Health and Social Care Committee

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

GOFAL AM GYMRU . TAKING CARE OF WALES

RESPONSE TO THE NATIONAL ASSEMBLY FOR WALES
HEALTH AND SOCIAL CARE COMMITTEE
ENQUIRY INTO RESIDENTIAL CARE FOR OLDER PEOPLE

Who are we?

Care Forum Wales is the leading professional association for independent sector social care providers in Wales and a signatory of the Welsh Government's Memorandum of Understanding *Securing Stronger Partnerships in Care.* Of particular relevance to this enquiry is the fact that our membership includes those who provide care homes and domiciliary care services for older people. Our members come from both the private and third sectors and we aim to engage and professionally support independent providers, to spread good practice, and help members provide a high quality service.

We are willing and keen to give oral evidence to the Committee, based on the experience of our members in providing care for older people. We would also be happy to facilitate the committee in visiting providers.

Our members include a variety of structures: large corporate groups, home-grown small and medium enterprises (SMEs), registered social landlords, and voluntary or charitable bodies.

Our members include organisations providing support to older people in a variety of ways:

- Residential care homes
- Nursing homes
- Domiciliary care providers, which provide social care to people in their own homes
- Extra care housing providers, offering varying levels of support facilities for tenants living in their own apartments.

Some organisations provide more than one type of service e.g. running care homes and providing domiciliary care. Some provide social care for others types of clients who need it, not just older people, and some care homes, in both the residential and nursing sectors, also provide care for

those with Elderly Mental Health (EMH) needs. As the committee will know, residential care is the care provided in a care home to those whose needs are classed as social rather than nursing. Nursing homes can accept residents who do not need nursing care (i.e. are classed as receiving residential care) but residential homes cannot care for people who need nursing care, as defined by the Funded Nursing Care provisions, i.e. more than the district nurse would normally provide. Therefore residential clients should not have unpredictable nursing needs. These complex definitions can make the sector difficult to understand for professional staff, let alone the public.

The state of residential care for older people

The committee sets out: *To examine the provision of residential care in Wales and the ways in which it can meet the current and future needs of older people*

The residential care sector has always adapted to meet expectations and needs. Where this is most apparent is in the slow, but clear, increase in the dependency of residents over the last ten to twenty years. Those currently receiving residential care, would previously have been classed as needing nursing care, while many of those currently receiving nursing care would have previously been in hospices. These changes have taken place gradually, and providers have accepted residents with such high needs voluntarily, but other changes have been hastened by statute. This can be evidenced by the move to, for example, single rooms and en suite facilities, which were once rare or an 'add on extra'. This level of service is now common and may be expected by many people who use services and by the regulators. We are also now seeing increased development of extra care housing facilities to meet the population demand.

We have three significant concerns with regard to the current provision of residential care which we feel must be addressed:

- The development of a two tier system and the inability of those who cannot self-fund to choose residential care. The perception is too often that care in a residential home is a choice of last resort, despite the fact that many residents do choose it in order to have the reassurance of 24 hour care and escape the social isolation that many experience in their own home. Information should be made available to explain the advantages and disadvantages to individuals of both home care and residential care.
- Local authority planning and commissioning arrangements, including fee setting, which in many areas do not adhere to the principles of the Welsh Government's Commissioning Framework Guidance and Good Practice *Fulfilled Lives, Supportive Communities* or the Memorandum of Understanding *Securing Strong Partnerships in Care*. This has led to fee levels in many areas which are unsustainable and do not permit the investment needed to maintain provision let alone improve it.
- The lack of sufficient incentives to encourage providers to meet the needs of increasing numbers of older people with dementia.

We expand further on these points in our answers to the Committee's questions 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.

