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Health and Social Care Committee

Meeting Venue:
Committee Room 1 – Senedd

Meeting date:
22 March 2012

Meeting time:
09:30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:

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Agenda

1. Introductions, apologies and substitutions (09.30)

2. Inquiry into Residential Care for Older People – Discussion with Prof. John Bolton (09.30 – 11.00)

Break 11.00 – 11.10

Please note that the order of business for items 3 & 4 has changed (as of 20.03.12) to accommodate witnesses' schedules.

3. Inquiry into Residential Care for Older People – Evidence from the Welsh Local Government Association and the Association of Directors of Social Services Wales (11.10 – 12.00) (Pages 1 – 40)

David Street, ADSS Cymru
Emily Warren, Welsh Local Government Association

HSC(4)-11-12 paper 4 – ADSS Cymru & WLGA
HSC(4)-11-12 paper 5 – City & County of Swansea
HSC(4)-11-12 paper 6 – Monmouthshire County Council
HSC(4)-11-12 paper 7 – Bridgend County Borough Council
HSC(4)-11-12 paper 8 – Cardiff Council
HSC(4)-11-12 paper 9 – Pembrokeshire County Council
HSC(4)-11-12 paper 10 – Conwy County Borough Council

4. Inquiry into Residential Care for Older People – Evidence from

Local Authorities (12.00 - 12.50) (Pages 41 - 61)
HSC(4)-11-12 paper 1
Bob Gatis, Service Director Community Care, Rhondda Cynon Tâf County Borough Council
Luisa Bridgman, Service Manager, Rhondda Cynon Tâf County Borough Council

HSC(4)-11-12 paper 2
Susie Lunt, Service Manager, Flintshire County Council

HSC(4)-11-12 paper 3
Parry Davies, Director of Social Services, Ceredigion County Council

5. One-day inquiry into still births in Wales - Consideration of terms of reference (12.50 - 13.00) (Pages 62 - 68)
HSC(4)-11-12 paper 11

6. Papers to note (Pages 69 - 72)
Minutes of the meetings held on 8 March
HSC(4)-08-12 minutes
HSC(4)-09-12 minutes

6a. Follow up information from 25 January meeting - EU matters - Residential care for the elderly in EU member states (Pages 73 - 78)
HSC(4)-11-12 paper 12

Health and Social Care Committee
HSC(4)-11-12 paper 4

Inquiry into residential care for older people - Welsh Local Government Association and the Association of Directors of Social Services Cymru

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DATE: 16 December 2011

RESPONSE BY: ADSS Cymru/WLGA Joint Response

RESPONSE TO:

The Health & Social Care Committee of the National Assembly for Wales

ON: The Inquiry into Residential Care for Older People

The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities, the three fire and rescue authorities, and four police authorities are associate members. It seeks to provide representation to local authorities within an emerging policy framework that satisfies the key priorities of our members and delivers a broad range of services that add value to Welsh Local Government and the communities they serve.

The Association of Directors of Social Services Cymru (ADSS Cymru) is the acknowledged professional leadership organisation for Social Services in Wales. It represents the interests of the 21 statutory Directors of Social Services and the

heads of services (adults, children and business) that support them in delivering Social Services responsibilities and accountabilities, across the twenty-two Councils in Wales. Its primary purpose is to support social care & health policy development and formulation, and thus, provide a national voice for the care and protection of adults and children in vulnerable situations in Wales.

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To: Mark Drakeford, AM

Chair, Health and Social Care Committee

National Assembly for Wales.

Dear Mark,

Re: Inquiry into Residential Care for Older People

ADSS Cymru and WLGA welcome the opportunity to respond on behalf of the local government family to your inquiry into Residential Care for Older People.

The response is submitted jointly by ADSS Cymru and WLGA, and as such provides professional and political perspectives to the wider agenda of providing sustainable services to older people in Wales.

Our response will focus on key issues that continue to present significant challenges to service transformation, and based on your request for evidence based on the Terms of Reference outlined in your letter dated 24 October, 2011.

You will have received detailed responses to your Inquiry from a number of local authority social services departments, and for your information we have attached key messages arising from their responses as Appendix 1.

In developing our response we have consulted with Elected Members and statutory directors of social services, heads of adult services responsible for the planning and delivery of residential and home care to older people, NHS colleagues and key external partners including GP'S and the Royal College of Psychiatrists.

We believe that considering Nursing Homes as part of your inquiry would add considerable value and provide a greater overview of the service, its pressures and challenges.. Nursing care is part of the same continuum of care for vulnerable older people, and we would consider both residential and nursing care as potential options for individuals depending on their presenting needs.

Executive Summary

i. ADSS Cymru, WLGA and the Social Services Improvement Agency (SSIA) are actively supporting local authorities in the development of new models of services for older people in Wales as part of our wider work on 'Sustainable Social Services'.

ii. These models of care are predicated on a person-centred approach, with a sharper focus on preventative care, early intervention and reablement. We share the vision of the Welsh Government, to support older people to remain as independent as possible for as long as possible in their homes. Where this is no longer possible we endeavour to ensure they are accommodated close to home in community or residential settings that can appropriately meet their needs.

iii. It is important to recognise that there is place for residential care in Wales, as it can be the most appropriate means of meeting the increased or complex needs of an individual where they are no longer able to remain living independently. We are mindful however that care has to be fit for purpose and many authorities are developing modernised provision (e.g. the new community services and facilities that form the basis of the Builth Wells project). However the modernisation of services is often met with significant local political opposition. It is important that as part of the 'Sustainable Social Services' agenda Local Government and partners locally and nationally are able to develop a stronger dialogue around delivering services differently and using money more effectively, clearly setting out the benefits to local communities.

iv. However in achieving this we would expect that there is national recognition by Government of the need to ensure alignment of key policies such as 'Together for Health' and 'Sustainable social services'. At present we are not convinced that this has happened at a national level, and may reduce the potential beneficial effect at a local authority/LHB level. In addition work commissioned by the NHS (Setting the Direction) and Social Services Improvement Agency (Better Support at Lower Cost) around modernised community provision and resourcing needs to inform policy making.

v. Demographic projections indicate a steady increase in the 50+ population, and that statistic coupled with the economic downturn has placed severe pressures on councils to meet the needs of local populations. The current

system for funding of care is no longer fit for purpose, and needs early resolution .We urge that Welsh Government continues to lobby that the report of the Dilnot Commission (July 2011) is considered by the UK Government in a timely and effective manner, and that within Wales 'Paying for Care' remains a policy priority through an informed and well publicised commitment across welsh society.

vi. The social care system in Wales provides care and support through a means-tested system, which is delivered at the local level by local authorities. Further consideration of the means testing of social care versus NHS funded care that is free at the point of provision is called for.

vii. Local Authorities mostly purchase residential care from independent providers, and traditionally rates are negotiated at a local authority level in line with demand, demography and need. However as part of our collaborative agenda, work is underway to negotiate fees in a range of service areas at a regional or national level. In our response to 'Sustainable social services', we set out our support in principle for a national care contract. We fully accept the principle and potential benefits of a national care contract. However, before this can be achieved we believe significant work is needed at a national and local authority level to address current tensions between the statutory and independent sectors and reach a mutually satisfactory solution which provides a basis for constructive joint working in the future, and which recognises the financial challenge faced by local authorities.

viii. We expect that as part of the partnership agenda with providers, they work with local authorities towards achieving the following outcomes as part of 'Sustainable social services' :

- a focus on outcomes for older people in residential and nursing homes
- a requirement for independent providers to demonstrate a clear link between costs, outcomes and quality in the pricing of residential home fees
- the development of robust needs analysis and joint commissioning strategies, particularly for high cost, low volume placements
- working with the CSSIW and HIW for improved regulatory practice using an outcome focused approach
- encouraging the uptake of high quality care home staff training from authorities and private companies

Response

1. **Definitions**

For the purpose of this exercise and common understanding residential care refers to long-term care given to adults in a residential setting rather than their home. People with disabilities, mental health problems, or learning difficulties are often cared for at home by carers (paid or unpaid), such as family and friends, with additional support from social services or other agencies. However, if home based care is not appropriate for the individual, residential care may be required. For individuals with complex needs that also require medical intervention/support, nursing homes provide a similar service with registered general nurses to supervise the nursing tasks. Residents in nursing homes will be more dependent than those in residential care homes.

For the purposes of this Inquiry we did not consider other various models of supported living where an individual may maintain tenure; however, it is important to bear in mind that there is a range of flexible care options that are available to older people in addition to residential care.

2. **Demography**

Ensuring appropriate models of social care provision and funding is a key policy priority in Wales, and an extremely challenging one given the nature of the service, and the fact that it spans devolved and non devolved policy and legislative functions.

WLGA and ADSS Cymru support a continued focus on this area through policy and legislation to ensure services and funding models are sustainable. We are already working to implement the findings of the John Bolton report, and to develop more sustainable models of service through 'Setting the Direction' and 'Sustainable Social Services'. We strongly advocate that existing policy and legislative opportunities such as 'Sustainable social services', the Social Services Bill, Dilnot Commission and Paying for Care are used to best effect, given the likely impact on public services of changing demography in Wales, as demonstrated by the following headline facts:

- A growing Welsh/UK population.
- An aging population (50+) with an increased risk of dementia, and of physical and mental health problems, i.e. those with inter-related needs.

- An increase in the number of individuals with complex needs at risk of entering residential care at an earlier age (e.g. those with Learning Disabilities).
- That by 2020 a minimum of 243 Extra Care Housing places will be required to meet future demand.

These risks are assessed as part of LA commissioning plans for older people, particularly to effectively manage the market environment of high cost, low volume provision.

3. Vision

The shared vision across Wales is that older people, with appropriate support, can live happily, healthily and safely in their own homes, for as long as possible. Thus, the holistic model of care for older people has been to develop relevant, appropriate and flexible services to meet people's changing needs, whilst at all times encouraging independence and self determination. This has contributed to a strong ethos of developing person-centred/citizen directed services in Wales, particularly for people with learning disabilities.

Significant work has already been implemented through the Social Services Improvement Agency, and in partnership with the NHS through programmes such as 'Setting the Direction', work on reablement and the 'Gwent Frailty Project'. We expect that this work will continue as part of 'Sustainable Social Services' and that the commitment from Government to develop an outcomes framework as part of this agenda will support partners to develop a shared vision and objectives in complex areas of service provision such as this.

Keeping people in their homes and communities also supports them to meet their need for relative independence and overall well-being. Thus, promoting community care as opposed to institutional care is often more expensive, but the outcomes for the individual can be much better.

Where residential care may be more appropriate to support the complex needs of an older person, all attempts are made to keep individuals 'close to home', that is, within the same community. However, there are difficult decisions taken by families and authorities as there might not be adequate provision of appropriate or quality EMI residential care in the locality.

4. **Planning & Delivery**.

Residential care can be an appropriate means of meeting the increased or complex needs of an individual, but that care has to be fit for purpose. The close partnership developed by Local Health Boards and Councils has brought significant advantage in being able to establish a focused person-centred approach for service improvement for older people, including those in residential care.

Collaborating more closely with the NHS has encouraged whole systems thinking, and this has resulted in effective strategic planning. This needs to be built upon and extended. Joint assessment, planning and reviewing, to shape better pathways of care that focus on outcomes for older people has helped to prevent inappropriate hospital admissions and/or delayed transfers of care to residential, nursing or home care settings.

Crucial to better care planning and service development is the involvement of users and carers in the process, and local authorities are working to develop better ways of involving them in care planning process in a way that is effective and engaging. The Social Services Improvement Agency's 'Getting Engaged' programme is a testament to this commitment and learning continues to be developed and embedded. In addition we look forward to working with colleagues in welsh government to commence changes to the assessment process to ensure its more outcome focused, less bureaucratic and more person centred.

Effective strategic collaboration with the NHS has supported a Human Rights approach across alternative care options for older people. Joint assessment and planning has supported clear care pathways and outcomes for older people in residential and nursing homes.

Greater professional awareness has led to better understanding that the management of risk is enhanced in the effective planning and delivery of good quality services, and this is more consistent with taking a Human Rights approach across the board. This means educating and training professionals to utilise residential care in a flexible way , for example, to provide temporary respite care for a vulnerable older person so that his or her Carer has a well deserved break from caring, or to provide a brief period of rehabilitation following hospital care.

The emphasis on reducing inequities and the management of 'overlapping' services for older people means that the NHS and Councils need to bridge the gaps in the health/ social care interface, through a much greater sense of shared responsibility. We continue to lobby for 'joined up' policy making at a

national level with clear alignment between key strategic policy and legislation to support further collaboration with the NHS. We would welcome a greater move towards a shared ownership of key parts of the agenda, through adopting a person centred approach to service provision.

There is still much progress to be achieved and we continue to develop ways to overcome the challenges to integrated working, such as cultural and resource. We welcome the announcement of plan rationalisation and believe there will be new opportunities as part of the requirement for local government to develop a Single Integrated Community plan. However in achieving this we would expect that there is national recognition by Government of the role of health in contributing to the plans, through alignment of national policy: 'Together for Health' and 'Sustainable social services'. At present we are not clear that this has happened at a national level, and are concerned that a missed opportunity may reduce the potential beneficial effect at a local authority/LHB level.

5. Eligibility

We have moved away from a system where local authorities provided the majority of residential care, to one where local authorities operate a system of eligibility for Community care, the majority of which is now purchased by local authorities (and those people who can afford to pay for care) from independent providers.

Due to the intense financial pressures that councils are now facing, most local authorities have raised the eligibility threshold to '*substantial*' and '*critical*'. People with moderate or low needs are sign-posted elsewhere (usually to voluntary sector organisations); however, the risk is that moderate need may escalate to substantial without appropriate or adequate community support.

6. Funding of Care

Unlike NHS services, social services are not free at the point of provision. This means older people are assessed to determine if they are to contribute toward the cost of their care in a residential or nursing home.

