

## Health and Social Care Committee

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Meeting Venue:  
**Committee Room 1 – Senedd**

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Meeting date:  
**23 February 2012**

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Meeting time:  
**09:15**

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Cynulliad  
Cenedlaethol  
Cymru

National  
Assembly for  
Wales



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### Agenda

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#### **1. Introductions, apologies and substitutions**

#### **2. Inquiry into Residential Care for Older People – Evidence from the Older People's Commissioner for Wales (09.15 – 10.05)** (Pages 1 – 14)

Ruth Marks, Older People's Commissioner for Wales  
Sarah Stone, Deputy Older People's Commissioner for Wales  
Alun Thomas, Head of Review, Examination and Policy

HSC(4)–06–12 paper 1

#### **3. Inquiry into Residential Care for Older People – Evidence from the My Home Life programme (10.05 – 10.55)** (Pages 15 – 38)

John Moore, My Home Life Cymru  
HSC(4)–06–12 paper 2  
Tom Owen, Director, My Home Life  
HSC(4)–06–12 paper 3

Break 10.55 – 11.05

#### **4. Inquiry into Residential Care for Older People – Evidence from the Social Care Institute for Excellence and the Institute of Public Care (11.05 – 11.55)** (Pages 39 – 51)

Prof John Bolton, Institute of Public Care, Oxford Brookes University  
HSC(4)–06–12 paper 4

Julie Jones, Chief Executive, Social Care Institute for Excellence  
HSC(4)-06-12 paper 5

**5. Papers to note** (Pages 52 – 56)

Minutes of the meetings held on 2 & 8 February

HSC(4)-04-12 minutes

HSC(4)-05-12 minutes

**5a. Forward Work Programme – Spring 2012** (Pages 57 – 59)

HSC(4)-05-12 paper 6

**5b. Inquiry into the contribution of community pharmacy to health services in Wales – Additional information from the Minister for Health and Social Services**  
(Page 60)

HSC(4)-02-12 paper 7

**6. Motion under Standing Order 17.42(vi) to resolve to exclude the public from the meeting for item 7 (11.55)**

**7. Public health implications of inadequate public toilet facilities – Consideration of summary of evidence (11.55 – 12.10)**

## **Health and Social Care Committee**

### **HSC(4)-06-12 paper 1**

## **Inquiry into residential care for older people – Evidence from the Older People’s Commissioner for Wales**

### **Introduction**

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

- (a) to promote awareness of the interests of older people in Wales and of the need to safeguard those interests;
- (b) to promote the provision of opportunities for, and the elimination of discrimination against, older people in Wales;
- (c) to encourage best practice in the treatment of older people in Wales;
- (d) to keep under review the adequacy and effectiveness of law affecting older people in Wales.<sup>[1]</sup>

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

### **United Nations Principles**

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

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

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

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

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

### **Entry into care**

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

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

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

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

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

A Scoping Study of Advocacy with Older People for OPCW by Andrew Dunning.

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

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

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

### **Capacity and staffing**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Financial security of care home providers**

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

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

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

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

### **Choice and Diversity of provision**

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



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

### **Paying for Care**

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

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

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

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

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

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

The Review covers the advocacy arrangements of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Link to Advocacy Counts 3 – Report and Executive Summary

[http://www.olderpeoplewales.com/en/news/news/11-03-01/Advocacy\\_Counts\\_3.aspx](http://www.olderpeoplewales.com/en/news/news/11-03-01/Advocacy_Counts_3.aspx)

Link to scoping study of advocacy arrangements in Wales and Executive Summary

[http://www.olderpeoplewales.com/en/news/news/11-08-11/A\\_Scoping\\_Study\\_of\\_Advocacy\\_with\\_Older\\_People\\_in\\_Wales.aspx](http://www.olderpeoplewales.com/en/news/news/11-08-11/A_Scoping_Study_of_Advocacy_with_Older_People_in_Wales.aspx)

## Appendix 1



**Older People's Commissioner for Wales**  
**Comisiynydd Pobl Hŷn Cymru**

Cambrian Buildings  
Mount Stuart Square  
Cardiff  
CF10 5FL

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

31 January 2011

Dear Steve,

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

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

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

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

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

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

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

Yours sincerely,

Ruth Marks

Older People's Commissioner for Wales



Llywodraeth Cynulliad Cymru  
Welsh Assembly Government

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Dyddiad/ Date: 13 April 2011

