Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
14 March 2012

Meeting time:
09:30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:

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Committee Clerk
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Agenda

1. Introductions, apologies and substitutions

2. Inquiry into Residential Care for Older People - Evidence from Local Health Boards (9:30-10:30)

Carol Shillabeer, Director Nursing, Powys Teaching Health Board

HSC(4)-10-12 paper 1 - Powys Teaching Health Board
HSC(4)-10-12 paper 2 - Aneurin Bevan Health Board
HSC(4)-10-12 paper 3 - Cwm Tâf Health Board
HSC(4)-10-12 paper 4 - Cardiff and Vale University Health Board
HSC(4)-10-12 paper 5 - Betsi Cadwaladr University Health Board
HSC(4)-10-12 paper 6 - Hywel Dda Health Board

3. Papers to note (Pages 1 - 2)

Minutes of the meeting held on 29 February

HSC(4)-07-12 minutes

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Nursing Directorate

Health and Social Care Committee

HSC(4)-10-12 paper 1

Inquiry into residential care for older people – Powys Teaching Health Board

8 December 2011

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

Dear Mr Drakeford

Inquiry into Residential Care for Older People

Powys teaching Health Board is pleased to provide the following evidence in support of the above enquiry. Representatives would be willing, as deemed appropriate, to provide verbal evidence to the Committee as required.

Powys is the largest county in Wales covering 25% of the land mass of Wales a distance of 130 miles from north to south, but has only 4% of the population at 130,000. The numbers and proportion of older people in the population of Powys is growing significantly with the numbers and proportion of younger people within Powys reducing.

There are a number of market towns within Powys, however only one (Newtown) has a population larger than 10,000. This sparsely geographically spread population means that the provision of services including support to the population requires a different approach to that of more urban population centres. Furthermore the healthcare pathways are complex with a number of District General Hospitals, some in England, providing care to the population of Powys. This evidence therefore largely focuses on the significant issues that rurality brings, and the different thinking required in order to meet the needs of a sparsely populated county.

Process for entering residential care and the availability and accessibility of alternative community-based services, including reablement and domiciliary care.

Over the last two years or so Powys teaching Health Board and Powys County Council have worked closely to redesign the pathways of care for older people within the county. The co-terminosity of the teaching Health Board and the County Council has brought significant advantage in being able to establish a focussed approach for service improvement for the population.

Two years ago up to 59 patients each month were 'stuck' in a Powys hospital awaiting their transfer of care, some with very extended lengths of stay. A significant proportion of patients were awaiting a care home placement, either residential or nursing. Many patients encountered a significant delay and it was clear that in the minority of cases patients care needs increased whilst delayed.

Joint work reviewing and reshaping pathways of care has been undertaken with very positive results and outcomes. Currently there are approximately 20 – 25 patients each month delayed in hospital (a reduction of approx 60%) with a length of delay greatly reduced (by approx 40%). This has been achieved through a number of means including:

- the introduction of extended hours District Nursing services working to provide as much care as possible in people's own homes.
- the introduction of reablement services in some parts of Powys, currently being rolled out across Powys.
- the introduction of Care Transfer Coordinators, largely nurses or therapists, whose role it is to track and support Powys patients within District General Hospitals to return to their own home where possible with community based support. Where additional rehabilitation support is required following an acute episode of care, patients are transferred into local community hospitals within Powys.
- the introduction of PURSH – Powys Urgent Response at Home Service – a Third Sector development supported by both Health and Social care to support patients and/or carers with immediate care to prevent a hospital admission. This service is protocol driven and enables the statutory services to arrange sustainable care options. Furthermore, the role of the Third Sector has been invaluable in building capacity and community cohesion. A practical example is the development of Volunteer Bureaux where increasing the numbers of trained volunteers in communities helps to identify people who may benefit from low level support to maintain life in their own homes, or escalate to statutory agencies those people who require early intervention/anticipatory care.
- the development of palliative care services through a Hospice At Home service, linking general care through to specialist care.
- Additional resources from social care.

There are however challenges that remain in the provision of alternatives to residential care within a rural setting, these include:

- the availability of appropriate workforce to deliver alternatives to residential care. For example, there have been difficulties recruiting into domiciliary care services in some parts of the county potentially resulting in other 'less preferred' options of care being considered and implemented. As fewer younger people live in Powys this difficulty could be set to continue.
- The availability of specialist services for those for example with dementia to work with people and families in their own homes and communities. The cost effectiveness of the provision of community based specialists may be challenging, however this would require balancing against the longer term costs of residential care solutions.
- The ability to implement different modalities of care provision within a single community. For example, the ability to develop the wide range of options for small communities (10,000 people) to include domiciliary support, telecare/telemedicine/telehealth, supported/assisted living accommodation, small numbers of residential care – particularly Elderly Mentally Infirm (EMI) residential care, and nursing home care. The timescales for delivering such a model of care can be challenging particularly if capital funding is required and where differing funding streams may be required for example by health and social care. There are further challenges regarding the financial sustainability of such a small and varied model of care provision based within multiple communities. This will be further explored later in the evidence.

Capacity of the residential 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.

Generally speaking there is a shift in need of the population from 'general' residential care – which can often be instigated because of concerns about overnight and weekend care options – to EMI residential care as improved community solutions have been implemented for general care patients. Largely the capability to care for general residents has been reasonable within Powys with ease of access. Far greater issues exist in relation to the access to EMI residential care, and given the demographic profile of the population of Powys this is likely to continue to be a significant issue unless change is brought to bear in relation to service models. There are patients currently within hospital who may wait a considerable period of time for an EMI placement (both residential and nursing) to become available.

The teaching Health Board staff support residential care both general and EMI through services such as District Nursing, Specialist Nursing such as tissue Viability, Palliative Care where a clear health surveillance or intervention is required. Some challenges exist where people have been settled within a residential care home setting and their care needs escalate. Residents are often reluctant to 'move home' given the upheaval this brings. In many cases, Care Home owners/managers are reluctant to support residents staying where they may not be able to meet their needs particularly nursing care

needs and this presents tension in the relationship and system of care. Equally, some Care Home owners/managers will try to maintain residents within the home even when their care needs increase in order to reduce disruption to residents. This can put residents in danger of not receiving the appropriate care, provided by skilled professionals. Clearly the ability and facilities for people to move through the levels of care within a single care setting (as described above: from supported housing through to nursing care) would present significant advantages.

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.

From the teaching Health Board perspective the range of services provided either 'under one roof' or in adjoining facilities requires improvement. As indicated above, there is inflexibility of the current model in meeting the changing needs of people as the level of care they require increases. This is particularly important in a rural setting where people generally wish to stay within their local community. People currently may have to move some considerable distance away to access the long term care that they require, resulting in difficulty for visiting relatives and friends (including the cost and inconvenience of travel) potentially increasing social isolation.

In relation to care home closure, within Powys the arrangements are clear, particularly where Escalating Concerns procedures have been instigated. The Local Authority works well with the teaching Health Board in this regard.

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

As new models of care are being developed there will be a need to review inspection arrangements. Within Powys for example the development of a Health and Social Care Centre/facility means that a range of residential, nursing care and GP/multidisciplinary team beds will be provided. The regulatory framework, specifically in relation to CSSIW and HIW will require further clarification in support of new models of health and social care.

Financial viability and the seemingly commonly held view that a care home requires 60 beds to maintain such viability presents difficulties within a rural setting. The provision of large care homes of 60 beds or more will require a pull of people into the care home from a number of communities/market towns. This means that people will have to travel and make a life decision to leave their communities to receive certain types of care. Bearing in mind the often split nature of residential and nursing care it may also include a move between care homes often in different market towns.

Powys teaching Health Board suggests that for a rural setting there is a need to provide generally smaller units of care home support within a broader range

of bed based and community/at home services. This graduated care model would require smaller amounts of certain types of care to be provided locally (for a population of approx 10,000 people). It is recognised that this could be seen as unattractive to the current care providers, particularly within the national residential and nursing care home sector, for reasons of financial viability and therefore may require a greater role for the public sector in partnership with the independent and Third sectors. For the independent sector there may be more opportunities to spread cost over a broader range of service options rather than singly residential or nursing care.