There are significant challenges ahead as public services seek to respond to current financial pressures. This is particularly pertinent to the provision of adult social care where recent performance data shows that out of the total adult population in Wales, 2,343,014 (those aged between 18 and over) 1 in

26 are supported by their local authority. Out of these supported the majority (72%) are aged 65 or over. Social services in particular, continue to face considerable pressure in the context of an ageing population with more complex and demanding needs. There are high levels of entitlement and high expectations from users and carers, along with a strategic commitment to supporting as many people as possible to live independently in the community. It is therefore crucial that any reforms are able to respond to these very real issues.

The costs of both residential and non-residential social services are predicted to rise significantly over the next 20 – 30 years largely due to demographic growth which prompted the "'Paying for Care'" consultation [Welsh Assembly Government (2009) Paying for Care in Wales: Creating a Fair and Sustainable System], and the subsequent work undertaken by the Dilnot Commission 'Fairer Care Funding' for the UK Government. We now have a direction of travel with 'Sustainable Social services' but issues around paying for care are yet to be resolved. The reality is that Welsh councils are struggling within existing budgets to meet demand and improve services. A comprehensive reappraisal of NHS and Local Government funding/resources is needed.

People who fund all or part of their own care are not seeing improving levels of investment on . savings or assets due to the economic downturn. Thus, many have dropped below the national thresholds and funding is now being picked up by social services. There needs to be further consideration of the means testing of social care versus NHS funded care that is free at the point of provision.

If we want to move from reliance on the acute sector to community based provision, we are of a view that the present social care funding arrangements are no longer fit for purpose, and needs reform. We are mindful that it will be the UK Government that will address the detail of a reformed financial system for Wales. However, there is central role for the Welsh Government to ensure that resources intended for the care system in Wales are protected, and that funding is sufficient and sustainable.

In our joint consultation response to 'Paying for Care' we outlined key principles on which local government believe that future reforms should be predicated. These include securing sustainable funding, achieving a national/local balance and the delivery of citizen centred services through prevention, intervention, and reablement.

Our analysis of the proposed models of funding suggested that the majority of our membership is in favour of the taxation option being revisited. The view at a local level is that taxation may present the most sustainable

mechanism of securing funds, and feel that sufficient explanation for its ruling out has to date, not been provided by Government. We acknowledge, however the significant implications of this method.

In addition to the WG consultation on 'Paying for Care' The WLGA and ADSS Cymru gave evidence to the 'Fairer Care Funding' Enquiry by the Commission on Funding of Care and Support earlier this year. The Commission's report (July 2011) recognised that the present system of funding of care and support for adults, conceived in 1948, is not fit for purpose for the 21st Century. It proposed a new model of the cost of care in the future. The report confirmed that everyone who receives their care for free now will continue to do so but a cap is proposed so that individuals should take responsibility for their own costs up to a certain point but, after this point, the state should pay. The Commission proposed a significant increase in the threshold at which means-tested support is taken away, so that extra protection is given to those with the lowest incomes and wealth. The combination of the capped cost model and an extended means test would ensure that no one going into residential care would have to spend more than 30% of their assets on their care costs. Furthermore, to tackle the extremes of the 'postcode lottery', it recommended a shift to a new national eligibility threshold and better assessment processes for both those needing care and those giving care (carers). The Enquiry notes that around one in 10 people, at age 65, face future lifetime care costs of more than £100,000. As a result, in paying for care, some people can lose the majority of their income and assets. In particular, those entering residential care are often forced to sell their homes – this is widely regarded by the public as unfair. We endorse the general direction of travel of the Commission's recommendations for England, and the implication for Wales has to be carefully considered.

7. Providing Choice for Older People

Developing the market in Wales to provide a range of services and choice of service providers is a key commitment from local authorities but is often a challenging. Local Authorities purchase a large proportion of residential care from independent providers, but there are problems in setting, annually, a standard contracting rate for places in independent residential care homes. We fully accept the principle and potential benefits of a national care contract. However, before this can be achieved we believe significant work is needed at a national and local authority level to address current tensions between the statutory and independent sectors and reach a mutually satisfactory solution which provides a basis for constructive joint working in the future.

A number of external developments have made it necessary for local authorities to review how care home fees are determined. In August 2010, the Welsh Government published new statutory guidance on commissioning social services; Fulfilled Lives, Supportive Communities: Commissioning Framework Guidance and Good Practice sets out the responsibilities of local authorities in this area of work. The Framework has two parts. Part 1 of the guidance was issued under Section 7(1) of the Local Authority Social Services Act 1970. It contains thirteen standards; these provide the benchmark against which the effectiveness of local authority commissioning activity will be measured. In addition to the legislation and statutory guidance surrounding residential placements and commissioning of placements, there has been a successful public law challenge to Pembrokeshire Council's policy for setting care home fees, known as the 'Forest Care Home' case [1]. Although the judicial review covered the fee setting process and methodology adopted by Pembrokeshire, the judgment has implications for all local authorities when negotiating fees with independent providers of residential care homes.

The WLGA and ADSS Cymru are currently working with Welsh Government and the Care Forum Wales to take forward an improved approach in recognition of the need for greater consistency and to ensure future judicial challenge is avoided, given the financial implications which result in local authorities facing legal bills of millions of pounds that is resource diverted away from frontline services. An important step, recently achieved is the sign up by Local Government, NHS, Welsh Government and the Independent Sector to a jointly owned 'Memorandum of Understanding'.

At the same time, we recognise that we have to develop as far as possible a shared understanding across key stakeholders about factors such as market risks, the needs of current residents within nursing and residential care homes, the needs of the care and nursing home providers, the needs of other residents in the local authority area and finally the needs of other service sectors within the local authority's areas of responsibility. This work is time consuming and fraught with difficulties including continued threats of legal challenge by independent providers.

The level of payment has a considerable impact upon the budgets of the social services departments because of the number of placements involved. This will be a considerable cost pressure in coming years. Local authorities will need to undertake a programme of work with the independent sector as a matter of urgency to ensure that the services provided are efficient, effective and mindful of the pressures on the public purse. They will be asking providers to demonstrate that their financial arrangements keep people safe, asking them to show that their business is sustainable in terms of occupancy

rates, cash flow, volumes and transparent accounts. The quality of residential placements varies greatly across Wales. So, it is equally important that providers demonstrate a clear link between costs, needs and quality in the pricing of residential home fees.

Rurality has its own challenges. Authorities like Powys cover large rural areas and thus, it is not possible to have the economies of scale and critical mass as elsewhere. Where numbers in specific geographical locations are small, the financial sustainability of providers is important in managing and developing the market. Yet in rural settings, there is a need to provide smaller units of care, smaller units of care home support, within a broader range of residential and community/at home service, but this is not an attractive option to current care providers. The cost of travel to deliver care at home represents a significant overhead to the cost of care. Effective partnership working with the independent sector is critical in order to negotiate reasonable fees for good quality care, but with reductions in spending and with grant streams ending local authorities' purchasing power has deteriorated.

To address the many challenges described above, local authorities are developing robust needs analysis and joint commissioning strategies which allow the independent sector to be better informed and thereby plan their services for the future, and allow authorities to manage the market more efficiently. The demise of large scale providers of residential care (e.g. Southern Cross) has created uncertainty for all parties. The market is turbulent and may continue to be unstable over the next few years. Thus, balancing social responsibility for the well-being of older people within financial constraints is even more challenging. As a start, providers' financial viability has to be assessed.

8. Developing Better Care for Older People

Local Authority responses to the Inquiry shows that there is greater investment in preventative, early intervention, and reablement services by collaborating more with the Third Sector to build capacity and consolidate community cohesion. It is important that outcomes for older people in residential care and domiciliary care, and the experience of care for older people in residential settings are properly evidenced.

Local Authorities are considering the implications of recommendations of the SSIA report by John Bolton Better Support at Lower Cost: Improving Efficiency and Effectiveness in Services for Older People in Wales, April 2011. It is hoped that it will help address serious service deficits for older people.

New and emerging models of care, such as the Gwent frailty programme, Bridgend's reablement & intermediate care and Merthyr's extra care programmes, are some of the exciting initiatives that focus on older people with very complex needs e.g. those with dementia. The impetus behind all models is to reconfigure services to maximise independence and self determination as a key customer focus

ADSS Cymru and the WLGA work closely with the SSIA - Social Services Improvement Agency's Reablement Learning & Improvement Network to develop community based reablement services. The network comprised of local authority officers is chaired by a member of our Association, a head of adult services in a local authority.

Developing *Extra Care* and other housing options is an important strand to delivering the strategic shift away from residential care. Enhanced supported community living (e.g. tenancy based models with integrated social and clinical services) amongst others have helped older people with changing needs. We are awaiting results of the Welsh Government's study into the viability of Extra Care housing.

A key plank of local governments commitment to the 'Sustainable social services' agenda is partnership working across social care and health and the requirement to modernise services, deliver improved outcomes for service users and cost efficiencies. As such Local authorities are collaborating regionally to create regional commissioning hubs for high cost/low volume (typically LD; MH; PD & sensory loss) adult residential placements. For example the South East Wales Improvement Collaborative (SEWIC) has a change programme that consists of a three stage strategic approach that seeks to develop platforms that will deliver disinvestment in residential and secondary care and movement towards community and primary care solutions; contribute towards greater service user choice and control; and promoting and maintaining independence and wellbeing.

Key elements of the this programme is the development of the regional brokerage procurement hub targeting new placement activity; controlling costs across the region and delivering cost avoidance; coupled with the ongoing review and 'right sizing' of existing high cost/low volume placement costs which are delivering significant cost savings across the region. Further, the programme is developing commissioning platforms as alternatives to residential care such as the development and extension of the 'Shared Lives' service that delivers more person centred support and cost savings against comparable residential and day care models.

The Mid & West Wales Social Services Improvement Collaborative (MiWWSSIC) are building on their existing regional high cost/low volume adult procurement hub; assessing outcomes to date; and putting in place developments to ensure the service moves forward and delivers the required outcomes.

More work on supporting development of new service models, led by SSIA, forms an important part of the local government response to 'Sustainable social services' and will be a key component of sustainable social services in Wales into the future.

9. Capacity & Training

We welcome the protection to the social services budget, however in real terms budgets are reducing which have resulted in a reduction of professional capacity, and on providing a broad range of services to citizens and the community. The Third Sector is likewise experiencing cuts to their grants and reduced commissioning of services from local authorities. This has impacted the range of services it is able offer to support individuals with low or moderate need. As mentioned above, moderate need can soon escalate to substantial or critical need without appropriate community support, and at this point social services is accessed, adding to further pressure on councils.

We have deep concerns on the quality and provision of appropriate staff training in specialist residential care (e.g. learning difficulties, EMI). We are concerned that the lack of uptake of local authority training by some providers is not always financially motivated but stems from a lack of priority given to development of care home staff. The direct impact is on service quality and outcomes for older people.

10. Regulation and Inspection

There is a need for more robust and regular review processes for residential homes in order to raise standards, and challenge discriminatory practice. To this end, ADSS Cymru has been in discussions with the CSSIW about the review arrangements for the new regulatory framework. Both CSSIW and HIW regulatory frameworks require a level of integration in order to support new models of health and social care.

In relation to residential care it is problematic when CSSIW utilise an artificial categorisation of dementia nursing and dementia residential care which places residents at risk of having to have to move from a care setting to a nursing home on the grounds of a diagnosis or clinical needs assessment. We support the College of Psychiatrists who advocate a move away from the use of

diagnostic categories as the primary influence in considering the type of care home a client should access. The needs and wants of an older person are paramount, and the environment that is most conducive to supporting these is the preferred choice. Indeed, our view is supported by the National Dementia Strategy for Wales.

11. Concluding Remarks

At the heart of social services is a commitment to enable and empower citizens and service professionals. We advocate for older people to have control over their own lives so that they are able to live confidently, whatever the setting. To this end, ADSS Cymru, WLGA and the Social Services Improvement Agency will now work in partnership with other key partners to lead improvement across older people's services. This will fundamentally change services and help embed an ethical approach which we, along with service users, believe are necessary to underpin a dignified life, characterised by independence, choice, social inclusion, and well-being. For individual older people who access residential care, this could not be more important, as they have expectations and needs. For Social Services, it is about ensuring the commissioners and practitioners understand how outcomes can be achieved and how the levels of service and direct support can be quantified for each individual older person in residential care. For providers, it is about delivering improved outcomes for older people, so that their aspirations and life is fulfilled. For the regulators and inspectors it is about accepting that outcomes are an intrinsic part of monitoring and evaluating the quality of care in residential homes.

Over the last 18 months, WLGA and ADSS Cymru have been actively involved in shaping the Welsh Government's primary agenda for social services in Wales, '*Sustainable Social Services: A Framework for Action*' (SSSFFA). The framework provides a clear policy framework with core requirements to achieve sustainability, such as financial efficiency, regional collaboration across councils and sectors, and quality service outcomes. Within this context, there are specific challenges in delivering and sustaining a range of residential or community based . services so that older people can exercise choice, both between providers and options in how their aspirations can be met.

The Older People's Commissioner is undertaking work around advocacy and older people entering residential care and the findings of this work should inform and support this enquiry.

ADSS Cymru and WLGA are committed to playing a pivotal role in addressing the challenges of service provision in respect of residential care, and we look forward to a mature engagement with the National Assembly for Wales and the Welsh Government as we move forward.

We hope that our response is helpful, and we look forward to providing oral evidence to the H&SC Committee Inquiry in 2012.

Councillor Meryl Gravell OBE

WLGA Spokesperson for Social Services

Welsh Local Government Association

Parry Davies,

President, ADSS Cymru and

Director of Social Services, Ceredigion Council &

Interim Director Care & Well-being, Powys County Council

Nygaire Bevan

Chair of the All Wales Heads of Adult Services (AWASH) Group &

Head of Adult Services, Powys Council

Executive summary from 'Better Support at Lower Cost'

The current environment is one of unprecedented challenge for social services in Wales. The pressures on public finances combined with an ageing population pose particular problems for those who lead and work in social care. Whilst there is recognition that 'more of the same' won't do, a consistent and realistic understanding of the radical change required has yet to emerge.