Residential care has seen a huge transformation over the past decade. It has effectively evolved into a two tier system. Ten years ago residential homes provided support for significant numbers of people who would move around their local neighbourhood with some independence but required assistance or prompting with cooking and perhaps intimate personal care. Now, such clients are still there but, in smaller numbers, and all are self-funding. Local authorities are no longer funding people in residential care unless they are highly dependent: often unable to bear their own weight or to manage their own intimate personal care needs. Ten years ago, people who were doubly incontinent and needed two members of staff to assist them to move would have been classed as requiring nursing care. Today this is a standard profile of state-funded clients in residential care. In part, the increase in dependency can be accounted for by some people's desire to remain in their own homes for as long as possible supported by domiciliary care services as appropriate and by the development of sheltered and extra care facilities. This is welcome. However, what is not welcome, is the misfortune of those who feel isolated and afraid at home and would choose to have their complex needs met in a residential care setting but who are unable to do so as they are not able to self-fund and the local authority will no longer fund such care – even where it would be more cost effective than the domiciliary care which is being provided.

Residential care is not something any of us wish to contemplate while we are fit and well, however as our confidence and physical abilities decrease it may be the best solution for us, particularly if we would otherwise be living on our own. It is clear that many of those with the means to do so are choosing residential care, significantly earlier than those reliant on state support. These residents say that they choose to enter residential care in order to meet their needs for security and belonging in a social environment. They are often anxious and lonely, particularly at night, and want the security of knowing assistance is available on site. Others, recognising their deterioration want to move into residential care whilst they can still be in control of the process and take their time making a choice of home. Care home providers also report that often, after moving in to a care home, residents and their families express the wish that they had done so sooner.

The complex domiciliary care arrangements put into place to support people at home can be more expensive in financial terms, and also increase the marginalisation and deprivation suffered by these people who are housebound and isolated form society. This can be exacerbated by the way domiciliary care is commissioned, focussing on tasks to be performed, rather than the well-being of the person receiving the care. It is entirely right that LA commissioners should recognise the wishes, indeed the right, of people to remain in their own homes for as long as possible, but those that desire to enter residential care should have equal consideration.

All the evidence from our members indicates that those who are in a position to self-fund residential care make informed decisions to move at an earlier time when they are healthier both physically and mentally than local authority policies would normally commission. In contrast local authority funded clients frequently enter residential care due to a crisis, often involving illness or inability to cope any longer by members of their family. For example:

> A provider running a home taking both nursing and residential clients describes a Friday a few weeks ago where she was asked to take four emergency admissions. One was nursing but the other three were residential: one was admitted due to a family crisis; the other had already been admitted to a residential care home but because a risk assessment had not been done for the use of a zimmer frame was not able to stay – following an assessment they returned to the original home just over a week later; the third was admitted as the relative who cared for them was unwell: they were seen by the out of hours GP on Saturday, Sunday and Tuesday and demanded to be admitted to hospital.

These emergency admissions and high turnover of residents put considerable additional pressure on homes which are not paid an additional entry or turnover fee for such clients. The residents themselves are also often distressed by such admission processes. A manager describes an emergency admission where the transport was arranged from the ambulance service at 2 pm but did not turn up till 9pm and the client did not arrive into the home until 9.45pm. Incidents like this are not atypical for state funded residential clients and show a clear disregard for the anxiety caused to them and their relatives, neighbours and friends and the lack of respect for them as people and their dignity in being treated so indifferently in such traumatic circumstances.

There is also often a difficulty in appropriately assessing admissions in an emergency situation to ensure that the home can meet their needs and that the local authority is paying the appropriate fee to meet their dependency levels. Mistakes can take some time to rectify.

Of course residents do not always enter residential care permanently, but may do so for respite care or for reablement, Sometimes respite care can be well planned and clients may have a home where they go regularly for respite. This respite provides families and carers with well-needed support and often individuals will be managed much longer in their own homes as a consequence. Similarly reablement after a stay in hospital, or preventing an admission to hospital, can work well both in the community and in care homes that are trained to provide such a service.

We would like to see an assessment of those requiring social care that considers their future prognosis, whether they are likely to require a care home placement, and if so the risks and benefits of making that move at any particular time. The issue is often about the suitability and desirability of community based services rather than their availability per se.

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.