New and emerging models of care

It is clear that health and social care, along with housing departments in Local Authorities must work together as statutory organisations. The work of John Bolton and within the NHS 'Setting the Direction' clearly articulates how integrated working will benefit citizens. Greater emphasis should be placed on developing outcomes for the population irrespective of whether the onus on performance sits with the NHS or Local Authorities. Early intervention and specific focus on health intervention for example have a clear impact on whether a persons needs escalate to requiring residential care. The provision of social care where and when healthcare professionals recommend it in order to provide hopefully temporary support is also an important feature. Where immediate social care support (as a rapid response to an issue) fails to materialise, healthcare professionals may consider hospitalisation. For those people over 77 years of age, a hospital stay of more than 20 days significantly increases their chances of requiring residential/bed based care rather than a return to their own home with support. This 'whole system thinking' is starting to emerge but does need a greater emphasis, particularly at times of constraint budgets.

Exciting new models of care such as the Builth Wells, Powys model outline how in a rural setting a whole system approach can be developed. Truly integrated care centred in the community is a vision that is currently being implemented and will focus on understanding the needs of the population, targeting specific help/care toward at risk members of the community to support them within their own homes, provide 'step-in step-out short term bed based care from the NHS, provide supported housing, residential care and nursing care. The challenges of integrated working however include regulation and inspection – who will be the key regulator/inspector? If CSSIW then does HIW have a role to play? The issue of shared budgets is another consideration. Although welcome, there will need to be a further consideration of the means testing of social care versus NHS funded care.

The balance of public and independent sector provision, and alternative funding, management, and ownership models, such as those offered by cooperatives, mutual sector and third sector, and registered social landlords.

As outlined above, the model of residential care delivery as part of a wider system must take into account the specific needs of the rural population. Having large care home establishments providing a single type of care will not

be sufficient. A graduated care model drawing on at home, community based and bed based care is required within specific community areas. Financially and from a governance (NHS, Local Authority/Third Sector/Independent Sector) perspective further work is required. The teaching Health Board would be keen to further explore options where NHS premises can be developed and built upon to provide such graduated care models in partnership with other sectors. Given the shift from ‘hospital’ care to community care the community hospital buildings within Powys could play a significant role in the provision of graduated care within a more innovative funding and management model. This potentially provides an excellent opportunity for local communities to retain and build upon the value they already place on community hospital buildings with a purpose for future generations. The focus must remain on meeting the needs of the population of Powys.

I hope this evidence is helpful for your inquiry.

Yours sincerely

Carol Shillabeer
Nurse Director

Health and Social Care Committee

Inquiry into residential care for older people

RC22 – Aneurin Bevan Health Board

NATIONAL ASSEMBLY FOR WALES
HEALTH & SOCIAL CARE COMMITTEE

INQUIRY INTO RESIDENTIAL CARE FOR OLDER PEOPLE

ANEURIN BEVAN HEALTH BOARD
SUBMISSION OF EVIDENCE

Introduction

The Health Board welcomes the opportunity to provide evidence to the Health and Social Care Committee regarding Residential care for Older People.

The Health Board interfaces with the Residential Care Sector at many levels and in varying degrees. Our Safeguarding Team provides POVA advice and guidance to visiting professionals whilst our Nurse Assessors and District Nurses play a more direct role in both assessment of older people in residential homes as their needs change and in the direct provision of clinical care.

The Health Board together with a number of Local Authorities have appointed Integrated Service Managers who commission both Residential and Nursing Care. The new Frailty Community Resource Teams are also playing an active role with the Residential Care Sector to help prevent avoidable admissions and early discharge.

These are just a small example of the ways in which the Health Board interfaces with the Residential Sector.

The evidence provided below has been collated from responses across the Health Board both in terms of clinical and corporate services. The evidence is not based on research but on peoples experiences of the system and should be viewed in that context.

Evidence

The letter indicates a number of key areas for which the Committee is seeking evidence and the responses are detailed below.

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

The process by which people enter Residential Care is experienced by the Health Board from a hospital perspective. Following a Multi Disciplinary Team Assessment if the person requires Residential Care this is arranged via the relevant Local Authority. There can be significant delays in this process due to available capacity, funding and patient and carer choice. Sadly on occasions this has meant that people have deteriorated in terms of independence and have gone on to become eligible for Continuing Health Care and been admitted to a Nursing Home.

The level of community services and support available as an alternative to Residential Care is improving. There have been a number of initiatives across the Health Board and Local Authorities to enhance this provision.

Reablement services are now offered through the Gwent Frailty programme and our Community Resource Teams provide support to aid people back to independence. Reablement is now becoming the automatic focus for initial support for most referrals and the Frailty teams are successfully reducing dependency for care post intervention. In Newport for example a recent review found that 55% of people were discharged from Frailty with either a reduced package of care or no further needs. Pre frailty many of these people would have transferred from Hospital into the residential Care sector.

However there is still a lack of community capacity to support the numbers of people who could potentially remain at home rather than enter Residential Care, particularly when considered in the context of expected demographic change. There are also constraints on the numbers of people that the Domiciliary Care Agencies can manage at any one time. Limited resources, service (workforce) availability and the need to be clear about how public monies are spent for maximum impact will still need to be a factor in determining service models.

Whilst the alternative community provision continues to develop there is a real shortfall in the current level of residential care capacity particularly in relation to EMI residential provision, this is also true of EMI nursing provision.

Key issues which need to be considered are:

- How risks will be managed in the community in the future
- The point at which it is considered unsustainable to continue to support someone in their own home (trigger points for entering residential care - risk assessment/ mental capacity/ choice/cost)
- Thresholds for accessing social services -raising the eligibility bar for social services as a means of managing demand may be counter productive in terms of reducing the likelihood for people to need residential care at a future point

The capacity of the residential care sector to meet the demand for services from older people in terms of staffing resources, including the

skill mix of staff and their access to training, and the number of places and facilities, and resource levels.

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From a Health Board point of view it would appear that the there is insufficient capacity to meet demand particularly for EMI residential placements and this is often reflected in the Health Boards Delayed Transfers of Care numbers. There are also issues emerging about elderly people having to moves homes as their needs change i.e. if they develop dementia or need nursing care. Ideally the model should be a flexible one that can take account of peoples changing needs.

There is also a view that many of the “homes” are poor in terms of the environment and are quite institutionalised.

We are unable to comment on the staffing resource available in Residential Care Homes.

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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The Health Board experiences the quality of Residential Care Services through a number of avenues.

Firstly the level and types of admission from Residential Care Homes can be seen as an indicator of quality. We now monitor admissions via WAST by Residential Home (and indeed Nursing Home) and by the reasons for admission. Appendix 1 is data for June to September 2011 indicating the calls by home and reason for admission. Falls are clearly a key issue. Anecdotally there are concerns that people are not “allowed” to die at home and that they are admitted when they could be supported via District Nursing. Within this monitoring we look for “Frequent Flyers” and again support is offered at both a patient level and Home level. Our Frailty Service is now actively engaged in supporting admission avoidance and early discharge to Residential Homes.

Secondly the level of POVAs and Home Closures gives another indication of quality of care. This varies considerably across the Health Board area. Torfaen, for example are quoted as having the highest POVA levels in Wales whilst Newport are seeing falling POVAs and homes becoming engaged in the roll out of the 1000 Lives Plus Campaign. Blaenau Gwent has an Integrated POVA Team supporting all the homes in the area.

The Health Board also experiences very low levels, if any, of referrals for Fast Track Palliative Care for people in Residential Care Homes.

In terms of improving quality consideration should be given to the staffing models required to do more than just provide basic personal care. There is need to invest in the workforce in terms of education and remuneration so that people want to be care workers and feel valued and proud of what they do.

Registration might be part of this. Statutory services should also ensure appropriate access to NHS primary and secondary care services for people resident in care homes. This would mean that people would not necessarily have to move as their needs changed.

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

The Health Board has limited involvement in the regulation and inspection of Residential Care Homes.

New and emerging models of care provision.

The Health Board have an agreed operational procedure for ensuing that the care for older people who reside in nursing homes and who receive care on behalf of the NHS is delivered in such a way that it promotes dignity and respect, health, wellbeing and safety and is consistent with human rights. The Health Board would be happy to share this as an area of good practice.

Whilst there has been significant improvement in joint working there is still a need for more effective collaborative working between health, housing and social services and this was a key theme of the recent Health and Housing Conference (Healthy Homes – Health Lives). The aim of which would be collaborative support to maintain people in their own homes. The outcome of the conference was the proposed establishment of a Health Board led Health and Housing Partnership Forum.
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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.

The recent experience of the Southern Cross Homes has in some part brought a sharp emphasis on contingency planning and for this reason there does need to be an exploration of the funding, management and ownership models which support both the Residential and Nursing Home Sector.

