Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Canolfan Catrin Finch, Prifysgol Glyndŵr, Wrecsam

Dyddiad:
Dydd Iau, 14 Mehefin 2012

Amser:
10:45

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:

Polisi: Llinos Dafydd
Clerc y Pwyllgor
029 2089 8403/8041
HSCCommittee@wales.gov.uk

Agenda

1. Cyflwyniad, ymddiheuriadau a dirprwyon

2. Ymchwiliad i ofal preswyl i bobl hŷn – Tystiolaeth gan ddarparwyr preifat (10.45 – 13.00) (Tudalennau 1 – 32)

10.45 – 11.30 Fforwm Gofal Cymru a chartref gofal Haulfryn

HSC(4)-17-12 papur 1- Fforwm Gofal Cymru
HSC(4)-17-12 papur 1- Fforwm Gofal Cymru – Gwybodaeth ychwanegol
Mario Kreft, Cadeirydd, Fforwm Gofal Cymru
Mary Wimbury, Uwch Gynghorwr Polisi, Fforwm Gofal Cymru
Peter Regan, cartref gofal Haulfryn
Sandra Regan, cartref gofal Haulfryn

11.30 – 12.15 BUPA

HSC(4)-17-12 papur 2
Matthew Flinton, Pennaeth Materion Cyfreithiol a Pholisi

12.15 – 13.00 Terra Firma / Four Seasons

HSC(4)-17-12 papur 3
Eithne Wallis, Terra Firma
Jim McCall, Rheolwr Gyfarwyddwr Cymru a Gogledd Iwerddon, Four Seasons

3. Papurau i'w nodi (Tudalennau 33 - 36)
Cofnodion y cyfarfodydd a gynhaliwyd ar 24 a 30 Mai
HSC(4)-15-12 cofnodion
HSC(4)-16-12 cofnodion

3a. Y Flaenraglen Waith - Haf 2012 (Tudalennau 37 - 39)
HSC(4)-17-12 papur 4

Health and Social Care Committee

HSC(4)-17-12 paper 1

Inquiry into residential care for older people – Evidence from Care Forum Wales

GOFAL AM GYMRU . TAKING CARE OF WALES

RESPONSE TO THE NATIONAL ASSEMBLY FOR WALES
HEALTH AND SOCIAL CARE COMMITTEE
ENQUIRY INTO RESIDENTIAL CARE FOR OLDER PEOPLE

Who are we?

Care Forum Wales is the leading professional association for independent sector social care providers in Wales and a signatory of the Welsh Government's Memorandum of Understanding *Securing Stronger Partnerships in Care.* Of particular relevance to this enquiry is the fact that our membership includes those who provide care homes and domiciliary care services for older people. Our members come from both the private and third sectors and we aim to engage and professionally support independent providers, to spread good practice, and help members provide a high quality service.

We are willing and keen to give oral evidence to the Committee, based on the experience of our members in providing care for older people. We would also be happy to facilitate the committee in visiting providers.

Our members include a variety of structures: large corporate groups, home-grown small and medium enterprises (SMEs), registered social landlords, and voluntary or charitable bodies.

Our members include organisations providing support to older people in a variety of ways:

- Residential care homes
- Nursing homes
- Domiciliary care providers, which provide social care to people in their own homes
- Extra care housing providers, offering varying levels of support facilities for tenants living in their own apartments.

Some organisations provide more than one type of service e.g. running care homes and providing domiciliary care. Some provide social care for others types of clients who need it, not just older people, and some care homes, in both the residential and nursing sectors, also provide care for

those with Elderly Mental Health (EMH) needs. As the committee will know, residential care is the care provided in a care home to those whose needs are classed as social rather than nursing. Nursing homes can accept residents who do not need nursing care (i.e. are classed as receiving residential care) but residential homes cannot care for people who need nursing care, as defined by the Funded Nursing Care provisions, i.e. more than the district nurse would normally provide. Therefore residential clients should not have unpredictable nursing needs. These complex definitions can make the sector difficult to understand for professional staff, let alone the public.

The state of residential care for older people

The committee sets out: *To examine the provision of residential care in Wales and the ways in which it can meet the current and future needs of older people*

The residential care sector has always adapted to meet expectations and needs. Where this is most apparent is in the slow, but clear, increase in the dependency of residents over the last ten to twenty years. Those currently receiving residential care, would previously have been classed as needing nursing care, while many of those currently receiving nursing care would have previously been in hospices. These changes have taken place gradually, and providers have accepted residents with such high needs voluntarily, but other changes have been hastened by statute. This can be evidenced by the move to, for example, single rooms and en suite facilities, which were once rare or an 'add on extra'. This level of service is now common and may be expected by many people who use services and by the regulators. We are also now seeing increased development of extra care housing facilities to meet the population demand.

We have three significant concerns with regard to the current provision of residential care which we feel must be addressed:

- The development of a two tier system and the inability of those who cannot self-fund to choose residential care. The perception is too often that care in a residential home is a choice of last resort, despite the fact that many residents do choose it in order to have the reassurance of 24 hour care and escape the social isolation that many experience in their own home. Information should be made available to explain the advantages and disadvantages to individuals of both home care and residential care.
- Local authority planning and commissioning arrangements, including fee setting, which in many areas do not adhere to the principles of the Welsh Government's Commissioning Framework Guidance and Good Practice *Fulfilled Lives, Supportive Communities* or the Memorandum of Understanding *Securing Strong Partnerships in Care*. This has led to fee levels in many areas which are unsustainable and do not permit the investment needed to maintain provision let alone improve it.
- The lack of sufficient incentives to encourage providers to meet the needs of increasing numbers of older people with dementia.

We expand further on these points in our answers to the Committee's questions below.

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.

Residential care has seen a huge transformation over the past decade. It has effectively evolved into a two tier system. Ten years ago residential homes provided support for significant numbers of people who would move around their local neighbourhood with some independence but required assistance or prompting with cooking and perhaps intimate personal care. Now, such clients are still there but, in smaller numbers, and all are self-funding. Local authorities are no longer funding people in residential care unless they are highly dependent: often unable to bear their own weight or to manage their own intimate personal care needs. Ten years ago, people who were doubly incontinent and needed two members of staff to assist them to move would have been classed as requiring nursing care. Today this is a standard profile of state-funded clients in residential care. In part, the increase in dependency can be accounted for by some people's desire to remain in their own homes for as long as possible supported by domiciliary care services as appropriate and by the development of sheltered and extra care facilities. This is welcome. However, what is not welcome, is the misfortune of those who feel isolated and afraid at home and would choose to have their complex needs met in a residential care setting but who are unable to do so as they are not able to self-fund and the local authority will no longer fund such care – even where it would be more cost effective than the domiciliary care which is being provided.

Residential care is not something any of us wish to contemplate while we are fit and well, however as our confidence and physical abilities decrease it may be the best solution for us, particularly if we would otherwise be living on our own. It is clear that many of those with the means to do so are choosing residential care, significantly earlier than those reliant on state support. These residents say that they choose to enter residential care in order to meet their needs for security and belonging in a social environment. They are often anxious and lonely, particularly at night, and want the security of knowing assistance is available on site. Others, recognising their deterioration want to move into residential care whilst they can still be in control of the process and take their time making a choice of home. Care home providers also report that often, after moving in to a care home, residents and their families express the wish that they had done so sooner.

The complex domiciliary care arrangements put into place to support people at home can be more expensive in financial terms, and also increase the marginalisation and deprivation suffered by these people who are housebound and isolated form society. This can be exacerbated by the way domiciliary care is commissioned, focussing on tasks to be performed, rather than the well-being of the person receiving the care. It is entirely right that LA commissioners should recognise the wishes, indeed the right, of people to remain in their own homes for as long as possible, but those that desire to enter residential care should have equal consideration.

All the evidence from our members indicates that those who are in a position to self-fund residential care make informed decisions to move at an earlier time when they are healthier both physically and mentally than local authority policies would normally commission. In contrast local authority funded clients frequently enter residential care due to a crisis, often involving illness or inability to cope any longer by members of their family. For example:

> A provider running a home taking both nursing and residential clients describes a Friday a few weeks ago where she was asked to take four emergency admissions. One was nursing but the other three were residential: one was admitted due to a family crisis; the other had already been admitted to a residential care home but because a risk assessment had not been done for the use of a zimmer frame was not able to stay – following an assessment they returned to the original home just over a week later; the third was admitted as the relative who cared for them was unwell: they were seen by the out of hours GP on Saturday, Sunday and Tuesday and demanded to be admitted to hospital.

These emergency admissions and high turnover of residents put considerable additional pressure on homes which are not paid an additional entry or turnover fee for such clients. The residents themselves are also often distressed by such admission processes. A manager describes an emergency admission where the transport was arranged from the ambulance service at 2 pm but did not turn up till 9pm and the client did not arrive into the home until 9.45pm. Incidents like this are not atypical for state funded residential clients and show a clear disregard for the anxiety caused to them and their relatives, neighbours and friends and the lack of respect for them as people and their dignity in being treated so indifferently in such traumatic circumstances.

There is also often a difficulty in appropriately assessing admissions in an emergency situation to ensure that the home can meet their needs and that the local authority is paying the appropriate fee to meet their dependency levels. Mistakes can take some time to rectify.

Of course residents do not always enter residential care permanently, but may do so for respite care or for reablement, Sometimes respite care can be well planned and clients may have a home where they go regularly for respite. This respite provides families and carers with well-needed support and often individuals will be managed much longer in their own homes as a consequence. Similarly reablement after a stay in hospital, or preventing an admission to hospital, can work well both in the community and in care homes that are trained to provide such a service.

