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Health and Social Care Committee

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Committee Room 1 - Senedd

Meeting date:
29 February 2012

Meeting time:
09:30

Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales

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Agenda

1. Introductions, apologies and substitutions

2. Inquiry into Residential Care for Older People - Evidence from service users, their families and carers (09.30 - 12.00)

2a. The older person's perspective (09.30 - 10.20) (Pages 1 - 10)
HSC(4)-07-12 paper 1
Nancy Davies, Pensioners' Forum Wales
Haydn Evans, Pensioners' Forum Wales

HSC(4)-07-12 paper 2
Phil Vining, Age Concern Cardiff and Vale
Linda Thomas, Age Concern Cardiff and Vale

2b. The experience of people with sensory loss (10.20 - 11.10) (Pages 11 - 23)

HSC(4)-07-12 paper 3
Rebecca Woolley, Action on Hearing Loss Cymru
Ansley Workman, RNIB Cymru
Sue Brown, Sense Cymru

BREAK (11.10 - 11.20)

2c. The carer's perspective (11.20 - 12.00)
Roz Williamson, Carers Wales
Dr Rosie Tope, Wales Committee of Carers Wales

3. Papers to note

3a. Correspondence from the Minister for Health and Social Services - Additional information following scrutiny session on 25 January (Pages 24 - 27)
HSC(4)-07-12 paper 4

3b. Inquiry into Residential Care for Older People - Supplementary paper from Prof John Bolton (Pages 28 - 39)
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3c. Petition P-03-295 Kyle Beere - Paediatric Neuro Rehabilitation Services (Pages 40 - 45)
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3d. Petition P-04-362 Ambulance Services in Monmouth (Pages 46 - 47)
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Health and Social Care Committee

HSC(4)-07-12 paper 1

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

Pensioners Forum Wales

National Old Age Pensioners Association *of Wales*

Civil Service Pensioners Alliance

Unite Retired Members Association

Unison Retired Members Wales

PCS Retired Members Group

PROSPECT

National Association of Retired Firefighters

National Association Of Retired Police Officers

National Federation Of Occupational Pensioners

NUT Retired Members Section

National Pensioners Convention Wales

A forum of independent national pensioner and retired member organisations working together for the benefit of all pensioners in Wales

Supported by Age Cymru

Pensioners Forum Wales is pleased to respond to the National Assembly for Wales's inquiry into Residential Care for Older People. We are very pleased to see this important issue being addressed by the National Assembly for Wales.

Pensioners Forum Wales is a forum bringing together representatives of national pensioner organisations in Wales, which includes the following organisations:

- Civil Service Pensioners Alliance
- National Association of Retired Firefighters
- National Association of Retired Police Officers
- National Federation of Occupational Pensioners
- National Old Age Pensioners Association of Wales
- National Union of Teachers Retired Members Section
- PROSPECT
- Public & Commercial Services Retired Members Group
- Unison Retired Members Wales
- Unite Retired Members Association
- National Pensioners Convention Wales

Inquiry into Residential Care for Older People.

Shown below are what we believe are the key issues and concerns that the inquiry should consider in their deliberations. Pensioners Forum Wales would also like to be given the opportunity to give oral evidence to the inquiry, as we feel older people's views and experiences need to be heard before important decisions are made on the future residential care of older people in Wales.

1. Places may not be readily available in residential care homes if reports of "bed blocking" in hospitals are accurate. There have also been reports of private sector homes having to close because local authorities will not fund residents at a level which makes the homes viable. As demand increases, which it is likely to do, the pressure on places will grow.

2. A member of one organisation went to live in a care home in Llanishen some years ago. The home was run by a local authority/housing association partnership. The lady was given her own very comfortable room and at first spent her time in a small day room with four or five ladies. This seemed an excellent

arrangement. Later, as she became more frail and less able to communicate, she spent the day in a much larger day room where there was very little interplay between the residents. The staff appeared to be very kind to her and she appeared to be quite contented.

At this home the fitter residents were escorted on shopping trips and had a Christmas lunch at a local hotel. What other stimulation was provided is not known, but when she was visited in the large day room, it was a case of a large number of older people

sitting around the room ignoring the television and either asleep or gazing into space. One plus point was a large dog, which was allowed to wander around the day room and appeared popular with the residents. The quality of the food provided at this home seemed good and when the lady was extremely frail, she was allowed to stay in the dining room, on her own, to eat her meal at leisure, which she was able to do and given enough time.

3. We have been told of one gentleman who was in a local authority home in Cardiff. When the home closed he was moved to a private care home. His experience was that his quality of care in a private home was not as good as he had experienced in the local authority home.

4. Another member of our organisation spoke of an acquaintance that had been in a private sector home for many years. Over the years she had paid nearly £100K for her care. At that point her resources were exhausted. The local authority was not prepared to pay the fees the home demanded, so she had to be moved to a cheaper residence. Frail old people very often die as a result of having to move to an unfamiliar environment at such a late stage in their lives.

5. For some years now local authorities have been reducing their provision of residential homes. We understand the reason for this is to reduce their costs. This results in an inevitable deterioration in staff pay and conditions. The private care home has to make a profit. It is hard not to draw the conclusion from this, that the quality of care provided will suffer as a result of the transfer of homes to the private sector.

6. The ever rising number of older people in Wales has been grossly exaggerated by identifying those aged 50+ as older people. Only a small percentage of older people will need residential care, approximately 4.5%.

7. If as Lord Taylor claims (BBC1 21.11.11), we spend £45K each year on Wandsworth prisoners and £33K each year on young offenders; we should find a way to look after the diminishing generation, we celebrate so lavishly in the Royal Albert Hall and in Whitehall each November. As we now make special provision for older prisoners in Bridgend, it would seem that there is an equality issue to consider.

8. There is a great need to monitor the cost of fuel and taxes levied on it. Those people, who cannot afford to heat their homes in winter, may begin to stay in bed in order to keep warm. They could become bedbound and thereby create a greater, avoidable need for residential care.

Listed below are the recommendations Pensioners Forum Wales would like the inquiry to consider:

1. Social services should provide information about the residential care system and homes in the area, to both local authority funded and self-funding older people entering care.

2. More dedication needs to be given to eliminating age discrimination, as this is the only way to tackle elder abuse effectively.

3. A proportion of National Insurance contributions should be dedicated solely to care services. It is unfair that some of those unfortunate enough to require care, bear the whole cost, whilst others pay nothing.

4. The local authority network of homes should be expanded, as they are more concerned with care than profit. Care homes need better regulation and staff deserve better training and remuneration for their vital and important work.

5. The Welsh Government needs to prepare a National Care Prevention Plan. Pensioners Forum Wales submitted a basic framework for a collaborative plan in May 2010 and received a response from Ms Sarah Austin, of the Independent Commission for Social Services, in June 2010.

6. Older people need to be supported to remain in their own homes for as long as possible.

7. Older people, staff and relatives need better public information on residential service provision throughout Wales.

8. Provision of adequate numbers of quality trained staff throughout the residential care sector across Wales.

9. Better planning to ensure older people are not traumatised at the prospect of entering residential care.

10. Inspection of residential homes to include all aspects of food hygiene and the feeding of clients.

11. Unannounced inspections to residential care settings should be increased.

12. The number of warden controlled sheltered housing schemes across Wales should be increased.

13. Private residential care home fees should be regulated and monitored by the Care Standard Inspectorate in Wales. A full breakdown of charges should be made public and include food, accommodation and laundry costs. However government chooses

to do it, it is important to monitor properly and safeguard private care home providers, without whose services, local authorities would be hard pressed to cope with care provision in their areas.

14. Staff employed in the residential care sector should earn more than the minimum wage and be rewarded on an increasing scale depending on the skills and qualifications attained.

15. Married couples should be housed in the same residential care setting should the need arise.

16. Adequate entertainment and stimulation to be provided by all residential care homes with some funding provided by the Welsh Government. 'Live Music Now' is a scheme that might be used for this purpose, along with singing sessions.

Pensioners Forum Wales would like to be kept informed of the progress of the inquiry and look forward to receiving a copy of its findings.

Signed - Mrs. Nancy Davies

Chair of Pensioners Forum Wales

Date – 07.12.11

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Health and Social Care Committee

Inquiry into residential care for older people

RC17 – Age Concern Cardiff and the Vale of Glamorgan

The following is a summary of comments on the consultation made from a selection of Age Concern Cardiff and the Vale of Glamorgan staff. These are staff that have a considerable breadth of experience over many years of working with older people in residential care homes. Those that took part in preparing the comments were:

Advocacy Service Manager
Advocacy Workers
Ageing Well Co-ordinator
Hospital Discharge Service Manager
Operational Manager
Placement Advisors
Regional Safeguarding manager

*** All are willing to take part in providing verbal evidence at a later date if required.**

<u>Response</u>

To examine the provision of residential care in Wales and the ways in which it can meet the current and future needs of older people, including:

Some general comments and priorities

- *In relation to good quality experiences of residential care It is essential to maintain third sector services such as independent advocacy and Placement Advisors (who support the transition from hospital into care settings)*

- *There is a clear need for cultural change to ensure the homes are involving and enabling;*

- *There is a clear need for activities to be part of management and embedded into the culture of homes;*

- *Residential care homes for older people should not be run for profit;*

- *both the savings threshold level and pocket money allowance need to be increased*

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.