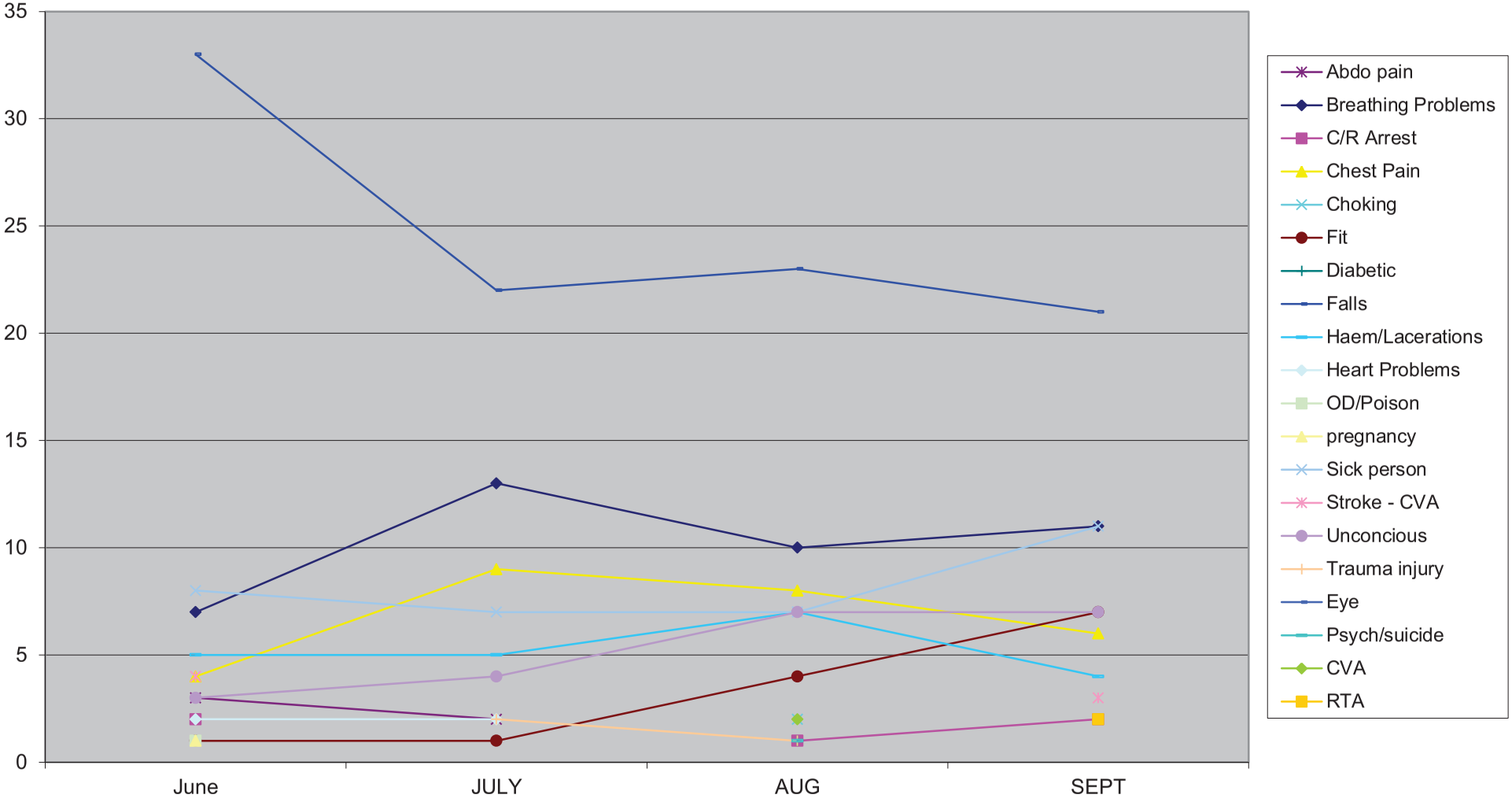
There is also the issue of the fabric of the premises, with many being quite old and some poor environments. The issue of how homes access capital to develop modern facilities is a key concern.