Dear Ruth

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

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

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

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

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

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

Yours sincerely



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



## Health and Social Care Committee

### HSC(4)-06-12 paper 2

## Inquiry into the Residential Care of Older People in Wales – Evidence from My Home Life Cymru

### Introduction

The My Home Life programme has been active in Wales since the latter part of 2008 and is funded through the Voluntary Sector Small Grant facilitated by Health Challenge Wales. The aim of My Home Life Cymru is to promote the improvement of the quality of life of those who are living, dying, visiting and working in care homes for older people. My Home Life also aims to celebrate existing good practice and promote care homes as a positive option for older people. Since the end of 2008 until this time, the programme has been working intensely with 38 homes from across the country. These homes are representative of the whole care home sector in Wales in that they cover:

- 18 local authority areas
- 31 independent sector homes (including small and national providers)
- 3 local authority homes
- 4 third sector homes
- Homes in both rural, urban and semi-urban areas
- Welsh language homes
- Faith homes
- Homes of varying capacity, ranging from 7 to 100 residents
- Homes that cover a variety of services:
  - Residential care
  - Nursing care
  - Respite care
  - Day care
  - Older people mental health (EMI) care

### Events, training and resources

Over the last 3 years, My Home Life Cymru has hosted a number of events around the country to raise awareness of the programme and develop the My Home Life Network of homes:

- Annual conferences every year beginning in 2009. This year's event takes place at the Metropole Hotel in Llandrindod Wells on 27 March. These conferences have had an average attendance of 113.
- A National Seminar was held in Cardiff in November 2010, which included presentations by many of the leading names in the UK care home sector including David Sheard and Prof. Mike Nolan. This event attracted an attendance of 185.

- 8 regional seminars we held between March 2010 and May 2011. These were held across the country and had a combined attendance of 175.
- 7 manager's days have been held since April 2009. These events were targeted at the 38 homes that form the core of the My Home Life Cymru network.
- In response to identifying some development needs among these homes, several training events have taken place throughout the country:
  - Ensuring human rights in care homes
  - A whole home approach to activities in care homes
  - Open your heart to see me – supporting people with a dementia
  - Getting to know you – life story and reminiscence work in care homes
  - Low Impact Functional Training (LIFT)

The development of resources has been an integral part of our work in Wales. These resources include:

- Our quarterly newsletter which is sent to all care homes for older people in Wales
- [www.agecymru.org.uk/mhlc](http://www.agecymru.org.uk/mhlc) These pages contain up to date news and links to documents, presentations and other valuable information.
- 'Getting to know you' booklet. This was published to accompany the training delivered in 2011.
- 'Open your heart to see me' booklet. This was published to accompany the training delivered in 2011.
- My Home Life Cymru booklet. This introductory booklet helps care home staff, residents and their families to understand the My Home Life approach.
- My Home Life Cymru Good Practice Guides. This is a suite of 8 guides that investigate the My Home Life themes:
  - Maintaining identity
  - Creating community
  - Sharing decision making
  - Managing transitions
  - Improving health and healthcare
  - Supporting good end of life
  - Keeping workforce fit for purpose
  - Promoting a positive culture
- My Home Life Cymru is developing a 'Care Home Checklist', which will support individuals and their families to plan ahead for the move into a home.
- 'Developing Volunteering in Care Homes'. This publication will aid care homes, volunteers and volunteer organisations to work in partnership to encourage the support and development of volunteers in care homes.

We will continue to develop resources in partnership with care homes to address the changing needs of the care home sector in Wales.

All of the activity mentioned above has helped to establish My Home Life Cymru in Wales and the care home sector has increased its engagement with us accordingly. Up to this point, the number of homes that have shown an active interest in the programme is 225. This number is almost 30% of the sector in Wales. These homes have attended events, volunteered to be part of the programme and also actively responded to our resources.

### **Listening to providers, residents and relatives**

My work with the core 38 homes has included visiting all of them and spending time with staff members (managers, owners and all levels of staff), residents and their relatives/ visitors to the home. This has given me an insight into the unique perspective that each of these groups hold in relation to their role in the life of the care home.

No matter the size of the home and the number of residents, each home is delivering very similar services. They are also supporting a client group which presents them with the same needs. The relatives and visitors group also looks the same throughout the country. The staff teams face the same issues and the management teams are subject to the same legislation, regulation and local authority scrutiny. However, this does not mean that every home is the same. On the contrary, each home has its own approach and personality. The approach is heavily influenced by the background of the senior staff team e.g. nursing/ health background, social work and client group experience. I have encountered many managers and staff who come from a learning disability service background. In these cases the individual has brought an enhanced understanding of 'value' to their services. The development of learning disability services over the past 25 years has produced many professionals who work from a strong values base and they have taken this with them into their present roles.

The care home sector in Wales is mostly made up of small independent sector providers. Their position is one that is valuable and yet precarious. As a small organisation, they do not benefit from the support that comes from being part of a larger organisation e.g. national provider, local authority. This regularly means that the manager does not receive the support they need. This comes in the areas of service development, adjusting to new legislation, regulatory requirements etc. Also, the area of peer support is key to a homes development. Managers that are linked by a common employer usually have a support network to aid them in their roles. However, managers without this circle of support tend to struggle. This imposed isolation

has been addressed in many areas by the setup of provider forums and other networks. However, these groups often get caught up with the ongoing issue of fees and never really address the main areas of support that are key to a manager's role.

