social care
institute for excellence

Inquiry into Residential Care for Older People in Wales

Submission from the Social Care Institute for Excellence

Introduction

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

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

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

4. A summary of our main points:

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

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

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

Admissions in crisis situations

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

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

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

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

Self-funded and council-sponsored residents

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

Home care and prevention

9. There have been some increases in home care provision and extra care housing. Community services need to be tailored and targeted if they are to reduce or delay the need for residential or hospital admission. Intermediate care has been used successfully as an alternative for those who don‟t need to be in hospital, as well as a service for those leaving hospital. Both intermediate care and reablement services require close joint working and resourcing by the NHS as well as social care if they are to be effective and timely in restoring people to maximum independence.

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

[7] Reablement – a cost effective route to better outcomes. SCIE. (April 2011).

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

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

Sector capacity

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

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

Staffing, skills mix and training

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

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

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

Resources

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

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

Personalisation

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

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

and we have defined clearly what makes for “excellent” care.[3,4]

Dignity

19. SCIE has carried out extensive work into the area of „Dignity in Care“. Our Dignity in Care guide is the main repository for information and resources on this subject:
http://www.scie.org.uk/publications/guides/guide15/index.asp
The evidence, recommendations, resources and practice examples relating to each of these areas are available on the Dignity in Care guide. It was agreed the main themes relating to the subject of dignity in care are as follows:

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

The SCIE Dignity in Care research overview explores both what protects dignity and what threatens it. See
http://www.scie.org.uk/publications/guides/guide15/selectedresearch/index.asp

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

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

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

- Dignity
- Experience of care and support

[3] The Dignity Factors. Social Care Institute for Excellence. Guide 15.
[4] A definition of excellence for regulated adult social care services in England. SCIE. (October 2010).

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

Integrated working

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

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

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

[5] Supporting black and minority ethnic older people's mental wellbeing. SCIE report 38. (December 2010).

Care home closures

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

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

Regulation

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

Inspection

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

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

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

Financial viability

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

5 - New and emerging models of care provision.

Traditional residential care

31. A good deal of residential and nursing home care is still very traditional in its approach. It is focused on the physical and some medical care needs of residents, and is geared to the group rather than the individual. It doesn‟t take very much account of the psychological or spiritual needs of older people. Practical and recreational activities are integral parts of the residential experience in some homes, and tailored to people‟s individual interests and backgrounds. In others, the role of activities coordinator is tacked onto the job of one or two staff, and becomes operational only on the odd occasions when they have time to spare.

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

New approaches.

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

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

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

35. Outcomes-based support and care Another area of development is the adoption of outcomes-based approaches in residential and nursing homes. Until recently, both social workers and care providers might have found it alien to talk about the outcomes residential care was striving to achieve. People went there when they couldn‟t cope at home or elsewhere, and the home‟s job was to provide them with care and attention, usually until they died. Work is now under way to formulate outcomes statements and frameworks applicable to residents in care homes.

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

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

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

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

Integrated care models

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

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

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

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

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

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

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

SCIE
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