We would like to see an assessment of those requiring social care that considers their future prognosis, whether they are likely to require a care home placement, and if so the risks and benefits of making that move at any particular time. The issue is often about the suitability and desirability of community based services rather than their availability per se.

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.

Staffing and training

Well trained, caring staff are absolutely vital to a good home, but often they do not feel sufficiently valued by society for the vital work that they do. We would like to see a continuing professionalization of care work, and think it is unfortunate that the decision not to continue working towards registration of "hands on" staff, gave a signal that their role was not recognised. Ideally we would like to see a professional organisation for care staff, for example a revival of the Academy of Care Practitioners.

Providers have also been concerned, in times of high employment, that it has been difficult to retain staff and turnover can be high. This is often due to the lack of resources to improve staff pay and conditions. Providers would like to improve staff terms and conditions, where possible, to those of the NHS and local authority employees, but this is not feasible at the current fee levels paid by local authorities. The current economic climate has made recruitment and retention less pressured. However, members are concerned that any economic upturn combined with stricter restrictions on immigration may make recruitment more difficult again.

Many of our members are Small and Medium Enterprises (SMEs), but often find that despite the professed intention of Welsh Government and local authorities to grow and support SMEs and encourage the spending of the Welsh pound in Wales, there is less recognition of the role they can play in creating employment than there is for those working in, for example, the tourism or energy sectors. If we want high quality provision as a nation, we must invest in the training and development of social care staff and see them as a vital part of the economy. Social care should be seen as important, both in terms of meeting a need, but also in terms of providing employment. Like many other employers social care employers would like to be able to recruit staff with better basic skills.

We would also like to see an improved development of training provision. Some councils offer excellent free training courses which we would like to see replicated everywhere. Care Forum Wales provides some training to its members and generally find this is extremely well received. However, often training providers are not properly quality assured by regulators there is a superficial audit trail based upon attaining targets at any cost. In many cases training provision has been reduced to a rigid unimaginative process, driven by funding rather than quality of outcomes for the people we support.

Number of places and facilities

The Commissioning Framework Guidance and Good Practice *Fulfilled Lives, Supportive Communities* was published by Welsh Government in 2010. Key standards require local authorities to ensure:

- Commissioning plans have been developed with partners and have involved all key stakeholders including users, carers, citizens and service providers in the statutory, private and third sector.
- The local authority has ensured that its Financial and Contract Standing Orders allow social care commissioners to be efficient and effective in developing the local social care market.
- Commissioners have understood the costs of directly provided and contracted social care services and have acted in a way to promote service sustainability.

The Memorandum of Understanding *Securing Strong Partnerships in Care* was signed by all the key players, including Welsh Government, the WLGA, ADSS Cymru and ourselves in 2009. We all agreed to respect each other's commitment to best outcomes for people in need. We regret that there has not been as much progress on this as we would have liked on a local level where our members too often report still experiencing distrust from commissioners. We feel it would be useful for commissioners to spend time in homes, getting to know how they work, in order to ensure a better understanding of the sector by those commissioning from it. We also think providers would benefit from an enhanced dialogue with commissioners about the types of services they are likely to commission in the future.

A number of residential homes have closed recently, due to the decline in residential placements by local authorities outlined above. Despite this in some areas of the country there remains over-supply of residential beds compared to funding of places. However, we still see successful residential homes in populous areas, providing an excellent service that are full with a waiting list. It is often significantly harder to find an Elderly Mental Health (EMH) placement than it is to find a general residential placement.

All demographic predictions indicate not just an increase in life expectancy, but a substantial increase in the number of older people with dementia. There appears to be little evidence of joint planning with all partners on the future need for this type of provision in Wales and as a consequence there is currently across much of Wales a shortage of provision for EMH placements. Some of the barriers to existing providers moving in to EMH are:

- How to manage the switchover – EMH residents are often perceived as noisy, disturbing others and needing increased security measures – few homes are constructed in a way to facilitate this changeover with existing residents and new EMH residents easily.
- Providers often feel this would be a great leap into the unknown and that the increased fees for EMH placements do not fully account for higher staffing costs, increased specialist equipment, specialist activities, increased wear and tear on the building and increased staff training needs.

If the need for a greater number of EMH placements is to be met, as identified, by statistical projections such as Daffodil funded by Welsh Government, and local planning, we believe stronger incentives must be provided to reassure and encourage providers that commissioners are serious about purchasing this type of care in the future.

Resources

In general, financial resources in the independent sector are extremely tight. Fees are too low and often do not cover reasonable costs. An ordered list of the lowest residential fee paid by each local authority is attached as an appendix. It can be seen that many authorities are paying less than the cost of a night in a budget hotel, for the care and sustenance of vulnerable elderly people requiring significant levels of assistance with personal care and many aspects of daily living. On these sort of fees many businesses only remain viable based on charging residents a top up fees, private residents paying a higher rate, delaying repairs and capital investment, and owners working extremely long hours for low returns.

The level of fees across Wales is something of a lottery. The lowest fee for basic residential care is £316.60 per week in Carmarthenshire and the highest £504 per week in Newport and Torfaen. Although there are some local variations in both cost and the needs of those placed, we do not believe such a large variation can be justified. Nor do we believe that £316.60 comes anywhere close to covering the actual costs of care.

Quite rightly residential care is heavily regulated. Staff costs are the most significant element of a home's budget, followed by food and power. All these areas have seen inflation above RPI in recent years and are difficult to find significant savings in. We recognise, of course, that this is a difficult time for local authority budgets, but in the care sector there is no fat to trim. Anything other than a fair increase to meet additional costs can only adversely affect the vulnerable older people being care for. Our members, like other businesses are finding that many lenders are changing terms and increasing pressure. Examples include banks requiring homes to be profitable at 85% occupancy, even when their occupancy is consistently over 90%, in order to secure lending.

Everyone wants to see a sustainable care sector. Yet a recent report from Wilkins Kennedy Accountants indicates that the number of UK care homes going into administration has more than doubled from 35 in the year to end September 2010 to 73 to end of September 2011. The media attention has focussed on Southern Cross, but we have also seen a number of smaller companies go under including north Wales-based Southern Care Group, and South West Wales based Kappians care. Without fees covering costs we fear that we will see more homes, particularly those in less affluent areas where private clients are unable to subsidise state-funded ones, go to the wall.

Fees are of course a difficult issue for local authorities. In many areas they are in a monopsony position: they are by far the biggest buyer of residential care home services with a small market of private self-funders and some NHS commissioned continuing healthcare. In such a market there needs to be an intervention to ensure fair fees are set: fair to both providers and council tax payers. In 2004, the Welsh Local Government Association commissioned William Laing to develop a fair means of determining fees in Wales. However, the resulting toolkit has never been fully implemented.

We are concerned that we are seeing an increasing development of individual local authorities using consultants to develop their own questionnaires to local care homes to set fees. While we agree that it is important to take into account local factors, we are concerned by the cost and complexity of some of these questionnaires. They often fail to take into account of significant factors and by

increasing complexity, increase the overall cost of the system to both the local authority and to providers.

We hope that the intentions of Welsh Government spelled out in *Sustainable Social Services for Wales: a framework for action and* the report to the Minister for Social Services and Local Government *Local, Regional, National: what services are best delivered where?* will help us move away from 22 different commissioning arrangements towards a more streamlined approach, more suitable to a country the size of Wales.

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;

We see evidence of some extremely good residential provision in Wales, and Care Forum Wales is keen to promote quality by providers. Good providers provide a service that residents and families want and, as part of their quality assurance programmes, collect feedback from service users and their families and make changes accordingly. They also provide care to meet the needs of each individual service user through an individual care plan recognising and understanding their history and diversity of needs. In a country the size of Wales it is important that we have the mix right to ensure, as far as is possible, a variety of provision to meet the needs and desires of those entering residential care. Some will prefer a small home, some a larger one, some provision with hotel-style all mod cons, others something more homely. There is also a place for homes catering to particular needs e.g the Polish home in Gwynedd or the Jewish home in Cardiff, which cater for a specific community. Commissioning plans must take into account the desire for this diversity. For example, a fee setting regime that only looks at larger homes costs cannot meet the desire of some residents to live in a small home, if they are unable to stay in their own home.

We of course recognise that there are providers that are less good than others and believe that commissioning policies should be focussed on ensuring that good homes thrive and others improve or are driven out of the market.

We also would like to see consideration given to the fact that a care home can become an individual's home. A consultation is currently under way to consider whether those residents who develop EMH needs should continue to be required to move, or the home seek a variation in its registration, if their needs could be met by appropriate staff and training. Similarly palliative care for those nearing the end of their life can now be provided in a person's own home, if they wish to remain there and someone is available to take on appropriate tasks after training. Consideration should be given to whether in certain circumstances palliative care should be made available in residential homes, rather than force a resident nearing the end of their life to move to a nursing home.

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

We are pleased the indications that we have had from CSSIW about their intention to focus in the future on service user experience rather than box ticking and await with interest to see how this

new regime develops. We recognise the need for strong and effective regulation and inspection of the sector. We are also keen that it is not over burdensome: every minute that providers spend filling in forms and dealing with inspection regimes are minutes that are not spent directly improving the care in the home or supporting a vulnerable person.

We are also keen that local authority commissioners use the resources of CSSIW inspections to support their role. It is important that what could effectively be a parallel system of inspection is not created with similar, but not necessarily identical, forms to complete, similar visits etc. Regulation and inspection arrangements should always be proportionate and the burden placed on providers is a key component within that.