My Home Life Cymru is endeavouring to develop its network on a regional and national basis. The original 38 homes are at the core of this development and we will look to engage with more homes in the coming months and years.

There are still a good number of homes in Wales that are comparatively small in comparison to the rest of the market. The larger the home, the more financially viable it will be, but the smaller homes and also the homes that are split into small units can offer an environment that is more conducive to developing a 'homely' atmosphere. When a home/ unit is small and there is good continuity in the staffing arrangements, the atmosphere lends itself to the development of good relationships in the home. The residents have less staff to get to know and visa versa. The relational aspect of care home life can not be underestimated. When staff members, residents and their families work together, this can lead to the development of relationships that help in the delivery of services that really are moulded around the resident.

The Senses Framework (Nolan et al 2006), looks at the issue of quality of life of those living in, working in and visiting long term care settings for older people. The framework identifies the Six Senses that inform quality of life for all. Each has a sense of:

- Belonging
- Security
- Continuity
- Purpose
- Significance
- Achievement

My Home Life Cymru is encouraging homes to develop the relationship centered approach that encourages staff to look at how they do what they do. They can then adjust their approach accordingly to concentrate on quality of life issues, not the care tasks that they have to perform. Regularly, staff within the home see their role as carrying out a list of tasks that are mostly related to care. Supporting residents to get the best out of their lives means more than just being supported with their personal care.

The approach of the home to the service it provides is crucial in developing and maintaining a good quality of life for all associated with the home. During my visits to the 38 homes throughout the country, I met many residents and their families who have experienced

living in and visiting more than one home. This can be due to a variety of reasons:

- A resident moving from a residential home to a nursing home
- A resident whose changing needs are best met in another environment
- Residents may also move to be closer to family members
- A resident may move due to a home closure

All of those I met mentioned that the home they were living in/ visiting now was their best experience of a care home. Their previous experiences ranged from ok to poor to very poor. As all care homes for older people deliver very similar services, I asked, 'what made the difference in their experience of a good home?' The answers from all of the individuals I spoke to are listed below:

- 'It's the people'
- 'It's the approach of the home and those who work there'
- 'It's how they do what they do'
- 'It's how they are with you'
- 'It ain't what you do, it's the way that you do it'

The journey that families and new residents have to take as newcomers to the care homes arena can be a difficult, arduous and painful one. The pathway that leads to moving into a care home can have its start in several places:

- A patient in hospital is not able to return home due to the extent of their needs and the availability of support
- An older person can no longer care for themselves at home
- A family may reach a crisis in that they can no longer provide the support needed to care for their loved one
- An older person and/ or their family may be advised by a professional e.g. GP; social worker, that a care home is the best option in meeting their/ their loved ones needs

This period of transition into the home is fraught with difficulty. When going through a social worker, the older person or their family may be given a list of homes to choose from. They are not usually given any information about the home other than what it might cost them. Regularly, they are given a very limited period of time to come to a decision as to which home they are going to choose. In this situation, how does an older person or their family know how to identify the best home for them? How do they tell a good home from a not so good one? Why do they need to be limited to just a few homes to choose from? This transition period is emotionally traumatic for the family and resident-to-be. Regularly, they are told, 'I'm afraid you/ your loved one will have to move into a home'. The way in which the message is

conveyed reconfirms the negative view that most of the population has toward care homes.

My Home Life Cymru is developing a resource for those who are beginning their care home experience, to aid them at that difficult time.

### **Staffing**

Many staff in care homes are doing a wonderful job in supporting residents who may present them with challenges. Older age, frailty, physical and mental illness and disability, emotional anguish and frustration (from both residents and their families) and regularly coping with the death of residents who they have come to know well, makes the job of working in a care home an extremely difficult one. In addition to this, the majority of staff receive remuneration that is not far above the minimum wage. Staff training can also not hit the standards that it should, with many only receiving the minimum of training in core areas e.g. health and safety, manual handling, first aid etc.

### **Conclusion**

The care home sector in Wales is a varied one with providers facing multiple challenges. However, there may be other areas in which they face challenges such as rurality, isolation from support and negativity from the community.

The political drivers that have seen an emphasis being put on older people staying in their own homes for longer, has meant that new residents coming into a home, are doing so with more complex and multiple needs. This is putting increased pressure on providers and their staff teams.