Age Concern Cardiff and the Vale has run a Placement Advisor service (Placement Advisors support the transition from hospital into care settings) for the last seven years and this has proved invaluable to older people and their families when faced with finding a care home

Sometimes older people are pushed into residential care without a real consideration of the alternatives. This may be partly due to real pressures to discharge people from hospital. At present, in some cases there may be no realistic alternatives.

The Cardiff East Locality Team (CELT) is a good model for rehabilitation and should be replicated elsewhere.

If home care is to be a real alternative then the quality must be consistently high

More access is needed to Direct Payments as an alternative

More Extra Care housing is needed

A real choice is needed (at present the funding system in Cardiff and the Vale of Glamorgan does not allow for real choice of a care home and this is dictated by price) . Very often in practice the "Directions of Choice" policy does not equate to an actual choice

More initiatives are needed on preventative services

Need to look at ALL housing options e.g. Shared Lives

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.

Locally there appears to be enough capacity but not if couples want to share a room. There seems to be a lack of provision in the city centre of Cardiff.

Providers need to listen to individual needs

There needs to be a cultural change driven by government that would result in more control for residents etc Culture needs to be more involving and enabling for residents and for families as well.

Activities in homes need to be a part of the management structure and at a management level responsibility - should also be the responsibility of all staff and not just one person who may have the title of activities co ordinator.

Age Concern Cardiff and the Vale's Ageing Well project provides training which is not simply about "providing good activities"(which instantly suggests a choice of bingo, exercise and film sessions), it is all about involving residents in their own hobbies, interests and their home. A few group events can be suggested and Age Concern can train people in delivering these activities, but the training ethos is about "Creating an atmosphere of fun and opportunity"

The most important activities are the ones people do for themselves which give them a feeling of self worth.... they are the ones that are seen the least by outsiders, and are the easiest to remove by disempowering residents

Lack of support for Activity Co ordinator - There is evidence that the role of Activity Co ordinator receives no guidance, support or administration support. An average Activities Co ordinator will put in 6 hours unpaid a week...do planning and preparation out of work time, and bring in materials and resources from home, purchase out of their own pocket as they don't have the time to fundraise, or they are not able to fundraise enough to buy the resources needed for the activities to take place.

Their colleagues in the home are as supportive as they can be, but can isolate the Activity Co ordinator's role not because they don't care, but because they do not recognize that it is their part of their role. Care Staff are the ones who provide most prizes for raffles, and are the ones who purchase most raffle tickets. I witness appeals time and again in staff rooms for wool and craft material donations as the Activities Co

ordinatoer has discovered these are the group who do donate, where as residents and families reply is often "we pay enough already"

<u>Poor working culture of care staff</u> - This is a culture that allows carers to work 12 hour shifts, pay is docked for a 15minute break every 6hrs,

There is little or no allowance for the fact they are dealing with people. Pay is barely above minimum wage and there is a constant expectation from the public due to media criticism they must treat their clients with "dignity".

<u>The way care staff are treated must have an impact on the quality of care provided</u>

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.

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It is important to note that <u>in our considerable experience</u>, the quality of care provided by not for profit homes far exceeds that where homes are run for profit. This issue has already been raised through correspondence with the Older People's Commissioner for Wales

Homes that are too big (often over 100 beds) are not "homely"

Age Concern Cardiff and the Vale provides independent advocacy in many local care homes and has done so for many years. This is absolutely vital to the voice of residents being heard.

Service users and families are concerned about high turnover of staff

Service users and families are often afraid to complain

A link is needed for families to contact the CSSIW (to some degree, independent advocates can fill this role and are able to feed back general issues in those homes that have residents' meetings etc.) However, some managers are defensive about issues and about concerns raised by residents.

Good managers will take time to get to know the residents well and to chat to them on a regular basis

Some managers work for large companies that run many care homes and are so their role may be dictated to by senior management

There is often resistance to cultural change from managers and care staff

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

CSSIW do not have enough power

Poor care homes should be "named and shamed"

Local Authority embargoes on contracting beds (often as a result of repetitive POVA reports) are kept quiet. Why?
If Care homes are failing to improve after several warnings there should be real financial penalties, reductions in bed numbers or closure

new and emerging models of care provision.

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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.

Prices for care home beds must be transparent. At present self funders can be paying higher prices for the same room than other residents

Homes should be run by not for profit organizations

Local authority homes have higher relative costs but the quality of care is not better

The social enterprise model needs to be adopted more widely

The savings threshold level of £22,000 needs uplifting

The pocket money allowance needs uplifting

Contract prices are not on a parity with private homes

Health and Social Care Committee

HSC(4)-07-12 paper 3

Inquiry into residential care for older people – Evidence from Action on Hearing Loss Cymru, RNIB Cymru and Sense

About us

Action on Hearing Loss Cymru

Action on Hearing Loss Cymru is the new name for RNID Cymru. We're the charity working for a Wales where hearing loss doesn't limit or label people, where tinnitus is silenced – and where people value and look after their hearing.

Care & Support Services is the largest component of the Action on Hearing Loss group. We support Deaf and hard of hearing adults, some of whom have additional needs such as learning disabilities, mental health, physical disabilities and dual sensory loss. Nearly a third of our service users (27 per cent) in residential care in Wales and the South West of England are over the age of 60.

RNIB Cymru

RNIB Cymru works on behalf of an estimated 115,000 people in Wales with sight loss. We campaign to create a society more inclusive of people with sight loss and we promote eye health by running public health awareness campaigns. We also work in partnership with organisations across Wales to provide local services, providing practical solutions to everyday challenges.

Sense

Sense Cymru is the leading charity in Wales that supports and campaigns for children and adults who are deafblind. We provide expert advice and information as well as specialist services to deafblind people, their families, carers and the professionals who work with them. Sense Cymru provides community services, including communicator-guide services, in many areas of Wales, working closely with local authorities who commission these services.

Deafblindness is a combination of both sight *and* hearing difficulties. Most of what we learn about the world comes through our ears and eyes, so deafblind people face major problems with communication, access to information and mobility. People can be born deafblind, or become deafblind through illness, accident or in older age.

Vocabulary
Throughout this response we use the term 'people with hearing loss' to refer to people with all levels of hearing loss, including people who are profoundly deaf.

This response uses the term ‘people with sight loss’ to refer to any people who are living with significant sight loss, and some have vision which is equivalent to people who are partially sighted or blind.

People with hearing and sight loss are referred to in this response as people with dual sensory loss.

The term ‘people with sensory loss’ is used to refer to people with hearing, sight or dual sensory loss.

Our response
As laid out in the introduction (below) there is a high proportion of people with sensory loss in Wales. As the population ages there will be an increase in the levels of people with sensory loss, together with a likely increased need for residential care. It is critical that current and future providers of residential care are able to meet the needs of people with sensory loss in Wales – providing people with an exemplar service and meaningful choice in terms of residential care provision.

The effect of sensory loss, single or dual, is underestimated in relation to social isolation, loss of independence, mental ill health, nutrition and wellbeing. People with sensory loss are more likely to have difficulty with moderate exercise, mental stimulation, maintaining social contact and healthy eating resulting in poor health outcomes.

With the right advice and support, such as one-to-one assistance, mobility and communication training or equipment, people with sensory loss can be enabled to live active and healthy lives, maintain independence, be socially active and maintain good mental health.

The common perception that sensory loss in older people is an inevitable part of ageing should be resisted. Many older people's sight and / or hearing can be enhanced or maintained, and a great deal can be done to help someone to use the remaining sight and hearing that they do have.

Sense have provided this powerful example of what the process of entering residential care can be like for someone with dual sensory loss.

“Sheila is an elderly deafblind woman who lived alone for the whole of her adult life. Until her sensory impairments degenerated significantly in her early eighties, Sheila had an active life, took part in the W.I. and helped with the reading programme at a local school.

Sheila was only given 2 hours per fortnight of a combination of paid and voluntary support. She became increasingly confused due to her deafblindness and the decision was made, against Sheila's wishes, to place her in residential care.

The staff at the home do not know how to support her, for example they leave her food on a tray in front of her but don't communicate with Sheila to tell her that her food is there and as a result Sheila may go hungry. Sheila has depression and talks of suicide.

The Sense professional working with Sheila firmly believes that if Sheila had been given 2 hours per day of communicator guide support at an early stage to help her to readjust to her sensory impairments and thereafter 3 hours twice a week of one to one support, then Sheila could have remained in her own home."

The following example, also from Sense, highlights the impact of inadequate recognition of sensory loss on an individual:

Sense Cymru has recently been involved with an elderly lady with 'challenging behaviour' who was placed in a North Wales residential care home by an English Local Authority. On investigation, this 'challenging behaviour' was found to largely emanate from frustration. The person was deafblind, but she could read Braille fluently and communicated by using deafblind manual alphabet. However, none of these skills/needs were picked up during the assessment or provided for in the residential establishment. The case was brought to the attention of Sense Cymru not through any systematic process, but by a basic grade care worker who had some personal knowledge of deafblindness. The lady died before the situation could be rectified.

Our response will focus on key issues that relate to people with hearing loss, sight loss and dual sensory loss.

We have set out a series of recommendations which, if implemented, would help people in residential care in Wales lead more full and active lives.

We cannot answer every question but have chosen to respond to the part of this call for evidence where we feel we can add value to the Inquiry.

We are happy for the details of this response to be made public.