Of course there may be circumstances where drastic action is needed, but in the main, and at its best, inspection should be a tool that assists providers in improving and supporting their service where appropriate not a stick to beat them with.

Similarly any move to increase the scrutiny of providers' financial viability must look at the issue in the round. Any concerns should be used to help identify ways in which providers may be able to help themselves. There also needs to be a recognition of the pressure lenders are placing on homes with regard to financial viability and the appropriate level of resourcing in terms of care home fees.

New and emerging models of care provision.

As we said earlier care provision has always adapted to meet the needs and wants of citizens. Extra care and technological developments in terms of telecare etc. are all important developments in meeting the care needs of some people. We are also seeing the increasing development of smaller units in larger homes, to meet some people's desire to be an a more homely atmosphere while recognising commissioners' desires to fund larger homes that provide economies of scale. However, we cannot see a situation in which residential care as we know will not continue to be the right answer for some individuals. The independent sector has always been flexible and will offer services that commissioners and individuals want. How that care is provided requires future planning either on a local or regional basis with input from all parties. This is the key to meeting the needs of the population of Wales.

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.

Our members include both private and not-for-profit providers. We believe a variety of funding mechanisms help to provide a diversity of provision and we can learn from the best in each sector. It is also important to the ecology of the provision in care that no provider becomes too dominant. We must of course remember that care homes requires significant investment in buildings, equipment and their maintenance and any provision must have access to sufficient capital to provide this.

There has been a move by local authorities away from their own in house care provision. Initially this was perceived by some councillors as being a loss of control and against their inbuilt social care principles. In fact they appear to have recognised increasingly is that independent social care providers are able to make better quality provision at a fraction of the cost that their own homes need. They also have recognised that the commissioning guidance has given them the freedom to plan more effectively for future needs and to look more objectively to the needs of their local communities. They have also found that independent providers have been able to adapt to changing needs within each care centre as the workforce accept change more readily. Now the independent sector provides the vast majority of the care beds across Wales we need to ensure that it remains quick to respond to ever changing demands and is financially viable to ensure the communities of Wales have the care provision they will need in the future.

Appendix 1 – lowest fee paid per resident per week for older people's residential care

It should be noted that we may not be comparing like with like as some authorities with lower fees may place less dependent residents than those with higher fees.

	Basic Fee
Newport	504
Torfaen	504
Rhondda Cynon Taff	478
Pembrokeshire	469
Vale of Glamorgan	468
Bridgend	462
Swansea	450
Conwy	448
Ceredigion	440
Flintshire	437.76
Monmouthshire	430
Neath Port Talbot	426
Ynys Môn	423
Blaenau Gwent	402
Caerphilly	401
Merthyr Tydfil	389
Gwynedd	371.97
Powys	354
Denbighshire	348
Wrexham	342.44
Cardiff	324.2
Carmarthenshire	316.6

Health and Social Care Committee

HSC(4)-17-12 paper 1a

Inquiry into residential care for older people – Additional evidence from Care Forum Wales

GOFAL AM GYMRU . TAKING CARE OF WALES

Mark Drakeford AM
Chair
Health & Social Care Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Friday 1 June 2012

Dear Mr Drakeford

Enquiry into Residential Care for Older People in Wales

We would like to thank the Committee for its invitation to give evidence on Thursday 14 June and we would like to take this opportunity to submit additional evidence following on from our written evidence submitted in December 2011.

Our three significant concerns outlined previously still stand:

- The development of a **two tier system** for residential care and the inability of those who cannot self-fund to choose residential care. The perception is too often that care in a residential home is a choice of last resort, despite the fact that many residents do choose it in order to have the reassurance of 24 hour care and escape the social isolation that many experience in their own home. Information should be made available to explain the advantages and disadvantages to individuals of both home care and residential care.
- **Local authority planning and commissioning** arrangements, including fee setting, which in too many areas do not adhere to the principles of the Welsh Government's Commissioning Framework Guidance and Good Practice *Fulfilled Lives, Supportive Communities* or the Memorandum of Understanding *Securing Strong Partnerships in Care*. This has led to a lack of

appropriate planning, and fee levels which are unsustainable and do not permit the investment needed to maintain provision let alone improve it.

- The lack of sufficient incentives to encourage providers to meet the needs of increasing numbers of older people with **dementia**.

In our earlier submission in relation to staffing and training we mentioned the potential for reviving the **Academy of Care Practitioners** after a successful pilot. This was re-launched in May with the backing of both the Health Minister and the Deputy Minister for Children & Social Services. It is the first professional organisation of social care workers anywhere in the UK. The aim is to promote, support and develop Care Practitioners and raise standards in social care provision - and raise the status of this undervalued profession.

The Academy of Care Practitioners has three major objectives:

Provide a reference point for Care Practitioners

- Provide value, status and influence by belonging to a professional organisation
- Promote consultation and representation at a local, regional and national level
- Provide communication channels and support between Social Care Practitioners

Support members by offering advice and providing information

- Provide regular publications, via hardcopy and using ICT and other technology
- Hold Care Practitioner seminars, workshops and conferences
- Provide access to research and reports and links to professional and statuary bodies

Encourage and promote continual professional development

- Promote career progression via structured horizontal and vertical career pathways
- Provide careers, learning and development advice and guidance
- Provide information about local and accessible training courses and events
- Empower members through recognition via celebratory Care Awards

The Academy has been set up as a company limited by guarantee with the aim of it becoming a charity and Glyndwr University, in Wrexham, will be its main base for the foreseeable future.

We have also seen significant developments in terms of the consultation on the draft **Social Services (Wales) Bill**. This includes a number of positive developments: a stronger voice and more control for those needing social care, and an end to doing things 22 different ways. Overall we feel the draft Bill provides a great opportunity to refocus social care in terms not just of clinical and personal care needs but emotional well-being.

However, we do have one significant concern regarding the proposal to **time-limit the registration of social care providers**. As things stand, the regulator is able to de-register providers where necessary in cases of exceptional bad practice. We believe time-limited registration would have a serious adverse impact on the sustainability of social care provision in Wales. We are most concerned about the potential financial implications for providers. In light of these proposals providers have consulted lenders and investors, who have indicated that they would view a business

that only had a time-limited registration significantly less favourably than one with a permanent registration. This is likely to lead to higher interest rates, and a pressure to pay back any loans and make a return on investment more quickly. There will be an adverse effect on both access to and the cost of credit making existing provision more expensive to maintain and new provision or improvements to provision prohibitively expensive.

We have a number of other concerns with this proposal:

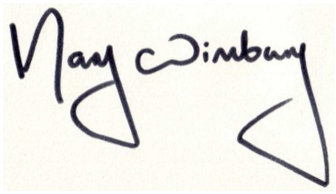
- Instability in the workforce: when a provider was nearing the end of its registration period it might find it impossible both to retain and recruit staff.
- A deterrent to providers considering entering the market in Wales thus leading to a lack of sustainability of provision.
- The bureaucratic burden taking time and money away from front-line care.

There may also be a threat to the continuity of care for people using services. We would see such a model as particularly unsuitable for organisations requiring capital investment and/or significant staff numbers, such as care homes. Overall our view would be that the system isn't broken and doesn't need fixing.

Our members wish to provide flexible, innovative, professional services which are properly funded. We hope that Wales will lead the way to a country where providers are properly engaged by commissioners through the Memorandum of Understanding, where there is meaningful partnership working and vastly improved outcomes for those in need of social care, where care workers are appropriately professionalised through the Academy of Care Practitioners and where those using care services receive the best outcomes possible.

We look forward to the opportunity to give evidence to you.

Yours sincerely



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Committee Clerk
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA.

15 December 2011

Dear Sirs

Please find enclosed our response to the inquiry into residential care for older people. In summary, our response is that:

- A sustainable solution needs to be based on a realistic estimation of the costs of delivering good quality care.
- If additional finance is to be raised from individuals it must be clear that sufficient funds will be raised to meet the policy objectives.
- A national system of entitlement will be required to secure support for a new system.
- A system of fair fees is required.
- There should be a greater integration between the NHS and social care.
- The sector must be aware of the implications of the Southern Cross scenario.

We would be delighted to discuss any of the issues raised in this response with you at any time.

Yours sincerely

Ailsa Pemberton
Senior Legal Adviser (New Legislation)
On behalf of Bupa

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Health and Social Care Committee
Residential Care for Older People

About Bupa

Bupa's purpose is to help people lead longer, healthier, happier lives.

A leading international healthcare group, we offer personal and company health insurance, run care homes for older people and hospitals, and provide workplace health services, health assessments and chronic disease management services, including health coaching, and home healthcare.

With no shareholders, we invest our profits to provide more and better healthcare. We are committed to making quality, patient-centred, affordable healthcare more accessible in the areas of wellness, chronic disease management and ageing.

Employing nearly 52,000 people, Bupa has operations around the world, principally in the UK, Australia, Spain, New Zealand and the USA, as well as Hong Kong, Thailand, Saudi Arabia, India, China and across Latin America.

Bupa Care Services (BCS) is the second largest care home operator in the UK and the biggest provider of specialist dementia care. We care for over 18,500 residents in more than 300 care homes, with over 70 per cent of our residents financed wholly or in part by local authorities or primary care trusts. In Wales itself, we have 12 homes comprising 349 registered beds of which 57 per cent are contracted to local authorities. All our Welsh homes have been inspected and no requirements have been imposed.

For more information, visit www.bupa.com.