The public's view of care homes has generally been a negative one and yet their expectation of homes continues to increase. The new generations now moving in to care homes are bringing with them lifestyles and expectations that will seriously challenge services. The increase in dementia among the older and younger populations will require an enlarged and expert workforce who have adequate and continued support.

My Home Life Cymru as part of Age Cymru aims to work with the sector in identifying the needs and areas of development of homes, and subsequently support them to support those who are living, dying, visiting and working in care homes for older people in Wales.

**John Moore, My Home Life Cymru Programme Manager  
7 February 2012**

## Health and Social Care Committee

HSC(4)-06-12 paper 3

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

#### Introduction

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

#### Summary of main points

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

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

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

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

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<sup>1</sup> National Care Forum, English Community Care Association, Registered Nursing Home Association, National Care Association in England; Care Forum Wales; Scottish Care; and Independent Health and Care Providers in Northern Ireland.

- Care home managers should be required as a condition of their registration to demonstrate that they receive some form of professional supervision and engage in continuing professional development.
- Care home managers should be required to be members of an independent institute or body which represents their profession. This representative organisation should offer professional help and guidance (particularly in whistle-blowing) and work in their interests rather than those of the wider provider organisations who have many associations of their own. The organisation should represent care home managers, promote excellence in care home practice and help to shape health and social care policies
- Local commissioners should be required to contract only with those care homes where the Registered Manager is a member of the professional body, creating a lever for ensuring that managers are receiving professional supervision to deliver quality.

***Research Message 2: Decrease the amount of paperwork***

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

- In line with the Government's desire to reduce red tape, an audit of paperwork required of care homes should be prioritised. MHL can help identify the sources of paperwork that care homes experience.
- Agencies should be required to work in partnership with care homes to co-create paperwork that is realistic, helpful and proportionate.
- A review of the respective roles of agencies responsible for fire, health & safety, commissioning, safeguarding regulation should be undertaken to reduce the burden placed upon care homes.

***Research Message 3: Acknowledge the changing role of care homes***

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



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

- Care home managers should be valued as professional experts in balancing rights and risks, and, through their national body, should develop evidence based briefings that offer clarity to the sector on key principles of good practice.
- Commissioners should recognise that care homes are seen as part of the portfolio of services in their local area, and actively support their professionalization through access to appropriate education and support.
- Government should recognise that a national star rating system delivered by the regulator has its advantages both to local authorities and to care homes themselves so long as there are sufficient resources for inspectors to properly assess safety and quality and an acknowledgement of the challenging work that care homes do often in isolation.
- Multi-agency and multi-professional national leadership should be promoted to support development and dissemination of good healthcare practice in care homes, supported by clinical guidance and quality standards. Messages need to be targeted in the right format
- Local authorities and PCTs should seek to create mechanisms to support care homes to deliver quality rather than simply reacting to problems and issues. There is some evidence that care home support teams can make a real difference both to care homes and in reducing unnecessary hospital admissions.
- Acknowledgement should be made in policy that given the multiple co-existing conditions that our care home residents experience, the needs of care home residents need to be seen as a priority group given the same range of access to health and support services to those younger and living in the community
- Policy should aim to outlaw the discrimination of access to services that is offered according to the likelihood of an individual resident being able to return home. Equal access should be provided to those who may still benefit from support even if it will not mean a return to living independently
- Access to counselling services should be prioritised to our oldest citizens given the huge emotional upheaval and multiple losses experienced near the end of life

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

- Local NHS planners/commissioners should ensure that clear and specific service specifications are agreed with their local NHS providers. These need to link with quality standards based on patient experience and appropriate clinical outcomes.
- Care home residents should be at the centre of decisions about their care. An integrated social and clinical approach should support anticipatory care planning, encompassing preferred place of care and end of life plans.
- Service specification for providing healthcare support to care homes should guarantee a holistic review for any individual within a set period from their move into a care home, leading to healthcare plans with clear goals. This will guide medication reviews and modifications, and clinical interventions both in and “out of hours”.
- Healthcare services to support the achievement of these goals should be integrated. This should combine enhanced primary medical and nursing care with dedicated input from departments of old age medicine, mental health services, and other specialisms such as palliative care and rehabilitation medicine according to local needs.
- The UK nations’ health departments should clarify NHS obligations for NHS care to care home residents.
- Statutory regulators should include in their scope of scrutiny, the provision of NHS support to care homes and the achievement of quality standards.

***Research message 4: Encourage community engagement in care homes***

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

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

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

- Government may wish consider replicating the Long-term Care Ombudsman program developed in Massachusetts which makes use of volunteer advocates to work within care homes (see paper1)
- A programme of better public understanding of the rules and workings of the long-term care system, what we can expect would help connect the public with the very challenging world of care homes.
- Funding should become available to support piloting work in care homes to offer more flexible range of services, in reaching out to those most vulnerable in the community, to offering a place for members of the public to learn more about ageing, frailty, dementia.