Staffing and training

Well trained, caring staff are absolutely vital to a good home, but often they do not feel sufficiently valued by society for the vital work that they do. We would like to see a continuing professionalization of care work, and think it is unfortunate that the decision not to continue working towards registration of "hands on" staff, gave a signal that their role was not recognised. Ideally we would like to see a professional organisation for care staff, for example a revival of the Academy of Care Practitioners.

Providers have also been concerned, in times of high employment, that it has been difficult to retain staff and turnover can be high. This is often due to the lack of resources to improve staff pay and conditions. Providers would like to improve staff terms and conditions, where possible, to those of the NHS and local authority employees, but this is not feasible at the current fee levels paid by local authorities. The current economic climate has made recruitment and retention less pressured. However, members are concerned that any economic upturn combined with stricter restrictions on immigration may make recruitment more difficult again.

Many of our members are Small and Medium Enterprises (SMEs), but often find that despite the professed intention of Welsh Government and local authorities to grow and support SMEs and encourage the spending of the Welsh pound in Wales, there is less recognition of the role they can play in creating employment than there is for those working in, for example, the tourism or energy sectors. If we want high quality provision as a nation, we must invest in the training and development of social care staff and see them as a vital part of the economy. Social care should be seen as important, both in terms of meeting a need, but also in terms of providing employment. Like many other employers social care employers would like to be able to recruit staff with better basic skills.

We would also like to see an improved development of training provision. Some councils offer excellent free training courses which we would like to see replicated everywhere. Care Forum Wales provides some training to its members and generally find this is extremely well received. However, often training providers are not properly quality assured by regulators there is a superficial audit trail based upon attaining targets at any cost. In many cases training provision has been reduced to a rigid unimaginative process, driven by funding rather than quality of outcomes for the people we support.

Number of places and facilities

The Commissioning Framework Guidance and Good Practice *Fulfilled Lives, Supportive Communities* was published by Welsh Government in 2010. Key standards require local authorities to ensure:

- Commissioning plans have been developed with partners and have involved all key stakeholders including users, carers, citizens and service providers in the statutory, private and third sector.
- The local authority has ensured that its Financial and Contract Standing Orders allow social care commissioners to be efficient and effective in developing the local social care market.
- Commissioners have understood the costs of directly provided and contracted social care services and have acted in a way to promote service sustainability.

The Memorandum of Understanding *Securing Strong Partnerships in Care* was signed by all the key players, including Welsh Government, the WLGA, ADSS Cymru and ourselves in 2009. We all agreed to respect each other's commitment to best outcomes for people in need. We regret that there has not been as much progress on this as we would have liked on a local level where our members too often report still experiencing distrust from commissioners. We feel it would be useful for commissioners to spend time in homes, getting to know how they work, in order to ensure a better understanding of the sector by those commissioning from it. We also think providers would benefit from an enhanced dialogue with commissioners about the types of services they are likely to commission in the future.

A number of residential homes have closed recently, due to the decline in residential placements by local authorities outlined above. Despite this in some areas of the country there remains over-supply of residential beds compared to funding of places. However, we still see successful residential homes in populous areas, providing an excellent service that are full with a waiting list. It is often significantly harder to find an Elderly Mental Health (EMH) placement than it is to find a general residential placement.

All demographic predictions indicate not just an increase in life expectancy, but a substantial increase in the number of older people with dementia. There appears to be little evidence of joint planning with all partners on the future need for this type of provision in Wales and as a consequence there is currently across much of Wales a shortage of provision for EMH placements. Some of the barriers to existing providers moving in to EMH are:

- How to manage the switchover – EMH residents are often perceived as noisy, disturbing others and needing increased security measures – few homes are constructed in a way to facilitate this changeover with existing residents and new EMH residents easily.
- Providers often feel this would be a great leap into the unknown and that the increased fees for EMH placements do not fully account for higher staffing costs, increased specialist equipment, specialist activities, increased wear and tear on the building and increased staff training needs.

If the need for a greater number of EMH placements is to be met, as identified, by statistical projections such as Daffodil funded by Welsh Government, and local planning, we believe stronger incentives must be provided to reassure and encourage providers that commissioners are serious about purchasing this type of care in the future.