Introduction
Sense has recently carried out some research into hearing and sight loss amongst older people in care homes (Sue Pavey, Manveet Patel, Liz Hodges, Graeme Douglas, and Anna McGee (2011) The Identification and Assessment of the Needs of Older People with Combined Hearing and Sight Loss in Residential Homes, University of Birmingham). They plan to submit a full copy of the research findings to the inquiry, but these are some key points from the findings:

- The concept of combined hearing and sight loss was broadly unfamiliar to both staff and residents.
- Simple strategies to help people with combined hearing and sight loss to manage, such as a loop system, large print newspapers, and different coloured plates could help.
- Medical and clinical appointments related to hearing and vision are very important in monitoring deterioration in sight or hearing. Many residents were unaware of when they had last seen, or would next see, a clinician.
- Few homes, and therefore residents, had any contact with voluntary organisations related to hearing or sight loss, or the services and support they could provide.
- While residents were appreciative of the efforts of staff for their care, staff had little training in sensory loss (particularly combined sensory loss) and were often too busy to spend much time with residents.

Prevalence of hearing loss

- It is estimated that there are 534,000 people with hearing loss in Wales.
- More than 300,000 people would benefit from using hearing aids – 1 in 10 of the population (10%).
- Almost two out of three people (65%) with hearing loss are over the age of 65.

Because of the ageing population, the number of people with hearing loss is set to grow by 14% every 10 years.

About people with hearing loss

Depression, anxiety, stress

Research reveals that people with hearing loss have a higher prevalence of depression, anxiety and stress. A recent study shows that older people with hearing loss are 2.45 times more likely to develop depression than those without hearing loss.[1]

Dementia

Recent research also shows that people with mild hearing loss have nearly twice the chance of developing dementia compared to people with normal hearing. The risk increases threefold for those with moderate and fivefold for severe hearing loss.[2]

Falls

People with hearing loss are highly likely to have problems such as tinnitus and balance disorders which contribute as risk factors for falls and other accidental injuries.

Learning Disabilities

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[1] Saito H, Nishiwaki Y, Michikawa T, Kikuchi Y, Mizutari K, Takebayashi T, Ogawa K '*Hearing handicap predicts the development of depressive symptoms after 3 years in older community-dwelling Japanese'* J Am Geriatr Soc. 58(1):93-7. 2010

[2] Lin, Frank, E Jeffrey Metter, Richard O'Brien, Susan Resnick, Alan Zonderman and Luigi Ferrucci *'Hearing Loss and Incident Dementia'.* Arch Neurol 68(2), 2011

It has been suggested that almost 40 per cent of adults with a learning disability will have a hearing loss yet for many people the loss will not be diagnosed because their audiology services are not accessible to them. For many, the loss will be identified but the support they receive may not be adequate for them to benefit from a hearing aid.

The consequences can be a double disadvantage, their learning disability precludes them from receiving adequate support for their hearing problem and the failure to address their hearing loss will in turn exacerbate the effects of their learning disability. More research needs to be undertaken in this area to ensure the provision of appropriate services.

On average, there is a 10-year delay in people seeking help with their hearing loss
Early diagnosis and intervention is fundamental to preventing and reducing the impact of hearing loss, supporting independence and wellbeing and preventing mental ill health. However, on average, there is a 10-year delay in people seeking help with their hearing loss.

Prevalence of sight loss

- There are an estimated 115,000 people with sight loss in Wales.
- 1 in 5 people over the age of 70 have a significant sight loss.
- 1 in 2 over the age of 90.

The number of people with sight loss will double in the next 25 years.

Sight loss isn't confined to those who are registered blind and partially sighted. It includes people who are waiting for, or having, treatment such as laser or other surgery to improve their sight. And it includes people whose vision loss could be improved by wearing the right glasses.

About people with sight loss
Depression and suicide

- 35 per cent of older people with sight loss are living with some form of depression. (Hodge, Barr and Knox (2010) Evaluation of Emotional Support and Counselling within an Integrated Low Vision Services. University of Liverpool.

- Older people with sight loss are three times more likely to experience depression than people with good vision.

- The British Medical Journal reports that sight loss is one of the top three causes of suicide among older people.

Stroke and sight loss
There is a high prevalence of sight loss amongst people who have had a stroke. A systematic review of prevalence of sight loss in stroke patients is due for publication by RNIB shortly, but visual impairment is reported in the region of 70% of stroke survivors.

Dementia and sight loss
It is estimated the number of people over 75 years with dementia and sight loss, based on the data for each individual morbidity, to be 2.5 per cent. However, this figure is likely to be an under-estimate because visual impairment studies will not have accounted for individuals that are considered 'untestable'. It is important to diagnose both dementia and sight loss in order to maximise the treatment and care of the individual, as the degree to which a person with dementia is able to cope will be influenced by sight loss

Falls
Historically, falls were accepted as an unavoidable problem of advancing years and frailty. However, there is now a large-body of evidence based research that considers that such events can be predicted and prevented. Effective interventions are important and can result in significant benefits with regard to improving individual well-being.

- Approximately 60 per cent of people living in care homes experience recurrent falls each year.

- Poor eyesight is one of three major risk factors contributing to falls among older people leading to accidents and death.

- Older people with sight problems are almost twice as likely to have a fall, and have 90 per cent higher odds of multiple falls than a person without visual impairment.

- Falling has been identified as a major complication in people who have had a stroke. It has been estimated that up to 70 per cent of individuals who return home after a stroke will fall especially during the first few months and this could result in a move to long term care.

- Recurrent falls are associated with increased disability and are the leading cause of death resulting from injury in people aged 75 years and over. Age UK reported in 2010 that an older person dies every five hours as a result of a fall.

Learning Disabilities
- People with learning disabilities are 10 times more likely to have serious sight problems than other people. People with severe or profound learning disabilities are most likely to have sight problems

- 6 in 10 people with learning disabilities need glasses and often need support to get used to them. People with learning disabilities may not know they have a sight problem and may not be able to tell people. Many people think the person with a learning disability they know can see perfectly well.

The BME population
People from black and minority ethnic communities are at greater risk of some of the leading causes of sight loss. 5 per cent of the population of Wales may fall into this category.

Prevalence of people with dual sensory loss

- It is estimated 18,850 people in Wales are currently affected by both visual and hearing impairments.

- 212 per 100,000 will have a loss of a severity to classify them as deafblind.

- 62 per cent of the deafblind population is aged over 70

- The number of people who are both deaf and blind is estimated to grow by 60 per cent in 20 years (2030) largely driven by general demographic change.

- People over 70 will be most affected with an 87 per cent increase by 2030.

Figures based on prevalence statistics and the Centre for Disability Research, 2010 report: Estimating the Number of People with Co-Occurring Vision and Hearing Impairments in the UK.

The terms of reference
As described above, we cannot answer all the terms of reference, but have included relevant terms of reference to make clear which point we are referring to.

- **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.**

Care and Social Services Inspectorate Wales (CSSIW)
During 2012-2014 Action on Hearing Loss Cymru, RNIB Cymru and Sense Cymru will be working with the CSSIW and the Care Forum Wales on how residential care homes can better meet the needs of people with sensory loss. We hope this partnership will include different strands of work including an expert users group and help make sure that CSSIW are aware of the needs of people with sensory loss in residential care in Wales. The paper submitted to CSSIW is attached to this document.

Person centred planning
We believe that it is important to make sure that people with sensory loss are given choice and control. Service users need to be at the centre of the Care Planning process from the beginning and they need to be provided with clear information so they can make informed choices . This will mean that not only are people’s needs catered for in terms of their sensory loss, but also in terms of their other needs (eg. medical, cultural, social etc). We believe that

everyone with a sensory loss should be able to plan and be in control of the support they will receive.

The Person Centred plan should be drawn up with the full involvement of the service user. This is not possible unless you can establish meaningful communication. It must also be recorded in a format which is easily accessible to the service user.

Regular eye and hearing checks
Regular checks should be part of the individual's Personal Plan. This should be recorded and monitored. This applies to all service users within residential care, not just those with a previously diagnosed sensory loss. Diagnosis is essential in terms of ensuring the appropriate care and support.

Information
Information should be made available in a range of formats, so that people are kept informed and given a meaningful choice. Information should be produced as standard in Clear Print, Plain English / Clir Cymraeg and be available in Braille, large print, audio, electronic, British Sign language (BSL) and Sign Supported English (SSE).

It is important this information is available in an appropriate format and in a timely fashion. It is also important to consider that friends and family who are helping the individual to make a choice about residential care, or may in some instances be taking that decision for them (for example, if they have Power of Attorney), may have sensory loss. Their needs must be considered along with the service user.

One of the factors causing people with sensory loss to enter residential care is the lack of adequate support in the community to meet specialist needs related to sensory loss, as illustrated by the example of Sheila in the introduction to this response. Rapid identification of sensory loss and provision of adequate reablement and long term support could reduce the need for residential care.

- **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.**

Given the prevalence of sensory loss amongst older people it is essential that any provider of services to this group, including the residential care sector, has the skills and knowledge to meet their needs. The research quoted earlier indicates that staff have little training in this area. Sense produced some guidance for care home and home care providers on supporting people with dual sensory loss, called **"Seeing Me"**.

Sensory loss will affect many aspects of a person's life in residential care:

Training and equipment

Training for staff is absolutely crucial to ensure that they are able to meet the needs of people with sensory loss in residential care. This includes communication techniques, understanding of sensory loss, how to operate and maintain equipment, including hearing aids and loop systems.

Service users should have the specialist equipment they require to maximise their independence. For people with a dual sensory loss this will include a range of high and low tech equipment. Loop systems can help anyone who uses a hearing aid to hear speech or the TV. Magnifiers can help with reading. A specialist assessment may be necessary to identify the best solutions, including tactile markers, vibrating alarm clocks, task lighting.