***Research message 5: Open up new debate on funding.***

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

- Policy should require funding levels for individual placements to be scrutinised in terms of the extent to which it is based upon ageist assumptions. Equity across client groups in terms of funding must be provided.
- Policy should begin with a frank discussion about the extent to which as a society we do want to properly invest in supporting our frailest citizens with dignity and quality care rather than pay lip service to it.

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

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

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

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

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

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

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

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

**Factual Information**

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

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

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

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

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

### ***Personalisation themes (all staff)***

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

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

### ***Navigation (all staff)***

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

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

### ***Transformation (managers)***

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

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

### ***What is Relationship-Centred Care?***

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

### ***Where does the Senses' Framework fit?***

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

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

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

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

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

### ***What does the house represent?***

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

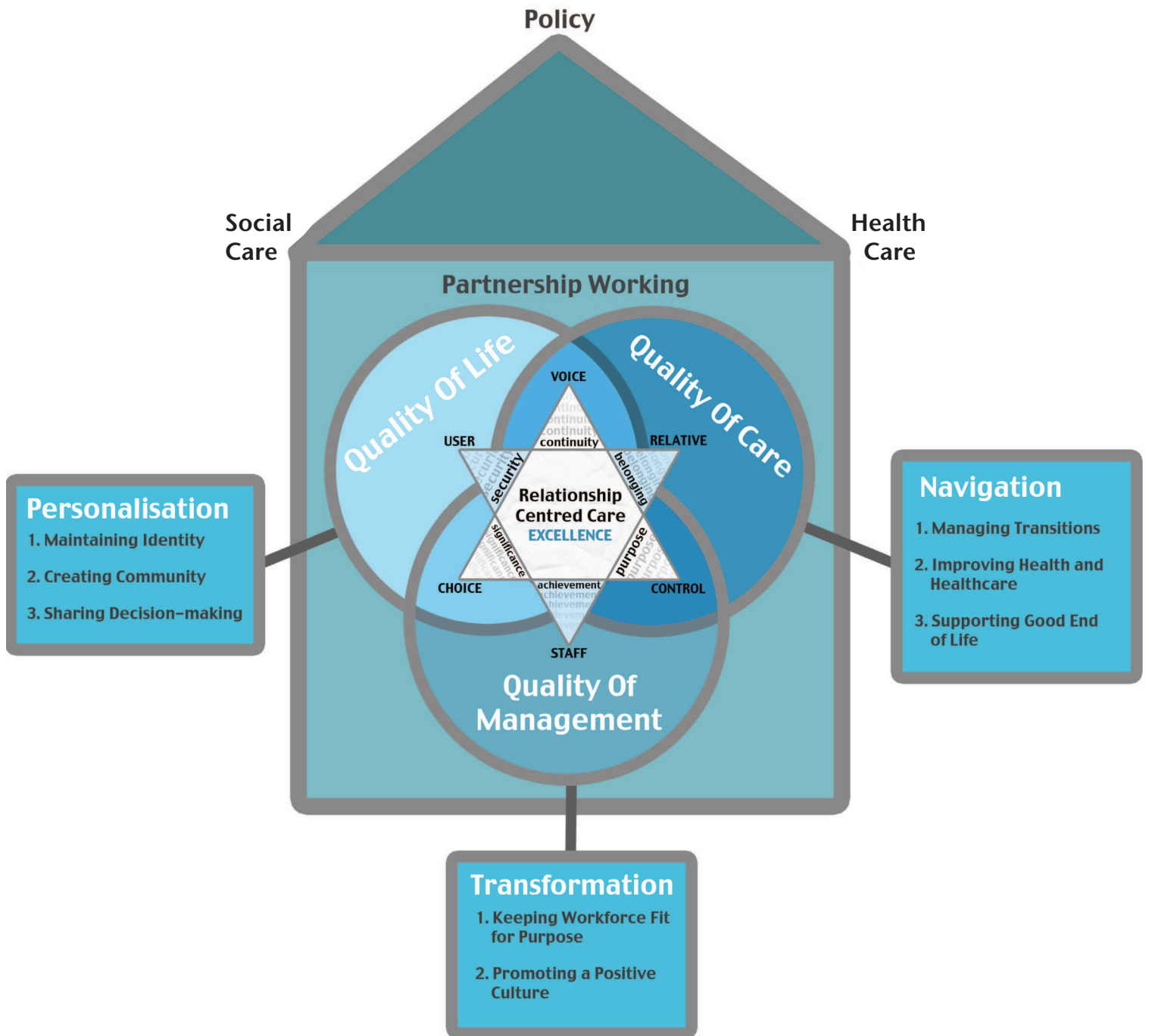
### **Recommendations**

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

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

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







# **The Senses Framework:**

**Improving Care For Older People  
Through a Relationship-Centred Approach**

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## Factors Creating a Sense of Security