Introduction

Bupa welcomes the inquiry by the National Assembly for Wales into residential care for older people. This response builds on our Green Paper submission from last year, a copy of which is annexed.

This response provides a summary of what we believe are the key issues in residential care for older people, the overriding theme of which is the need to create a sustainable, adequately funded system.

Our response

1. *Alternative funding, management, and ownership models, such as those offered by the cooperative, mutual sector and third sector, and Registered Social Landlords*

Bupa has no shareholders and pays no dividends. Bupa reinvests its profits back into its business to provide more and better healthcare for our customers.

Bupa's status is similar to that adopted by Glas Cymru – the single purpose company formed to own Dŵr Cyrmu/Welsh Water.[1] Like Glas Cymru, Bupa is a 'company limited by guarantee' and has no shareholders and pays no dividends.[2] Again, as in the case of Glas Cymru, Bupa has Members – holding the Board to account for the management of the business, monitoring the standards of corporate governance, and keeping the focus on our customers. Bupa's Members are senior and distinguished people who act independently and are free from personal interests in the organisation.

[1] http://www.dwrcymru.com/en/Company-Information/Glas-Cymru/Membership.aspx

[2] http://www.bupa.com/investor-relations/our-status-and-governance

This means that Bupa is not driven by the need to make short-term profits and is able to plan for the future and take a long-term view.

This status and operating model means that Bupa is a robust company with international healthcare expertise, Today, Bupa operates more than 300 care homes in the UK, as well as care homes and retirement villages in Spain, Australia and New Zealand.

2. A sustainable solution needs to be based on a realistic estimation of the costs of delivering good quality care.

Without a realistic estimate of the costs of providing sustainable care, the system will not be able to deliver the improved outcomes necessary to ensure support for frail, older people in the medium and long-term.

There is wide agreement that the current system is under-funded and to maintain minimum standards and deliver improved services will require higher levels of expenditure on social care than currently envisaged.

The anticipated cost of residential social care must include so-called 'hotel' costs as our residents and their families rightly see residential care as a single service in which accommodation and nutrition are an essential part of the care package. If 'hotel' costs are not included, an additional funding mechanism will be needed, which will result in an overly complex system.

It is currently not possible to quantify reductions in care costs from improvements in telecare and preventative care and there is no track record of delivering reductions in care costs from previous improvements. While care homes do seek efficiencies, the scope for savings is extremely limited. For example, providers cannot reduce staff numbers, without the unacceptable outcome of compromising quality and safety. So we believe that it would be wrong to base a new system on the assumption that such staffing reductions will occur.

3. If additional finance is to be raised from individuals it must be clear that sufficient funds will be raised to meet the policy objectives.

We believe a voluntary or optional approach is unworkable because even if Wales were to achieve a participation equal to France (which, at 15% of the eligible population, has the highest participation rate in any voluntary long-term care scheme in the world) this would still not provide enough funds to meet the policy objective of system-wide improvements.

Evidence shows that the only way to reduce the overall costs of the system to individuals is to achieve the widest possible risk pooling and this can only be achieved at very high rates of participation. Successful reforms that we are aware of (Japan, Germany and Australia, for example) have been based on compulsory participation.

Voluntary pre-funded long-term care insurance has been offered in the past by various providers in Wales but all have withdrawn as there was not enough interest in the product.

In terms of possible solutions, we believe that it may need to be recognised there could be two cohorts to address – younger people, for whom a long-term, well-funded solution can be put in place now; and, say, people aged over 50 for whom a different solution may be appropriate.

4. A national system of entitlement will be required to secure support for a new system.

Successful reform in other countries has included national entitlement and assessment. We believe that consistent national entitlement is required so that there is clarity and consistency about the benefits that the public will receive from contributing to the reformed system. This transparency will allow individuals to plan what further allowance, if any, they would like to make for their later years.

A national system would also prevent local commissioning bodies taking decisions to restrict care

entitlements in order to meet short-term funding constraints, which is a key concern with the current funding system.

A national entitlement would of course imply that if entitlement levels are set nationally (whether on a cash entitlement basis or by reference to set service levels) then funding should be raised on a national basis.

5. *Funding of social care: fair fees*

We know that many people are living longer which means that people are entering care homes at an older age and more frail than ever before. Bupa's most recent international census of the dependency levels of residents in its care homes in Australia, New Zealand, Spain and the UK, showed that:

- 62% are living with the effects of dementia, stroke or Parkinson's disease;
- 48% are immobile; and
- 94% have a clinical reason for seeking a residential care home place.

In 2003, Bupa care homes in the UK looked after just under 4,000 people who were living with dementia, in 2011 this figure is close to 7,000 and rising.

To provide aged care of the standard that meets this higher dependency level, there needs to be a public acceptance that investment is needed to continually train and develop staff, research new and innovative approaches to care, upgrade existing facilities, and build modern care homes that can cater for the individual needs of older people.

The Welsh Government quite clearly want the independent sector to provide services, but those services are largely funded by public money.

The Care Forum Wales (CFW), which represents more than 500 independent care providers, announced recently that the care of vulnerable people has been "chronically underfunded" for years.

In late December 2010, Mr Justice Hickinbottom came to the conclusion that the approach adopted by Pembrokeshire Council in relation to setting the fee rate for the year 2010/2011 was unlawful and granted the application for judicial review. The decision of the Council was set aside and the Council was ordered to remake the decision lawfully by 31 January 2011.

The CFW now believe they are beginning to see a change in attitude from some local authorities worried about the possibility of being subjected to Judicial Reviews in the High Court.

Following the judicial review of Pembrokeshire Council, Conwy councillors recently voted to increase payments to private residential and nursing homes. They are upping payments from £346 to £448 per elderly resident per week to private care homes – an increase of 29.5 per cent. Payments to homes for elderly and mentally ill residents (EMI) will be raised by 8.1 per cent from £442 to £478. Nursing home costs will also go up from £561 to £598, and EMI nursing home patients from £603 to £637.

There are two further Judicial Reviews in progress at the High Court in Cardiff. A second case involving Pembrokeshire care homes taking on the county council again and Neath Port Talbot Council.

It is vital that the year on year chronic underfunding is addressed. Early in 2011, Bupa published 'Who Cares?[3]', a report that highlighted the ongoing problems caused by local authorities paying fees that were below the real cost of providing care for older people. It predicted that, unless action is taken to reverse this trend, a combination of home closures and increased demand would mean up to 100,000 frail older people in the UK being unable to access care home places that they need. Given the increasing level of dependency of people living in care homes, it would be likely that those unable to gain a place would instead turn to the NHS for their long term care, creating a bed-blocking crisis for hospitals.

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[3] http://www.bupa.com/about-us/information-centre/uk/who-cares

Despite the Pembrokeshire Judicial Review, many local authorities are currently offering low fee increases: in real terms reductions. This comes after previous years of below-cost fee increases in which operators have already worked to identify efficiencies that do not compromise care as their major costs continue to rise. Unfortunately, a number of local authorities have not been paying proper heed to Welsh Government guidance or adhering to their legal responsibilities. Some years ago a "toolkit" was agreed by the care sector and the Welsh Local Government Association. The figures were not liked by local authorities and have not been widely implemented. In fact even the increases in Conwy are still well short of the figures in the toolkit, but it is a step in the right direction.

Unless other local authorities take heed it is likely that there will be even more Judicial Reviews because hard-pressed providers have no other redress.

We will be interested to consider the new Social Services Bill which should provide a Welsh solution to the whole dimension of social care in Wales.

6. Promoting integration between the NHS and social care system

While Bupa believes that care homes and hospitals face different challenges, and should be considered separately, we want to see even greater integration between the NHS and the social care system so that older people are not disadvantaged by unnecessary boundaries that slow discharge from acute hospital wards and hamper the exchange of information such as patients' medical notes.

Greater integration between health and social care would also enable care homes to make a greater contribution to some of the challenges facing the NHS.

In many cases acute hospital wards are not appropriate for the long-term care of older people with chronic conditions and NHS staff and facilities are not equipped to do so. Such people can be looked after far more effectively in residential care than the NHS, yet older people remain in hospital beds longer than necessary as they are unable to return home because adaptations are needed or community-based services are not available. Greater use of nurse-led home healthcare and care homes can help the discharge of older people to a community setting which is more appropriate to their individual needs and helps the NHS use its resources more efficiently.

Councils should work with the NHS to improve the integration of health and social care systems and budgets. Local government should build further on its initial steps so that integrated plans can be developed that cross 'budget borders' in developing alternative care solutions for older people.

7. Implications of the Southern Cross scenario for the sector

Our view is that further regulation of the social care sector, following the collapse of Southern Cross, is not necessary and would not work in practice. For the sake of transparency, it's important to point out that while we were approached in relation to taking over some of the Southern Cross homes, we have chosen not to do so.

Whilst it would be in the interests of the sector and care users for there to be fewer instances of operators getting into financial difficulty, we believe that there is already sufficient regulation in place and we disagree that the sector is lightly regulated.

We recognise that there may be a need for improved market intelligence and monitoring of providers, such as better information sharing and greater analysis of provider performance. But we disagree that there is a requirement for improved post-failure regimes such as changes to insolvency or the risk pooling of funds among providers.

It now appears clear that homes operated and residents served by Southern Cross will, in the vast majority of cases, be transferred to new operators with no interruption in care. It may be that a small number of homes which are too expensive to bring up to current standards or in areas where there is an excess of residential care beds will close. But the overall transfer has been successfully managed with no need for direct government intervention, financial or otherwise, in contrast with other sectors.