Action on Hearing Loss Cymru has also worked with CSSIW and the University of Manchester to create the attached report: **"Older people who use BSL – preferences for residential care provision in Wales" (2010**). This extract from the report makes the case for deaf awareness training in residential care:

"Deaf awareness within residential care homes
Whilst being able to communicate in one's own and preferred language within a residential setting was the main concern of those interviewed, all in different ways also highlighted the importance of Deaf awareness within the living environment of residential care homes.
When the one current resident we interviewed was asked what she enjoyed doing in the home, she at first could not answer. When prompted that she might like watching television with the other residents she said 'no' because the subtitles on the TV were never switched on and in fact the staff did not actually know how to do this. Other respondents also raised the issue of inaccessible television within the broader context of communication isolation.

However, not all Deaf people of that generation would necessarily be good readers as one respondent pointed out, thus further reinforcing the significance of face to face communication. Television as a proxy means of keeping up with what was going on in the world, or simply for entertainment, was not for some Deaf people a viable option, even if subtitles were to be switched on.
However, good Deaf awareness in residential care was also strongly linked by those we interviewed, to supporting residents' independence and sense of control within their living environments. For example, several respondents discussed the provision of vibrating pagers/alerters to residents so they could be aware if there was an emergency or a fire alarm and so they could alert staff in a timely manner to their distress."

Social contact and activities
Keeping active is vital to keeping healthy as we get older. Enabling people to maintain leisure and social activities and cultural interests will require thought about what support the person needs to do this. People who appear to no longer be interested in activities they previously enjoyed may simply be finding them too difficult due to sensory loss and steps need to be taken to make these activities accessible again.

Food, meals and mealtimes
For people with sight loss, eating can be difficult. Dining rooms can be noisy, making speech difficult to understand. If a person's hearing and sight loss is severe, it is essential that they know the food is there.

The environment
It is critical that the environment is suitable for people with sensory loss – taking into account the need for good colour contrast to help, for example, identify doorways and preventing falls.

Good environmental design aids independence and reduces the risk of falls. It has also been reported by a large Care provider in England that utilising good design principles also reduced the levels of incontinence.

The environment must also be suitable for someone with a hearing loss – with loop systems maintained to aid communication. Without this people may become isolated and unable to participate in group activities.

RNIB have also produced guidance **"Seeing it from their side".** A guide to recognising and supporting sight loss in your care home, which is attached.

RNIB Cymru have designed 'Visibly Better', an accreditation scheme developed to meet the needs of the increasing numbers of people with sight problems who live in sheltered housing and extra care homes. While RNIB assumes that tenants living in sheltered housing receive a quality service in all aspects of life within their housing environment, 'Visibly Better' is focused on improving the service and equality of rights for clients who have sight loss.

This type of scheme could be used in residential care to ensure they are meeting the needs of people with sensory loss.

- **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.**

Equality Act 2010
Residential care homes need to take the needs of people with sensory loss into account. If due regard is not taken of residents' sensory loss, residential care homes will be in breach of the Act by;

- not removing or minimising disadvantages experienced by people due to their protected characteristics
- not taking steps to meet the needs of people from protected groups where these are different from the needs of other people

Commissioning
Providing for the sensory loss of an individual is not currently seen as a significant factor in current commissioning processes. Consequently services are being provided which may be totally unsuited to individual need, leading to

unnecessary isolation and additional risks to the individual, commissioner and the provider.

British Sign Language residents
The **"Older people who use BSL – preferences for residential care provision in Wales" (2010**) report calls for a specific provision for BSL users in Wales in order to meet the needs of BSL users in residential care.

Currently people who are deaf can either be placed in a care home where they are likely to be the sole resident who is a BSL user or sent to one of the few specialist care homes in England – away from their family, as highlighted by the report:

"Arguments for specialist residential care
The establishment of specialist residential care provision for Deaf older people was strongly supported by those who participated in the research. It was not regarded as the one size fits all solution, but the requirement for it to be resourced and available was argued because of:

• inadequacies of current provision which do not meet Deaf people's linguistic and cultural needs that are fundamental to their well being, safety and basic human rights

• the potential growth in demand as a result of the ageing population in general which equally applies to Deaf people

• the long standing lobbying by Deaf citizens themselves

• the clear advantages for the maintenance of personal independence, mental well being and happiness that a supportive signing care environment could create with other Deaf people."

A copy of this report is attached.

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

See work with CSSIW, described above.

Recommendations

Awareness training
It is essential that social care staff be aware of how to communicate with people who have sensory loss and that their needs are taken into account in the design and management of residential care services. Sensory loss awareness training should be part of initial and regular staff training.

Training packages already exist that can quickly improve practice, both with staff in residential care and with those who commission such services in line

with the mandatory requirements of the new Qualification and Credit Framework [QCF], operational from 01/01/11.

Access to information
Information should be made available in a variety of formats and communication support should be available, where necessary, at all stages of a person's dealings with social services. For instance, service users should be able to make an appointment with social services via email or SMS text. All written information should be produced as standard in Plain English/ Clir Cymraeg in at least size 12 arial font (Clear Print). Information should be made available in audio; electronic, large print, BSL, SSE, Easy Read and Braille formats.

The environment
The environment needs to be appropriate for people with sensory loss, including colour and tonal contrast, appropriate lighting and noise insulation. As a minimum, loop systems and fire strobes need to be in all communal areas, kept in good working order and how to maintain them included in training.

Policy and procedure
Residential care homes need to include sensory loss throughout their policies and procedures, which could be included in the contract from the commissioning body. This would also ensure compliance with the Equality Act and should be included in CSSIW inspections procedure.

Person centred plan
Service users should be central in the planning of their stay in residential care. The plan should be drawn up with meaningful communication with the service user and made available in their preferred format. This plan should be shared with all staff and people involved in the care and support of the service user as appropriate.

Sensory Champions
The development of a 'Sensory Champion' in each home would have a very positive effect in motivating colleagues and keeping this on the establishments/company's agenda.

Accessing external services and support
Care Homes often do not access the wide range of external organisations that could support residents, e.g local Visual Impairment societies, Age Cymru and Sense. This support could reduce isolation and help individuals to maximise wellbeing. Care Home providers should be encouraged to engage with external organisations through individuals' Person Centred Plans.

CSSIW Inspector Training / Awareness raising
Inspectors should undergo training / awareness raising on sensory loss issues. This has been agreed with the CSSIW for 2012.

Maintenance of hearing aids

Staff should be trained in maintenance of hearing aids and regular maintenance recorded and monitored.

Regular eye and hearing checks
Regular checks should be part of the individual's Personal Plan. This should be recorded and monitored.

Wales Low Vision Service
Care Homes should be expected to utilise the Wales Low Vision Service if appropriate to ensure that individual's vision is maximised.

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

Eich cyf/Your ref
Ein cyf/Our ref SF/LG/7199/11

Mark Drakeford AM
Chair of the Health and Social
Care Committee
HSCCommittee@wales.gsi.gov.uk

16th February 2012

Dear Mark,

During my attendance at the Health and Social Care Committee on 25 January 2012, I agreed to provide the Committee with the following information:

Vacant Doctors Posts in Wales

As at 31 December 2011, the NHS reported to the Welsh Government there were 201 medical (i.e. doctor) vacancies. This number was based on a vacancy being defined as "an established post which is currently unoccupied and despite actively taking steps to recruit to the post, no appointment has been made". This represents less than 4% of medical staff working in the NHS in Wales. In the last 10 years, the number of medical and dental staff employed in the NHS has increased by around 45%.

I have already provided the Committee with a summary table of medical & dental vacancies by grade as at December 2011.

Marketing Campaign to Recruit Doctors to Wales

At Committee, briefly referred to the Marketing Campaign Reference Group which has been established. The Group are currently concluding their findings and I will write to you again to provide you with an update on the success criteria.

Bae Caerdydd • Cardiff Bay
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CF99 1NA

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Llinell Ymholiadau Cymraeg 0845 010 4400
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Flying Start Programme

Delivery of the manifesto commitment to double the number of children who benefit from Flying Start to 36,000, is in part dependant upon an appropriate workforce being in place to expand the services, and in particular on having sufficient numbers of health visitors with a capped caseload of 1:110. This caseload allows health visitors to provide a more intensive service to support the needs of disadvantaged families, and is core to the Flying Start offer.

The provision of health visiting services at the same caseload level as currently employed (i.e. one health visitor per 110 children) will require an additional 163 new posts in order to meet the Flying Start manifesto commitment to reach an additional 18,000 children by the end of the Assembly term.

We are proactively planning and providing funding for the recruitment and training of additional health visitors to deliver the Flying Start service. The recruitment of additional health visitors has been properly costed, and a proportion of the additional £55 million allocated for the expansion of Flying Start over the next three years will be used to pay for the Flying Start workforce.

A recruitment drive is already underway to achieve the number of health visitors the expanded Flying Start programme will require.

Regulation on Cosmetic Surgery Providers

As you are aware, a high number of women have been placed at risk of harm as a result of the recent Poly Implant Prosthese (PIP) failure. In Wales we have taken firm action to ensure that the risk of harm to women who have had PIP implants is minimised.

As stated at Committee, I have written to the Secretary of State for Health, drawing his attention to the Surgical Materials Testing Laboratory (SMTL) in Bridgend. SMTL has an international reputation and is the only facility of its kind in the UK and is ideally suited to provide testing services for all medical devices on a UK wide basis. I have also encouraged the Department of Health, and other devolved administrations in the UK, to make use of this expertise and invest in SMTL's services.