### For older people

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

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

### For staff

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

### For family carers

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

### For students

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

## Factors Creating a Sense of Belonging

### For older people

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

### For staff

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

*NB More important with big group companies*

### For family carers

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

### For students

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

## **Factors Creating a Sense of Continuity**

### **For older people**

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

### **For staff**

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

### **For family carers**

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

### **For students**

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

## **Factors Creating a Sense of Purpose**

### **For older people**

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

### **For staff**

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

### **For family carers**

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

### **For students**

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

## **Factors Creating a Sense of Achievement**

### **For older people**

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

### **For staff**

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

### **For family carers**

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

### **For students**

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

## **Factors Creating a Sense of Significance**

### **For older people**

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

### **For staff**

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

### **For family carers**

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

### **For students**

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

# Agenda Item 4

## **Health and Social Care Committee**

**HSC(4)-06-12 paper 4**

**Inquiry into residential care for older people - Evidence from Professor John Bolton**

Please find attached link to the Better Support at Lower Cost report by Professor John Bolton, which has been published on the SSIA website.

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

Committee Service





## **Inquiry into Residential Care for Older People in Wales**

### **Submission from the Social Care Institute for Excellence**

#### **Introduction**

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

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

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

4. A summary of our main points:

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

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

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

Admissions in crisis situations

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

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

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

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

#### Self-funded and council-sponsored residents

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

#### Home care and prevention

9. There have been some increases in home care provision and extra care housing. Community services need to be tailored and targeted if they are to reduce or delay the need for residential or hospital admission. Intermediate care has been used successfully as an alternative for those who don't need to be in hospital, as well as a service for those leaving hospital. Both intermediate care and reablement services require close joint working and resourcing by the NHS as well as social care if they are to be effective and timely in restoring people to maximum independence.

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

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<sup>7</sup> Reablement – a cost effective route to better outcomes. SCIE. (April 2011).

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

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

### Sector capacity

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

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

### Staffing, skills mix and training

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

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

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

#### Resources

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

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

#### Personalisation

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

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

and we have defined clearly what makes for “excellent” care.<sup>3,4</sup>

### Dignity

19. SCIE has carried out extensive work into the area of „Dignity in Care“. Our Dignity in Care guide is the main repository for information and resources on this subject:

<http://www.scie.org.uk/publications/guides/guide15/index.asp>

The evidence, recommendations, resources and practice examples relating to each of these areas are available on the Dignity in Care guide. It was agreed the main themes relating to the subject of dignity in care are as follows:

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

The SCIE Dignity in Care research overview explores both what protects dignity and what threatens it. See

<http://www.scie.org.uk/publications/guides/guide15/selectedresearch/index.asp>

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

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

<http://www.scie.org.uk/topic/people/olderpeople/dignity/minimisingrestraint>

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

- Dignity
- Experience of care and support

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<sup>3</sup> The Dignity Factors. Social Care Institute for Excellence. Guide 15.

<sup>4</sup> A definition of excellence for regulated adult social care services in England. SCIE. (October 2010).

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

### Integrated working

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

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

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

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<sup>5</sup> Supporting black and minority ethnic older people's mental wellbeing. SCIE report 38. (December 2010).

### Care home closures

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

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

### Regulation

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

### Inspection

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

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



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

#### Financial viability

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

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

#### Traditional residential care

31. A good deal of residential and nursing home care is still very traditional in its approach. It is focused on the physical and some medical care needs of residents, and is geared to the group rather than the individual. It doesn't take very much account of the psychological or spiritual needs of older people. Practical and recreational activities are integral parts of the residential experience in some homes, and tailored to people's individual interests and backgrounds. In others, the role of activities coordinator is tacked onto the job of one or two staff, and becomes operational only on the odd occasions when they have time to spare.

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

#### New approaches.

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

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

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

35. Outcomes-based support and care Another area of development is the adoption of outcomes-based approaches in residential and nursing homes. Until recently, both social workers and care providers might have found it alien to talk about the outcomes residential care was striving to achieve. People went there when they couldn't cope at home or elsewhere, and the home's job was to provide them with care and attention, usually until they died. Work is now under way to formulate outcomes statements and frameworks applicable to residents in care homes.