Prepared on Behalf of Aneurin Bevan Health Board by

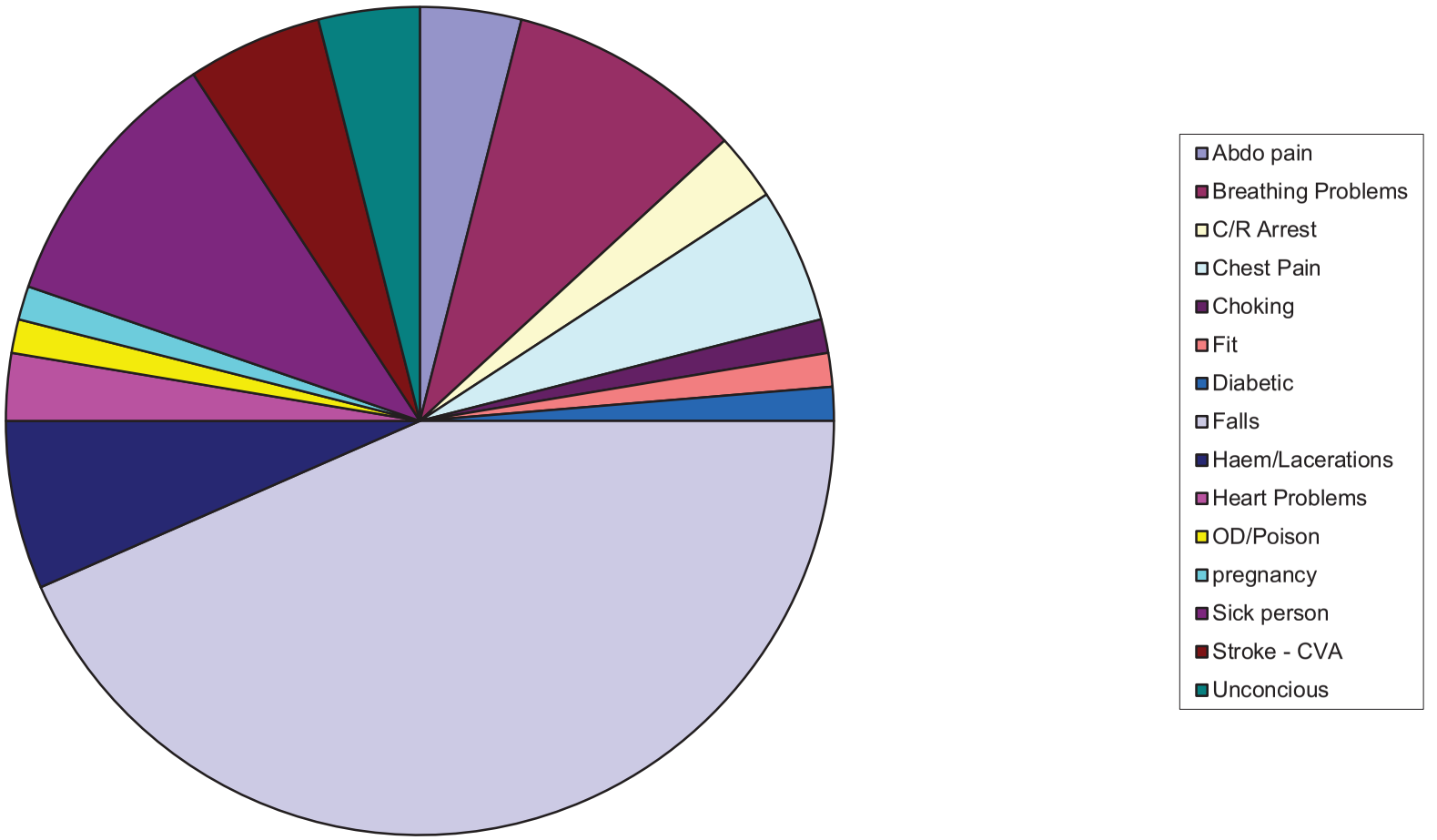
Julie Thomas
Locality Director Newport

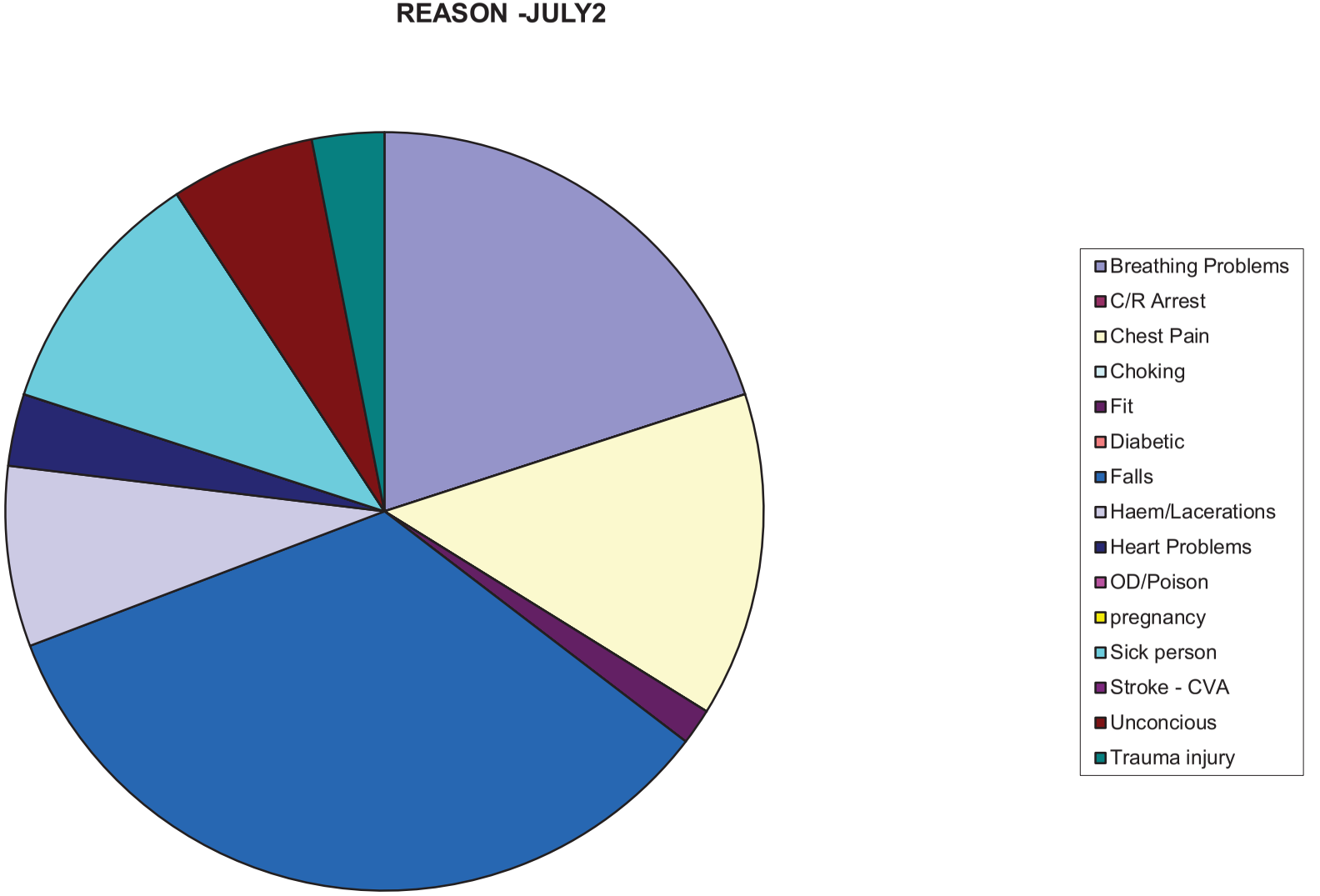
BG	JUNE	JULY	AUG	SEPT
Woffington	4	6	5	3
Rookery	3	3	8	3
Bridge house	0	0	0	2
C	**JUNE**	**JULY**	**AUG**	**SEPT**
Churchview	6			5
Hillside	7	1	4	4
Abermill	6	4	9	8
Millbrook	5	3	7	5
Parkside	1	1		
White Rose	1			
Oakdale Manor	1	1	3	7
churchview		7		
whiterose		3		
M	**JUNE**	**JULY**	**AUG**	**SEPT**
Castle Court	3	1	1	3
Bethany Christian Home	1	1	1	1
Belmont House	1	4	6	2
Parade House	1		2	
Penpergwm House	2			2
Ty Gwyn	3	3	1	3
Cantref		1		
N	**JUNE**	**JULY**	**AUG**	**SEPT**
Glenmore	2		1	
Mayfield	2		1	2
Florence Justice	2	1		
Ashton Park	2		2	
The Willows	1		2	1
Emmaus	1	1		
T	**JUNE**	**JULY**	**AUG**	**SEPT**
Plas Y Garn	7	4	4	1
Arthur Jenkins	2	9	2	5
Regency House	9	12	10	14
Cwmbran House	3		4	4
Mayflower			1	

REASON FOR CALL-RESIDENTIAL HOMES



REASON -June


Abdo pain
Breathing Problems
C/R Arrest
Chest Pain
Choking
Fit
Diabetic
Falls
Haem/Lacerations
Heart Problems
OD/Poison
pregnancy
Sick person
Stroke - CVA
Unconcious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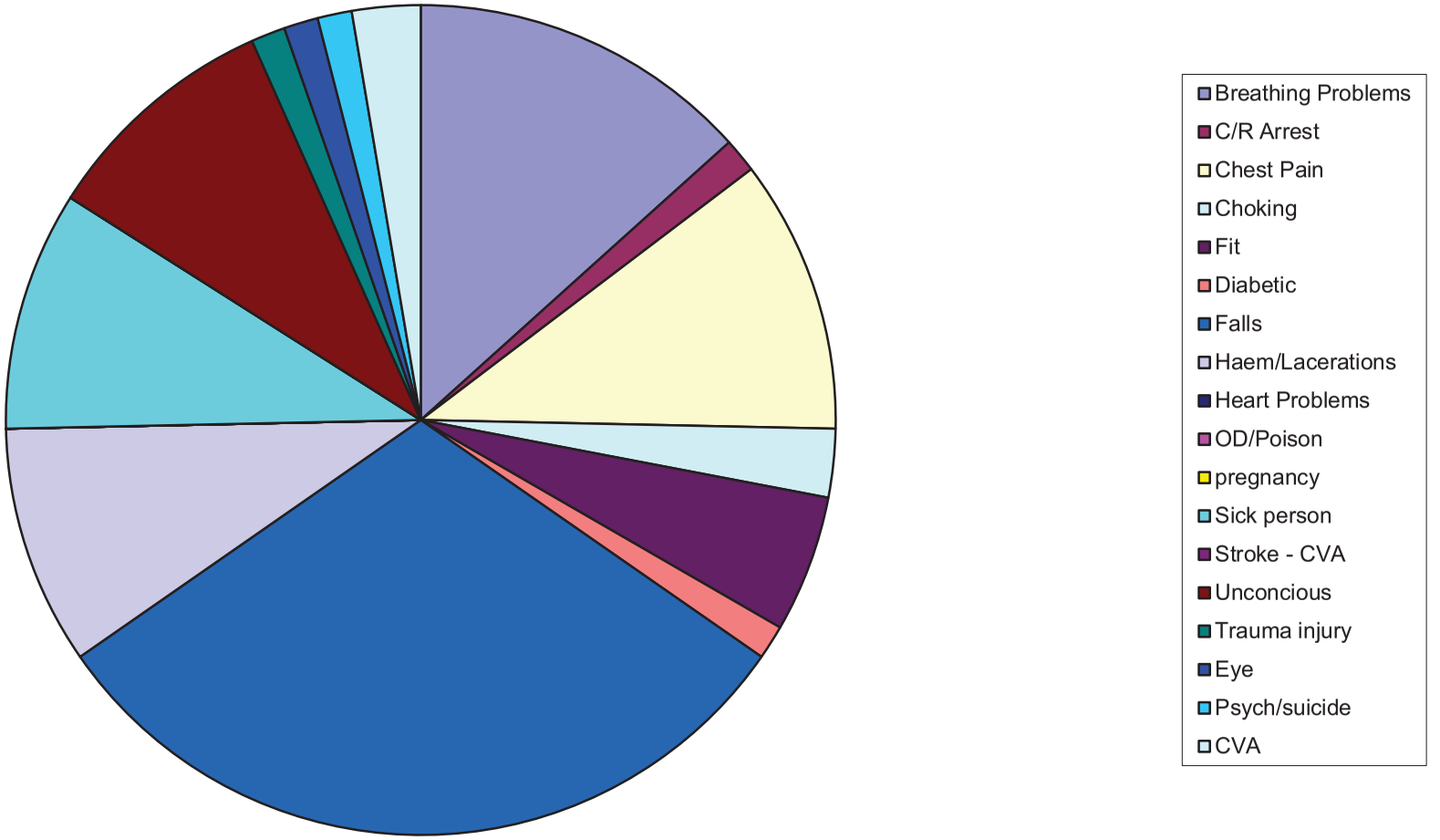
Breathing Problems
C/R Arrest
Chest Pain
Choking
Fit
Diabetic
Falls
Haem/Lacerations
Heart Problems
OD/Poison
pregnancy
Sick person
Stroke - CVA
Unconcious
Trauma injury

