlog 17.42(vi) i eithrio'r cyhoedd o'r cyfarfod ar gyfer eitemau 5 a 6

4.1 Cytunodd y Pwyllgor â'r cynnig.

5. Ymchwiliad un-dydd ar wasanaethau cadeiriau olwyn yng Nghymru - ystyried y prif faterion

5.1 Ystyriodd y Pwyllgor y prif faterion o'r ymchwiliad un-dydd i wasanaethau cadeiriau olwyn.

6. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru - trafod yr adroddiad drafft

6.1 Ystyriodd y Pwyllgor yr adroddiad drafft ar gyfraniad fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru.

TRAWSGRIFIAD
Trawsgrifiad o'r cyfarfod.