It is increasingly recognised that the twin goals of improving efficiency and delivering better outcomes for service users are not necessarily in conflict with each other. Some councils recognise that the kinds of service transformation they are now contemplating would make sense in terms of service improvement even if current financial constraints – which require Welsh councils to find 4% annual efficiencies over the next 3 years - were not present.

The policy context in Wales presents particular opportunities and challenges. The Welsh Assembly Government's commitment to 'Citizen Directed Support' sits well with models that aim to maintain and support independence for the individual in ways that suit their specific circumstances. However, imminent changes in national charging policy will place a limit of £50 a week regardless of the package of care in question and the individual's ability to pay. The resulting need for councils to make up the difference will mean additional
pressure on budgets that are already severely stretched.

This study reveals that against this backdrop all councils in Wales have begun to reshape their services for older people, with much evidence of a shift towards a reablement approach to care and general reductions across Wales in the number of older people being cared for in traditional residential settings. As would be expected, the rate of progress is mixed and some councils are further down this road than others. The configuration of
services and balance between, for example, residential and non-residential care is mixed across the country. However all councils demonstrate effective practice in one or more areas of their service, and a commitment to build on this as they move into the future. In doing this it will be important to concentrate on creating robust financial plans to support their commissioning strategies, developing further the use of assistive technology and reconfiguring services through the decommissioning of traditional, high cost services in favour of more preventative models. Genuine partnership with health (already evidenced through a number of joint strategies for older people and cross-sector approaches to service delivery), the third and private sectors will be important in maximising efficiency and ensuring that people are supported proportionately and in a way that maintains independence as long as possible. Ensuring that other local government services – notably housing and leisure – are involved in the development of new models will also be vital.

Drawing on examples of good practice in Wales and evidence from successful models elsewhere in the UK, the report suggests a future model of care for Wales which seeks to improve outcomes for users, encourage support within the community thus reducing pressure on traditional social care services and develop new approaches to commissioning which optimise the money available.

Establishing such a model will involve significant challenges for councils and their partners: shifting prevailing cultures within social services as patterns of care change, being prepared to see numbers of people cared for go down as more people are supported effectively 'outside the system' and seeking genuinely citizen-centred approaches that will call into question traditional modes of delivery. The clear evidence is that councils and other organisations are up to this challenge. With support from national government and agencies like the Social Services Improvement Agency (SSIA) the opportunity is there to consolidate recent advances and build older people's services fit for the 21st century.

Full version can be viewed here: www.ssiacymru.org.uk/4845

ssia
Improving Social Care in Wales

wwww.ssiacymru.org.uk/reablement

Demonstrating Improvement through Reablement

Promoting independence is a cornerstone of social services policy and within this awareness of demographic pressures and the growing focus on outcomes has meant that reablement services are becoming increasingly important.

In 2007, SSIA held its first Learning Exchange event – "From the margins to mainstream: Exploring models for reablement" and following on from this sought expressions of interest for its "Demonstrating Improvement" Fund with a number of applications received about the development of reablement services. It was therefore agreed that a collaborative approach should be taken and a scoping workshop identified the key areas that people wished collectively to address which led to the formation of an Action & Learning Set (ALS).

The definition of reablement adopted by the ALS is: "*services for people with poor physical or mental health or disability to help them live as independently as possible by learning or re-learning the skills necessary for daily living."*

The ALS have contributed their knowledge, skills and time over the last twelve months, supported by Whole Systems Partnership, to develop a Reablement Toolkit.

The toolkit contains:

- A baseline questionnaire with the ability to interrogate this by Authority or by question posed;
- A self-assessment tool against a gold standard with the ability to prioritise development areas and plan for change;
- A simulation tool designed to indicate the scale and impact of an optimised reablement service.
- A competency framework

Using the toolkit Authorities can self-assess their reablement services and prioritise local developments, as well as identify and share notable practice from elsewhere.
In addition the toolkit provides access to a systems model that simulates potential capacity

requirements and can be scaled to give an indication of the likely capacity required and benefits expected from an optimised reablement service. This is supported by a 'business case' framework which complements these tools and assists in the preparation of a business case for the development of reablement services locally.

Underpinning any successful reablement services is a well trained and developed workforce. The training sub group of the ALS have identified the competences needed.

Work remains ongoing and a discussion forum has been created to enable further dialogue and shared learning.

Reablement Resources

There a whole host of resources available, including a local authority on-line questionnaire and standards toolkit, discussion forums, document resources and an on-line capacity model.

SSIA web resources and discussion forum:
www.ssiacymru.org.uk/reablement

Toolkit:
http://www.ssiaresources.org.uk/reablement/

Capacity Model:
http://ns360.ukclouddns.com/netsims/peter%20lacey/ssia_reablement_model_nov_09/

Contact

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Health and Social Care Committee

HSC(4)-06-12 paper 5

Inquiry into residential care for older people - City and County of Swansea

Regarding your consultation on residential care, I would like to inform you of *in-house* development work in Swansea regarding residential care for people living with dementia.

I believe this work is relevant to the following:

- *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.*

- *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.*

City & County of Swansea, in partnership with ABMU HB has been working on the development of a relationship centred (Nolan et al 2006) **residential** care home for people living with dementia, in the belief that many people living with dementia are unnecessarily placed in **nursing** care homes because of so called challenging behaviour, when in fact, what is needed is a therapeutic and nurturing 'enriched environment of support' with a strong focus on positive social psychology rather than the use of anti-psychotic medication. The service model is based on the **VIPS** model of **person centred care** as developed by Professor Dawn Brooker (Brooker 2007), which has four key principles, each with an associated set of indicators for use in service evaluation:

V- **valuing** *all* stakeholders, whether older people, carers or staff
I - an **individualised** approach to support planning drawing on life history and functional ability
P - designing and delivering the service from the **perspective** of the person with dementia
S- providing a positive supportive **social** psychology through relationship centred practice

This service has been developed in **Ty Waunarlwydd** residential care home in Swansea and we are already evidencing that people living with dementia, their family carers and the staff who work with them benefit from this **strengths based** approach, and a determination to break down the 'us and them' barriers that are so often a feature of care home culture.

I have attached a short photo story which illustrates the work of this home. We are in the process of developing outreach and mentoring support to other care homes in Swansea, in the hope of extending this model of practice.

If you would like further information about this home, please let me know. I am sure that the team would be happy to tell you more.

References:

Brooker, D. (2007), *Person centred dementia care: making services better*, London, Jessica Kingsley

Nolan, M., Brown, J., Davies, S., Nolan, J. and Keady, J. (2006), *The Senses Framework; Improving Care for Older People Through a Relationship-Centred Approach*, Sheffield University GRiP (Getting Research into Practice) Report No.2

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CYNGOR monmouthshire COUNTY COUNCIL sir fynwy

SOCIAL CARE AND HEALTH DIRECTORATE

Health and Social Care Committee
HSC(4)-11-12 paper 6
Inquiry into residential care for older people - Monmouthshire County Council

"Working with the citizens of Monmouthshire"

Date:/Dyddiad: 24th November 2011
Contact:/Cysylltiad: Ceri York
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Committee Clerk
Health and Social Care Committee,
National Assembly for Wales,
Cardiff Bay,
CF99 1NA.

Dear Sir/Madam

Inquiry Into Residential Care for Older People

This inquiry into the provision of residential care for older people is very much welcome; significant changes have been seen across older peoples' social care services in recent years including; re-ablement, extra care housing and most recently the Frailty Programme, consideration of the future role of residential care needs to be given in the context of this new landscape.

At both a local and national level the focus is very much on supporting older people to remain as independent as possible, living within their own homes and communities. However it is also acknowledged for some older people this will not be the most appropriate outcome and their needs require meeting in a residential setting. Exploring the reasons why older people chose residential care, understanding their experiences of living in care and their expectations and aspirations should fundamentally shape the future development of residential care.

It would be helpful if the inquiries terms of reference included not just the process by which people came into residential care but also the reasons: why they chose it ? what would have enabled them to stay in their own home ? has the reality of residential care lived up to their original expectations ? did they feel under any pressure from family, health or social care professional to choose residential care ?

Exploring the role, effectiveness and efficacy of the current regulatory and inspection regime in supporting the delivery of high quality residential care is essential, as is scrutinising what impact the recent introduction of Section 7 guidance in respect of the escalating concerns process.

Thank you for this opportunity to comment on the committee's inquiry and if you have any queries please contact me on the above telephone number.

Yours faithfully

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Ceri York
Group Manager Service Delivery and Development.

Health and Social Care Committee
HSC(4)-11-12 paper 7
Inquiry into residential care for older people - Bridgend County Borough Council

Bridgend County Borough Council
Wellbeing Directorate
Adult Social Care

Health and Social Care Committee
Inquiry into Residential care for Older People

The terms of reference for the inquiry are as follows:

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, including:

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

The great majority of older people who enter residential care in Bridgend are usually as a result of being directed to this decision by Assessment Care Managers either from their homes or from a hospital. A smaller percentage of older people enter residential care through their own volition in self funding arrangements. All those older people who enter a residential home with the support and guidance of an Care Manager would have been assessed as needing such a service and have a unified assessment and care plan produced to identify and highlight the scope and range of the care and support they would require at a residential setting. The care plan would then be provided to the registered manager of the home for them to assess whether they can meet the needs of that person on admittance to the home.

Bridgend's County Borough Council's (BCBC) Adult Social Care Commissioning Plan vision statement is 'To promote independence, wellbeing and choice that will support individuals in achieving their full potential in healthier and vibrant communities' This will mean promoting the principles of choice, independence, empowerment, opportunity, dignity and respect. It will involve safeguarding vulnerable people and developing preventative approaches to ensure that people receive the most appropriate level of assistance at any time to avoid the need for long term support from statutory agencies. To this end Bridgend both provides directly and commissions a range of domiciliary services with the demand for such 'home care' services increasing year on year.

The Local Authority is keen to explore new models of services which is a shift away from more traditional models of residential care. BCBC is currently working with health colleagues in order to develop an integrated re-ablement service offering six beds at one of our residential home which will be opening during June/July 2012. The aim of the service is to provide a multi-agency re-ablement service to older people to enable them to gain confidence and the skills required to enable them to return to their homes in the community.

Bridgend has similar objectives as stated above in our investment in our Telecare Service 'BridgeLink'. The BridgeLink vision is that: 'A person is able to access and use

Telecare as the part of a care plan or a preventative measure which enables them to continue to live in and perform daily tasks within their home irrespective of the limitations imposed by their frailty or disability'. In short we are seeking to develop a range of service that will aid older people in remaining in their own homes rather than moving into residential care. It must also be recognised that for all of these projects a culture of 'Positive Risk Management' plays an important role in planning, design and delivery of these services.

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

It is our belief that there is an over provision of residential care in the Bridgend area, with there being 25 Residential/Nursing Homes in the Bridgend area providing 1058 beds consisting of 598 residential beds and 460 nursing home beds. Over the past three years there has been a noticeable trend in regard to the number of vacancies across these homes and for example week ending 2/12/2011 there were 36 residential vacancies and 46 Nursing home vacancies a total of 82 vacancies – predominantly within the independent sector. This number of vacancies, as already stated has been sustained for several months and there has been a similar pattern over the past few years. We have concerns in respect of the CSSIW proposal to remove the registration category for Elderly Mentally Infirm (EMI – dementia) for residential homes. This category of care is an important aspect to help commissioners differentiate between service provision and placements. There is a risk that we could see a more general service being provided by care homes to people suffering from dementia which could potentially take away the specialist staffing and resources required to effectively meet their needs. We do however recognise that there needs to be a flexible and balanced approach applied by the CSSIW in terms of the application of the registration for dementia – especially where a resident at a general care home is diagnosed with dementia. At this point there needs to be a pragmatic approach and rather than enforce that the resident moves to a home registered for dementia, especially if their needs continue to be met adequately.

It is our belief that meeting the care and support needs of people with dementia is one of the major challenges for Social Care over the coming years. However, we also believe that this challenge can be met by reallocation of existing resources if a whole service and sector approach is adopted. It is important that health and social care partners work with housing colleagues to plan effective preventative service and effective community based services, such as extra care schemes to enable older people to remain within their local communities. Social care will also need to create sustainable community based services which have a re-enablement culture. This will require a shift towards more specialist training for community based staffing & services, in order ensure that the right kind of support is delivered at the right time and in the right environment.

Another factor that has a baring on the capacity of residential homes sector to meet the demands for services from older people in terms of staffing resources is fee levels However, we aim to work in partnership with the private sector, voluntary sector and key stakeholders to promote a whole sector workforce approach within the local market. We will assist adult social care staff to become appropriately skilled, trained and qualified to perform the range of responses and functions required in the future. We will also target

funding that sustains the adult social care employment market and improve staff recruitment and retention arrangements.

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

As a Commissioner Adult Social Care in Bridgend we aim to build on our current partnerships with providers and consolidate effective working relationships by continuing to forge robust contracting processes. The aim is to involve providers in a positive way to participate in planning and commissioning to help drive up quality and improve value for money, including a clear direction of commissioning intentions for the market. We will work co-operatively and be both transparent and flexible so that we can establish a more financially affordable mixed economy of care; improved quality responses and outcomes for service users; and greater employment opportunities for local people. We are already building bridges to promote person centred planning and outcome focused delivery of care across care homes. We feel that an outcome framework would enable commissioned services to strive towards collecting and measuring outcomes for individuals in a more structured way – which would demonstrate the effectiveness at a service level and market level.

Our experience to date on the residential service provided within the Bridgend area is that there are differences in the quality of the services provided in this sector. We have been using our quality premium fees standards to drive the quality of care forward. Over the last 12 months this approach has genuinely seen an improvement in the care which individuals experience- with a greater shift in terms of personalised approaches and activities, to help the individuals feel part of the home and community.

The recent demise of Southern Cross nationally very much focused our attention upon what our responses would be in the event of a residential home/s going into liquidation/bankruptcy etc and to this end we developed a Business continuity plan in partnership with our colleagues in health to guide our responses if such an occurrence happened. We are also considering our processes for accrediting new & existing providers to ensure financial viability is assessed and recognised. Although we do feel that the CSSIW and other regulatory bodies have a role to explore the fitness of agencies and their financial stability – especially where the regulators have a platform to look across the whole sector and take a national view of agencies financial stability.