REASON -AUG


Breathing Problems
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Choking
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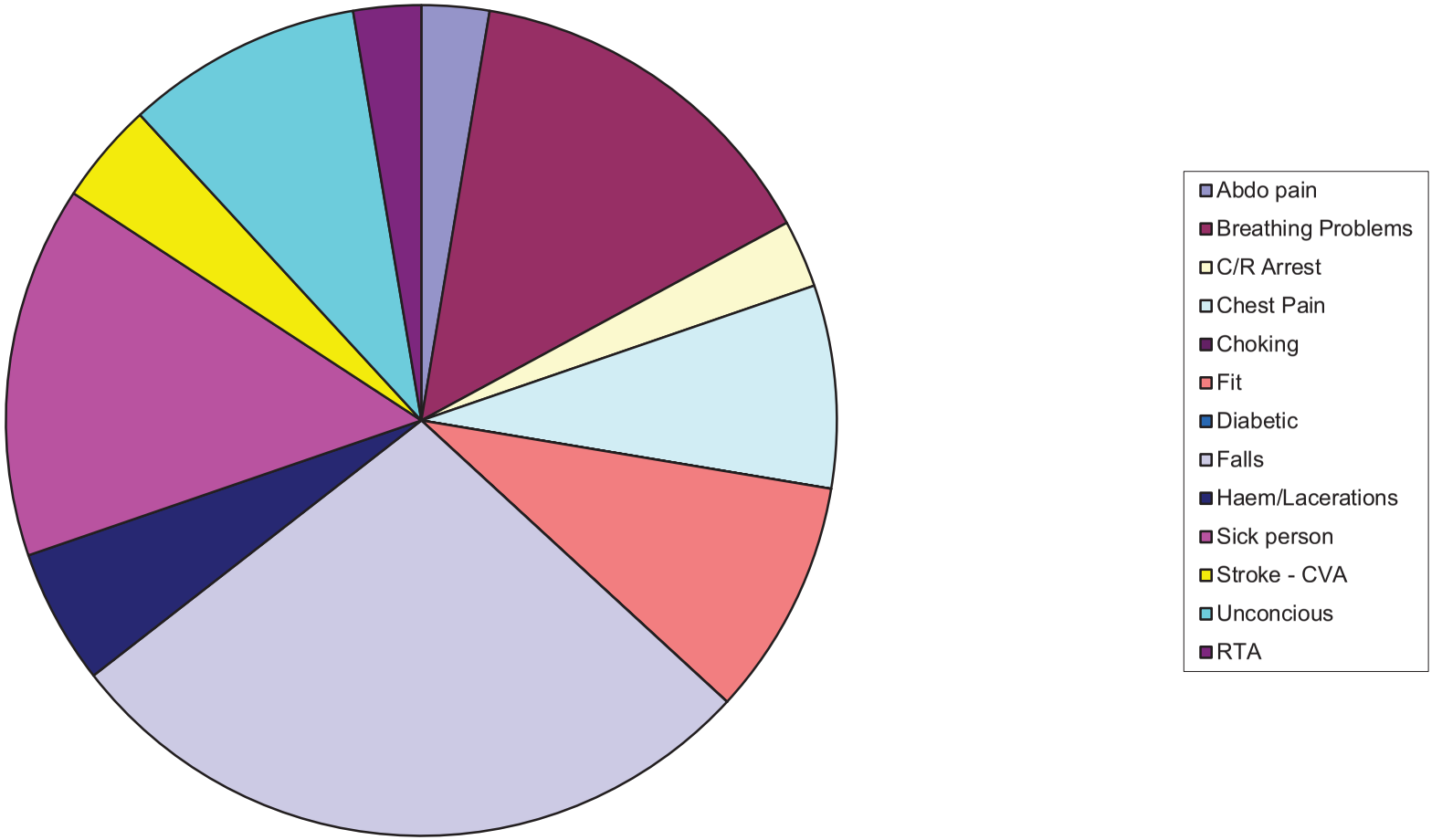
Diabetic
Falls
Haem/Lacerations
Heart Problems
OD/Poison
pregnancy
Sick person
Stroke - CVA
Unconcious
Trauma injury
Eye
Psych/suicide
CVA

REASON -SEPT


Abdo pain
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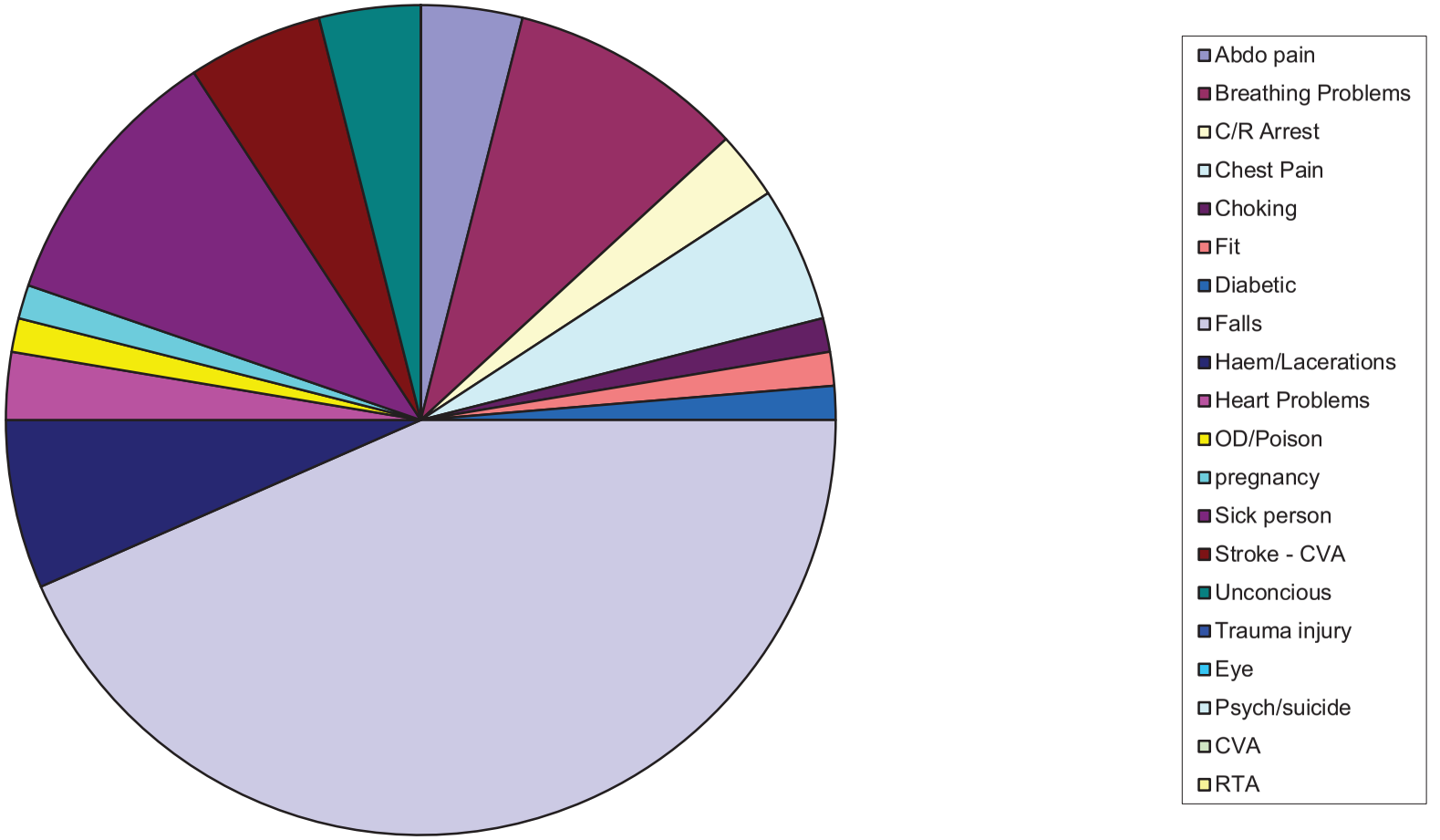
Chest Pain
Choking
Fit
Diabetic
Falls
Haem/Lacerations
Sick person
Stroke - CVA
Unconcious
RTA

