Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Nursing Directorate

Health and Social Care Committee

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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
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