We do believe that fee setting is paramount and links to the quality of care. As mentioned previously Bridgend have a quality fee within our fee structure, which allows us to incorporate quality and outcomes within the assessment of fees. The Local Authority and Local Health Board in Bridgend are currently undertaking a piece of work to understand the cost pressures across the sector to help inform future fee setting. This exercise is important following recent judicial reviews relating to fee setting and the introduction of the WG Commissioning Guidance and Framework in 2010. The guidance sets the scene for fee setting and the recent judicial reviews place an emphasis on LA's to ensure that the fees are based on the cost of care rather than the LA's financial position. With this in mind it would be helpful for WG to give LA’s a greater steer and direction regarding fee setting to ensure that there is a consistent approach to mitigate & reduce the challenges regarding fee levels.

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

Adult Social Care in Bridgend fully recognises the benefits that have been gained for the residential homes sector with the implementation of the National Minimum Standards for this sector. However, we believe that while the CSSIW still have a critical regional role in the monitoring of residential homes, the key player in driving up standards in this sector are going to be the Contract Monitoring Team. The CSSIW teams' are becoming more centralised and there is a concern that they could loose valuable local intelligence which could impact on a holistic view of services. They are closer in geographical terms to these services and often are in daily contact with services when they are in crisis. We would also argue that the Contract Monitoring Teams within LA's have a greater understanding of the market forces at work shaping the delivery of these services and as such are better placed to scrutinise the financial viability of providers. In addition the contracting relationships and monitoring reports between LA's and providers tend to highlight greater inconsistencies in care and practice across care homes – where the CSSIW reports tend to focus on regulatory issues and enforcement seems to be driven by LA's.

5. **New and emerging models of care provision.**

Adult Social Care in Bridgend is working towards establishing integrated, inclusive and seamless advice and assistance that promotes positive outcomes for vulnerable people. This approach will involve flexible and accessible preventative responses within local communities which are tailored to individual circumstances and choice. This approach will focus on assisting people to identify the risks to their independence, and jointly determining strategies to minimise that risk as appropriate. To this end we are seeking to develop and commission a range of models of care provision from mixed community extra care to extra care specializing in supporting people with dementia, core and cluster services, key ring communities, community based floating support and as already stated re-ablement. Our aim is to develop a mixed social care market that can effectively respond to the care and support needs of older persons no matter where they are located on the care continuum.

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

Adult Social Care in Bridgend has actively explored all of the above referenced options as part of its re-modelling agenda. We believe that in these times of economic challenges that any such developments must be based upon a sound social care business case that has both direct and indirect benefits for the communities serviced by the authority. We are currently exploring possible partnership arrangements with RSLs in the development of extra care facilities in the Bridgend area.

Health and Social Care Committee
HSC(4)-11-12 paper 8

Inquiry into residential care for older people – Cardiff Council

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.

In Cardiff we have the following three initiatives which support people at key stages in the care cycle, with the aim to maintain/regain independence, and minimise escalation of need and admission to NHS or residential care.

Our Short Term Assessment and Response Team (START) provide 6 weeks of intensive support for people upon leaving hospital, with a strong 're-ablement' focus. Admission to the service is via the Contact & Assessment team, hospital ward staff or a hospital social work department. An assessment is required, and the service is free for up to six weeks after which normal charging applies. On average [in 2009-10] only 30% of START clients are referred for ongoing care at the end of the 6 week program, and the service receives excellent feedback via its Customer Satisfaction program to which all users are asked to contribute.

Our Elderly Care and Assessment Scheme (ECAS) operates from Rookwood Hospital, and receives referrals from the GP services for vulnerable older people who require urgent but not immediate assessment and investigation. Without the option of ECAS intervention, the GP would usually admit the patient to hospital. The service provides Medical, Physiotherapy, OT and Social Work intervention with a view to keeping older people in their own homes, the aim of the Social Work support being to provide a long-term care package via a care agency, within 5 days of Short Term Intervention Home Care putting in a service. Again, this service receives consistently excellent feedback via the Customer Satisfaction program that supports it.

The Cardiff East Locality Team (CELT) is a pilot scheme funded by the Welsh Government and developed collectively by Cardiff Adult Services and the Cardiff Local Health Board, who take the lead on the project. The service aims to prevent avoidable hospital admission though multi-agency intervention, including occupational therapy and social work as well as substantial Health input. Access is via referral from frontline GP and district nursing services in particular, typically responding within one working day or the same day where urgently needed. Within the evaluation period approximately 75% of referrals were from service-users in their own homes, and 25% were for those needing supported hospital discharges.
Work has now begun on developing locality-based teams for the rest of Cardiff, and the Vale.

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, facilities and resource levels.

Cardiff has a mixed market of residential care providers who are currently absorbing the demand for residential care for older people leaving some capacity in the market for growth.

We hold a quarterly Residential and Nursing Provider Forum to share best practice and development opportunities within the market. Attendance at the Forum is voluntary and is reflective of a core group of providers, including the Chair of the Cardiff Care Homes Association.

In addition, we work closely with providers through our Social Care Workforce Development Program (SCWDP) to provide access to training and resources wherever available.

Access to training and qualifications through SCWDP is available to support all providers who are in a contractual relationship with Cardiff; engagement is voluntary in that many independent sector providers have their own provision for training in house or for the purchase of training from private sector training companies. One key element of the training programme is the need for basic skills training which underpins an individual's ability to attain National Minimum Standards within the established training targets for care staff. A further issue impacting staff resourcing is the turnover rate of care staff in a number of establishments.

SCWDP has a varied suite of training methods accessible to support providers and aims to be responsive to areas of identified need.

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.

In 2009 and 2010 we undertook Customer Satisfaction surveys of our Cae Glas and Ty Mawr homes, targeting primarily the family/friends of residents but also professionals who had cause to visit the homes. Response rates and levels of satisfaction were particularly high and any criticisms that arose were all investigated and resolved.

Service users who receive care in an independent sector residential setting in Cardiff are also regularly surveyed to assess their levels of satisfaction and again the responses received have shown particularly high levels of satisfaction with the services they receive.

The authority also grant funds Age Concern to provide a placement advocacy service across the residential and nursing home sector to underpin our quality assurance processes.

The care homes providing residential care to older people through the Councils internal provision and the independent sector have proved to be very effective in their ability to meet the needs of the diverse population of older people in Cardiff.

The Council recently completed an “Enhanced Dementia Care (EDC) Project which took place between 2008 and 2011. The project was funded by the Welsh Government’s ‘Promoting Independence and Well Being Grant Scheme’. Its aims were to contribute to improving the quality of dementia care in Cardiff by working in partnership to reduce inappropriate admissions to care homes and to enhance dementia care knowledge, skills and understanding in care homes and support the delivery of person centred care (Copy of the draft report attached).

Over the next 12 months the Council has planned to close its 2 remaining residential homes and has mapped a path for the closure following a formal decommissioning process, communicating and involving residents their families and carers throughout the ongoing process.

The Council undertakes monitoring of the residential care in Cardiff through the Adult Services Contracts & Service Development Team who work in conjunction with other organisations. Joint investigations with Care and Social Services Inspectorate for Wales, Health and the Independent and Voluntary Sector Agencies are regularly undertaken to improve the quality of services delivered to the people in residential care.

The Council has a dedicated safeguarding team, which adheres to the policy and procedures as outlined in the "All Wales Adult Protection Policy and Procedures" and the principals as outlined in the document "In Safe Hands". The team endeavours to protect vulnerable adults from abuse (including Physical/sexual/emotional/Financial abuse and neglect) and investigate allegations of abuse together with other professional and partner agencies. The team are contactable by any person(s) but in particular by the service user, family member or service provider, including staff under the whistle blowing guidelines and advocacy agencies including Age Concern.
Under the guidelines various types of meetings e.g. strategy meetings/case conferences, whole home enquiries, provider performance, escalating concerns meetings, Joint Inter Agency Monitoring Protocol meetings and serious case reviews are convened as and when appropriate to assess and manage the safety of vulnerable persons who may be at risk and also to assess systemic and organisational concerns such as poor care and practice. Where appropriate and under the terms of the policy and procedures, service users, family members and advocates are involved in the meetings

In recent times the safeguarding team have been conducting assurance visits to residential homes where issues have been raised. These have been both

announced and unannounced and have proved productive in gleaning first hand information, evidence of concerns, monitoring homes and safeguarding vulnerable persons.

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

Cardiff Council has an excellent relationship with the Care and Social Services Inspectorate for Wales (CSSIW) and has worked closely with them to ensure that residential care services for older people are provided at a high quality and in a safe environment. This has included the coordination of CSSIW inspections and Contract Performance Monitoring visits as well as a number of joint initiatives.

The Council would welcome the scope for the CSSIW to have the ability to increase the scrutiny of service providers' financial viability in the interest of safeguarding the care provided to its citizens.

The Council will continue to work closely with the CSSIW in order to ensure a robust response is delivered to those providers where poor performance has been identified. Where necessary this happens in the residential care sector with the close cooperation of the providers.

New and emerging models of care provision

Over the last 4 years the Council has developed 3 Extracare schemes in Cardiff and is interested in developing and adopting potential new models for the delivery of residential care to older people.

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.

Cardiff Council welcomes the opportunity to take part in this inquiry into residential care provision for older people and would be interested in further exploring the possibility of alternative funding arrangements, management and ownership models such as those offered through alternative provision by cooperatives, the mutual and third sector and Registered Social Landlords.

Health and Social Care Committee
HSC(4)-11-12 paper 9

Inquiry into residential care for older people - Pembrokeshire County Council

Pembrokeshire County Council

Adult Community Care Services

WA Inquiry into Residential Care for Older People

The National Assembly for Wales' Health and Social Care Committee is undertaking an inquiry into **residential care for older people.** The terms of reference for the inquiry are as follows:

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, including:	**Comment**
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.	How residential care is funded, and how it is funded differently from non-residential care makes it difficult to fund new models of care. The care plan should be defining the route of the care, how that is delivered could be a variety of difference ways. How the care sector is set up makes this difficult – it makes service provision difficult and inflexible. Continuing Health Care funding has brought its own added complication which has had a dramatic impact on provision. Alternatively based services need to be funded. The process of how people enter into residential care is often externally driven or by a hospital admission.
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.	How many Residential Care providers employ Occupational Therapists and/or Physio Therapists? This type of service facility within the Residential Care setting should be a part of the established staff base. Without these services, residential care homes are not meeting the requirements of CSSIW. Residential care homes do not have the skills to manage dementia. Local

	authorities do not have the skills to manage delivery of dementia services in residential care settings - therefore NICE guidance is urgently required.
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.	The quality of service provision is often reliant upon the registered manager of the home. A person is safe when receiving a residential care service so when there are limited numbers of communities' staff, they do not prioritise people in residential care for a variety of different services.
The effectiveness of the regulation and inspection arrangements for residential care, including the scope for increased scrutiny of service providers' financial viability.	This is a tick-box process and does not pick up on social activities and/or social inclusion.
New and emerging models of care provision.	It is cheapest to "warehouse" people in a residential care home. We have to be careful not to be financially driven to "warehouse" people. How the financial assessment is undertaken can impact on setting up/commissioning new models of care. It would help all local authorities in Wales if the Welsh Government were to take on responsibility as to how much local authorities pay. This has been set up in Scotland whereby the Scottish Government have taken over the control of this process. We are funding venture capitalists and entrepreneur's lifestyles.
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.	Please refer to Pembrokeshire County Council's recent judicial review.

Health and Social Care Committee
HSC(4)-11-12 paper 10

Inquiry into residential care for older people – Conwy County Borough Council

RESIDENTIAL CARE FOR OLDER PEOPLE

The process and availability of other services.

Any older person who approaches Conwy SSD as regards admission into residential is subject to a comprehensive assessment of their care needs. Through the Unified Assessment process information is gathered regarding the person's care needs and the eligibility criteria is applied. We currently provide services for clients who have needs that are deemed to be critical or substantial.

This process applies whether the older person requires assistance to fund the placement or whether they are self-financing.

Any older person considering admission into residential care is encouraged to visit care homes before they make a decision. The Care Providers also routinely visit the older person in their own home prior to any admission. Older people are informed of the availability of advocacy services to support them through the process.

Admission into residential care however is seen very much as a last resort and every effort is made initially to support the older person to maintain their place in the community. To this end, we have a range of community –based services available in the County.

For example:

1. Conwy has developed 2 new Extra Care Housing schemes and has another 2 in the pipeline. (They have replaced Part 3 care facilities). The focus within the schemes is on maintaining and promoting independence.

2. Conwy's Provider Unit has modernised its Home Care Teams and changed the focus to providing a re-ablement service which is available free of charge for a period of up to 6 weeks for any older person with an identified re-ablement potential.

3 Traditional long term/maintenance care packages are still required and are commissioned via the Independent Sector.

4. The one remaining Part 3 care home has been developed as an EMI specialist facility providing specialist Day Care, Respite care and Residential care for older people with dementia and their carers.

5. TRIO day care has been commissioned via CHC monies, again for people with dementia and their carers – providing an alternative to the more traditional methods of care provision. This service is provided free of charge.

6. A specialist Dementia Team has also been developed internally to provide longer term care and support for older people with dementia in their own homes.

7. Two apartments in one of the ECH Schemes have been funded via CHC monies and are managed jointly with BCUHB to provide short term care and respite for older people (over 55 years) and their carers, the focus again being on re-ablement and maintaining independence.

8. Direct Payments are actively promoted with all older people in Conwy as an alternative to the more traditional methods of care provision.

9. Older People whenever possible are encouraged to access facilities that are already available within their communities i.e. luncheon clubs, social activities and other services provided via the 3rd Sector.

10. Conwy SSD and BCUHB through CHC monies have also recently developed a project relating to "End of Life" care to enable people to remain in their own homes.