REASON FOR CALL PIE CHART



BG	JUNE	JULY
Woffington	4	6
Rookery	3	3
Bridge house	0	0
C	**JUNE**	**JULY**
Churchview	6	
Hillside	7	1
Abermill	6	4
Millbrook	5	3
Parkside	1	1
White Rose	1	
Oakdale Manor	1	1
churchview		7
whiterose		3
M	**JUNE**	**JULY**
Castle Court	3	1
Bethany Christian Home	1	1
Belmont House	1	4
Parade House	1	
Penpergwm House	2	
Ty Gwyn	3	3
Cantref		1
N	**JUNE**	**JULY**
Glenmore	2	
Mayfield	2	
Florence Justice	2	1
Ashton Park	2	
The Willows	1	
Emmaus	1	1
T	**JUNE**	**JULY**
Plas Y Garn	7	4
Arthur Jenkins	2	9
Regency House	9	12

Cwmbran House	3	
Mayflower		

AUG	SEPT
5	3
8	3
0	2
AUG	**SEPT**
	5
4	4
9	8
7	5
3	7
AUG	**SEPT**
1	3
1	1
6	2
2	
	2
1	3
AUG	**SEPT**
1	
1	2
2	
2	1
AUG	**SEPT**
4	1
2	5
10	14

	June	JULY	AUG	SEPT	
Abdo pain		3	2		2
Breathing Problems		7	13	10	11
C/R Arrest		2		1	2
Chest Pain		4	9	8	6
Choking		1		2	
Fit		1	1	4	7
Diabetic		1		1	
Falls		33	22	23	21
Haem/Lacerations		5	5	7	4
Heart Problems		2	2		
OD/Poison		1			
pregnancy		1			
Sick person		8	7	7	11
Stroke - CVA		4			3
Unconcious		3	4	7	7
Trauma injury			2	1	
Eye				1	
Psych/suicide				1	
CVA				2	
RTA					2

	JULY		AUG
Abdo pain	2		
Breathing Problems	13		Breathing Problems 10
C/R Arrest			C/R Arrest 1
Chest Pain	9		Chest Pain 8
Choking			Choking 2
Fit	1		Fit 4
Diabetic			Diabetic 1
Falls	22		

4	4
1	

Haem/Lacerations	5
Heart Problems	2
OD/Poison	
pregnancy	
Sick person	7
Stroke - CVA	
Unconcious	4
Trauma injury	2

Falls	23
Haem/Lacerations	7
Heart Problems	
OD/Poison	
pregnancy	
Sick person	7
Stroke - CVA	
Unconcious	7
Trauma injury	1
Eye	1
Psych/suicide	1
CVA	2

	SEPT
Abdo pain	2
Breathing Problems	11
C/R Arrest	2
Chest Pain	6
Choking	
Fit	7
Diabetic	
Falls	21
Haem/Lacerations	4
Sick person	11
Stroke - CVA	3

Unconcious	7
RTA	2

GIG CYMRU NHS WALES
Bwrdd Iechyd Cwm Taf Health Board

Your ref/eich cyf:
Our ref/ein cyf: C_17/LWcn
Date/Dyddiad: 15 December 2011
Tel/ffôn: 01443 744835
Fax/ffacs:
Email/ebost: Claire.northwell2@wales.nhs.uk
Dept/adran: Corporate Services

Contribution to the Health & Social Care Committee: Inquiry into Residential Care for Older People

Name: Cwm Taf Health Board

Role Profile: Cwm Taf Health Board was established on 1 October 2009 and is responsible for the provision of health care services to over 325, 000 people principally covering the Merthyr Tydfil and Rhondda Cynon Taff Local Authority areas.

Our Vision is to *'Create Altogether Healthier Communities'* by aiming to prevent ill health, protect good health and promote better health' through working with partners to provide services as locally as possible and reducing the need for hospital inpatient care wherever feasible. Acute, intermediate, community and mental health services are delivered across a network of Community Clinics, Health Centres and Community Hospitals supported by two District General Hospitals.

Older people would usually enter the residential care setting following a crisis either at home or following a hospital admission. This would mostly be with a multi-disciplinary multi-agency assessment of need.

The current process can be disjointed, and whilst tremendous work was undertaken a few years ago on unified assessment, this has not significantly progressed between agencies at a local operational level. We have been advised that there are plans to revisit this at a Welsh Government policy level, and as a partner organisation we would welcome this, and an opportunity to participate.

It would be vital for this strategic work to include a single assessment process for all possible outcomes for the individual (e.g. social care, at home, health and social care joint package and continuing health care). The earlier work identified barriers, the most significant of which was the need for connective IT systems between health and social care.

The ability to give personal information only once and for it to be shared appropriately between organisations would be significant to the individual being assessed and to those working with the person.

There has been significant progress in the development of alternatives to residential care across the community, these are often on a multi-agency basis e.g. reablement services and medication projects but they are often linked to certain geographical areas. The ability to roll these schemes out further is often limited to resources both financial and staffing.

The residential care sector manage a range of provision for individuals with often complex needs, there appears to be good support networks for trawling through the Local Authorities social workforce development programmes. Within the Health Board area there appears to be sufficient residential care provision to meet demand, however this is often tempered by the availability of the more desirable homes and the consequential impact than hospital discharges as individuals await their home of choice.

The availability of new and emerging models of care delivery, based in community following the policy direction of 'Setting the Direction' will possible effect the residential care home sector, and Health Boards will need to work with Local Authority partners and the sector to consider the opportunities this presents

Please do not hesitate to contact me if you have any queries.

Yours sincerely

Lynda Williams
Assistant Director of Nursing (Regulation and Legislation)

Health and Social Care Committee
HSC(4)-10-12 paper 4
Inquiry into residential care for older people – Cardiff and Vale University Health Board (UHB) Falls and Bone Health Programme (F&BHP)

Role of responder

This response is from the Cardiff and Vale University Health Board (UHB) Falls and Bone Health Programme (F&BHP), which sits under the Cardiff and Vale Integrated Health and Social Care Programme. A working group comprising of members from statutory, the Third and independent sectors advises the F&BHP.

The F&BHP has made contacts with care providers through individual meetings and at two seminars to ask their needs and requirements for falls prevention and management. A major concern of the independent sector is the variable level of communication from the NHS. The UHB is committed to working in partnership.

Background Information - Falls and Bone Health

Although not an inevitable part of ageing, nevertheless the risk of injurious falls increases with age and frailty. The changing demographic picture is an imperative driver to reduce harm from falls and minimise risks. Currently falls and fractures are estimated to cost Cardiff health and social care £10-12 million a year (with hip fractures the greater part). The human cost of falls and fractures is immense with loss of confidence and independence, which may result in social isolation, depression and admission to residential care.

Falls prevention is a complex issue and all ambulant residents are at a high risk of falls in care and other institutional settings. The frequently quoted figure for risks in care settings is 1.5 falls per bed per year. Amongst the challenges that the UHB faces, for example balancing risks with the importance of promoting an autonomous life for a resident/patient, are well understood by the care provider sector.

Entering residential care

Falls are a common factor in the decision for people to enter care homes. People who have fallen benefit from multifactorial assessment, in many cases this reduces the risks or frequency of future falls. Where falls are a feature contributing to a decision to enter a care home the relocation itself may not reduce the risk of falling.

UHB discharges many patients to the residential care sector who have fallen (this includes following a falls related admission from the

community; following a fall in residential care or an in-patient fall). It is important that partnership working and a standardised approach to falls and bone health is promoted across the sectors, as the sectors are interdependent on one another. A whole systems approach is crucial to improve the patient experience.

Community based services

In November 2011, the UHB launched two new falls and bone health pathways (aligned to the *1000 Lives+ "Reducing harm from a fall"* programme). An older person attending Unscheduled Care with a fall from the community or care setting who is not admitted is screened for an on-going falls risk. Primary Care is informed of the result and undertakes further assessment, interventions and referrals. It is expected that through the interventions the risk of another fall is reduced and independence promoted. The pathway includes a home safety checker leaflet by *Care and Repair.* This gives useful community based information for home adaptations and other services to ensure that a person can remain for as long as possible in their own home.

The Cardiff and Vale Community Resource Teams (CRTs) in Phase 2 (from Spring 2012) will support reablement and admission avoidance (from acute care and residential care). The fore-runner of the CRTs (models such as Penarth Integrated Care Team or Cardiff East Locality Team have demonstrated admission avoidance and appropriate step-up and step-down provision.