We believe that provided operators can generate a reasonable return from providing care to support and invest in their homes, operators will always step in to take over homes from an operator who (as was the case in Southern Cross in our view) over-extends themselves and, while generating a surplus from operations, cannot fund the payments to their lenders or landlords. This may not be the case, however, in future if thinly-capitalised operators have their margins squeezed yet further through real terms reductions in fees.

Further information

Should the Commission have questions about information contained within this response, we would be happy to engage further

ANNEX

Bupa response to Social Care Green Paper consultation paper
February 2010

Executive Summary

- **Bupa is a leading international healthcare company, it has over 10 million customers in more than 190 countries and employs over 52,000 people around the world**
- **Bupa Care Services (BCS) is the second largest care home operator in the UK and the biggest provider of specialist dementia care. We care for over 18,500 residents in more than 300 care homes, with over 70 per cent of our residents financed wholly or in part by local authorities or primary care trusts. 12 of these homes are situated in Wales and comprise 349 registered beds of which 199 are contracted to the local authorities.**
- **We welcome and support the recognition in the Green Paper that reform of social care is urgently required and the emphasis on personalisation, transparency, universality and fairness**
- **The most important aspect of social care reform is the question of adequate funding, although improved personalisation and operational effectiveness are also vital for the success of any new system**
- **The current system is under-funded, which results in unmet need, pressure on the NHS and under-investment in social care**
- **We believe the key issues that are not addressed in the Green Paper are:**
  - **The need to secure sufficient capacity of high quality care - the Green Paper is silent on this issue and this appears to be a missed opportunity**
  - **The need to raise the status and quality of care workers - The Green Paper mentions this issue but no reference is made of the obvious remedy, funding an increase in rates of pay for those workers (this step has recently been taken in New Zealand) to attract the most appropriate candidates**
  - **The exclusion of accommodation and food costs of residential care from the funding support to be provided for residential care – this effectively leaves half the costs of those most vulnerable and at financial risk in the current system not covered by the new system and undermines the Green Paper's claim to propose a comprehensive solution**
- **We support the "Comprehensive" option set out in the Green Paper as it is the only proposal which in our view could adequately address the issues in the social care system**

About Bupa

Bupa is a leading international healthcare company. Established in 1947, it has over 10 million customers in more than 190 countries and employs over 52,000 people around the world.

Our main interests are health insurance, care homes for older and young disabled people, workplace health services, health assessments and chronic disease management services, including health coaching and healthcare services in the home.

While Bupa's largest and original business is in the UK, we have significant businesses in Spain, Australia, Denmark and the USA. Bupa also has businesses in Hong Kong, Thailand, Saudi Arabia,

New Zealand, India, China and Latin America including care homes in Spain, Australia and New Zealand.

Bupa has no shareholders. We reinvest our money to provide better healthcare for our customers, helping them to live longer, happier, healthier lives.

Bupa Care Services (BCS) is the second largest care home operator in the UK and the biggest provider of specialist dementia care. We care for over 18,500 residents in more than 300 care homes, with over 70 per cent of our residents financed wholly or in part by local authorities or primary care trusts. In Wales itself, we have 12 homes comprising 349 registered beds of which 57 per cent are contracted to local authorities. We have the highest proportion (88%) of care homes rated Excellent and Good by the Care Quality Commission of any large operator in England and although a rating system is not used in Wales, all our Welsh homes have been inspected and no requirements have been imposed. BCS is a committed participant in long-term residential care, and the only major brand in all the markets in which we operate. Our expertise, name and quality distinguish us from other participants.

We are constantly innovating to improve the care we give to our residents and have developed the following systems in house:

- We have introduced Personal Best, a unique staff initiative to recruit, train and retain a skilled workforce to underpin quality of service and focus on individualised person-centred care.
- QUEST, a standardised assessment and care planning tool and associated documents which significantly improves care planning.
- Key Operating Guides – illustrated guides to key care-giving processes to ensure that they are implemented correctly.

Introduction

We believe that the most important aspect of social care reform is the question of adequate funding, although we acknowledge that personalisation and operational effectiveness is vital for the success of any new system. We are pleased that the Social Care Green Paper recognises the key issue that the current system is under-funded, which results in unmet need, pressure on the NHS and under-investment in social care.

In considering this issue, it is also relevant to understand that:

- In 2006, people aged over-65 accounted for 43.1% of NHS spending. We estimate that the spending per head is 3.4 times the average for the over-65s, 4 times for the over-75s and 8.3 times for the over-85s, based on similar statistics from other countries. This proportion has been rising in recent times and looks set to continue to do so.

- Between 2005 and 2041, it is estimated that the numbers of users of non-residential formal services will rise 102% from 1.5 million to 3.1 million, due to demographic pressures and the numbers of older people in care homes (and long-stay hospital care) will rise by 139% from 345,000 to 825,000.

- The percentage of older people in care homes is higher in many comparable countries than in the UK. According to the Wanless report only 5% of the UK's over-65 population were in care homes in 2003. This compared with 6% in Australia, 8% in Sweden, 9% in Holland and 12% in Norway. This indicates that it will not be possible to save costs by substantially reducing the proportion of older people in residential care. Since that time the numbers of residential care beds in England and Wales has fallen.

Reflecting the views of our customers

We recently submitted a consultation response to the Government's Green Paper on social care, as part of this process Bupa invited our customers to have their say and share their views on the state of social care for older people in the UK:

- The responses to our website showed that many people do not understand the rationale behind the current social care system and believe that their National Insurance contributions made during

their working lives have funded any care they needed in later life. They see the NHS pledge of care from the "cradle to the grave" as also involving the provision of social care.

- Almost 70% of respondees said that the Government should fund care in later life, with a further 10% saying it should be down to local councils.
- Furthermore, respondees clearly showed that older people feel their issues are not being addressed by policy makers and that they are reliant on their families to support them. Some 83% of respondees said they felt they were 'not well' or 'not at all well' supported by the government, compared to more than 73% saying they were 'quite well' or 'very well' supported by their own families.
- Local communities and the media did not fare much better. Only 20% said they were 'quite well' or 'very well' supported by their communities with only 28% saying they were 'quite well' or 'very well' supported by the media in general.

We believe this shows that efforts to reform the system will also need to explain why social care need is not seen as an absolute entitlement in the same way that health care needs are met through the NHS.

The Green Paper Consultation

We have split our consultation response into three main areas following the Green Paper chapters. We first of all consider the challenge; then the transformation of the social services in Wales; and finally the new models for funding social care. On the whole we have not given specific answers to the consultation questions set, but have instead dealt with the issues on which we feel able to comment as a narrative. We hope that you will accept our response format and find our comments useful.

Chapter 1: The Challenge

We are heartened that the demographic trends for Wales have been included and form part of the motivation for necessitating change in the care and support services. We also agree that the set of principles drawn up by the Wales Stakeholder Advisory Group on paying for care, reflect the needs of the new system. However, we are of the opinion that only one of the reform options allows for a sustainable system, the comprehensive option, and we set out our detailed explanation in Chapter 3.

Chapter 2: Transformation of Social Services in Wales

We agree with the strategy for the new Welsh social service system set out in chapter 2 of the Green Paper. However, in simple terms, we believe the fundamental requirements are that the system should be fair, simple and affordable and that, without reform, the effects of under-investment will only worsen in the future, as it is generally accepted that the numbers of people needing care and support will increase rapidly over the next 20 years. The key to tackling this failure is to get more *new money* into social care on a *sustainable* basis We are, therefore, concerned that the three vital facets of fairness, simplicity and affordability will be significantly undermined by the following factors, which we believe the Green Paper has failed to adequately address:

1. **Striving for excellence and improvement**

   There is agreement, by most observers, that the requirement for social care in all settings is increasing and will continue to do so for many years.

   The current system governs supply by imposing cash limits which are not linked in any systematic manner to the anticipated demand. In other jurisdictions (such as Canada and Australia) there are systematic assessments (based on demographic metrics) of the capacity required to meet demand in regions. This drives decisions in relation to the social care system about the appropriate level of resources required and also the cost of providing services of the quality of provision required.

   The Green Paper is silent on this issue and this appears to be a missed opportunity.

2. **Workforce**

It is vital to ensure that the staff involved in delivering the services are suitably motivated and skilled and trained so they are able to deliver the high standards required. The Green Paper mentions raising the status and quality of care workers, but no reference is made of the most obvious method of doing so, which is funding an increase in rates of pay for those workers (this step has recently been taken in New Zealand) in order to attract the most appropriate candidates.

We endorse the view of the Low Pay Commission (LPC) in its May 2009 report: "We recommend that the commissioning policies of local authorities and the NHS should reflect the actual costs of care, including the National Minimum Wage." The LPC made this statement because in its view care home fees paid by state commissioners do not currently adequately allow for the Minimum Wage regime. Clearly, it would assist providers to maintain and improve care quality, if the funding regime allowed them to pay above the minimum wage to attract care staff.

3. **Commissioning and Partnership**

We agree with the approach of joined-up services and believe that, to help achieve this goal, the new system should incorporate a major extension of individual budgets to give people control over their care.

The present system has evolved into a postcode lottery. Its replacement must address this issue and enable people to understand the workings of the system without reference to geographical area. The system needs to be transparent, universal and fair. We support a national assessment process and entitlement regime which is based on need, not geography, and implemented in the same way whether you live in Canterbury, Coventry or Cardiff. We believe that there should be one new system which applies to both England and Wales in order to eliminate cross border issues, which are already seen with prescription charging in the NHS. Better communication and cooperation between the new system and the NHS is also imperative. In our experience there are too many examples where the current systems are at odds with each other and which ultimately affect the user detrimentally.