The capacity of the sector to meet demand

The increased care needs of older people being admitted into residential care is recognised and consequently the potential increase in staffing levels and the skills required within the care facilities. This inevitably impacts on the rationale for calculating a fair price for care. Conwy has recently undertaken a massive piece of work in consultation with the Independent Sector in relation to reviewing the current fee levels and in adopting a rationale for a fair fee setting process within the County and across the region.

Conwy is actively involved in looking towards a more regional approach to commissioning and working in collaboration with neighbouring authorities. SSD Training is open and accessible to all our external care providers, and as part of the conditions of the contract the Providers are required to complete statistical figures informing us of what training staff have attended. Managing market activity is something we have not been able to progress in Conwy due to resourcing issues but this is recognised as a very important role.

Generally in Conwy there is a good provision of the full range of residential places including EMI residential. EMI Nursing Care places are however very scarce across the whole of North Wales.

The Quality of residential care services

User feedback forms are sent out to a random selection of our service users on a regular basis. These are not specifically in relation to residential care however and are more general. Every older person whom we fund in a residential care home is formally reviewed/reassessed 4-6 weeks post admission and then at least annually to determine whether the placement continues to meet their needs.

This review does not necessarily focus on the experience of the service user and their families and the focus is very much more on needs and whether they are being met. In Conwy we recognise that this is a current gap in our monitoring provision, and to this end we have recently developed a new role of Monitoring Officer. The role is currently being piloted for a 3 month period with a view to making this a permanent role.

Conwy in collaboration with neighbouring LA's and the BCUHB have developed Regional Contracts for Residential /Nursing care. It is envisaged that this contract will strengthen the

monitoring element and also ensure a more consistent approach to monitoring is applied across the region.

In terms of meeting the diverse need of older people the CSSIW process involved when a residential home wants to apply for a variance in their registration is seen as complex and cumbersome.

We have very recently in Conwy experienced and had involvement in the management of care home closures following the recent closure of a local EMI establishment. We have a policy and procedures in place and as a result of this recent incident we are currently in the process of reviewing how those are applied. We also have very positive experience of a well planned closure in terms of the modernisation of the Provider Unit and the recent closure of two large residential homes.

Regulation and Inspection arrangements

We are aware of the recent change in the inspection format to be more reliant on Self-Assessment and this is a cause for some concern as it is reliant on the honesty of the Provider in terms of the information provided. The current inspection regime doesn't involve themselves in the financial viability of care providers and we feel this should not be within their remit. This is an important feature of the work already undertaken and which is still on-going in relation to the work around setting the fees levels which is led by our Contracts Team.

New and emerging models of care

As discussed in the first part there are a great deal of new models of care already established in Conwy e.g. ECH, DP's. Other models of care such as Personalised Budgets are emerging but are not yet available in Conwy.

The balance of public and IS and alternative models

There is a distinct change in Conwy and an obvious increase towards more IS provision. The Independent Sector now provides most of the residential care in the County. We are also being much more creative in terms of our commissioning arrangements and we are working in partnership with 3rd sector and Health to commission o range of services for our clients. Adult Placement schemes are also available for older people as are Approved Landlord Schemes. The balance is certainly shifting on economic grounds as we are able to purchase cheaper than we can provide.

Other general issues discussed.

Concern regarding large conglomerates who own large numbers of care facilities in the county and the risk involved when there are concerns re their financial viability.

The under resourcing of the Health element for Nursing care and CHC – the Independent Sector acknowledge that the set rate applied by Health for FNC is not sufficient which means LA's are subsidising care costs for those residents. There have been representations from the LA's and the Independent Sector that the CHC rates are lower than LA/BCUHB rates (in some Authorities) which are currently being challenged.

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Health and Social Care Committee
HSC(4)-11-12 paper 1
Inquiry into residential care for older people - RCT County Borough Council

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

My Ref REG\SO ***Date*** 19th December 2011
Please ask for Mr Bob Gatis
Ext 5401

Health and Social Care Committee Call for Evidence on Residential Care for Older People

1.0 Introduction

1.1 Rhondda Cynon Taf County Borough Council (RCT) welcomes the opportunity to provide evidence to the Health and Social Care Committee on residential care for older people.

1.2 As a Council we have statutory responsibilities in assessment of individual need, including the need for residential care. We also have statutory responsibility for commissioning care home places and as a Council we operate 12 residential homes.

1.3 Beside the Council's 12 homes we also commission residential and nursing home places in 27 independent sector homes within Rhondda Cynon Taff with a total of just over 1500 beds available across the sector for Residential, NHS funded care and continuing health care placements.

1.4 We currently commission residential beds at £464 per week, and pay an enhancement for dementia care at £492 per week. In 2010/11 we supported the placement of 355 people in residential care and 230 people in Nursing care.

1.5 Whilst we understand the need for the Committee to limit the scope of its enquiry to deliver achievable outcomes, as will be seen throughout this paper it cannot and should not be divorced from the wider accommodation needs of older people in particular the NHS funded nursing care needs and continuing health care needs of older people. In Rhondda Cynon Taf only a quarter of the independent sector residential homes have only a residential registration.

1.6 Common themes running through the evidence are those of resources; financial, human and time and the value which we place on older people more generally all of

which because of their scarcity risk having a negative impact on older people's experience of care.

2.0 Process and alternatives to residential care

2.1 Where people need residential care the process is without doubt confusing for the individual and the impact of having to make a major life decision, often in a short period of time cannot be underestimated. For someone who is generally in poor health, finding it difficult to come to terms with the prospect of moving, often from a hospital environment and not their home, with a variable degree of cognitive impairment, and relying on family and friends to obtain information is extremely difficult and anxiety promoting. Add to this the complexity of needing to understand the financial implications of such a move and it can easily become overwhelming.

2.2 Evidence shows that where a move to residential care home or a closure of a home is well planned and the individual is properly informed and engaged the outcomes are good. The difficulty particularly for the NHS is that the pressure to discharge people is so great that the process for individuals and families can feel rushed and chaotic and thus the potential positive benefits of residential care are not fully realised.

2.3 RCT's draft commissioning strategy identifies that as a Council we are committed to helping people retain their independence and to remain at home rather than in a residential environment. Given the current economic position and outlook, there are perverse financial incentives for Council's to support people in residential care. Generally the cost to the public purse is significantly less for those in residential care opposed to those supported in the community, the current maximum charge of £50 per week for domiciliary services exacerbates this position.

2.4 As a Council we continue to develop and commission services that will support people in their own homes, reablement and intermediate care services with our LHB colleagues, aids and adaptations and importantly preventative services such as meals on wheels, community day centres and support to the third sector. These generally follow the model that John Bolton advocated in his paper for the Social Services Improvement Agency 'Better support at lower cost; improving efficiency and effectiveness in services for older people.'

2.5 Whilst these services will support people to remain at home longer, they are unlikely to ever completely remove the need for residential care as people will because of circumstances such as the risk to their independence being too great or through choice to reduce social isolation choose to go into residential care, as people tell us they remain in their own homes..

2.6 Only 16% of the people that the Council support are in residential care 84% are supported in the community and there is a small but steady improvement in the balance of care. This provides evidence that the balance of provision is rightly centred on community based care the challenge is to increase the momentum away from residential care.

2.7 We have seen good outcomes for people within our intermediate care and reablement service with upward of 70% of people who complete a rehabilitative programme needing no immediate further support from Health or Social Care services. We are in the process of investment into this area and redesigning our

operating model so that their will be an increased focus on short term interventions such as re-ablement and equipment to support daily living that will help people to be independent for longer.

3.0 Capacity of the sector

3.1 Recruiting people to work in the care sector remains a challenge with relatively low pay for care staff, a shift pattern of working and challenging working conditions, yet within our homes we have good retention of staff and a highly committed workforce.

3.2 We have a number of programmes within RCT that seek to support the sector. The Social Care Workforce Development Partnership (SCWDP) provides good opportunities for training and development and responds to needs identified by the sector, it has encouraged NVQ2 Care by providing underpinning courses. Recently we have delivered an Alzheimer's Society programme for Managers to look at different models of support to people with dementia.

3.3 Likewise both the Independent Sector and Local Authority are looking to the work of Stirling and Bradford Universities relating to care for people with dementia to look to improve standards.

3.4 The RCT Social Care Workforce Development Partnership has been working successfully with Coleg Morgannwg to enable 16 –18 year olds to enter the World of Residential Care suitably qualified and "job ready" having completed a BTEC First Diploma in Health & Social Care. This is a one year full time (or 2 year part-time) course providing both theoretical and practical skills including undertaking work placements in Social Care settings. This initiative was a shortlisted finalist at the Welsh Social Care Accolades Awards Event this year."

3.5 We are making progress in changing the opportunities in the training and development and thinking of care staff and managers. However there are structural difficulties, the difficulty in recruitment of staff and in some areas staff retention mean that irrespective of the cost, managers are not able to release staff for training. We need to consider ways in which we can support staff with development opportunities in the workplace so that individual development is person centred and focussed on the individual needs of current residents.

3.6 The Council's draft commissioning strategy identifies that with an emphasis on keeping people at home the demand for residential care for frail elderly will remain static and therefore fall as a proportion of the number of older people aged 65+. We anticipate though an increase in demand for residential dementia beds of about 11% in line with population trends for people with dementia. To address this we pay an enhanced fee to the sector to encourage the development of dementia beds and have over the last three years increased the capacity of our own homes to manage dementia patients by 23 beds whilst decreasing the availability of general residential beds. The area of greater concern is for EMI nursing beds where demand is outstripping the provision and there is no incentive for the sector to develop capacity and even less for the provision of continuing health care placements.

3.7 There is a risk that the way in which services are commissioned across Health and Social care will continue to distort the market. The issues identified above have meant that the relative costs between residential and nursing care are having an undue influence on the cost of residential care, with Local Authorities meeting within

their fee structures elements, particularly staffing, that might be considered as nursing costs. There is a need for closer working with the NHS on the commissioning of residential services for older people.

4.0 Quality of Care

4.1 The quality of residential care is influenced by a wide range of factors, but a critical one that we have identified in our commissioning of services is the leadership of the home, in the majority of instances where we have concerns as a commissioner the competency of the manager and their relationship with owners or more regional managers is an issue. We seek to support managers through SCWDP and through the commissioning process meet with managers but this is a voluntary arrangement and time pressures often mean that managers are not able to attend.

4.2 The Dignity in Care Programme is a welcome initiative to help us reflect on the way we see and treat older people, within our own twelve residential homes 80% of care staff have an NVQ2 qualification and all managers have the appropriate registration.

5.0 Regulation and Inspection

5.1 The oversight of residential homes through the Care management review function, contract monitoring, the Protection of Vulnerable adults (POVA) processes and then regulation is extensive yet the reporting of protection of vulnerable adults issues remains high. In 2010- 2011 92 cases of abuse were investigated in Rhondda Cynon Taf representing about 30% of all POVA referrals.

5.2 There continues to be a need for formal regulation and inspection and the move to more self assessment against standards and risk based inspection does have weaknesses as shown in a number of recent incidents in England.

5.3 CSSIW appear hampered by the legal framework and do not have strong sanctions short of deregistration to act quickly to effectively minimise risk to residents. As a Commissioner of services we find ourselves acting under our contractual powers to place embargos on new placements in homes when often it is regulatory standards that are not being met. This can lead to confusion for everybody concerned and there is a need to consider the appropriate balance between regulation and commissioning.

5.4 The viability of providers is not solely about financial models but about how the sector is resourced and the balance of funding between the individual and the public purse, the uncertainty of the future funding model from successive governments does not assist commissioners or providers in planning for the future. The Dilnott report makes recommendations and decisive decisions need to be made on this as a matter of urgency to provide some certainty for everybody going forward.

6.0 New and Emerging models of provision

6.1 There are different models of provision emerging, sheltered accommodation and extra care models, retirement villages, use of telecare technologies, rehabilitation services etc. Some of these offer genuine opportunities to support people for longer within their existing home and social networks. We have identified above how

rehabilitation services can support peoples independence and the opportunities that assistive technology can offer need to continue to be explored. As a Council we are appointing a dedicated officer to help us to develop this potential.

6.2 Older people have access to considerable sheltered accommodation within RCT but no dedicated Extra Care facility for older people. We believe there is a role for Extracare within the range of services needed to support older people to remain independent.

6.3 There is a need for a balance and range of provision to support older peoples accommodation needs. Increasingly Local Authorities have difficulty in raising capital for new projects and we will look to a range of providers such as those suggested in your terms of reference. We do not have a particular view at this time on which is the preferred future model other than to recognise the importance we place on public sector provision in providing benchmarks for the delivery of quality care.

7.0 Conclusion

7.1 In conclusion Rhondda Cynon Taf takes seriously its statutory duties toward older people, We have evidenced a commitment to this through increasing fees to the sector, sector wide training and development opportunities and starting to implement different models of care particularly for people with dementia.

7.2 There remain challenges and uncertainty in the sector, the balance of funding between the individual and public services need to be clearer and the relationships between the Council, NHS, the independent sector are at times tense as we all seek to balance competing resource pressures.

7.3 We are investing in different community based services but continue to recognise that there is a long term role for residential and nursing care for older people.

Bob Gatis
Service Director Community Care

Health and Social Care Committee

HSC(4)-11-12 paper 2

Inquiry into residential care for older people – Flintshire County Council

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

Social Services for Adults, working jointly with others, is responsible for safeguarding and improving the well being of vulnerable adults. We seek to promote independence and choice; support people to live full and active lives; support carers to be able to continue in their caring role, keeping service users and their carers at the centre of assessment and care planning. In order to achieve this we aim to plan strategically to anticipate developments and changes and make effective use of resources to meet demand.

The overall purpose of Older People's Services is to provide, in partnership, a range and choice of individual quality services for the older residents of Flintshire, and their carers. To do so in a timely and equitable manner, with the focus on maintaining and promoting independence, health & well-being and keeping people safe within their own homes and communities.

Flintshire is successful in its priority of supporting people to remain in the community and as a result has a relatively low number of residential care placements. Performance indicators within Social Services for Adults evidence this.