Experiences of service users

The UHB has not undertaken consultation with service users of residential care relating to falls and bone health, but extensive consultation was undertaken with community dwelling older people to:

- Set the direction and develop the outcomes for the Falls and Bone Health Programme
- Explore information needs and develop two leaflets (in-patients and a home safety checker).

Quality of services

Falls risk assessments and care plans

There is a statutory requirement for care providers to undertake a falls risk assessments, and a requirement to record and register all falls. Many care providers use a modified "S*tratify"* tool – however studies have shown this tool performs poorly and its use is no longer supported by its author. Best evidence suggesting a care planning approach. There is a tension between what are CSSIW regulatory requirements in terms of assessment and evidenced-based practice. Routine risk assessments for bone health are not undertaken, although a question on osteoporosis is asked.

Falls registers in current use
The maintenance of a falls register is a requirement for all care home operators. However, various forms of registers are kept and monitoring of trends is not a routine; not all systems are easily auditable. CSSIW Inspectors ask different responses following a fall. Some homes report all falls via a Regulation 38 document, while others only report falls requiring hospital treatment. Domiciliary care providers use a Regulation 26 document for serious injury.

Beds and equipment are an issue for care providers, for example beds in care homes are often of a normal divan type without the facility to become ultra low for a person likely to fall. The availability of ultra low beds in nursing homes is variable and so are hip protectors.

Training
The Care Provider sector (nursing, residential and domiciliary) was consulted during the development of the UHB's *"Falls prevention and management procedures"*. The sector was invited to the launch in April 2011 and copies of the document with useful appendices were sent to each provider. The UHB with Cardiff and the Vale of Glamorgan's Social Care Workforce Development Co-ordinators held a successfully evaluated seminar in November 2010, providing joint training for health and social care staff. A further seminar is planned for February 2012 with training based on the Royal College of Physicians *"National Audit of Falls and Bone Health Audit" (*This audit whilst focussed on health service providers includes returns from operators of a numbers of residential care settings). The seminar will provide training guided by the Audit Recommendations and include such issues as when to call primary care following a fall and post falls investigations.

It is worth noting that carers undertaking Qualification Credit Framework (QCF) Diplomas training receive information about risks from a health and safety perspective but not about intrinsic risks for an individual, for example dementia.

New and emerging models of care provision
The RCP Audit Recommendations ask that care homes have:

- Accurate data and information for service planning
- Medication reviews for all residents
- Access to exercise
- Provision of training

Recommendations
1. That the complex issues of falls prevention and management and bone health protection require a co-ordinated approach with health working in partnership with the care provider sector. This might include:

- improving communication between the sectors
- sharing documentation with care providers
- joint learning/training experiences

2. That the RCP Recommendations are implemented through:
   - promoting the use of easily auditable falls registers by the care providers
   - promoting and supporting a standardised approach to falls prevention
   - improving accurate data and information about falls
   - ensuring systems are in place for regular medication reviews
   - availability of therapeutic exercise
   - a focus on admission avoidance following a fall in both the community and in a home
   - training events on falls prevention; post falls management and bone health protection issues
   - reviewing of local authority and health contracts

Amanda Ryan, Falls and Bone Health Programme Manager,
Denise Shanahan, Consultant Nurse Older Vulnerable Adults,
Cardiff and Vale University Health Board
December 2011

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
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Dyddiad / Date: 15th December 2011

Dear Mr Drakeford,

Re: Submission of Evidence Inquiry into Residential Care for Older People.

Thank you for the opportunity to submit evidence to the Inquiry into residential care for older people. Whilst Betsi Cadwaladr University Health Board recognises the enquiries main focus is on residential care. Evidence has been gained from health professionals who provide input and support to residential homes. The staff groups who have contributed include District Nurses, Locality Matrons and Continuing Healthcare Managers.

Evidence has been sought on the questions you plan to examine as part of the inquiry:

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

The Health Board are utilising discharge planning and redesign of intermediate care to ensure that alternatives are considered as a first option for any person who has re-ablement potential. In the future, this will include re-ablement beds for those people who need additional short term support. Extra care housing options are available in certain areas but there is a need for additional capacity. Coordination of Health and Social Care in localities over 24 hours is in development and there is a requirement to join up Health and Social Care out of hours services to include intermediate care services, with support from the third sector.

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

Whilst it is the responsibility of the Local Authority to monitor residential care, there is increasing concern from a health perspective in relation to the fact that there is no guidance on minimum safe staffing levels or skill mix in residential care. This is unhelpful to homes and to stakeholders and is required as part of good governance arrangements.

In relation to the need to meet the demand for services, there is often a need to move people to a nursing home when their condition becomes more complex. For residents, this is in effect moving them from their own home and it would be useful to have simpler and quicker processes for variation of contract to enable health input, rather than the present way of an individual variance.

In relation to training, the development of core competencies and mandatory training is key in ensuring quality care and the ability to recognise change in condition and deal with the increasing level of complexity that presents in a residential setting. Joint provision of training between Local Authorities, CSSIW and Health, requires input to maintain standards in relation to training. Key areas of training should include POVA, tissue viability, dignity and respect, infection control, nutrition and manual handling.

Health Services support residential homes in this area with training and also in review of residents who require health input.

The quality of residential services and the experience of service users and their families, the effectiveness of services at meeting the diversity of needs amongst older people; and the management of care home closures

Although this is the direct responsibility of Local Authorities, Health Services provide support to local authorities in this function. This includes the management of any care home closures and review of any residents as part of escalating concerns, and is a resident's condition deteriorates and therefore becomes the responsibility of Health when their needs change.

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

This is not a responsibility of Health but there is a need for effective regulation and inspection to safeguard residents. This should include the scope for increased scrutiny of financial variability. If a home is not financially viable this tends to impact on care and the provision of an early warning. If there is lack of financial viability this can enable additional support and prevent deterioration in care for residents.

New and emerging models of care provision

There is a requirement as part of the development of localities, to have the ability to access flexible as required as part of a pathway approach with integrated Health and Social Care services providing care at home and with strengthened function of intermediate care which is undertaken as part of care services.

Key elements of this would include step up to extra care, short term residential care and intensive rehabilitation. There is a need to look creatively at beds in the residential sector – e.g. to provide palliative care or an intermediate care type facility where a resident required

24 hour supervision which could be provided by mainstream community services. As highlighted previously, this would require changes to variation function by CSSIW.

The balance of public and independent sector provision and alternative funding, management, and ownership models such as those offered by co-operative, mutual sector and third sector and registered social landlords.

This approach would be welcomed as there are good emergent examples of alternative models across the United Kingdom that would merit further exploration. Any development of alternative models needs to provide effective governance arrangements and provide assurance that it meets local need.

I hope this is helpful and Betsi Cadwaladr Health Board would be pleased to follow up this submission with oral evidence as part of the inquiry.

Yours sincerely,

Mary Burrows
Chief Executive

Health and Social Care Committee
HSC(4)-10-12 paper 6
Inquiry into residential care for older people – Hywel Dda Health Board

The Health and Social Care Committee's Inquiry into Residential Care for Older People.

Response on behalf of Hywel Dda Health Board.

The below response recognises that the questions outlined by the HSC Committee and the Inquiry into Residential Care is largely a matter for Local Authority partners. The Health Board plays an active part in discussions with Local Authority colleagues around Long Term Care and long term care planning and strategy and this is reflected in the below response.

Joint Health and Social Care posts have been created at a senior level at a County level within the Health Board. This has further increased the level of joint planning and direction around Health and Social Care issues and the development of joint community based service solutions.

Our partner Local Authorities have provided and submitted detailed responses in respect to the above on their specific practices and strategies. The Health Board has not commented on the questions below relating directly to statutory duties on Local Authorities and / or areas of specific planning for LA partners.

A broader response on the general direction with regards to community and Long Term Care (LTC) developments and schemes has been provided as an overview.

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

  Clear processes are in place by all three partner Local Authorities around admission to Residential care. The emphasis, similar to Hywel Dda Health Board (HDHB), is to maintain as many clients within the community setting for as long as possible through the development of community based services. This is in line with the direction outlined in key publications f.e Designed for Life and the locally developed Health and Social Care and Well Being Strategies.

The extended range of community based provision aims to enable older people to live longer independently, within their own homes, delaying the onset of admission to Long Term Care. Service strategies for the partner Local Authorities and the Health Board are concentrated on strengthening service provision in this key area – enabling early identification and, by default, prevention of ill health and mobility issues. The development of low and medium level support for service users and their families aim to promote independence within the community and home environment. Third Sector provision and schemes have also been developed through a partnership arrangement, to ensure a level of support and care for carers and service users on a day to day basis. However, it is acknowledged that a greater level of service for carers is needed to ensure that carers are able to continue with their caring role on a longer term basis and provide a sustainable service solution.