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

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

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

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

#### Integrated care models

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

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

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

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

<http://www.scie.org.uk/topic/careneeds/dementia>

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

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

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

**SCIE**  
**February 2012**

## Health and Social Care Committee

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Meeting Venue: **Committee Room 3 – Senedd**

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Meeting date: **Thursday, 2 February 2012**

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Meeting time: **09:30 – 11:30**

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Cynulliad  
Cenedlaethol  
Cymru

National  
Assembly for  
Wales



This meeting can be viewed on Senedd TV at:

[http://www.senedd.tv/archiveplayer.jsf?v=en\\_400000\\_02\\_02\\_2012&t=0&l=en](http://www.senedd.tv/archiveplayer.jsf?v=en_400000_02_02_2012&t=0&l=en)

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### Concise Minutes:

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#### Assembly Members:

**Mark Drakeford (Chair)**  
**Mick Antoniw**  
**Rebecca Evans**  
**Vaughan Gething**  
**William Graham**  
**Elin Jones**  
**Darren Millar**  
**Lynne Neagle**  
**Lindsay Whittle**  
**Kirsty Williams**

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#### Witnesses:

**David Worthington, Welsh Government**  
**Chris Brereton, Welsh Government**  
**Chris Humphreys, Welsh Government**  
**Rob Wilkins, Food Standards Agency**

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#### Committee Staff:

**Sarah Beasley (Clerk)**  
**Llinos Dafydd (Clerk)**  
**Meriel Singleton (Clerk)**  
**Stephen Boyce (Researcher)**

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### 1. Introductions, apologies and substitutions

1.1 There were no apologies or substitutions.

1.2 In accordance with Standing Order 17.49, the Chair welcomed Joyce Watson AM to the meeting, who was attending item 2 on the agenda on behalf of the Enterprise and Business Committee.

## **2. Draft Food Hygiene Rating (Wales) Bill – Technical Briefing from Welsh Government officials**

2.1 The officials responded to questions from members of the Committee on the Draft Food Hygiene Ratings (Wales) Bill.

2.2 The officials agreed to provide the following additional information, as requested by the Committee:

- figures for the number of ‘hits’ on the FSA’s food hygiene ratings webpages;
- a breakdown of the number of hospitals in Wales in each food hygiene rating category;
- the number of hospitals in Wales currently displaying their food hygiene rating; and
- an accurate figure of the number of food businesses in Wales that have been rated since October 2010, broken down to Local Authority level, and a breakdown of the number of businesses in each rating.

2.3 The Committee agreed to hold a similar session once the consultation on the Draft Bill has closed.

## **3. Inquiry into Residential Care for Older People – Discussion on public engagement work**

3.1 The Committee discussed its external engagement for the inquiry into residential care for older people.

3.2 The Committee agreed the proposed engagement activity proposed and agreed to appoint Age Cymru and Crossroads Care to work collaboratively to facilitate this work.

## **4. Forward Work Programme – Discussion on 'one-off' evidence sessions**

4.1 The Committee discussed topics for four ‘one-off’ evidence sessions for the spring and summer terms.

4.2 The Committee agreed to pursue one-day inquiries in relation to the following topics:

- Wheelchair waiting times in Wales: follow-up work on the recommendations made by the Third Assembly’s Health, Wellbeing and Local Government Committee’s Report on Wheelchair Services in Wales;
- Venous thrombo-embolism prevention; and
- Reduced fetal movements and still births in Wales.

4.3 The Committee agreed:

- to re-visit the topic for their fourth session at a later date, deciding between co-responder services, access to medicines or orthopaedic waiting times;
- to await the report of the House of Commons Welsh Affairs Committee’s on-going inquiry into post-traumatic stress disorder before undertaking work on this topic; and

- that the subject of health inequalities would require longer than one day for consideration and, as such, should be placed on the list of possible future inquiry topics.

## **5. Papers to note**

5.1 The Committee noted the minutes of the meeting held on 19 January.

## **6. Motion under Standing Order 17.42(ix) to resolve to exclude the public from the meeting for item 7 and on 8 February**

6.1 The Committee agreed the motion to resolve to exclude the public from the meeting for item 7.

6.2 The Committee also agreed to exclude the public from the meeting on 8 February, with the exception of taking oral evidence from Jean-Pierre Girard on the residential care inquiry, which will take place in public.

## **7. Inquiry into the contribution of community pharmacy to health services in Wales – Consideration of key issues**

7.1 The Committee considered the key issues on its inquiry into the contribution of community pharmacy to health services in Wales and agreed to return to consider its key conclusions and recommendations at its next meeting on 8 February.

### **TRANSCRIPT**

View the [meeting transcript](#).