In addition, I have asked the Secretary of State for Health to consider strengthening the regulation of breast implants which is currently undertaken by The Medicines and Healthcare Products Agency.

Wheelchair Services

Following the Wheelchair Review an additional £2.2m per annum is being invested to reduce waiting times for wheelchair services, particularly for children and young people.

The funding will be used primarily to double the number of clinical staff across Wales. These staff assess individuals to enable them to have the most appropriate wheelchair to suit their need. Some of the funding is being used by the British Red Cross to continue providing wheelchairs for short term loans and also undertake a pilot study to identify ways of improving referral mechanisms e.g. standardising

access criteria. It is also supporting more training for health professionals, patients and their carers.

This work is overseen by a Partnership Board chaired by the Welsh Health Specialised Services Committee (WHSSC) with representation from service users. The next meeting of the Board will be on 1 March 2012 and an annual report, detailing service improvements and waiting times will be available at the end of the financial year.

Armed Forces Veterans

I have already informed Committee we are providing £485,000 per year for the all-Wales Veterans Health and Wellbeing Service. This demonstrates further the Welsh Government's commitment to improve the health and well-being of service personnel and veterans in Wales. Welsh Health Circular 051 (2008) published in 2008 and distributed to all relevant individuals and health bodies extended the provision of priority NHS treatment from war pensioners to all veterans who have a health problem as a result of their military service.

Key to this is a NHS target for health bodies to specifically consider the needs of service personnel and veterans when planning services. Each Local Health Board (LHB) in Wales has an ongoing Annual Operating Framework target to consider the needs of veterans and armed forces personnel when planning services.

In addition, the Health Board Veterans and Armed Forces Champions will advocate for veterans and service personnel to ensure that their needs are reflected in service plans and will provide links and disseminate information between them, the new service and external groups.

Kind Regards

Lesley

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

Medical & Dental Vacancies by Grade - December 2011

	ABM	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf	Hywel Dda	Public Health Wales	Velindre	Total
F1	0	0	0	0	0	1	0	0	**1**
F2	0	3	0	0	0	1	0	0	**4**
St Lower	10	0	4	2	10	5	0	2	**33**
St Higher	7	4	2.4	14	2	2	0	0	**31.4**
SAS	10.45	1.5	13.4	0	11	9	0	0	**45.35**
Trust	0	12	5	5	1	2	0	0	**25**
Consultant	19	4.8	12	3	5	17	1	0	**61.8**
Total	**46.45**	**25.3**	**36.8**	**24**	**29**	**37**	**1**	**2**	**201.55**

Medical & Dental Vacancies by Speciality - December 2011

	ABM	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf	Hywel Dda	Public Health Wales	0	Total
A&E	3.45	13.3	5	6	9	5	0	0	**41.75**
Anaes	4	0	0	0	1	0	0	0	**5**
Dentistry	4	0	5	0	0	0	0	0	**9**
General Practice	0	0	0	0	0	0	0	0	**0**
Medicine	13	3	13	6	9	4	0	0	**48**
Obs & Gynae	2	1	0	0	0	2	0	0	**5**
Paediatrics	5	2	4	4	0	6	0	0	**21**
Pathology	1	0	2.4	0	0	5	1	0	**9.4**
Psychiatry	3	3	4	0	10	5	0	0	**25**
Public Health	0	0	0	0	0	0	0	0	**0**
Radiology	3	0	1	1	0	3	0	0	**8**
Surgery	1	3	1.4	1	0	6	0	0	**12.4**
Other	7	0	1	6	0	1	0	2	**17**
Total	**46.45**	**25.3**	**36.8**	**24**	**29**	**37**	**1**	**2**	**201.55**

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National Assembly for Wales Health and Social Care Committee

The Future of Residential Care in Wales

John Bolton Submission

February 2012

OXFORD BROOKES UNIVERSITY

National Assembly for Wales Health and Social Care Committee

The Future of Residential Care in Wales

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1 Introduction

This report considers two aspects of the residential care market in Wales. First, the current patterns of usage of residential care by local authorities when they assess people and fund their care. Second, some of the key factors that the private sector may consider in entering the residential care market and how they might set their prices.

2 Councils and Residential Care

I am drawing on work that I undertook last year (2011) which was published under the title of 'Better Support and Lower Costs'[1]. The work was commissioned by the Social Services Improvement Agency (SSIA), to capture the way in which Local Authorities in Wales were seeking new ways to deliver more cost effective services for older people.

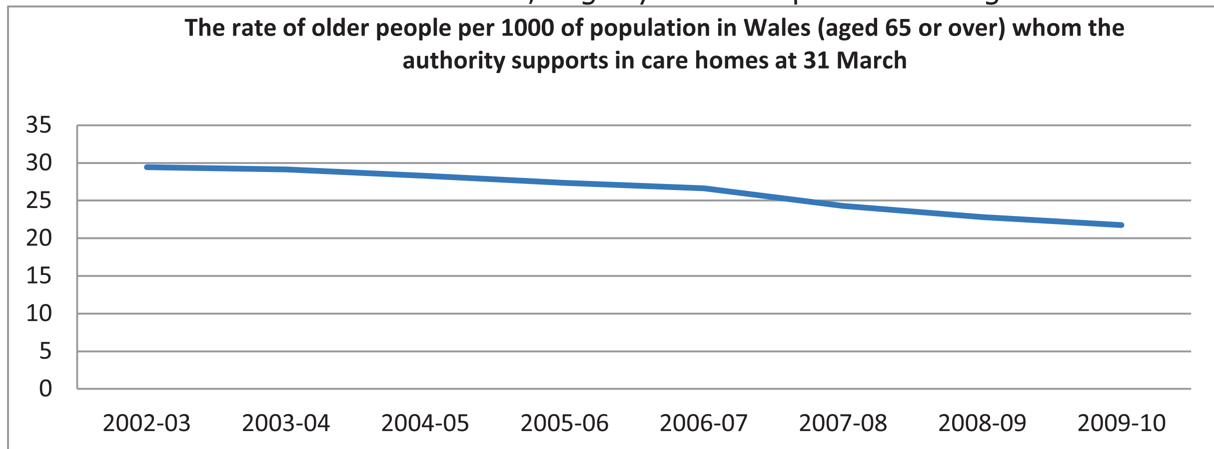
A key finding from the report was that almost every Welsh Local Authority had within their key strategies for adult social care a recognition that they needed to focus on reducing the number of placements that they funded for older people in residential care. This is not a new strategic direction and there has been an expectation for some time from the Welsh Government that the focus of social care is to help more older people remain in their own homes[2] – because that is what they say they want. For example:

"Gwynedd Council ran a series of events with older people in the County to find out their views on the services that should be planned for tomorrow. The overwhelming response from older people was that they did not want residential care for themselves. They did want enablement services that helped them regain independence; they wanted to be able to use the new assistive technologies that would help them remain safe and would enable a quick response when they had a crisis and they wanted domiciliary care that would help them at the times and in the way that suited them.[3]"

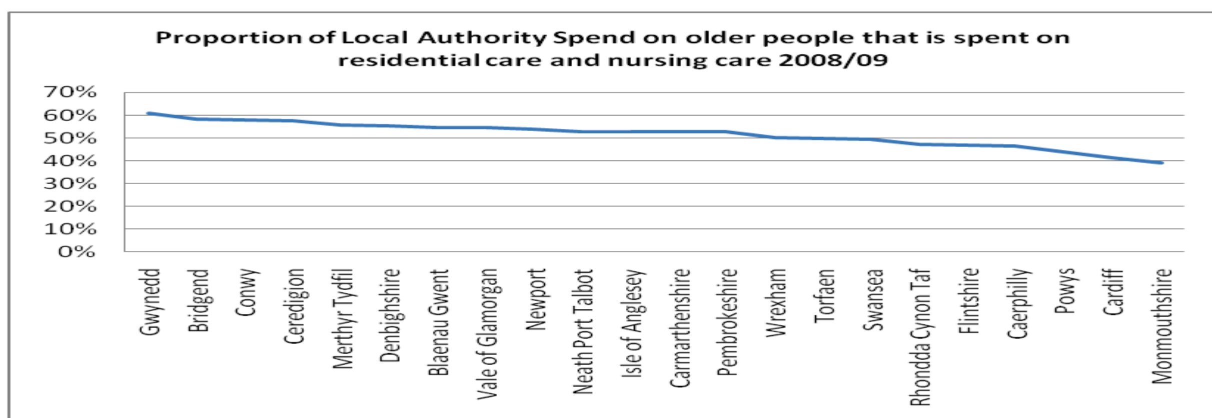
The rate at which Councils in Wales fund older people in residential care has reduced from circa 30 Older People per 100,000 in the population in 2002 to

[1] Better Support and Lower Costs – SSIA May 2011
[2] The Strategy for Older People in Wales
[3] Better Support and Lower Costs – SSIA May 2011

circa 22 per 100,000 in 2010 as can be seen in the table from the Local Govt Data Unit below[4]. There is a similar, slightly less steep trend in England.



The graph below shows the different proportions of the social care spend on elderly people in residential care from the Welsh Authorities (though not as wide as there is in England). For example, Gwynedd spent a much higher proportion of its allocated social services budget (61%) on supporting older people in residential care than Monmouthshire (39%)[5].



This variation does not appear to be simply dependent on levels of need or deprivation. Perhaps a more realistic key factor behind variation in use is related to the availability of the supply of residential care. In Gwynedd, for example there is may be an oversupply of care. But there clearly is a difference between those Local Authorities that have focused on helping older people to remain independent and continue to live in their own homes for some time, and those that are just starting that journey.