The focus of recent years has been to increase and expand on community provision and services. Greater investment in community based services has been seen both from the Local Authorities and Health Board with the anticipated long term achievement of a reduced need for residential placements – especially longer term. This work has been undertaken in co-junction with HDHB and third sector organisations.

A recent example of this work and the joint vision for the development of community based options are the services developed from the CHC Bids money, made available to LHBs and partners in 2009/10. A joint approach was taken with the LAs and Third sector organisations, and the development of community based alternative to long term care – both low level need (traditional LA funded area) and higher level need (traditionally CHC) were implemented.

A number of the schemes have resulted in less need for early admission to LTC and residential placement due to the increase in targeted community based resources. Schemes such as the *Through the Night Service*, dementia care services etc have resulted in a larger number of older people being supported at home for longer. The overall aim and strategy direction is to reduce the number of older people needing admission to Residential Care through the on-going development and implementation of targeted community based services – such as those developed through the CHC bids money.

As part of the Clinical Services Strategy review within Hywel Dda Health Board, the development of Community based services is a key objective and work is on-going in identifying services areas for development that will enable greater reablement opportunities within the community setting, especially for older adults.

For service users assessed as not being able to continue to live within the community, provision is available within residential care services. With such cases each LA has a clear process of eligibility and scrutiny of submissions for approval of access to residential care. Clear scrutiny is given to the service users' case – through a joint scrutiny panel, to ensure that any reablement opportunities can, and have been undertaken prior to admission to LTC. This option includes the LA direction of a higher level care and assistance for older people f.e intensive domiciliary care services, respite services and extra care housing. Services around dementia and mental health have been developed with the aim of managing more of this client group in the community for longer. In Pembrokeshire the development of the complex care team has resulted in better management of service users traditionally admitted to Long Term Care through increased domiciliary and reablement provision.

A number of joint meetings and planning opportunities are taking place to ensure where possible a joint approach to service planning and direction across the Health and Social care community. Current plans are being rolled out for wider community care services such as Virtual Wards etc to enable more effective discharge, reduced incidence of DTOC and enable a patient to be managed within their own home for complex chronic conditions, reducing the need for admission to residential care. However, where a clear need for residential placement is demonstrated, processes are well developed and are in place to enable a smooth transition for service users to their preferred home of choice.

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

Service Specific Question. Partner Local Authorities have provided their responses in respect of this question.

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

Service Specific Question. Partner Local Authorities have provided their responses in respect of this question.

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

Service Specific Question. Partner Local Authorities have provided their responses in respect of this question.

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

Significant work has been undertaken on developing services aimed at providing intermediate and reablement care within the community setting.

The focus and direction of the Health and Social Care Community has been to increase service provision within the community setting – enabling more and more clients to access these services and maintain their independence and ability to remain in their own homes. Examples of new and emerging models include the following examples:

- **CAT@H Telecare and Response** – assistive technology provision. Enabling a personalised service and management of client through developing technology. Service has been successful in rural areas where provision of domiciliary care workers is timely and costly. Key aims of service are:

  - To support people to remain in their own homes safely for as long as possible – reducing the need for admission to Long Term Care.
  - To assist in promoting independence
  - To reduce avoidable hospital admissions
  - To support hospital discharges / reduce DTOC
  - To support contingency plans for people in the community
  - Support informal carers

- **Through the Night Service** – Developed through CHC bids money. Service enables emergency and non emergency non medical night provision to clients in Carmarthenshire. Previously clients requiring night care provision would be admitted to Residential Care. The service enables clients to continue to live within the community through increased domiciliary arrangements to manage their care.

  - Prevention of admission to Long Term Care
  - Increased options for service users with low to moderate level needs within the community setting
  - Promotes independence for Service users.

- **Complex Care Team** . Pembrokeshire model. Development of four complex care teams made up of health, social care and

third sector staff with GPs to identify people at risk of loss of independence or unnecessary admission to hospital.

- Prevention of hospital admission
- Prevention of people falling into crisis
- Seamless service between health and social care.
- Reduction in admissions to Long Term Care.

- **Chronic Condition Management .** The development of a number of schemes targeted at clients with diagnosed chronic conditions. Current schemes and services include:

- **Chronic Condition Specialist nurses** to manage identified clients within the community setting or within a care home setting,
- **Expert patient Programme**, to assist those living with, or caring for a client with a long term chronic condition,
- Development of an **Epilepsy, Diabetes and MSK** service and pathways to help clients with these conditions to manage their conditions outside the hospital setting – reducing the need for specialist and long term care arrangements,
- **Virtual wards** – to manage clients identified at risk with chronic conditions within the community setting – again reducing the need for admission to long term care.
- **Primary Care Mental Health Service**: To better support clients within the community.

- **Provision of specialist Staff – Cross Roads**. The service is aimed at assisting carers with their caring duties.

- Prevent the need to admit the cared for to hospital or nursing home
- Allowing time for alternative care arrangements to be made in emergency situations
- Reduction in agency costs for Emergency respite for this client group

- **Convalescence Beds Service**. A model of care within Carmarthenshire. Services provides rehabilitation within identified care homes for a fixed term basis. The aim is to provide older people a period of convalescence in a care home setting following discharge from hospital. The aim of the service is to enable older people to maintain their independence, gain confidence and progress with their recovery in preparation for their return home or other long term care arrangements. The aim is to allow for a longer period of rehabilitation and reablement with the end goal of the client being able to return to the community setting.

- **Three Counties Care Home Support project**. Project supports care homes by providing a tailored training programme with on-going support to the care home sector by Health and social care staff . The aim is to improve clinical outcomes for service users in care homes.

  - preventing hospital admissions and decline into ill health within care homes
  - Improving training and care and governance within care homes across the Three Counties
  - Improving the management of physical and mental well being of older people – preventing a decline to ill health.
  - identifying and addressing deterioration in health at an early stage and halting the decline into CHC eligibility.

- **Dementia Day Care Services**: Ceredigion. Project to support clients with dementia in the community. The aim is to improve education and training to reduce the need for admission into long term care for this client group

- **Integrated Independent services** (Rapid Response Care at home service and Acute response service) The development of a Re-ablement and independence service to provide 7am – 5pm rapid response in the Ceredigion area. Service compliments service already operational in Carmarthenshire.

  - Avoid unnecessary hospital admissions
  - Facilitate earlier discharge home
  - Keep people in the community setting for longer.

  - **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.**

Service Specific Question. Partner Local Authorities have provided their responses in respect of this question.

Agenda Item 3

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 – Senedd**
Meeting date:	**Wednesday, 29 February 2012**
Meeting time:	**09:30 – 12:00**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/archiveplayer.jsf?v=en_200000_29_02_2012&t=0&l=en

Concise Minutes:

Assembly Members:	**Mark Drakeford (Chair)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle**
Witnesses:	**Sue Brown, Sense Cymru** **Nancy Davies, Pensioners' Forum Wales** **Haydn Evans, Pensioners' Forum Wales** **Linda Thomas, Age Concern Cardiff and Vale** **Dr Rosie Tope, Wales Committee of Carers Wales** **Phil Vining, Age Concern Cardiff and Vale** **Roz Williamson, Carers Wales** **Rebecca Woolley, Action on Hearing Loss Cymru** **Ansley Workman, RNIB Cymru**
Committee Staff:	**Meriel Singleton (Clerk)** **Catherine Hunt (Deputy Clerk)** **Philippa Watkins (Researcher)**

1. Introductions, apologies and substitutions

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

2. Inquiry into Residential Care for Older People – Evidence from service users, their families and carers

2.1 The witnesses responded to questions from members of the Committee on residential care for older people.

2.2 The Committee requested a copy of the report by the Social Care Institute for Excellence on the quality of care home provision provided by different sectors.

2.3 The Committee requested a copy of the report by the Commission on Improving Dignity in Care for Older People on Delivering Dignity.

3. Papers to note

3.1 The Committee noted the letter from the Minister for Health and Social Services.

3.2 The Committee noted the paper from Prof John Bolton.

3.3 The Committee agreed to await the outcome of the Petitions Committee's evidence session on the petition before taking any further action.

3.4 The Committee agreed to await the responses of the Minister for Health and Social Services and the Welsh Ambulance Service Trust to the Petitions Committee before considering any work on this matter.

TRANSCRIPT

View the meeting transcript.