# Health and Social Care Committee

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Meeting Venue: **Committee Room 1 – Senedd**

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Meeting date: **Wednesday, 8 February 2012**

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Meeting time: **09:15 – 10:30**

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This meeting can be viewed on Senedd TV at:

[http://www.senedd.tv/archiveplayer.jsf?v=en\\_200000\\_08\\_02\\_2012&t=0&l=en](http://www.senedd.tv/archiveplayer.jsf?v=en_200000_08_02_2012&t=0&l=en)

Cynulliad  
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## Concise Minutes:

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**William Graham**  
**Elin Jones**  
**Darren Millar**  
**Lynne Neagle**  
**Lindsay Whittle**

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### Witnesses:

**Jean-Pierre Girard, specialist in the development and management of co-operative, non-profit and mutual organisations (nominated by the Wales Progressive Co-operators)**

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### Committee Staff:

**Llinos Dafydd (Clerk)**  
**Catherine Hunt (Deputy Clerk)**  
**Stephen Boyce (Researcher)**

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## **1. Introductions, apologies and substitutions**

1.1 Apologies were received from Kirsty Williams. There were no substitutions.

## **2. Inquiry into the contribution of community pharmacy to health services in Wales – Consideration of key issues**

2.1 The Committee considered the key issues on its inquiry into the contribution of community pharmacy to health services in Wales.



### **3. Forward Work Programme – Further discussion on 'one-off' evidence sessions**

3.1 The Committee discussed its forward work programme. The Committee agreed, following its informal seminar on access to medicines, to scope a short inquiry into access to treatments in Wales.

3.2 The Committee agreed not to schedule business for a fourth 'one-off' evidence session. This is to allow sufficient flexibility in the forward work programme for the Committee to react to issues that may arise.

3.3 The Committee agreed to re-visit its work programme ahead of the Easter recess.

### **4. Inquiry into Residential Care for Older People – Discussion with Jean-Pierre Girard in relation to written evidence commissioned by Wales Progressive Co-operators**

4.1 Jean-Pierre Girard responded to questions from members of the Committee on the co-operative model for home care for older people in Quebec.

### **5. Papers to note**

5.1 The Committee noted the minutes of the meeting held on 25 January.

#### **TRANSCRIPT**

View the [meeting transcript](#).

# Agenda Item 5a

## Health and Social Care Committee

HSC(4)-06-12 paper 6

Health and Social Care Committee Forward Work Programme:  
February - April 2012

**To:** Health and Social Care Committee

**From:** Committee Service

**Meeting date:** 23 February

### Purpose

1. This paper invites Members to note the Health & Social Care Committee timetable attached at Annex A.

### Background

2. Attached at Annex A is a copy of the Health & Social Care Committee's timetable until the Easter 2012 recess.

3. It is published as an aid to Assembly Members and any members of the public who may wish to be aware of the Committee's forward work programme. A document of this kind will be published by the Committee at regular intervals.

4. The timetable is subject to change and may be amended at the Committee's discretion as and when relevant business arises.

### Recommendation

5. The Committee is invited to note the work programme at Annex A.

## ANNEX A

**THURSDAY 23 FEBRUARY 2012**

***Morning only***

**Inquiry into residential care for older people**

Scene-setting session

- Older People's Commissioner for Wales
- My Home Life / My Home Life Cymru programme
- Social Care Institute for Excellence / Institute of Public Care, Oxford Brookes University

**Public health implications of inadequate public toilet facilities**

Consideration of summary of evidence (private)

**WEDNESDAY 29 FEBRUARY 2012**

***Morning only***

**Inquiry into residential care for older people**

Oral evidence session – Service users, their families and carers

**THURSDAY 8 MARCH 2012**

***Morning and afternoon***

**Wheelchair services in Wales:** follow-up work on the recommendations made by the Third Assembly's Health, Wellbeing and Local Government Committee's Report on Wheelchair Services in Wales

**WEDNESDAY 14 MARCH 2012**

***Morning only***

**Inquiry into residential care for older people**

Meeting with reference group – to be confirmed

**THURSDAY 22 MARCH 2012**

***Morning and afternoon***

**Inquiry into residential care for older people**

Oral evidence session – Public Sector Providers

**WEDNESDAY 28 MARCH 2012**

***Morning only***

**Inquiry into residential care for older people**

Oral evidence session – Private Sector Users

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**Monday 2 April – Sunday 22 April 2012: Easter recess**

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Time will also be allocated to consider the Committee's report on the inquiry into the contribution of community health services to health services in Wales.

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



Llywodraeth Cymru  
Welsh Government

Mark Drakeford AM  
Chair of the Health and Social  
Care Committee  
[HSCCommittee@wales.gsi.gov.uk](mailto:HSCCommittee@wales.gsi.gov.uk)

16<sup>th</sup>

February 2012

Dear Mark,

**ENQUIRY FROM THE HEALTH and SOCIAL SERVICES COMMITTEE RE THE  
FUNDING OF ADDITIONAL COMMUNITY PHARMACY SERVICES**

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

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

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

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

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

Kind Regards  
Lesley

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

Bae Caerdydd • Cardiff Bay  
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Wedi'i argraffu ar bapur wedi'i ailgylchu (100%)

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