There is an increasingly strong reablement focus within Social Services for Adults. At the beginning of March '11, in Social Services for Adults in Flintshire, 23% of people received a reablement service from the reablement team and 78% of those people had no ongoing needs after exiting the service. Since March, staff in Social Services for Adults have been working to increase the numbers receiving a reablement approach and it is envisaged that by March '12, up to 80% of referrals will benefit from a reablement approach and about 60% should have no ongoing intervention after a reablement service. This includes providing a reablement service with people with low level dementia needs.

There are numerous other services within Flintshire that promote independence and support people to remain at home, including Telecare, OT aids and adaptations, Wellcheck, NEWCIS, Alzheimer's, Age Concern, Care & Repair, Extra Care, Neighbourhood Watch (including Owl alerts) and Red Cross.

Social Services for Adults has a strong Brokerage system which facilitates an efficient use of independent sector and local authority home care. Local authority home care focuses on reablement, end of life care and specialist / complex / dementia services.

Direct Payments are encouraged in order to maintain people's independence and has been highlighted as an area of further improvement within older people's services in Flintshire.

Flintshire works to a high threshold of domiciliary support packages, enabling people to remain at home for as long as possible.

Social work teams are professional, qualified staff who identify needs and provide support in the context of promoting independence and encouraging people to retain control over their own lives.

Where individuals are supported to access residential care, information is provided as to Approved Providers within and outside of Flintshire. Each individual is at the centre of all decisions making regarding planning for his or her care, and family, carers or advocates may be involved as appropriate. Advocacy services within Flintshire include generic advocacy via Age Concern, via IMHA and IMCA.

Any new Learning Disability (LD) service provision in Flintshire is channelled through the LD service panel, all options are considered and if it is deemed that residential service is the preferred option a referral is made to the North Wales LD Partnership which sources at least 3 options based on need, preference geography etc. There are very few new applications for residential services for people aged over 65 with learning disability in Flintshire.

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

Within local authority residential homes, managers follow staffing guidelines for each centre and are responsible for ensuring the homes are adequately staffed as the best interest of service users are paramount. All staff receive full induction and mandatory training including: manual handling, infection control, food hygiene, POVA, risk assessment, medication and first aid. These courses are scheduled for refreshers as appropriate. All staff are encouraged and supported to consider their own personal development and apply for courses that cover: equality & diversity, end of life care, dementia, reablement, violence and aggression, oral hygiene, tissue viability, falls,

communication, visual / deaf / stroke awareness, catheter care, lass & bereavement, continence management etc. Managers and duty managers within Local Authority residential homes are trained to high standards, including: Registered managers Award, NVQ Level 4 in Care, Dementia Care Mapping, and Competent Persons.

The Contract monitoring team requests workforce information from the independent sector on an annual basis and the information is used for training development. FCC is in receipt of funding from the Welsh Government to train the workforce (including independent sector / foster carers and personal assistants). FCC operates a voucher scheme where they provide training vouchers which can be used to purchase mandatory training from approved trainers. The independent sector can also access FCC training – 30% of places overall in the year are committed to the independent sector, although this is exceeded each year. Some courses are specifically commissioned by FCC for independent sector providers, this year has included 'learning to inspire' and adult protection. There is also access to qualification through the QCF centre in Flintshire.

FCC operates an Approved Provider list (APL) for residential and nursing homes. There are agreed rates for APL and non-APL placements. Capacity within the residential sector in Flintshire varies. There are vacant beds within the residential category; however demand outstrips availability in both EMH residential and EMH nursing beds in the county.

It is identified that within Flintshire homes, an increased focus on reablement and maintaining independence should be encouraged as well as enhancing skills and knowledge in relation to dementia as the numbers of people with the condition increases.

The residential market in terms of LD is mapped via the North Wales Partnership, there is currently in the region of 60 – 70 bed space voids across North Wales, the quality of these services will be monitored via a regional system currently being designed using outcome focused monitoring developed in Flintshire; this monitoring process is currently being piloted across North Wales.

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

There are a number of mechanisms for collecting the views of service users and carers within the Local Authority residential homes in Flintshire, including:

- Quality Standard Questionnaires

- Residents' meetings
- Individual reviews
- CSSIW Inspection reports
- Contract monitoring reports
- Rota visit reports

Local Authority homes work in a person centred way in order to identify and work to meet individuals' diversity of needs including language and health needs. There are some Welsh speaking staff working within the homes and where service users have other language needs (such as Chinese, polish, Italian and German) the homes work with families to establish communication mechanisms according to the person's needs.

Flintshire is currently working alongside Wrexham to develop an outcome focused monitoring tool which they will use in collaboration to monitor homes across Wrexham and Flintshire. The tool will consider aspects such as diversity of needs.

Social Services for Adults' contract monitoring team works closely alongside all Flintshire homes to support and improve standards of care. Where a home is in difficulty the team works closely with them and CSSIW to try and avoid closure. Where home closure is inevitable, there are agreed procedures for working together in the best interests of the residents in the most effective manner according to the 'Escalating Concerns and Home Closures Guidance' produced by the Welsh Assembly Government in 2009, promoting a standardised approach in dealing with concerns and closures.

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

The contract monitoring team in Flintshire works closely with the CSSIW however it is felt that partnership approach to raising standards of care could strengthen the process somewhat.

The effectiveness of services in terms of LD provision will be captured from a service level perspective by measuring outcomes; the financial viability aspect of these services is addressed via an open book accounting system used to manage the market on a regional basis. This is undertaken by a series of negotiations with a provider where viability and sustainability is addressed.

5. **New and emerging models of care provision.**

The three Local Authority homes have 6 short term assessment / reablement beds where people can be supported to regain

independence and return home, either following a period in hospital or in a bid to avoid hospital admission.

The future model of care in Flintshire will seek to improve outcomes for service users, encourage support within the community and develop new approaches to outcome focussed commissioning. Increasing use of Citizen Directed Support and Direct Payments will also drive innovation and creativity.

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

The independent sector provides 87% of the permanent residential and nursing care placements for older people in Flintshire in comparison with the local authority's 13%.

In line with our commissioning strategy for carers we commission a wide range of support for both Young and Adult Carers from the third sector, and work in partnership with BCUHB to commission the Home from Hospital Scheme from the Red Cross.

With the Transforming Social Services for Adults agenda in Flintshire, there is an intention to review the balance of internal and external providers and structure the market to focus upon reablement and independence. The continued drive to seek alternative means of providing Extra Care housing for older people is one such example where alternative funding mechanisms are being discussed.

For LD providers this is addressed via ongoing discussion with the market both formally and informally. It is also expected that the market balance, new models of provision and alternative funding. These will all form part of emerging commissioning strategies both locally and regionally.

Health and Social Care Committee

HSC(4)-11-12 paper 3

Inquiry into residential care for older people – Ceredigion County Council

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

Process by which older people enter Residential Care

The decision to move into residential care is not taken lightly by service users, their families, informal carers or Adult Services staff. It is a life changing experience and has been compared to bereavement by some: leaving behind your home, memories and independent living.

Every effort is made by Adult Services staff to provide services to enable service users to continue to live safely and as independently as possible in their own homes. When a referral is received whether it is a self referral, referral by family or friends or from a professional, a comprehensive assessment is made of needs. This assessment is informed by the service user, their family and friends (with their consent) and other professionals involved in their care (District Nurse, Psychiatric Nurse, GP, Hospital Staff, Occupational Therapist, and Physiotherapist, as appropriate). In discussion with the service user, family and friends a care plan is drawn up to meet the eligible needs identified and promote independence. This care plan is reviewed regularly and amended to meet changing needs.

This care plan can range from referrals to community services e.g. Age UK cleaning service, support by the Reablement Team for up to 6 weeks to regain previous independence, long term domiciliary care, or placement in a residential or nursing care home. Our priority aim is to provide the service in the service user's home for as long as possible with the appropriate management of risk and placement in a residential care home is only considered when this is no longer achievable.

It should be noted that those with the ability to fund their placement can enter private residential homes without recourse to Social Services.

Other than Joint Care or Emergency admissions, the Registered Manager or Assistant Manager will meet with service users who have been referred to their

Residential Home and carry out an assessment to ascertain if the Home can meet the needs of that service user.

Reablement Services are available by referral from a health or social care professional. It is a free service for up to 6 weeks and provides occupational therapy, physiotherapy and specialist support. It can arrange minor adaptations and equipment. This service is a targeted intervention aimed at regaining independence.

Meals at home can be provided free for up to 6 weeks post hospital discharge if they will not be required in the long term, subject to assessment and meeting eligibility criteria. They can also be provided on a long term basis, at a charge of £3.50 per day, subject to assessment and meeting the eligibility criteria. A regenerated meal option is also available.

Day Care is provided at various venues with some specialising in day care for people with dementia. This service is designed to address social isolation for those that attend and respite for their carers.

Respite care in a residential home can be arranged to support informal carers. This has the additional benefit to service users of the opportunity to have a break and socialise with their peers. This service is charged, subject to a financial assessment.

Short term care The Reablement Service's role includes reducing dependency on residential care. Anyone admitted to a short-term placement in residential care can be referred to the Reablement Service. Physiotherapists can work on improving transfers and mobility and Occupational Therapists can undertake home visits, provide advice about equipment and adaptations that may enable a return home and undertake a functional assessment to inform assessment of social care needs. Anyone admitted to a Joint Care Bed (joint health and social care funded beds in Local Authority residential homes) is thereby referred to Reablement to facilitate their return home. Where this is not possible within the maximum 28 day admission, the person is transferred to a short-term bed where the service will continue to work with them if it appears realistic they may be able to return home with this intervention. Anyone in long-term residential care can also be referred to the service if they wish to return home again.

Domiciliary Care is provided for those requiring assistance with personal care and activities of daily living, to enable them to continue living in the community, in accordance with their own lifestyle, with independence, dignity

and respect; Subject to assessment and meeting the eligibility criteria. This is subject to the fairer charging policy (maximum £50 per week).

Emergency Admissions

Home of Choice – The Hywel Dda Health Trust use the Home of Choice policy in instances where the patient's preferred place of care is not available. The patient is transferred to a Home of Choice bed temporarily until their preferred place of care becomes available. The policy is being reviewed at present, therefore cannot be included in this report.

Delayed Transfers of Care (DTOC) – A weekly meeting of Health and Social Care professionals is held to validate delayed discharges from hospitals in the catchment area. The group identifies any patients who may potentially have problems with discharge from hospital. All agencies work together to ensure that patients are discharged as soon as they are fit to a safe environment.

Bad weather contingency – During spells of bad weather 'place of safety' admissions are arranged for service users. This can be due to a failure in the electricity, heating or water supply, or if service users live in a remote area where care visits cannot be guaranteed.

Joint Care Beds – A health or social care professional can arrange for a service user to have a temporary care bed for a few days (up to a maximum of four weeks) to avoid being admitted to hospital or to avoid staying in hospital when reablement can be beneficial to recovery. The scheme ensures that service users receive the care and support that they need to help improve their ability to do things, so that they can return to their own homes as soon as possible.

5th December – The number of empty beds in our own Homes is 23. The number of empty beds in Ceredigion for residential and nursing care homes is 42, plus a further 20 will be available this week when the commissioning department receives the appropriate registration certificate for Hafan Y Waun.

Supporting People service is provided following assessment and referral for tenancy support. This can involve applying for sheltered accommodation or extra care housing, debt management, budgeting etc.

Sheltered accommodation – There are a number of sheltered accommodation facilities available across Ceredigion

Extra Care Housing – Not everyone wishes to move from their home the additional services and security of sheltered accommodation and in the

Cardigan scheme the in-house domiciliary care service provide an alternative to residential care for some.

Welfare Benefits Advisor - Ceredigion Social Services currently has a Welfare Benefits Advisor for those with a diagnosis of cancer or terminal illness and is in the process of appointing a Specialist Social Worker. These posts are funded by MacMillan.

There are various services in the community provided by charities:

Age UK: Cleaning, Befriending, Welfare Benefit Checks, Advocacy

Crossroads: Respite for carers by sitting service, Saturday Club, Dementia Day Centre

Beacon of Hope: Various services for those, or their carers, with terminal or life limiting illnesses

Several community transport schemes e.g. Country Cars, Cars 4 Carers, Volunteer drivers from Ceredigion Volunteer Bureau.

Ceredigion Volunteer Bureau is an invaluable source of information for Adult Care staff when creating innovative care plans to suit individual needs.

Adult Care Staff are also aware of general services provided by commercial providers in the home:

Home delivery of shopping, prescriptions, meals

Home visits by hairdressers, chiropodists, dentists, opticians, solicitors etc.

Taxis with wheelchair access.

The services available within the community both from Social Services, Private Providers and Charities that Adult Services staff will continue to provide innovative person centred support that will support people to continue to live safely and as independently as possible in their own homes for as long as possible. When this is no longer possible they will continue to support the service user in making their decision to move to residential/nursing care and ensure the move is managed as sensitively as possible.

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

Capacity to meet the demand for services

Staffing resources

The Authority employs 281 staff at 7 Residential Homes within the county.

There are no minimum staffing levels suggested by CSSIW but the department has set agreed safe levels as standard and the staffing levels are raised if there are high dependency; or end of life issues at a Home.

Sickness levels are above average for the authority in Social Services. The percentage of absenteeism for salaried staff within the Department is 4.98% whilst the percentage absenteeism for weekly paid staff is 10.3 %. The Department is implementing the sickness policy and undertaking absence review interviews in conjunction with Corporate Personnel for members of staff who are on long term sick and those who have reached trigger points. This is an ongoing process for the Department.

All staff absences are covered by other members of staff taking on extra shifts, relief care assistants covering or at times staff from other residential homes assist. When a resident requires extra care due to medical issues, GPs, District Nurses, the ART team, Beacon of Hope and Macmillan Nurses will assist the staff.

Skill mix

The majority of staff are qualified at NVQ level 2, 3 or 4 appropriate to their job role. Over 90% of staff in residential homes are qualified. 68% of residential homes staff speak Welsh

Access to training

On-site training is the preferred way of delivery of to enable staff to meet the regulations and registration requirements, in house training has been supplemented through Health Professionals coming in to the Homes and also Managers undertaking training through DVD training packs, thereby,

Managers can monitor and meet the 90 hours required for Care Council registration.