As an example we regularly experience considerable problems in obtaining the medical support, to which our residents are entitled, from the NHS primary care system. This appears to be a result of the surprisingly common but mistaken view that when users are in residential care, all their healthcare and social care requirements will be provided, or at least funded in whole or in part, by the social care provider when, in fact our residents' healthcare remains the responsibility of the NHS.

The customer's experience

Mrs D is wheelchair-bound, and has a number of health problems including angina, arthritis, oedema, as well as infections which sometimes give her hallucinations.

She managed on her own until the age of 93, but her daughter was increasingly concerned that she would fall and injure herself, with no-one nearby to help her. Even when she asked for community nurses to come into help her mother at home, the latest appointment possible was at 7pm - which left her without help during the evening and night.

Owning her own home took Mrs D over the assets threshold for local council funding. Her social services department did not agree that she needed nursing care, and refused to pay her care home costs, despite her GP stating that she needed 24-hour nursing care.

After being admitted to a Bupa home, her daughter had to sell Mrs D's home to fund her care. The council refused to allow her to defer her mother's care payments until the housing market recovered so she was forced to sell for much less than expected and now the proceeds will only cover around four years of Mrs D's care home fees.

After that, her daughter has no idea what they will do. She said: "The current system is very unfair to old people - they have no choice. While the care my mother is receiving at the Bupa home has been

fantastic, it is expensive. There is a big black hole facing us in four years' time, and I have absolutely no idea what we are going to do then."

Mrs D said "I've got no complaints about the home, they are very good to me and the service is excellent. I can't get out of bed or get dressed. I need help with everything really. I was so sad to leave my flat, all my things and all my memories. Thank goodness there are places like this for us to come to, there's no alternative."

The Green Paper is unclear as to how the interface between national assessment and the translation into local entitlements will be made. One of the benefits of a national assessment scheme is that service users can move between local authorities and across borders without having to be reassessed and, therefore, can be confident that their needs will continue to be met. It is unclear how that transition will work in practice. If one local authority is able to determine that certain needs can be met more cheaply, or in a different way, that seems to open up the possibility of uncertainty again. This scenario will also be achieved by Wales developing a separate and different system to England. We believe that a system for England and Wales should be developed by combining the skills of the Welsh Assembly and UK Governments.

4. **Person centred care**

There is now a general recognition that person-centred care is the best way to provide continuing quality of life to people living with dementia. This creates a focus on the personality and preferences of the person that remain, rather than on the problems of memory, understanding and communication created by the disease. Whilst we acknowledge that person centred care is mentioned in the Green Paper, we are keen to ensure that the strategy for social care in Wales includes this specific aspect of personalisation.

Case Study: personalisation of care

Bupa's "*Person First*" approach makes our homes uniquely qualified to deliver personalisation.

Our award-winning "*Personal Best*" programme has, for six years, been focusing our care on the individuality of each resident. Since its launch, levels of customer satisfaction have risen continuously. In our most recent survey 94% of residents, and 93% of their relatives, rate their care home as 'excellent, very good or good'.

In addition, we now provide more and better training to staff in our specialist dementia units and provide on-the-job leadership through our unique Dementia Champions, trained by the Alzheimer's Society to drive continuous improvement in the person-centred culture in their unit. We will have a Dementia Champion in place in each of our 192 dementia units by the end of June 2010, having invested more than £250,000 in their training.

One particular feature of *Person First* care is the provision of brief but regular social activities, tailored to the interests of each resident. Though most will remember the nature of the activity only for a few minutes, the feeling of wellbeing created lasts much longer. This level of insight into the nature of dementia is provided by our Director of Dementia Care, Dr. Graham Stokes, a psychiatric consultant who also sat on the advisory panel for the National Dementia Strategy.

Chapter 3: A New Model for Funding Care

The current system has failed to provide adequate funding, with the inequitable result that the whole risk of high social care costs falls on a large minority who have:

- Some assets (over £23,000) including housing equity; and
- High care needs, but which are not assessed to be high enough to qualify for NHS funding.

This is an historical accident, is unnecessarily complex and creates a large incentive on service users to seek to obtain NHS funding. A more equitable system would spread the costs more evenly across

society and thereby eliminate the need for those who find themselves needing high levels of care to run down their assets to pay for it.

We agree with the Green Paper that it is improbable that sufficient additional funding can be obtained at all, or on a sustainable basis, from general taxation. We, therefore, favour option 5 the "Comprehensive" option as the only proposal which will adequately address the issues which the English social care system faces. There would be a cost (which the Green Paper estimates at between £17,000 and £20,000 per person) but in return:

- The necessary improvements in the social care system would be delivered to the benefit of service users, informal carers and the NHS; and
- Older people would have confidence in their ability to obtain high-quality social care when they needed it without having to run down their assets.

To ensure that the costs are spread more equitably, and to make contributions affordable, funding will have to be shared on a risk-pooled basis. This would involve pooling the contributions from a large part of the population, not all of whom will need substantial amounts of social care. This cannot be achieved through voluntary social care insurance policies as our experience in the UK and other countries tells us that the take up of such policies is low because the public underestimates the cost and likelihood of needing social care. As a result, they do not believe such policies offer good value for money. In addition, the costs of those policies have been driven up because only those with a high probability of needing care have taken them out, which substantially reduces the benefit of risk-pooling.

For such a system to be politically acceptable to the public, the funding contributed by participants must not form part of general government resources and would need to be ring-fenced to provide the social care they need when they need it.

It is our view that the contribution payment required by the Comprehensive proposal could be funded in a variety of ways:

- It would be advantageous to allow it to form part of the tax-free lump sums payable from private pension arrangements.

- Another cost-effective, voluntary alternative for those planning to make the payment would be for people to take out insurance policies with a face value of the necessary contribution. This would be payable only if the insured survives to the end of the stated policy period (the date the contribution becomes due, currently assumed to be at 65). No benefit would be paid if the insured died before the date the contribution became due. Our internal projections suggest that a policy could be taken out at the age of 40 at an approximate cost of around £35 per month.

The exclusion of accommodation and food costs of residential care from the support provided under a reformed social care funding regime.

It is clear to us from the experience of our residents and from media coverage, that one of the most important unpopular features of the current means-tested funding system is the requirement on those with relatively low levels of assets to meet the full costs of their social care.

The majority of these costs (because of the intensive nature of the service provided) relate to residential social care. For example the Green Paper calculates that the average care costs an individual reaching 65 can expect to incur is £31,700. However, this does not include the food and accommodation costs of residential social care which we have calculated to be an additional £12,000 - giving a total amount of average expected care costs of £43,700, of which £24,000 relates to the care and hotel costs of residential care.

If, as is proposed in the Green Paper, these costs are excluded from the system of funding, a large element of the system which is currently very unpopular will be retained. Crudely the above projections indicate that one quarter of the typical social care costs faced by individuals will be excluded from the system but because only a substantial minority of individuals need residential care

this understates the problem. Typically permanent residents in our care homes are with us for about 2 years at a cost of upwards of £52,000.

In our experience, our residents and their relatives do not distinguish between care, and accommodation and food as both are a financial burden. Additionally, the exclusion of accommodation and food costs of residential care, risks perpetuating or in fact bolstering the current public perception that all social care costs are funded by the state.

In our view the Green Paper purports to advocate a comprehensive solution to social care funding while leaving this major issue not only not addressed but not even quantified. It is not clear to us why this misleading approach has been taken, as it risks undermining support for any resulting proposals and the sustainability of any new system in the medium term.

In addition:

- We believe it is inequitable to exclude the accommodation and food costs of residential care (which cares for the majority of social care service users with the highest care needs) as these form an integral part of their care (as it would in an acute care setting where no such exclusion applies). Given the frailty of residents and the long-term nature of the care provision, food with a high nutrition content and accommodation are fundamental parts of the care provided and have a significant impact on care quality.

- The reason an individual is typically placed in a residential care setting is because it is more cost effective (even after the additional accommodation and food costs) to care for them in that setting than to provide an equivalent level of care in their own homes. So, as the aggregate costs are lower, it is inequitable to exclude the accommodation and food costs from protection under the new funding system.

- If such an approach is taken any new system will not just retain the current complexity but increase it, as the present very unpopular means-tested system will continue to exist to fund accommodation and food costs alongside whatever new funding regime is introduced.

- Finally, the exclusion of funding for accommodation and food costs will result in the retention of the incentive in the current system, to seek care provision in the NHS acute sector or funding through the NHS rather than to use the social care system (this incentive is that all care including hotel costs is free to the user even if it is, from their point of view, the same care in the same location if Continuing Care funding is obtained). In general, direct NHS acute provision in this area is not effective (as the acute sector is not able to provide specialist aged care, for example, in caring for those with dementia in sufficient volumes) or efficient as the typical costs of treatment in the NHS exceed those of social care provision.

A nationally or locally determined funding system

It is our view that while the new system needs to be subject to a framework of assessment and entitlement set nationally, Local Authorities should be responsible for the implementation of the system on a local basis within the national framework.

Other international social care systems

There have been successful reforms in social care overseas, so change in the UK is possible. Some examples of key features of those reforms which have been successful are:

- National assessment and payment systems based on care needs. This provides a solid financial basis for care provision by eliminating unwarranted local funding variations and increasing the simplicity for the users of it.

- National capacity planning to help predict the numbers of older people requiring care in the future and to help plan for the consequent increase in social care capacity which is required.

- The introduction of the accommodation bonds system in Australia while controversial at the time, with the benefit of hind sight, has been a cost-effective and palatable way to introduce new money into the system.