There are a number of reasons why, overall, Local Authority funded places have fallen over recent years:

- Government Policy has put a strong emphasis on helping older people to remain in their own homes and many Local Authorities have responded positively to this
- Older People, when asked, consistently report that they wish to remain in their own homes for as long as it is safe. Older people report that it is

[4] Local Government Data Unit - Wales
[5] Local Government Data Unit - Wales

sometimes a combination from pressure from health professionals and families that lead them to accept residential care.

- Local Authorities have improved their commissioning of intensive domiciliary care, and this alongside the use of assisted technology (telecare), adaptations to people's homes (see study of Neath Port Talbot in "Better Support and Lower Costs[6]") and the development of both residential and domiciliary based enablement has kept more people at home.

Preventing unnecessary admissions to residential care is one of the areas where councils can make savings in their social care expenditure, and every Council continues to explore how they might further reduce the numbers of people who require residential care in their area. Already the figures for 2009-10 show a further reduction in a number of places. The key areas on which Councils have focused to reduce admissions include:

- Have a stated policy that no one should be admitted to residential care for a new long term placement direct from a hospital bed.
- Better intermediate care including beds with a focus on reablement and recuperation
- Ensuring older people are getting the appropriate health interventions to support their recovery such as falls programmes; incontinence support; early identification of dementia; stroke recovery programmes; foot care and dental care.
- Investment by Councils in Disabled Facilities Grants which adapt an older person's house so that they can remain in the home when they become frailer.
- Better use of telecare to help people remain in their own homes, e.g., some Councils have used an IT system called "Just Checking" to help with their assessment for older people with dementia.
- Better support for people to remain in their own home and more older people funding their own residential care.
- Development of extra care housing as an alternative model to residential care
- Consider the closure of the council run care home provision where there is plentiful supply of care (as this is the area where greatest savings can be made) – see section below on unit costs.

I was not able to find any specific data on what is happening in Wales for self-funders and have therefore referred to UK analysis that has been undertaken by Laing & Buisson (who are considered to be one of the best informed organisations on what is happening across the residential care market in the UK).[7]

The evidence suggests that though there continues to be a fall in the use of residential care by older people funded by the state this has in part been compensated through a small increase in the numbers of older people who are entering residential care as self-funders. This is what might be expected as we are now finding that a generation of older people who bought their own homes

[6] Better Support and Lower Costs – SSIA 2010
[7] Care of Elderly People – UK Market Survey 2009 – Laing & Buisson

move towards the age when they might require care. Around 70% of older people in the UK own their own homes and with the current charging arrangements for care requiring people with assets to use them to pay for the care then one might expect more self-funders in the future. I have been advised that Wales has the highest degree of home ownership amongst older people.

Laing & Buisson report that "Care home companies with high exposure to public funding are likely to fare worse from 2011/12 onwards. Companies with a focus on privately paying residents are likely to fare better. On the private pay side, a weak housing market and pressure on disposable income as Britain struggles to repay its debt burden is likely to spill over into a continuation of more modest private pay fee inflation, but personal care budgets are not as constrained as local authorities' and the economic climate is not expected to impact significantly on the volume of private pay demand for a needs driven service."

Some commentators have argued that the demand for paid care may be greatly increased in the future as women abandon their traditional role as providers of informal care, citing increased rates of divorce and remarriage, smaller family sizes, greater labour mobility and more employment opportunities for women. However, this demand has not yet been seen. Admissions to residential care are still dominated by older women aged over 85 who were living alone at the time of their admission. Others have argued that 'compression of morbidity' into a shorter period at the end of life will reduce the need for long term care. There is some evidence from the United States and Britain that rates of severe disability among very old people have declined in recent years, but the evidence is not sufficiently compelling to factor into future projections. However, potential medical advances such as, for example, a breakthrough in the treatment of Alzheimer's Disease suggest that this situation will have to be kept under regular review.

It may be considered that the reductions in admissions to residential care homes achieved by some local authorities can be made by others through, for example;

- improvements to their assessment process;
- the way in which they assist older people at the time of a crisis;
- the interventions that they offer, to further reduce the numbers of older people they assess as requiring residential care.

It is possible that these actions will produce a further 10% reduction in Local Authority supported admissions over the next 5 years, which could happen despite the increase in the numbers of older people in the population.

Laing & Buisson's survey of private and voluntary care homes for older and physically disabled people, in March 2009, found an average occupancy rate of 89.8 per cent, one percentage point below the previous year. The dip in occupancy rates followed from the 2 per cent increase in UK capacity, which was not quite matched by the 1 per cent increase in volume of demand[8].

On this basis most care home providers for older people would consider that they have some security in the knowledge that the residential care market will engender sufficient demand from self-funders for them to continue in business.

[8] Care of Elderly People – UK Market Survey 2009 – Laing & Buisson

The current UK proportion of self-funders of residential care is circa 41% (according to Laing & Buisson) and nearer to 50% (according to the IPC estimate in their work for the National Market Development Forum last year). - I think we can assume a similar proportion in Wales. We might expect the proportion of older people who access residential care with their own funds to continue to increase.

This means that the local authority influence in the market (on which we currently rely in part to check the quality of the provision) will continue to decline. This might also give providers more confidence in setting a "realistic" price rather than having to take the offer that the Local Authority may make (see below).

3 The Residential Care Providers – Calculating the Cost

The PSSRU (Personal Social Services Research Unit) research paper commissioned by the Department of Health In England in 2009[9] appears to assume that residential care costs of about £500 per week are split about half and half between 'care' costs (£250) and 'hotel' costs (£250).

The Joseph Rowntree Foundation and Laing & Buisson have developed a tool which helps to calculate the cost of an efficient care home[10]. I have used their report for 2009, where it suggests that the cost of care should be as follows (2008 prices)[11]:

All figures are £ per week	Nursing Care Frail Elderly/ dementia	Frail Elderly (Non-nursing)	Dementia Care (Non-Nursing)
Provincial Ceiling	665	538	566
Provincial Floor	589	463	491

They can break down these costs in the following table:

Fair market fees for Care Homes (Provincial Costs – not London)[12]

	Nursing Care	Frail Elderly	Dementia Care
Nursing Staff	107	0	0
Care Staff	157	144	171
Domestic	46	46	46
Management/Admin	40	40	40
Agency Costs	5	2	3
Training backfill	4	2	3
Total Staff	358	234	262
Maintenance and capital expenditure	19	19	19

[9] Fernandez and Forder, 2009, Department of Health
[10] Calculating the costs of efficient care homes – Joseph Rowntree Foundation 2009
[11] Care of Elderly People – UK Market Survey 2009 – Laing & Buisson
[12] Calculating the costs of efficient care homes – Joseph Rowntree Foundation 2009 and Care of Elderly People – UK Market Survey 2009 – Laing & Buisson

	Nursing Care	Frail Elderly	Dementia Care
Repairs and Maintenance (revenue)	11	11	11
Contract maintenance of equipment	3	3	3
Total Repairs	33	33	33
Food	23	23	23
Utilities	22	22	22
Handyman/Gardening	7	7	7
Insurance	5	5	5
Medical Supplies	3	3	3
Registration Fees	3	3	3
Recruitment	2	2	2
Training	2	2	2
Other	6	6	6
Total on current costs	79	79	79

Capital Costs (12% return on capital)

Land	**43**	**43**	**43**
Buildings and Equipment to meet national standards	**153**	**149**	**149**
Total	**195**	**192**	**192**

Fair Pricing for Home

For new homes that meet standards	665	538	566
For older homes not exceeding standards	589	463	491

One can read that the proportion of staffing costs varies from 60% in a Nursing Home to 54% in a Frail Elders Home or Dementia Care Home. The fixed costs of food, utilities, maintenance etc cover about 12-15% of the overall costs[13]. If a provider is receiving less than the market rate then it has a choice of where it will make its savings – it may determine to take less from the capital value of the asset, which is common practice for long established care homes where previous borrowing has already been paid off but it does mean that the provider is not able to borrow more money or to invest in the future of the building. Another factor that will impact on the costs of the home is the occupation levels. The reported 90% occupancy level of care homes will also determine the cost of the care as staffing levels have to be maintained whoever is in the home at any point in time.

The rate being paid by Councils for a similar service does vary, as can be shown in the table below which reflects work undertaken between the North Wales Councils together to compare the price they were paying for residential care in 2009[14].

[13] Care of Elderly People – UK Market Survey 2009 – Laing & Buisson
[14] Information provided by North Wales Councils in 2010 for Better Support and Lower Costs

	Conwy	DCC	Flint	Wrexham	Ynys Mon	Gwynedd
Residential Min	342.00	332.00	407.81	334.09	375.00	345.94
Residential Max	437.00	415.58	433.43	426.20	411.00	397.67
Nursing	557.90.	536.15	553.99	546.76	549.90	540.49
EMI Residential	437.00	427.72	469.73	465.12	445.00	397.67
EMI Nursing	597.90.	561.53	590.29	585.68	594.90.	572.97

(Yellow markings indicate the lower costs.)

The above tables show that none of the North Welsh Local Authorities were paying in 2008/09 a rate at the level recommended by the JRF/Laing & Buisson model. Laing & Buisson report[15] that from their survey of providers in Wales that the average price being paid (by both local authorities and private individuals) for care is £592 for a residential care home with nursing place and £421 for a standard residential care place (2009 figures) – this would indicate that private funders are supplementing the lower price covered by local authority purchases.