Resources

In general, financial resources in the independent sector are extremely tight. Fees are too low and often do not cover reasonable costs. An ordered list of the lowest residential fee paid by each local authority is attached as an appendix. It can be seen that many authorities are paying less than the cost of a night in a budget hotel, for the care and sustenance of vulnerable elderly people requiring significant levels of assistance with personal care and many aspects of daily living. On these sort of fees many businesses only remain viable based on charging residents a top up fees, private residents paying a higher rate, delaying repairs and capital investment, and owners working extremely long hours for low returns.

The level of fees across Wales is something of a lottery. The lowest fee for basic residential care is £316.60 per week in Carmarthenshire and the highest £504 per week in Newport and Torfaen. Although there are some local variations in both cost and the needs of those placed, we do not believe such a large variation can be justified. Nor do we believe that £316.60 comes anywhere close to covering the actual costs of care.

Quite rightly residential care is heavily regulated. Staff costs are the most significant element of a home's budget, followed by food and power. All these areas have seen inflation above RPI in recent years and are difficult to find significant savings in. We recognise, of course, that this is a difficult time for local authority budgets, but in the care sector there is no fat to trim. Anything other than a fair increase to meet additional costs can only adversely affect the vulnerable older people being care for. Our members, like other businesses are finding that many lenders are changing terms and increasing pressure. Examples include banks requiring homes to be profitable at 85% occupancy, even when their occupancy is consistently over 90%, in order to secure lending.

Everyone wants to see a sustainable care sector. Yet a recent report from Wilkins Kennedy Accountants indicates that the number of UK care homes going into administration has more than doubled from 35 in the year to end September 2010 to 73 to end of September 2011. The media attention has focussed on Southern Cross, but we have also seen a number of smaller companies go under including north Wales-based Southern Care Group, and South West Wales based Kappians care. Without fees covering costs we fear that we will see more homes, particularly those in less affluent areas where private clients are unable to subsidise state-funded ones, go to the wall.

Fees are of course a difficult issue for local authorities. In many areas they are in a monopsony position: they are by far the biggest buyer of residential care home services with a small market of private self-funders and some NHS commissioned continuing healthcare. In such a market there needs to be an intervention to ensure fair fees are set: fair to both providers and council tax payers. In 2004, the Welsh Local Government Association commissioned William Laing to develop a fair means of determining fees in Wales. However, the resulting toolkit has never been fully implemented.

We are concerned that we are seeing an increasing development of individual local authorities using consultants to develop their own questionnaires to local care homes to set fees. While we agree that it is important to take into account local factors, we are concerned by the cost and complexity of some of these questionnaires. They often fail to take into account of significant factors and by

increasing complexity, increase the overall cost of the system to both the local authority and to providers.

We hope that the intentions of Welsh Government spelled out in *Sustainable Social Services for Wales: a framework for action and* the report to the Minister for Social Services and Local Government *Local, Regional, National: what services are best delivered where?* will help us move away from 22 different commissioning arrangements towards a more streamlined approach, more suitable to a country the size of Wales.

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;

We see evidence of some extremely good residential provision in Wales, and Care Forum Wales is keen to promote quality by providers. Good providers provide a service that residents and families want and, as part of their quality assurance programmes, collect feedback from service users and their families and make changes accordingly. They also provide care to meet the needs of each individual service user through an individual care plan recognising and understanding their history and diversity of needs. In a country the size of Wales it is important that we have the mix right to ensure, as far as is possible, a variety of provision to meet the needs and desires of those entering residential care. Some will prefer a small home, some a larger one, some provision with hotel-style all mod cons, others something more homely. There is also a place for homes catering to particular needs e.g the Polish home in Gwynedd or the Jewish home in Cardiff, which cater for a specific community. Commissioning plans must take into account the desire for this diversity. For example, a fee setting regime that only looks at larger homes costs cannot meet the desire of some residents to live in a small home, if they are unable to stay in their own home.

We of course recognise that there are providers that are less good than others and believe that commissioning policies should be focussed on ensuring that good homes thrive and others improve or are driven out of the market.