- The increased availability of social care through the introduction of a comprehensive scheme in Japan has resulted in reduced demands on family carers and the acute hospital sector.

- In Germany, service users can pay relatives to provide social care for them. The rates of contribution are substantially less than those which apply for formal care but many people still prefer this option, which helps control the costs of care provision as well as supporting family carers.

Contact Details

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Terra Firma / Four Seasons Health Care's written submission to the Health and Social Care Committee, National Assembly for Wales

(in advance of the hearing on 14 June)

1. **About Four Seasons Health Care ("Four Seasons")**
   Four Seasons is the largest independent provider in the health and social care sector in the UK. It operates 445 care homes, with 22,364 registered beds in the UK, Isle of Man and Jersey. Its specialised services division, The Huntercombe Group, operates 61 hospitals and care centres, with 1,601 registered beds and is a leading provider in the areas of adult and child and adolescent mental health, acquired brain injury, neurodisability, eating disorder and addictions and children with special needs. Four Seasons employs more than 30,000 staff caring for more than 20,000 residents.

2. **Four Seasons in Wales**
   Four Seasons has seven care homes in Wales, as a result of acquiring them in 2011 from the former Southern Cross. Four Seasons employs 425 staff in Wales caring for circa 303 residents. Its homes are:
   - *Bargoed* in Mid Glamorgan, offering residential and nursing care as well as respite care to give home carers a break
   - *Red Rose* in Gwent, offering residential and nursing care, specialist care for people with physical disabilities, end of life care and respite care
   - *The Rookery*, Ebbw Vale, Gwent, offering residential care and specialist dementia care
   - *Valley View*, at Cafn Hengoed, Mid Glamorgan, offering residential and nursing care, specialist dementia care and respite care
   - *Ty Gwynno*, Pontypridd, Mid Glamorgan, offering residential and nursing care, specialist dementia care and respite care
   - *Ty Haford*, Cardiff, offering nursing care and respite care
   - *Ty Eirin*, Porth, Mid Glamorgan offering residential and nursing care and specialist dementia care

   Since taking on these homes, Four Seasons has provided much needed capital investment for refurbishment and equipment. It has provided strong regional management support to the home managers and delivered ongoing staff training programmes to raise quality of care and service performance. Average occupancy across these homes has increased. Staffing levels have been maintained at all seven homes and have increased in five of them. In considering development of its care operations, Four Seasons is informed by reference to the Strategy for Older People in Wales.

3. **About Terra Firma**
   Terra Firma is a leading private equity firm which invests in asset-backed businesses in essential industries that are undergoing change or where change is required. It has extensive experience of managing businesses in highly regulated environments and working closely with governments and regulators. Terra Firma adds value to its businesses by delivering improved strategy, operations and management together with sustained investment to support them to develop as best-in-class leaders in their sectors. Last year, it invested almost €1.9 billion in developing its existing businesses.

4. **The acquisition of Four Seasons by Terra Firma**
Terra Firma is acquiring Four Seasons for a total consideration of up to £825 million which will be financed through a mixture of over £300 million of equity and new debt of £525 million. On completion of the transaction, which is expected on or before 16 July, the company's existing debt of £780 million, which is due to be repaid in September, will be discharged in full. This will give Four Seasons clear ownership and substantially reduced borrowing over a longer-term, providing a stable financial structure. Four Seasons' debt will be reduced from being approximately 95% of its market value down to a sustainable level of approximately 64% of its market value.

5. **Four Seasons' financial health**
Four Seasons is trading successfully. It has the protection of flexible rent cover negotiated with a number of landlords in the event of difficult trading conditions. Four Seasons increased capacity by 40% or 6,000 beds in 2011 by acquiring the business of Care Principles and taking over homes from the failed Southern Cross. It has also achieved organic growth with occupancy continuing to rise to circa 88%-89% against the sector trend. It has achieved this through: (1) focus on quality of care with 88% of its homes in England rated good or excellent, a 14% improvement since 2009, making it one of the highest rated independent providers; (2) a diversification strategy that has given the company a sector lead in the development of specialist services for residents with higher dependency needs. In 2011, more than 80% of Four Seasons' beds were for higher dependency care, in contrast to the sector average of about 50%.

6. **Strategic principles for Four Seasons**
The priority for both Terra Firma and Four Seasons is to ensure continuity of care and continuous improvement in quality of care. Terra Firma intends to invest in Four Seasons and work with the senior management team to enhance the company and achieve long-term growth, building on its position as a sector leader.

We understand that high standards are a precondition for building a successful and sustainable business in this sector. Quality of care drives occupancy which is the key to viability and profitability and demands reinvestment to develop the business. Our ambition is to grow Four Seasons by increasing the number of beds we provide, as well as improving occupancy rates further. We will do this by delivering consistent high quality of care and developing specialist services for higher dependency residents. Terra Firma aims to invest in Four Seasons' estate to improve existing properties and potentially acquire homes and develop new ones. The business plan and Four Seasons' new capital structure will enable a higher level of investment to be made into the business than has occurred recently.

We recognise that Four Seasons' ability to attract, retain and develop high-quality professional staff is vital to the quality of service that residents and patients receive. This is particularly important as the industry moves further towards higher dependency services. Four Seasons is committed to support learning and staff development. The company has introduced innovative learning programmes to help employees develop their skills and potentially work towards accredited qualifications. A recent example is an e-learning initiative that enables participants to study for qualifications and improve their skills when and where it is convenient for them. The company's commitment to supporting staff development is matched by employee commitment to learning with 27,500 staff actively participating and a total of 626,000 course modules successfully completed, with more than half of them finished in 2011.

Terra Firma will set-up an effective governance framework for Four Seasons including the establishment of a UK-based board. The financial health of Four Seasons will be transparent,

as quarterly financial reports to holders of the bonds issued by the Four Seasons Group will be publicly available.

We are resolved to work with our service users and their families, our employees and their representatives, Government, the NHS, Local Authorities, regulators, and investors, to ensure Four Seasons' success and sustainability in the future.

7. **Market balance**
The independent sector has an important role in health and social care provision in the UK, particularly for the elderly; there are an estimated 450,000 independent operator beds versus circa 100,000 NHS hospital beds.

The independent sector is highly competitive and very fragmented with the five largest providers accounting for no more than 20% of the market. Four Seasons is the largest operator and has about 6.7% of the market, although it has a much lower presence in Wales. Approximately half of the independent care sector is comprised of small care home businesses with no more than a few converted homes each, often run by a husband and wife team; they tend to focus on basic residential care provision and lack any specialist capabilities.

Under current market conditions, we are likely to see consolidation within the sector as the smaller operators are vulnerable to an environment in which care homes are increasingly required to focus on higher dependency services and are under continuous pressure to achieve operating efficiencies. The larger independent providers can achieve efficiencies of scale through shared management overheads, bulk purchasing power, efficiencies in training and development, and investment in technology to optimise back office functions and to upgrade care facilities.

They represent potential partners for Government to affect change in the broader social care market. They have an important role to play in helping to ensure that market consolidation leads to an efficient and sustainable independent sector. Given the current fragmented market, with no operator having more than a single digit percentage share, consolidation is highly unlikely to lead to any erosion of competition in the foreseeable future, particularly given Local Authority commissioning structures.

8. **Development of specialist services for dementia and other higher dependency needs**
The competitive nature of the market and changing demand patterns have led the larger independents to develop the capability to provide higher dependency care services including: specialist dementia care; step-up and step-down care reducing time in hospital; end of life care; brain injury rehabilitation; neurodisability services, low and medium secure mental health; eating disorder and addiction services.

Four Seasons' PEARL dementia care service is one such example. It is estimated that there are some 800,000 people in the UK with a form of dementia in 2012, including more than 43,600 in Wales. This number is expected to grow rapidly due to an ageing population; the number of people over 65 is expected to increase by half over the next 40 years in common with the rest of the UK.

Four Seasons has developed the PEARL (Positively Enriching And Enhancing Residents Lives) specialised dementia service, the ethos of which is to recognise the individuality of each resident and support them in continuing to live their lives as closely as possible to the way that they always have. Each individual care programme is planned in consultation with the dementia resident and key influencers of his or her care experience, including relatives,

friends, staff, community clinicians and GPs. The programme uses a range of therapies in daily care. The validation process for a home to achieve accreditation as a PEARL specialist dementia care home is robust and may take more than a year to achieve. Staff undergo training in dementia care mapping, person centred care and experiential training.

The PEARL programme has been recognised for its market-leading excellence by The Improvement Foundation and is studied by care providers internationally. A notable success of the pioneering programme is a reduction in the need for psychotropic medication by as much as 64% and an average of 50% with improved wellbeing of residents.

9. **Optimising sector capacity**

In our submission, there is compelling evidence of the need for a more joined-up approach to the funding and commissioning of health and social care for the elderly. Below are two situations that would benefit from such a joined up approach:

1. The UK has more hospital beds per thousand people than most of Europe and the USA and the average stay in our hospitals is believed to be much longer and more expensive to the taxpayer. The reason is that between a quarter and a third of the beds in acute medical wards are occupied by people – most of them elderly – who do not need to be there for clinical reasons (commonly known as bed blocking). The independent sector already has much of the expertise and capacity to deliver clinical care to selected high dependency patients at a lower cost to the tax payer (between 35%-50% less than NHS tariff rates for hospital care). Greater use of the independent sector could provide a potential solution to bed blocking and help meet spending targets. It would be possible to achieve this without a drop in the quality of care and arguably provide a better all-round experience for patients.