Change of use at Awel Deg Residential Home

Cabinet has agreed that Awel Deg Residential Home which is a general residential home with a dementia unit can go ahead with plans to become a Care Home specialising in dementia care.

3 The quality of residential care sevices 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

Under the regulations each Home has four Responsible Individual visits per year, this highlights any issues at the Homes. All Homes have gained certification under the ISO 9001:2008 Standards and have proved continuous improvement.

Residents meetings take place regularly and minutes are taken and action points are fed back.

Monthly care plan reviews with Residents enables them to voice any choices or concerns they may have

Questionnaires are given out to residents, next of kin and staff; there is a very high satisfaction score. CSSIW Inspectors also carry out questionnaire surveys with residents, next of kin and staff they also include other agencies such as GPs, District Nurses.

The Authority has a robust complaints procedure in place and all residents have leaflets and are assisted should they wish to make a complaint. All compliments are forwarded to higher management.

Since 1st January 2011 our Homes have received 4 complaints and 153 compliments.

Diversity

Comprehensive person centred service user plans are completed and all relevant information is available to staff.

The residential care Statement of Purpose includes a detailed philosophy of care – (attached)

Escalation of concerns

Escalating concerns arise when there are accumulating issues relating to the operation of, or quality of care provided in a registered care home. Meetings held under the escalating concerns protocol focus on the care provider and are separate to adult protection meetings.

In circumstances where a failure in the provision of care causes or may cause significant harm, this is adult abuse. Where abuse is suspected the policy and

procedures to protect vulnerable adults must take precedence. In many situations it may be in the interest of service users to use the escalating concerns procedure alongside the adult protection procedures.

4 New and emerging models of care provision

Cylch Caron Project, Tregaron

Proposed project for a new development, bringing health and social care partners together to provide 'extra care' housing. Bryntirion, Tregaron Hospital, Tregaron Surgery to amalgamate to provide hospital, nursing, residential care, day centre as well as 'extra care'. Other services are expected to be involved, for example, assistive technology, reablement, domiciliary care etc. The Cylch Caron area will cover an area within, approx. 7 – 10 miles radius of Tregaron.

The project is at the 'Outline Business Case' stage with the Welsh Assembly Government

OP Modernisation – See attached document

5 Effectiveness of the regulation and inspection arrangements for residential care, including the scope for increased scrutiny of care home closures

The Department is currently reviewing the inspection arrangements for all contracted services including residential care and is developing a monitoring framework that will provide a range of information that relates to the quality, value, viability and effectiveness of services in delivering outcomes for service users. Aspects of this framework include:

- Regular monitoring meetings with providers,
- Tracking and risk assessment of POVA referrals, complaints and concerns
- Annual reporting and onsite inspection/ reality checks on a thematic basis covering key areas identified
- Scrutiny of annual accounts
- Scrutiny of CSSIW and other reports to highlight issues and avoid duplication

In addition the department has introduced a care provider forum to share good practice, discuss issues and joint working.

6 The balance of public and independent sector provision, and alternative funding, management, and ownership models, such as those

offered by the cooperative, mutual sector and third sector and Registered Social Landlords.

The department has an understanding of the balance between private and public sector provision and is working with private sector providers to deliver quality services and sustainability through the Monitoring framework, Care provider forum and the fee setting exercise.

Currently in Ceredigion within the Private Sector there are 110 private residential beds (including up to 12 EMI Residential beds. Cartref Henllan) and 62 private EMI residential beds.

The Local Authority homes provide 184 residential care beds and 8 EMI residential beds.

As a rural dispersed area the county does not have experience of a greater range of ownership models but would be keen to consider alternative options. In the last year the council has worked in partnership with an RSL to deliver the counties first extracare model of housing in Cardigan which has 48 units. The authority is keen to explore future developments along this theme and is currently working on an extracare proposal in Tregaron that will include health resources. This model will provide community hospital beds, residential care places, extracare housing units and a community health centre and is seen as an innovative approach to providing services to a rural community.

With regard to financial viability the department is working closely with the care provider forum to understand and fairly agree older persons residential care costs in response to the Welsh Assembly Government Statutory Guidance on commissioning: *Social Services Fulfilled Lives, Supportive Communities Commissioning Framework Guidance and Good Practice.*

This document requires that

'*Commissioners should have a rationale to explain their approach to fee setting. The primary concern is that services operate safely and effectively to promote the welfare of service users and carer and meet regulatory requirements."*

Through the care provider forum the Social Services Department agreed to work with a sample of providers to gain a better understanding of Ceredigion based provider costs in setting the fees for 2011/12. In future years this process will be expanded to work with a greater range of providers. This will ensure that viability and quality of provision will be considered concurrently and will assist in delivering stability within the sector.

In instances where viability has become an issue for some services the department has invoked the Welsh Government escalating concerns procedures which provides a template for managing issues relating to the operation of, or quality of care provided in registered care settings. It also provides guidance for managing home closure. This format provides a multi disciplinary approach to ensure that concerns are addressed in a collaborative way that aims to support providers and avoid closure where possible but also provides guidance on managing closures in a planned way. These processes help to ensure continuity of care for all service users involved.

Parry Davies

Director of Social Services

Ceredigion County Council

13th December 2011

Enclosures

The documents listed below can be accessed on the Committee's website through the link below – RC 19 Ceredigion County Council.

http://www.senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=2222

A – OP Integration Document

B – Eligibility/Commissioning Panels

C – Ceredigion Assistive Technology at Home leaflet and charges

D – Training Diary November 2011 – August 2011

E – Social Services Direct Services Training Strategy

F – Contract for Independent sector– Domiciliary Care/Residential/Nursing Homes

G – JCB Statement of Purpose

H – Extra Care document

I – Statement of Purpose for Residential Homes.

J – Meals at Home leaflet

K – Statement of Purpose for Ceredigion Reablement Service

L – Delayed Transfers of Care Working Group Terms of Reference

Research Service
Y Gwasanaeth Ymchwil

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Health and Social Care Committee

HSC(4)-11-12 paper 11

Inquiry into stillbirths in Wales – Suggested Terms of Reference

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Introduction

The Committee agreed at its meeting on 2 February 2012 to launch an inquiry into stillbirths in Wales that focuses specifically on poor fetal growth and reduced fetal movements.

The purpose of this paper is to present the Committee with some background information, suggested terms of reference and suggested witnesses.

This briefing has been produced by the Research Service for use by the Health and Social Care Committee.

For further information contact Victoria Paris in the Research Service
Telephone ext. 8678
Email: victoria.paris@wales.gov.uk

Research Service

Background information

Terminology

Depending on when a foetus/baby is lost:

- Miscarriage (or spontaneous abortion) – during first six months of pregnancy;
- Stillbirth – born after 24 or more weeks but did not, at any time, breathe or show signs of life;
- Early neonatal – the baby dies within seven days of birth;
- Perinatal – includes stillbirths and early neonatal deaths;
- Neonatal – baby dies within 28 days of birth;
- Post-neonatal – baby dies between 28 days and 1 year.

Prevalence of stillbirth

There are around 4,000 stillbirths every year in the UK and one in every 200 births ends in a stillbirth. Eleven babies are stillborn every day in the UK, making stillbirth 10 times more common than cot death.[1]

Causes of stillbirth

The cause of many stillbirths is unexplainable and although the below list of conditions and factors can contribute to the baby's death they are not necessarily the direct cause. These include:

- The mother haemorrhaging either before or during labour;
- The baby has a congenital abnormality;
- Problems with the placenta: which can separate from the womb before the baby is born (placental abruption), or the placenta can fail to provide the baby with enough oxygen and nutrients which means that the baby does not grow properly (intra-uterine growth restriction (IUGR) is associated with one-third of all stillbirths);
- Problem with the umbilical cord: which can slip down through the entrance of the womb before the baby is born (known as cord prolapse and it occurs in about 1 in 200 births), or it can wrap around the baby's neck;
- Pre-eclampsia: a condition that can cause high blood pressure in the mother; mild pre-eclampsia can affect up to 10 per cent of first time pregnancies and more severe pre-eclampsia can affect 1-2 per cent of pregnancies;
- An infection in the mother that also affects the baby.[2]

[1] Sands, Research, ***Statistics*** [accessed 12 March 2012]
[2] NHS Choices, ***Stillbirth - Causes*** [accessed 12 March 2012]

There are also factors which increase the risk of stillbirth. Stillbirths occur more frequently among the following women:

- twin or multiple pregnancies;
- older mothers, i.e. over the age of 35;
- teenage mothers;
- women with specific medical conditions, especially diabetes, hypertension and thrombophilia;
- women with a past obstetric history of complications (liver disorder);
- women who smoke;
- women who are obese;
- women living in areas of social deprivation;
- women from ethnic minority groups.[3]

Prevention

There are many things which can be done during pregnancy to help improve the mother's health and reduce the risk of a stillbirth. These include stopping smoking (if applicable), avoid drinking alcohol, eating healthily, attending antenatal appointments etc. It is important that mother and baby are monitored during pregnancy so that pregnancies that are at high-risk of complications and stillbirth are identified and the appropriate care is given. However, the majority of unexplained stillbirths occur in pregnancies where no risk has been identified, this could be due to lack of knowledge about certain pregnancies or inadequate monitoring of the mother and baby.

Sands (the Stillbirth and Neonatal Death Society) believe more effective methods of monitoring pregnancies need to be developed. These include:

- Fetal growth – there is an association between babies who do not reach their growth potential and stillbirth. However, currently only 30 per cent of growth restricted babies are identified during antenatal appointments.
- Fetal movements – babies that are stillborn often change their movement patterns before death.[4]

Small for gestational age (SGA) foetus

Small for gestational age (SGA) foetus is a term used to describe a foetus which has not achieved an estimated weight threshold by a specific gestational age. SGA foetuses are at a greater risk of stillbirth. There are a variety of methods used to detect SGA foetuses

[3] Sands, Research, ***Causes and risk factors for stillbirth*** [accessed 12 March 2012]
[4] Sands, Research, ***Identifying pregnancies at risk of stillbirth*** [accessed 12 March 2012]

including abdominal palpation, measurement of symphyseal fundal height[5] and ultrasound. However it is important that these tests are not done in isolation and that other factors such as foetus growth trend and maternal characteristics are taken into account.

Reduced fetal movements (RFM)

Fetal movements are first perceived between 18 and 20 weeks of gestation and rapidly conform to an observable pattern. Fetal movements consist of any discrete kick, flutter, swish or roll. A significant reduction or sudden alteration in fetal movement could be seen as an important clinical sign and reduced or absent fetal movements could be a warning sign of impending death.

Guidance

In November 2002 the Royal College of Obstetricians and Gynaecologists (RCOG) produced a guideline and made recommendations on the ***Investigation and management of small for gestational age fetuses***.

In March 2008 the National Institute for Clinical Excellence (NICE) published clinical guidance on ***Antenatal care: routine care for the healthy pregnant woman*** which provides information on best practice for baseline clinical and antenatal care of all pregnancies and provides evidence-based information on appropriate treatment in specific circumstances.

In February 2011 the RCOG published new advice for clinicians on the management of women with ***Reduced Fetal Movements*** (RFM) during pregnancy, providing recommendations as to how women presenting RFM in both the community and hospital settings should be managed.

In September 2011 the Welsh Government published ***A Strategic Vision for Maternity Services in Wales*** which sets out the Government's expectations of NHS Wales in delivering safe, sustainable and high quality maternity services.

[5] A measurement is taken from the pubic bone (symphysis pubis) to the top of the uterus or fundus, giving a fundal height in centimetres. The measurement in centimetres should closely match the foetus gestational age in weeks, within 1 or 2 cm, e.g., a pregnant woman's uterus at 22 weeks should measure 20 to 24 cm.

Suggested Terms of Reference

The purpose of this session is:

- To examine the awareness, implementation and effectiveness of current guidance and recommendations across the different sectors with regard to stillbirth prevention, especially in relation to poor fetal growth and reduced fetal movements, and where potential improvements can be made.

Witnesses

It is suggested that the Committee takes evidence from the following:

- Public sector bodies e.g. Welsh NHS Confederation; Public Health Wales;
- Professional bodies e.g. Royal College of Nursing Wales, Royal College of Obstetricians and Gynaecologists; Royal College of Midwives; British Medical Association;
- Third sector organisations e.g. Sands; National Childbirth Trust; International Stillbirth Alliance.

Members might also wish to seek written evidence from interested parties in addition to the general call for evidence.

At the end of the meeting a private session will be scheduled for Members to consider the evidence received and agree what action to take.

Agenda Item 6

Health and Social Care Committee

Meeting Venue:	**Committee Room 3 - Senedd**
Meeting date:	**Thursday, 8 March 2012**
Meeting time:	**09:30 - 11:50**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_700001_08_03_2012&t=0&l=en

Concise Minutes:

Assembly Members:	**Mark Drakeford (Chair)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Darren Millar** **Lindsay Whittle** **Kirsty Williams**
Witnesses:	**Keith Bowen, Contact a Family Wales** **Joseph Carter, Wales Neurological Alliance** **Jeff Collins, British Red Cross** **Philippa Ford, Chartered Society of Physiotherapy** **Ruth Jones, Chartered Society of Physiotherapy** **Sandra Morgan, College of Occupational Therapists Wales** **Matt O'Grady, Scope Cymru** **Ellis Peters, College of Occupational Therapists Wales** **Nicola Wannell, British Red Cross**
Committee Staff:	**Llinos Dafydd (Clerk)** **Catherine Hunt (Deputy Clerk)** **Victoria Paris (Researcher)**

1. Introductions, apologies and substitutions

1.1 Apologies were received from Elin Jones and Lynne Neagle. There were no substitutions.

2. One-day inquiry on wheelchair services in Wales - Oral evidence

2a. The user's perspective

2.1 The witnesses responded to questions from members of the public on wheelchair services in Wales.

2b. The practitioner's perspective

2.2 The witnesses responded to questions from members of the public on wheelchair services in Wales.

2c. The charitable provider's perspective

2.3 The witnesses responded to questions from members of the public on wheelchair services in Wales.

3. One-day inquiry into venous thrombo-embolism – Consideration of terms of reference

3.1 The Committee agreed the terms of reference for its one-day inquiry into venous thrombo-embolism prevention.

4. Papers to note

4.1 The Committee noted the paper on patients' rights to cross-border healthcare in the EU.

4.2 The Committee noted the paper on the modernising professional qualifications directive.

4.3 The Committee noted the paper on the Draft Food Hygiene (Wales) Bill.

4.4 The Committee agreed to undertake informal external visits during the Committee's allocated meeting slots on 28 March and the morning of 26 April as part of the inquiry into residential care for older people.