We also would like to see consideration given to the fact that a care home can become an individual's home. A consultation is currently under way to consider whether those residents who develop EMH needs should continue to be required to move, or the home seek a variation in its registration, if their needs could be met by appropriate staff and training. Similarly palliative care for those nearing the end of their life can now be provided in a person's own home, if they wish to remain there and someone is available to take on appropriate tasks after training. Consideration should be given to whether in certain circumstances palliative care should be made available in residential homes, rather than force a resident nearing the end of their life to move to a nursing home.

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

We are pleased the indications that we have had from CSSIW about their intention to focus in the future on service user experience rather than box ticking and await with interest to see how this

new regime develops. We recognise the need for strong and effective regulation and inspection of the sector. We are also keen that it is not over burdensome: every minute that providers spend filling in forms and dealing with inspection regimes are minutes that are not spent directly improving the care in the home or supporting a vulnerable person.

We are also keen that local authority commissioners use the resources of CSSIW inspections to support their role. It is important that what could effectively be a parallel system of inspection is not created with similar, but not necessarily identical, forms to complete, similar visits etc. Regulation and inspection arrangements should always be proportionate and the burden placed on providers is a key component within that.

Of course there may be circumstances where drastic action is needed, but in the main, and at its best, inspection should be a tool that assists providers in improving and supporting their service where appropriate not a stick to beat them with.

Similarly any move to increase the scrutiny of providers' financial viability must look at the issue in the round. Any concerns should be used to help identify ways in which providers may be able to help themselves. There also needs to be a recognition of the pressure lenders are placing on homes with regard to financial viability and the appropriate level of resourcing in terms of care home fees.

New and emerging models of care provision.

As we said earlier care provision has always adapted to meet the needs and wants of citizens. Extra care and technological developments in terms of telecare etc. are all important developments in meeting the care needs of some people. We are also seeing the increasing development of smaller units in larger homes, to meet some people's desire to be an a more homely atmosphere while recognising commissioners' desires to fund larger homes that provide economies of scale. However, we cannot see a situation in which residential care as we know will not continue to be the right answer for some individuals. The independent sector has always been flexible and will offer services that commissioners and individuals want. How that care is provided requires future planning either on a local or regional basis with input from all parties. This is the key to meeting the needs of the population of Wales.

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.

Our members include both private and not-for-profit providers. We believe a variety of funding mechanisms help to provide a diversity of provision and we can learn from the best in each sector. It is also important to the ecology of the provision in care that no provider becomes too dominant. We must of course remember that care homes requires significant investment in buildings, equipment and their maintenance and any provision must have access to sufficient capital to provide this.

There has been a move by local authorities away from their own in house care provision. Initially this was perceived by some councillors as being a loss of control and against their inbuilt social care principles. In fact they appear to have recognised increasingly is that independent social care providers are able to make better quality provision at a fraction of the cost that their own homes need. They also have recognised that the commissioning guidance has given them the freedom to plan more effectively for future needs and to look more objectively to the needs of their local communities. They have also found that independent providers have been able to adapt to changing needs within each care centre as the workforce accept change more readily. Now the independent sector provides the vast majority of the care beds across Wales we need to ensure that it remains quick to respond to ever changing demands and is financially viable to ensure the communities of Wales have the care provision they will need in the future.

Appendix 1 – lowest fee paid per resident per week for older people's residential care

It should be noted that we may not be comparing like with like as some authorities with lower fees may place less dependent residents than those with higher fees.

	Basic Fee
Newport	504
Torfaen	504
Rhondda Cynon Taff	478
Pembrokeshire	469
Vale of Glamorgan	468
Bridgend	462
Swansea	450
Conwy	448
Ceredigion	440
Flintshire	437.76
Monmouthshire	430
Neath Port Talbot	426
Ynys Môn	423
Blaenau Gwent	402
Caerphilly	401
Merthyr Tydfil	389
Gwynedd	371.97
Powys	354
Denbighshire	348
Wrexham	342.44
Cardiff	324.2
Carmarthenshire	316.6