2. There is currently a belief that it is better to provide domiciliary care to enable people to remain in their own homes for as long as possible rather than to fund their move into a care home. We believe that the growth in domiciliary care is also in part being driven by the belief that it is a cheaper option. However, in many cases, costs are simply being moved between different public purses rather than being saved.

Many elderly people being cared for in their own homes can typically receive between one to four visits a day by carers. Once costs such as housing, council tax benefits, pension credits and attendance allowance are taken into account, even a modest care package is likely to cost the taxpayer well in excess of £500 a week. For people with higher levels of dependency, residential care in a care home setting may be a more cost-efficient option that also meets their care and social needs better too.

Four Seasons is firmly of the view that people should be helped to remain at home for as long as it is their wish and is in their best interests. However, there should be an informed decision that takes account of the real total costs to the public purse and the relative risk of each option to the individual's health and well-being.

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Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – y Senedd**
Dyddiad:	**Dydd Iau, 24 Mai 2012**
Amser:	**09:00 – 15:25**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200001_24_05_2012&t=0&l=cy
http://www.senedd.tv/archiveplayer.jsf?v=cy_200000_24_05_2012&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Dr Raza Alikhan, Fforwm Thromboproffylacsis y DU** **Dr Simon Noble, Lifeblood** **Mr Nigel Davies, Coleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr** **Lisa Turnbull, Coleg Brenhinol Nyrsio Cymru** **Nicola Davies, Coleg Brenhinol Nyrsio Cymru** **Dr Andrew Davies, Cymdeithas Orthopedeg Cymru** **Dr Beverly Hunt, Coleg Brenhinol y Ffisigwyr** **Dr Alan Wilson, 1000 o Fywydau a Mwy / Iechyd Cyhoeddus Cymru** **Dr Bruce Ferguson, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg** **Dr Grant Robinson, Bwrdd Iechyd Aneurin Bevan** **Dr Brian Tehan, Bwrdd Iechyd Prifysgol Betsi Cadwaladr** **Grant Duncan, Llywodraeth Cymru** **Dr Chris Jones, Llywodraeth Cymru**
Staff y Pwyllgor:	**Llinos Dafydd (Clerc)** **Catherine Hunt (Clerc)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon
1.1 Cafwyd ymddiheuriadau gan Mick Antoniw. Bu Mike Hedges yn dirprwyo ar ei ran yn y bore, a bu Jenny Rathbone yn dirprwyo ar ei ran yn y prynhawn.

2. Ymchwiliad un-dydd i atal thrombo-emboledd gwythiennol - Tystiolaeth lafar
2.1 Bu'r tystion yn ateb cwestiynau gan aelodau'r Pwyllgor am atal thrombo-emboledd gwythiennol.

3. Ymchwiliad i ofal preswyl i bobl hŷn - Adborth ar waith ymgysylltu a gyflawnwyd hyd yma
3.1 Bu aelodau'r Pwyllgor yn trafod eu gwaith ymgysylltu ar yr ymchwiliad i ofal preswyl i bobl hŷn.

4. Blaenraglen Waith
4.1 Bu aelodau'r Pwyllgor yn trafod y blaenraglen waith, a chytunasant i gynnal rhagor o drafodaethau mewn cyfarfod yn y dyfodol.

5. Ymchwiliad un-dydd i atal thrombo-emboledd gwythiennol - Tystiolaeth lafar
5.1 Bu'r tystion yn ateb cwestiynau gan aelodau'r Pwyllgor am atal thrombo-emboledd gwythiennol.

5.2 Cytunodd cynrychiolwyr y byrddau iechyd i ddarparu gwybodaeth am nifer yr achosion cyfreithiol a ddygwyd yn erbyn byrddau iechyd mewn perthynas ag achosion o thrombo-emboledd gwythiennol a gafwyd mewn ysbytai, os yw'r wybodaeth honno ar gael.

6. Papurau i'w nodi
6.1 Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 2 Mai.

7. Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu eithrio'r cyhoedd o'r cyfarfod ar gyfer eitem 7
7.1 Cytunodd y Pwyllgor ar y cynnig.

8. Ymchwiliad un-dydd i atal thrombo-emboledd gwythiennol - Ystyried y dystiolaeth
8.1 Bu'r Pwyllgor yn trafod y dystiolaeth a ddaeth i law ar atal thrombo-emboledd gwythiennol.

TRAWSGRIFIAD
Trawsgrifiad o'r cyfarfod.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – y Senedd**
Dyddiad:	**Dydd Mercher, 30 Mai 2012**
Amser:	**09:00 – 12:10**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200000_30_05_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** **William Powell**
Tystion:	**Kevin Barker, Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru** **Mandy Collins, Arolygiaeth Gofal Iechyd Cymru** **Dr Owen Crawley, Llywodraeth Cymru** **Gerry Evans, Cyngor Gofal Cymru** **David Francis, Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru** **Lesley Griffiths, Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol** **Peter Higson, Arolygiaeth Gofal Iechyd Cymru** **Imelda Richardson, Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru** **Alison Strode, Llywodraeth Cymru** **Rhian Huws Williams, Cyngor Gofal Cymru**
Staff y Pwyllgor:	**Fay Buckle (Clerc)** **Meriel Singleton (Clerc)** **Claire Griffiths (Dirprwy Glerc)** **Catherine Hunt (Dirprwy Glerc)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Cafwyd ymddiheuriadau gan Lindsay Whittle a Kirsty Williams. Roedd William Powell yn dirprwyo ar ran Kirsty Williams.

2. Gwasanaethau cadeiriau olwyn yng Nghymru – tystiolaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

2.1 Ymatebodd y Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'i swyddogion i gwestiynau gan aelodau'r Pwyllgor am wasanaethau cadeiriau olwyn yng Nghymru.

3. Ymchwiliad i ofal preswyl i bobl hŷn – Tystiolaeth gan reoleiddwyr ac archwilwyr

3.1 Ymatebodd y tystion i gwestiynau gan aelodau'r Pwyllgor am ofal preswyl i bobl hŷn.

3.2 Cytunodd Ms Huws Williams a Mr Evans i ddarparu gwybodaeth am yr amserlen angenrheidiol ar gyfer uwchsgilio'r gweithlu gofal cymdeithasol er mwyn gallu ymateb i breswylwyr sydd ag ystod ehangach o anghenion, gan gynnwys y rhai sydd â dementia, ac i ddarparu copi o'r dystiolaeth a ddarparwyd gan Gyngor Gofal Cymru i'r Pwyllgor Menter a Busnes ar brentisiaethau.

3.3 Cytunodd Mr Evans i ddarparu copi o'r prosiect ymchwil, 'Care at home'.

4. Bil Sgorio Hylendid Bwyd (Cymru): Cyfnod 1 – dull o graffu

4.1 Cytunodd y Pwyllgor ar y dull o graffu ar Fil Sgorio Hylendid Bwyd (Cymru) yn amodol ar gynnwys rhai ymgyngoreion ychwanegol.

4.2 Cytunodd y Cadeirydd i ysgrifennu at y Gweinidog Iechyd a Gofal Cymdeithasol i ofyn am gopi cynnar o'r rheoliadau drafft a ddarparwyd ar eu cyfer gan y Bil.

5. Papurau i'w nodi

5.1 Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 16 Mai.

TRAWSGRIFIAD Trawsgrifiad o'r cyfarfod.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-17-12 papur 4

Blaenraglen Waith y Pwyllgor Iechyd a Gofal Cymdeithasol: Mehefin – Gorffennaf 2012

At: Y Pwyllgor Iechyd a Gofal Cymdeithasol

Gan: Gwasanaeth y Pwyllgorau

Dyddiad y cyfarfod: 14 Mehefin

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 yr hâf 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.

DYDD IAU 14 MEHEFIN 2012 – CYFARFOD ALLANOL YM MHRIFYSGOL GLYNDWR, WRECSAM

Bore a phrynhawn

Ymchwiliad ar ofal preswyl i bobl hŷn
Sesiynnau dystiolaeth lafar – darparwyr gofal preswyl preifat

DYDD MERCHER 20 MEHEFIN 2012

Bore yn unig

Blaenraglen Waith
Trafodaeth Pwyllgor ar fusnes ar gyfer tymhorau'r hydref a'r gaeaf

Ymchwiliad ar ofal preswyl i bobl hŷn
Sesiwn dystiolaeth lafar – Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol

Bil Sgorio Hylendid Bwyd (Cymru)
Sesiwn dystiolaeth lafar – Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

DYDD IAU 28 MEHEFIN 2012

Bore a phrynhawn

Ymchwiliad un-dydd: Marw-enedigaethau yng Nghymru
Sesiynnau tystiolaeth lafar

DYDD MERCHER 4 GORFFENNAF 2012

Bore yn unig

Ymchwiliad ar ofal preswyl i bobl hŷn
Ystyried y materion allweddol (preifat)

Sesiwn graffu cyffredinol
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

DYDD IAU 12 GORFFENNAF 2012

Bore a phrynhawn

Bil Sgorio Hylendid Bwyd (Cymru)
Sesiynnau dystiolaeth lafar

DYDD MERCHER 18 GORFFENNAF 2012

Bore yn unig

Bil Sgorio Hylendid Bwyd (Cymru)
Sesiynnau tystiolaeth lafar a'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Ystyried y materion allweddol (preifat)

Ymchwiliad ar ofal preswyl i bobl hŷn
Ystyried y materion allweddol (preifat)

Dydd Llun 23 Gorffennaf – Dydd Sul 22 Medi 2012: Toriad yr haf

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