4.5 The Committee agreed to extend the time of its meeting on the afternoon of 26 April to accommodate oral evidence sessions.

TRANSCRIPT

View the meeting transcript.

Health and Social Care Committee

Meeting Venue:	**Committee Room 3 – Senedd**
Meeting date:	**Thursday, 8 March 2012**
Meeting time:	**13:30 – 15:20**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_400005_08_03_2012&t=0&l=en

Concise Minutes:

Assembly Members:	**Mark Drakeford (Chair)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Darren Millar** **Lindsay Whittle** **Kirsty Williams**
Witnesses:	**Dr Maire Doran, Posture and Mobility Service, Betsi Cadwaladr University Health Board** **Gareth Evans, Betsi Cadwaladr University Health Boa** **Helen Hortop, Artificial Limb and Appliances Service, Cardiff and Vale University Health Board** **Fiona Jenkins, Cardiff and Vale University Health Board** **Andrew Lloyd, Artificial Limb and Appliances Service, Cardiff and Vale University Health Board** **Daniel Phillips, All Wales Posture and Mobility Service Partnership Board** **Dr Cerilan Rogers, Welsh Health Specialised Services Committee**
Committee Staff:	**Llinos Dafydd (Clerk)** **Catherine Hunt (Deputy Clerk)** **Victoria Paris (Researcher)**

1. Introductions, apologies and substitutions

1.1 Apologies were received from Elin Jones and Lynne Neagle. There were no substitutions.

2. One-day inquiry on wheelchair services in Wales - Oral evidence

2a. The NHS provider's perspective

2.1 The witnesses responded to questions from members of the Committee on wheelchair services in Wales.

2.2 Dr Doran agreed to provide the following additional information as requested by the Committee:

- A definition of “repair” (as referred to during the discussion on the approved repairer’s success in achieving its targets);
- Her thoughts on the trajectory for the development of services in North Wales over the next 12 months;
- A copy of the allocation letter received from the Welsh Government following the rejection of the North Wales service’s bid for resources to support adult services.

2.3 Mr Lloyd agreed to provide a draft copy of the new referral process being developed by the South Wales Artificial Limb and Appliance Service.

2.4 The witnesses agreed to provide their thoughts on the 3 key areas where further progress is needed in wheelchair services in Wales.

2b. The planner's perspective

2.5 The witnesses responded to questions from members of the Committee on wheelchair services in Wales.

2.6 Dr Rogers undertook to provide further information clarifying timescales in relation to planning and service specification delivery from the perspective of the WHSSC / the All Wales Posture and Mobility Service Partnership Board.

3. Motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for item 4

3.1 The Committee agreed the motion to resolve to exclude the public from the meeting for item 4.

4. One-day inquiry on wheelchair services in Wales - Consideration of evidence

4.1 The Committee considered the evidence it had received on wheelchair service in Wales and agreed that a paper setting out the key themes from the evidence should be prepared for its consideration.

TRANSCRIPT
View the meeting transcript.

Health and Social Care Committee

HSC(4)-11-12 paper 12

Residential care for the elderly in EU member states

Following on from the Health and Social Care Committee meeting on 25 January 2012, further information on:

- **Further information on whether there is a definition of 'not for profit' provision or whether this varies between countries**
- **Further details of provision in Holland and Germany in terms of ownership models, the ways in which provision is made (e.g. at local/federal state level).**
- **Clarification on whether 'England' actually refers to England only in figure 1 of the paper for the meeting on 25 January 2012**

This paper provides further information on the relative contributions of the public, private and non-profit sectors to the provision of residential care for older people in EU member states. It also provides more detailed information on arrangements in Holland and Germany. Colleagues and their contacts in the Assembly's Brussels office have contributed to the paper and may provide further information which will be forwarded to Members.

The mix of providers of residential care across EU member states

There is considerable variation in the composition of the residential care sector across EU member states, as shown in table 1 which is taken from a paper by Allen et al (2011)[1]. The same paper makes the following observations:

> While in central European countries the role of private non-profit organisations as providers of care has a long tradition, private for-profit organisations are on the rise everywhere. This development includes the Nordic countries where, however, a majority of services are still publicly provided.
>
> […]
>
> It should be underlined that the emergence of private for-profit providers has been a phenomenon of the past 20 years only.
>
> (p18)

Not-for-profit residential care provision across EU member states

There are a number of different providers of not-for-profit residential care for the elderly across EU member states; the most common types of providers across 11 member states are summarised below in Table 1.

[1] Allen, K. et al, *Governance and finance of long-term care across Europe*, page 19, September 2011 [accessed 1 March 2012]

Table 1: Long-term care provider mix and level of provision, by country

Country	*Public*	*Non-profit sector*	*Private*	*Expectations of Informal carers to provide care*
Slovakia	High	Medium (Church)	Medium	High
Finland	High	Low (NGOs)	Medium	Medium
Switzerland	Medium	Medium	High	Medium
Austria	Medium	High (charities and other non-profit organisations – traditionally affiliated to churches and political parties)	Medium	Medium
Netherlands	Low	High (non-profit organisations, mutuals)	Low	Medium
France	Low	High/medium (non-profit organisations)	Medium	High
Sweden	High	Medium (trusts, co-operatives)	Medium	Low
Greece	Low	Low (NGOs, church)	High (migrant care workers) Low (residential care)	High
UK (England)	Low	Medium (social enterprise, voluntary, non-profit organisations)	High	Medium
Denmark	High	Low	Medium	Low
Germany	Low (in-patient and out-patient services)	High (in-patient) and medium (out-patient services)	Medium (in-patient services) High (out-patient services)	Medium

Source: Allen, K. et al, Governance and finance of long-term care across Europe, page 19, September 2011 [accessed 16 February 2012]

It can be seen from Table 1 that there are a number of different care providers in the not-for-profit sector across EU member states, including mutuals, co-operatives, charities and non-governmental organisations. However, the authors add the caveat that countries may define different stakeholders in different ways.

Provision of residential care for older people in Holland

There has been a mandatory system of long-term care insurance in the Netherlands since 1968. Everyone who lives in the Netherlands is insured under the Exceptional Medical Expenses Act (the AWBZ in Dutch), which covers all chronic care especially concerning large expenses where insurance on a private market would not be feasible. This includes residential care for the elderly.[2] Institutional care plays a major role in Holland by comparison with other European countries; in 2007 6.8% of the elderly population were in

[2] Mot, E., The Dutch system of long-term care, page 9, March 2010 [accessed 16 February 2012]

institutional care, although Dutch government policy in recent years has been to promote care at home[3].

The Dutch government determines budgets for long-term care over a four year period, and the Department of Health, Welfare and Sport controls financial expenditure on long-term care. The government also bears overall responsibility for the provision of long-term care system, however many responsibilities lie with individual care providers.

Institutional long-term care for the elderly is regulated by the Dutch Healthcare Authority, which makes rules and supervises compliance in these areas. In regulated areas such as residential care for the elderly, **currently only non-profit providers are allowed to operate**.[4] These rules include determination of the maximum tariffs that can be charged for these services, and also outlines what care must be offered by providers.

In Holland for most types of care covered by long-term care insurance patients can choose whether to buy their own care through personal budgets, or for their regional care office to organise and purchase care for them. However, **for residential care, including that for the elderly, the regional care office organises and purchases care for the patient, although the patient can specify which provider delivers their care**.[5]

Regional care offices are affiliated to one of the health insurers in an area. In 2009 there were 32 regional care offices in the Netherlands operated by 12 health care insurers.[6] The remaining health insurers in a region voluntarily give a mandate to this health insurer to carry out the organisation and purchase of care for the people that they insure. Most health insurers in the Netherlands are not-for-profit organisations. This health insurer runs a regional care office as a separate legal entity, and it has to meet certain conditions set out by the Dutch Government to be able to perform the role.

The budgets that the regional care offices have to operate within are calculated by the Dutch Healthcare Authority. Regional care offices are expected to keep within this budget, although if they experience difficulties in doing so they can try to solve this through redistribution of money between providers within a region, or between regions.

There has been criticism within Holland that this model of operation provides few incentives for efficiency, and the previous Dutch Government planned to make changes by 2012 to improve this, however they were delayed by the fall of the cabinet in 2010.[7]

Not-for-profit providers of residential care for older people in Holland

Mutuals and other non-profit organisations provide residential care for the elderly in the Netherlands.[8] These organisations require a permit to operate from the Dutch Ministry of Health, Welfare and Sport. Historically, such providers were allied to religious (Catholic or

[3] Mot, E., The Dutch system of long-term care, page 11, March 2010 [accessed 7 March 2012]
[4] Ibid, page 17
[5] Ibid. page 10
[6] Van der Veen, R. et al, Governance and financing of long-term care: Dutch National Report, March 2010 [accessed 16 February 2012]
[7] Mot, E., The Dutch system of long-term care, page 23, March 2010 [accessed 16 February 2012]
[8] Allen, K. et al, Governance and finance of long-term care across Europe, page 19, September 2011 [accessed 16 February 2012]

Protestant) or political organisations. However such ties have weakened as providers have become more professionalised and business-like. In some cases providers have merged to meet the requirements of the Dutch welfare state, with which they are intimately connected[9].

Provision of residential care for the elderly in Germany

There has been a mandatory and universal system of long-term care insurance in Germany since 1994. Members of the public health insurance system become members of the public long term care insurance (LTCI) scheme, and those who have private health insurance are obliged to buy private, mandatory LTCI providing the same benefit packages. The LTCI does not cover all expenses incurred by long-term caregiving. All insurance benefits are capped. The aim is to provide insurance covering basic long-term care needs, but not for board and lodging.

The German long-term care system is based on three institutional levels of governance and financing and is embedded in the fundamental state principles of federalism and subsidiarity. The Federal Government and the Governments of the States (Länder) have a legislative function while the local authorities are responsible primarily for executive implementation. Local authorities in particular have a duty to avoid disparities in support and to ensure a regular supply of long-term care in every region of Germany. This takes into account the contribution of all local, state-owned, and non-profit-making care institutions and private enterprises.[10] **In Germany in 2010, 55 per cent of residential care services were provided by not-for-profit organisations, 40 per cent were provided by profit-making private sector organisations, and 5 per cent were provided by the public sector.[11]**

The Länder have regulation and inspection functions and responsibility for financing investments in premises for long-term care services. Regulations vary greatly among the 16 provinces. Some Länder directly finance investments in nursing homes, while others only provide subsidies for dependent older persons living in nursing homes who currently rely or who would otherwise rely upon social assistance.[12] While capital investments are considered the responsibility of the Länder, regulations on the amount of subsidies for such costs differ greatly among the Länder. In practice, these costs have often been passed on to residents, at an estimated average monthly amount of €347 in 2007.

In Germany the organisation of health care and therefore long-term care is based on self-administration. Each health insurance fund has an affiliated care insurance fund. In 2009 seven types of statutory long-term care insurance funds existed, with around 200 single funds. They are self-administrating corporations under public law, meaning that

[9] Dekker, P. in Evers, A and Laville, J. *The Third sector in Europe* (2004) chapter 7 The Netherlands: private initiatives and hybrids, pp148 & 160.
[10] Schulz, E., The long-term care system for the elderly in Germany, page 3, March 2010 [accessed 17 February 2012]
[11] Allen, K. et al, Governance and finance of long-term care across Europe, page 18, September 2011 [accessed 16 February 2012]
[12] Schulz, E., The long-term care system for the elderly in Germany, page 3, March 2010 [accessed 17 February 2012]

they carry out legally mandated tasks under government supervision but are organisationally and financially independent. In addition, around 40 private LTCI funds exist.[13] The insurance funds negotiate services to be provided and prices with the care provider, and funds operate collectively to negotiate rates with each individual care facility.

Not-for-profit providers of residential care for older people in Germany

According to Bode and Evers[14] voluntary welfare associations in Germany provide approximately two thirds of homes for older and disabled people and about 40 per cent of all hospitals (p108). The sector comprises various local agencies and non-profit enterprises organised into six nationally organised welfare federations:

> two are linked to the churches, one to the Social Democratic Party, one is not aligned and the remaining two are aligned with the Red Cross and a small Jewish agency
>
> (pp107-8)

Welfare associations are therefore culturally and politically embedded in German society although this is said to have weakened in recent years, in part due to the increasing professionalisation of welfare associations. Nevertheless, charitable donations and voluntary work make significant contributions to their work[15].

There has been a significant growth in private sector provision in recent years: private facilities increased by 50 per cent between 1999 and 2009. In the same period non-profit facilities increased by 27 % whereas the number of public facilities decreased by 17 per cent[16].

Do the graph and tables in the previous paper refer to England or the UK?

The tables and graphs in the paper discussed at the Committee's meeting on 25 January 2012 refer to long-term care for the elderly in England rather than the United Kingdom. They are based on research into long-term care for the elderly in England conducted as part of the *Assessing Needs of Care in European Nations*[17] (ANCIEN) research project, which has looked at different long-term care systems for the elderly in 21 EU member states. **The contribution for the UK is from the Personal Social Services Research Unit at the London School of Economics and looks at the English care system;[18] therefore the tables and graphs refer to England**.

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[13] Schulz, E., The long-term care system for the elderly in Germany, page 6, March 2010 [accessed 17 February 2012]
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