Laing Buisson reported[16] that in 2009 Welsh Authorities awarded the highest baseline fee increases with an average uplift of 4.6%. Wales saw a wide range of increases with the Isle of Anglesey awarding a 1.5% increase, while Bridgend's increase of 9% gives the council the highest nursing fees and the second highest residential fees in Wales. For nursing homes, Gwynedd awarded a 13.6% increase while Caerphilly awarded a 9.9% increase. Maximum nursing fees range from £487 (Blaenau Gwent) to £561 (Bridgend). Maximum residential fees ranged from £326 (Denbighshire) to £470 (Caerphilly).

We do not have information on the need for local authority supported residents to use "top-ups" to meet the costs of their care. This is where a care home's costs for care are greater than the rate offered by the local authority and the service user through a third party agrees to pay the "additional cost" themselves because this is the care home of choice. If Local Authority rates continue to fall behind the market cost of care it is likely that this will be increasingly required of older people when they are admitted to a care home of their choice.

We can see from the above table a market where local authorities appear to be spending less on the cost of care than independent advisors suggest is necessary. Local Authorities are covering around 60% of the costs. This means that either private funders are subsidising the rates paid for by the Local Authority or providers are having to cut corners to reduce costs and are less likely to be investing in the future of the business. It is considered by many that both of these are happening. Recent court cases (for example against

[15] Care of Elderly People – UK Market Survey 2009 – Laing & Buisson.
[16] Care of Elderly People – UK Market Survey 2009 – Laing & Buisson.

Pembrokeshire County Council in December 2010[17]) suggest that this is an area of serious contention between Local Authorities and providers.

4 Trends in the Market

The majority of residential care homes in the UK are owned and run by private companies, who are not quoted on the stock exchange and for whom it is sometimes difficult to access their accounts. About 45% of the market is run by providers who own 3 homes or less – this proportion has been decreasing as larger providers buy up businesses that are available for sale. A recent confidential report in a London Borough suggested that there is no shortage of offers to purchase residential care homes for older people. This was also demonstrated by the market response to the demise of Southern Cross where the majority of the homes were either taken forward by their owners (Four Seasons) or their owners created a new company to manage the homes they owned (HC One). Of those that went out of the market some were taken on by the voluntary sector, e.g. Methodist Homes. This is of concern to some commentators as it is often hard to trace the real ownership of the companies and the overall state of their financial health is hard to monitor.

One of the important factors to recognise with Southern Cross is that it was a publically quoted company and it was possible to trace what was happening with the Care Provider, e.g., Southern Cross. It was far from easy to trace what was happening with the Care owners some of whom were offshore financed, e.g., Guernsey, Cayman Islands, etc
The same level of information is not available for other providers. Laing & Buisson report the profits for the largest care providers which they indicate for 2007-08 varied between 7% at the highest level and 0% at the lowest (Southern Cross).

Laing & Buisson use a formula to ascertain whether there is sufficient supply of residential care in each region of the UK to meet their current understanding of demand (see Table Below). Their assessment for Wales in 2009 was that there was a slightly higher than required number of nursing home beds and a slightly lower than required number of residential care beds available[18]. I would advise to treat these figures with caution and would suggest that the figures indicate that there is sufficient supply to meet current demand as occupancy levels were at 89% for nursing homes and 94% for residential care homes[19] and there are indications that Welsh Local Authorities are intending to reduce the number of placements they make.[20]

The Laing-Buisson Demand model for Residential Care for Older People

	Number of Homes	**Number of Places**	**Index if UK average = 100**
Private and Voluntary	608	10,286	78
Local Authority	120	3,548	205
Total Residential	728	13,834	93

[17] Forest Care Home Ltd v Pembrokeshire County Council, England and Wales High Court December 2010
[18] Care of Elderly People - UK market survey 2009 – Laing & Buisson
[19] Care of Elderly People – UK Market Survey 2009 – Laing & Buisson
[20] Better Support and Lower Costs – SSIA 2011

	Number of Homes	Number of Places	Index if UK average = 100
Private and Voluntary Nursing Care	283	9,563	99
NHS geriatric/EMI		2,005	222
Total		11,567	109
Total for all Nursing and Residential			**100**

5 Conclusion and Future Pointers

At present it appears that overall demand for residential care is remaining fairly static and the predicted rise demand is not materialising because local authorities are finding better ways of supporting older people to either remain in their own homes or to live in alternatives to residential care such as extra-care housing. It is believed that local authority supported placements will continue to fall for the next few years[21] and we know this is the intention for most Local Authorities in Wales[22]. Future demand will depend on a number of factors:

- **The rules agreed by UK Governments for the longer-term funding of care.** If a cap is placed on the maximum amount that a person will have to pay out to fund their own care before the state picks up the tab then that may lead to a change in patterns of care. Local Authorities may use their influence to help more older people to remain in their own homes to delay the ceiling cost being reached. On the other hand in Wales, the £50 maximum weekly charge for domiciliary care could also change the practice as there is a perverse incentive for local authorities to encourage older people into residential care (particularly if they will have to fund their own care) rather than continuing to help them at home - where a higher proportion of the cost will be met by the local authority.
- **The impact of health services on demand for social care.** In Better Support Lower Costs I cite evidence that suggests that there are 6 main health conditions that have a particular impact on demand for social care – Incontinence and Urinary Tract Infections; Dementia Care; Falls; Strokes; Podiatry Care; and Dental Care. There is some evidence that health performance in these important areas for older people is not reaching the standards that are laid down by the Royal College of Physicians. If health performance declines it is likely that we will see an increase in older people requiring an admission to a care/nursing home. The Royal College of Physicians have already highlighted poor Stroke Care in Wales as a significant issue. Overall Health has a very direct impact on the use of residential care. (See later comments on Intermediate Care).
- **The development of alternative forms of housing such as enhanced sheltered housing or extra care housing** (which has been strongly supported by the Assembly Government in the housing for rent sector) might mean that a real choice is made available to older people which will lead to a

[21] Use of Resources in Adult Social Care – Department of Health (2009)
[22] Better Support and Lower Costs – SSIA 2011

reduction in demand for residential care. This may be particularly the choice of self-funders who will want to purchase their extra-care accommodation. This enables them to benefit as they can retain the value of their property whilst still receiving the care they need. Most of the extra-care housing schemes that have been built in Wales have only dealt with older people who want to be tenants. Now that capital grants to support such developments have reduced significantly, it is likely that any future schemes can only raise the capital if a good proportion of the accommodation is for sale. This will both meet the needs of the 70% of older people who are owner occupiers and allow Councils to continue to commission new developments without Welsh Government Subsidies.

- **The use of Intermediate Care as a resource where older people can receive enablement and recuperation before an assessment** is made for the older person's long term care needs can have a significant impact on admissions to nursing and care homes. The biggest single route for an admission to a care home is direct from a hospital bed. This might be challenged as poor practice as the older person will be at their worst state if they have occupied a hospital bed for more than a week. The assessment at that time might suggest that the older person could not support themself in their own home – but it does not give them a chance to see if they might recover. My work in various councils would suggest that 1 in 5 older people who are admitted to a care home may have had their admission avoided if more time had been taken over the assessment and a period of Intermediate Care offered after the admission. The drive to free up the hospital bed should not lead to a poor outcome for the older person. "Better Support and Lower Costs" gives an example in Wales where saving money in reducing delayed discharges has probably cost significantly more money in increased admissions to nursing homes.
- **Early dementia support.** In England the Department of Health's Dementia Care strategy in 2010 claimed that early provision of support provided within a patient's home can decrease institutionalisation by 22 per cent, while carer support and counselling at diagnosis can reduce care home placement by 28 per cent. Even in complex cases where highly skilled mental health teams are required, the DH claims that proper case management can reduce admissions to care homes by 6 per cent[23]. In order to achieve this, the strategy states that outcome based homecare practices must be rolled out on a national scale. This could be through dedicated teams which allocate time prior to the beginning of a care package to build a rapport with the client and family in order to design a person-centred care package rather than the task based 15 minute visits which can work for non-dementia care. To achieve this, the strategy calls for basic training in dementia care for all homecare staff and flexibility written into working practices.

So the future of residential care will be influenced by a number of factors. Some argue that it is a 19th Century solution to the care needs of older people which needs to be modernised. This is happening slowly. Others suggest that the increased rates of dementia amongst older people means that demand will continue to increase as a care home is the safest place to monitor and support

[23] Croucher *et al*. (2006); Vallelly, S., Evans, S., Fear, T. and Means, R. *Opening the Doors to Independence: A Longitudinal Study Exploring the Contribution of Extra Care Housing to Care and Support of Older People with Dementia*. (London: Housing Corporation and Housing 21, 2006); & Molineux, P. & Appleton, N. *Supporting People with Dementia in Extra Care Housing: An Introduction to the Issues, Housing Learning and Improvement Network Factsheet 14* (London: Health and Social Care Chang

an older person with memory loss. At present we are probably on a cusp – the direction will be strongly influenced by the policy of UK Governments. If residential care homes are to survive and play an important part in the care of the ageing population they will need higher funding from the state and a wider recognition that they will be assisting a very frail group of older people who are either experiencing a long term condition which requires constant care and attention or for people who require palliative care.

