CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL
CAERDYDD A BRO MORGANNWG
CARDIFF AND VALE OF GLAMORGAN

Health and Social Care Committee

Inquiry into residential care for older people

RC12 - Cardiff and the Vale of Glamorgan Community Health Council

Consultation on Residential Care for Older People.

The Process of Entry to Residential Care.

For those with sufficient private means application can be made to any private or independent residential home. This is a civil arrangement between the individual/family and the care provider. Such residents are not at present protected by the Human Rights Act 1998. Those people entering a local authority residential home or have their fees supported by the local authority have to undergo a needs assessment and a financial assessment. If the local authority does not pay the whole fee a top up fee may have to be paid by an individual or their family. For many individuals entry to a care home is preceded by a gradual worsening of their physical or mental capacity, frequently including stays in hospital following a stroke, or other medical crisis such as a fall, heart attack or severe breathing problems. I f the individual's capacity to carry out self care or cope with daily living is severely limited then residential care may be considered as an option. Individuals living alone or whose partner is unable to provide necessary care are particularly prone to be considered for a residential placement. There can be pressure on patients and relatives from hospital staff to discharge to a "safe" environment once acute treatment is accomplished and the patient is designated as a delayed discharge from care. Undue pressure may come from relatives/professionals in persuading a patient to go into a care home as this reduces their responsibilities for caring for them as they will be "safe" in a Home. Unnecessary extended stays in hospital are detrimental to patients' health, exposing them to risks of infection, institutionalisation and poorer rehabilitation outcomes.

The threshold for considering admission to residential care is contingent on several key factors: the quality of unified assessment process; availability of rehabilitation services; availability of immediate support after discharge (e.g. Care and repair/shopping/regular visits); the availability of medium or long term community support services including sheltered housing. These may be provided by local authorities, third sector or private organisations. It is noteworthy that in the current

financial climate local authority budgets are being reduced affecting both local authority and third sector community services. This tends to increase demand for residential care at the same time as some providers of residential care are withdrawing from the market as local authorities are paying a smaller proportion of actual costs in term of fees.

Despite some improvements in the coordination between hospitals and community services and that some community schemes are supported by the Big Lottery and other charitable grants we are likely to see increasing pressure on hospital provision with delays in providing either substantial packages of home care or residential care. Timely Unified Assessment is also a problem with reductions in hospital social workers and health staff less aware of the social dimensions of care and support in the community.

The Capacity of the Residential Care Sector to Meet Demand.

There is a high risk that more providers of residential care will go out of business placing further pressure on the whole system. In the last two decades the populations of residential care homes have changed dramatically. Most residents are 80+ years of age, have a greater degree of physical disability with a higher proportion affected by Alzheimer's Disease or other form of dementia. The workforce has not changed in response to this change either in the levels of training/skill or the staffing ratios within homes. The bulk of the staff in daily contact with residents have either no training or low levels of training, are poorly paid and have poor Welsh/English language skills. The skill mix means that there are too few people with higher levels of understanding and skill to support and lead junior staff. Unless there is a substantial increase in the resources provided for providing residential care homes, there will be limited scope for improving the overall quality of care. One alternative is for Health Boards to play a bigger role in the funding of residential care, since delayed transfers of care are a major source of disruption to elective and emergency hospital care. Also the longer patients stay in hospital the greater risk they face of infection, institutionalisation and poor rehabilitation outcomes. The recent experience of Southern Cross as a large provider indicate that , whether financed by local authorities or health Boards , unless there is an increase in fees in realistic line with actual costs it will be hard to meet demand and improve quality.

The Quality of Care.

At present the quality of care is very variable. Since there is currently no national survey of quality covering all of Wales generalisations are difficult. One small scale study of two care homes in Swansea showed that no members of staff had any training in nutrition- a key element in standards of care. At the anecdotal level there are reports of excellent and also very poor care. But recent scandals in England would support the unevenness of standards across the sector. There is ongoing research at Swansea University on homes closures which should have implications

for best practice in managing home closures. But in looking at the paths that patients travel in the health and social care system it should be a guiding principle that too many changes of environment in quick succession are disorienting, particularly to older people. There should be preparation to ease the transition to a new environment – something that is well accepted for children but frequently ignored for older people.

Regulation and Inspection.

The Care Council for Wales only requires relevant qualifications for senior staff, although it has set a target for half of care staff to be trained to NVQ Level 2. Improving training should be a high priority, particularly in the fields of Fundamentals of Care and dementia care. The inspectorate has made residential care one of its priorities during its next cycle of inspection activity. Impressionistically, even where standards are low, there is great reluctance to close a home which is seen as a last resort. We would support an increase in unannounced visits, having higher expectations of involving residents and relatives and resisting the move in some parts of the UK to "light touch" regulation. Community Health Councils at present are able to visit homes where there are health funded residents. Consideration could be given to the desirability and feasibility of extending the remit of CHCs to cover residential care homes.

New and Emerging Models.

There is a growing private/independent provision of retirement villages. But in many of these there is a limit on the range of social care and medical support available as residents capacity to be independent declines. Other social care providers have moved into extra care provision i.e. residents live in self-contained flats which can include different levels of common services and social care support. Whilst some projects may include dementia care in others the social care element is quite limited. Once above a certain threshold a resident would need to leave and enter alternative provision. Whilst there have been successful pilots of cooperative/mutual organisation of community services for older people, this becomes more complex for residential care with its pre-existing structure of mainly private/independent provision. The demographic trends indicate that there may be scope for losing some residential provision with poor physical/design environments for older people and developing newer models, appropriately designed and with management structures modelled on cooperative / mutual principles. Most people are faced with very limited choices when considering residential care and have very little influence on the quality of provision once they are a resident. Models which give much more weight and control to the users of the service need to be developed if we are to avoid older people being the passive recipients of care.

Final Comment.

There is a wealth of literature on the standards and quality of residential care for older people but the population and needs of residents have undergone a marked change in the last thirty years. It appears that little of this reservoir of knowledge has found its way into the training and support of residential staff directly caring for older people. Changing needs mean that the purposes and aims of residential care for older people need to be reformulated. There should be a greater emphasis on providing a stimulating and therapeutic environment rather than only providing for basic needs. In addition to residential homes providing long term care, consideration could be given to developing homes with a clear rehabilitation objective, linking with day care and home support services. Even with improved community services that avoid some older people becoming long term residents in residential care, providing high standards comes with a cost. Inspection and regulation will only help to avoid the worst standards rather than lead to excellence of provision. If older people are to be treated with dignity, then those caring for them need to be supported and provided with the skills and knowledge to provide humane and professional care of a high standard.

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