In the process of managing this transition carefully, ensuring efficiency and minimising the risk of services failure, the Commission may wish to consider the following approaches which IPC would recommend based on its long experience of service and market development across England, Scotland and Wales:

- Strengthen support for constructive market relationships in the sector. A good start was made in the work on the Memorandum of Understanding 'Securing Strong Partnerships in Care' agreed by the WLGA, ADSS Cymru, Care Forum Wales, The Registered Nursing Home Association & The UK Home Care Association in February 2009. In view of the changes in the market and in national policy since then it may be worth revisiting the Memorandum and investing in resources which provide advice and guidance for Local Authorities and their provider partners on how best to resolve disputes before going to court.
- Strengthen the market facilitation role of local authorities including the production of a market position statement. The IPC has worked in England and Wales to build partnerships between the public and the independent sectors. In order to achieve this, a number of tools have been developed. One specific tool which a small number of Welsh Authorities have already adopted is "a Market Position Statement". This is a document which sits alongside the Council's Strategic (Commissioning) Plan in order to give a clear indication for all providers as to the predicted demand for care within that authority (covering the predicted needs of self-funders and those for whom the Council is likely to be funding their care). It captures the current state of local provision and helps determine the likely pattern for future demand.
- Develop a national market overview role drawing together intelligence about costs and quality and governance of providers (which we consider is an omission in the understanding of what is happening in Wales) which can be used by Local Authorities, providers and the public to promote greater transparency and openness in the market.
- Build a national overview of evidence on good practice in prevention and early intervention to inform local authority future practices, to encourage Local Authorities and their provider partners to consider the evidence behind new forms of service provision which provide more successful alternatives to traditional residential care.

Professor John Bolton on behalf of
Institute of Public Care
February 2012

Cynulliad Cenedlaethol Cymru

National Assembly for Wales

Y Pwyllgor Deisebau
Petitions Committee

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

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff CF99 1NA

Our ref: P-03-295

February 2012

Dear Mark

Petition: Kyle Beere – Paediatric Neuro Rehabilitation Services

The following petition is currently open for consideration by the Petitions Committee.

'We, the undersigned, call upon the National Assembly for Wales to urge the Welsh Government to recognise and deliver services for the rehabilitation of brain injured children. There is currently no facility in Wales to provide this vital service. Despite there being a purpose built children's hospital being built in Cardiff, there is still no provision included in its design.'

The Committee would like to draw your attention to the issue raised in the petition, and would ask you to consider including the subject of neuro-rehabilitation services in Wales in your forward work programme. I attach correspondence from the Welsh Health Specialised Services Committee, Headway, and the petitioner for your information.

Thank you for your consideration of this issue.

Yours sincerely,

William.

William Powell AM
Chair, Petitions Committee
Encs: Correspondence from WHSSC; Headway; petitioner.

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Ffôn / Tel: 029 2089 8393
E-bost / Email: William.powell@wales.gov.uk

Croesewir gohebiaeth yn y Gymraeg a'r Saesneg / We welcome correspondence in both English and Welsh

GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC) Welsh Health Specialised Services Committee (WHSSC)

Your ref/eich cyf: P-03-295
Our ref/ein cyf: ML/NJ/CR- KB
Date/dyddiad: 12th December 2011
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William Powell AM
Chair, Petitions Committee
National Assembly for Wales
Petitions Committee
Cardiff Bay
Cardiff
CF99 1NA

Dear Mr Powell

RE : P -03-295 Kyle Beere – Paediatric Neuro Rehabilitation Services

Thank you for your letter dated 23rd November 2011, requesting the number of children requiring admission to Tadworth over the last 10 years.

I can confirm that since the 1st of February 2002 to date, 8 children have required admission to The Children's Trust, Tadworth.

I hope this answers your request. If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

Dr Cerilan Rogers
Director of Specialised & Tertiary Services

Welsh Health Specialised Services Committee
Unit 3a
Caerphilly Business Park
Caerphilly
CF83 3ED

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Uned 3a
Parc Busness Caerffili
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Chair/Cadeirydd: *Professor Mike Harmer*
Director of Specialised and Tertiary Services/Cyfarwyddwr Gwasanaethau Arbenigol a Thrydyddol: *Dr Cerilan Rogers*

Headway Cardiff

10th January 2012

William Powell AM
Chair, Petitions Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Dear William Powell,

Headway Cardiff is a registered charity that provides support and services to adults affected by acquired brain injury (ABI), their families and carers throughout south east Wales.

The survivors we assist are adults, but many sustained their injury during childhood and have experienced paediatric neuro-services first hand.

Firstly it is important to acknowledge the lack of accurate statistics relating to ABI due to a combination of shortfalls in the coding system and in the case of minor brain injury, non-identification or mis-diagnosis.

It is also important to not wholly focus on those who are classified as having a severe brain injury. Those with a moderate or even a mild classification have complex, life-long difficulties, that impact on their ability to live an independent life.

Beyond the acute setting, it is vital that children receive a period of specialist neurological intervention. Appropriate, timely specialist intervention can greatly improve the level to which individuals recover and the speed in which this happens.

As the input of the family is crucial at this stage and throughout recovery, this service needs to be as accessible to the family as possible and offer as flexible and as personalised a programme as possible.

Following this intensive period of rehabilitation, a long term community based specialist multi-disciplinary team should be available until the child reaches adulthood and then in theory, there is a seamless transition to specialist adult services.

Headway Cardiff
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Tel: 029 2057 7707 E.mail address: info@headwaycardiff.org

A Company Limited by Guarantee Registered in Wales No. 3331865 Registered Charity No. 1063221
Registered address: 5th Floor, Hodge House, 114 - 116 St Mary Street, Cardiff, CF10 1DY
Patron: Mr Jonathan Davies M.B.E.
Affiliated to Headway - the brain injury association. A Registered Charity

ARIENNIR GAN Y LOTERI
LOTTERY FUNDED

It is in the area of community services that the biggest gap appears in adult specialist neuro- services and it is vital that this area is considered in the development of any paediatric service.

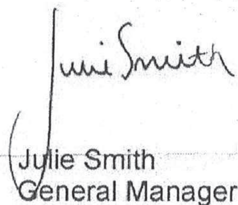
Community services in Wales have not kept pace with acute services and the piecemeal nature of services has left many survivors feeling isolated and unsupported leading to crisis and family breakdown. Many of the gains they make in the immediate aftermath are lost due to the lack of ongoing therapy and support.

For those children whose impairments are severe enough to warrant a placement in a specialist educational establishment, ongoing treatment such as Occupational Therapy, Speech and Language Therapy and Physiotherapy is available.

What then happens to those with moderate and mild difficulties, who frequently go undiagnosed, unrecognized or whose difficulties are attributed to behavioral problems?
Who then supports them as the child reaches each new stage of development?
Who then provides the individual with ongoing rehabilitation and strategies?
Who supports the family in ensuring the child's educational needs are recognized and they are statemented correctly?

Headway Cardiff wholeheartedly endorses the Petition to the Welsh Government to recognize the need for and to deliver specialist services for the rehabilitation of brain injured children within Wales.

Yours sincerely



Julie Smith
General Manager

Dear sirs

I apologise for the delay in replying, but I have been waiting on information from Aneurin Bevan and Hywel Dda Health boards, that have failed to comply with the freedom of information act.

In the last 5 years there have been a total of 529 paediatric patients (between Abertawe Bro Morgannwg University, Betsi Cadwaladr University, Cardiff & Vale University and Cwm Taf Health Boards) that could have benefited from a paediatric neuro-rehabilitation centre in Wales. Powys Teaching Health Board do not have any paediatric services which, although is concerning in itself, does not have any impact on this petition.

Yours faithfully

Katherine Simmons

Further correspondence from the Petitioner 30 January 2012

Dear sirs

We have now heard from Aneurin Bevan Health Board and they have had admitted 345 paediatric patients with acquired brain injury in the last five years. This takes the overall total to 874. We have still not heard from Hywel Dda.

In response to WHSCC's correspondence, there may have only been 8 children referred to Tadworth but is this due to cost or need? It seems 8 patients out of a possible 874 does seem disproportionate which would bear out the comments made by Headway.

Regards

Chris Wools
For and on behalf of Kyle and the trust.

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Y Pwyllgor Deisebau
Petitions Committee

Mark Drakeford AM
Chair, Health and Social Services Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff CF99 1NA

Our ref: P-04-362

February 2012

Dear Mark

Petition: P-04-362 Ambulance Services in Monmouth

At its meeting on 7 February, the Petitions Committee considered the following petition for the first time:

We believe that Monmouth should be granted the appropriate ambulance provision. With its population set to rise, and the Minor Injuries Unit at Monnow Vale recently closed down, demand will increase for the ambulance service.

National Assembly for Wales:
We request the Health and Social Committee of the National Assembly to undertake a scrutiny inquiry into the ambulance service in rural Wales. We would urge the Committee to investigate the particular problems in Monmouth and the impact of the closure of the Monnow Vale Minor Injuries Unit on the ambulance service.

Welsh Government:
We urge the Minister for Health and social Care to use her powers to require the Wales NHS Ambulance Trust to provide a uniformly high standard of ambulance provision throughout Wales and especially rural areas such as Monmouthshire.

Welsh Ambulance NHS Trust:
We urge Welsh Ambulance NHS Trust to increase provision for Monmouth in real terms, with a high dependency unit and/or ambulance based within Monmouth town.

The petition was submitted by Matthew Davies and collected 42 signatures.

The Committee resolved to write to you to seek your views on the petition, and in particular on the action the petition calls on the Health and Social Care Committee to take.

The Committee will also be seeking the views of the Minister for Health and Social Services and the Welsh Ambulance NHS Trust, and will consider the petition further once responses have been received.

Yours sincerely,

William Powell
Committee Chair